

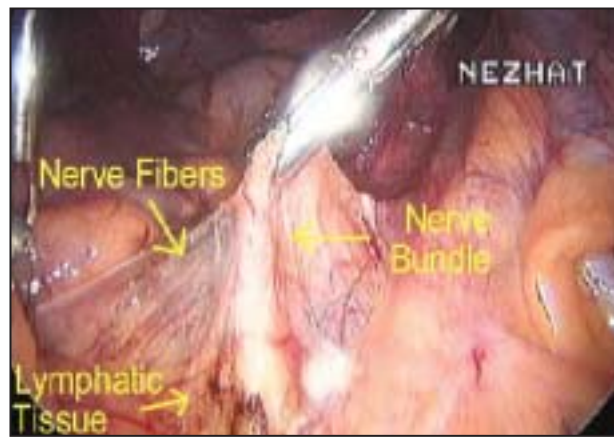
Continued from previous page

electrocoagulator. If harmonic shears are used, this is rarely necessary.

After removing retroperitoneal lymphatic and fatty tissue, we reach the hypogastric plexus and can identify the presacral tissue.

The nerve plexus is grasped with an atraumatic forceps, and using blunt and sharp dissection, I skeletonize, desiccate, and excise the nerve fibers.

All the nerve fibers that lie within the boundaries of the interiliac triangle must be removed, including any fibers entering the area from under the common iliac artery and over the left common iliac vein.



The presacral tissue is identified, and the nerve plexus is grasped with an atraumatic forceps.



All the nerve fibers that lie within the boundaries of the interiliac triangle have been removed.

I then irrigate the retroperitoneal space and coagulate bleeding points, if any. Sutures are not required to approximate the posterior peritoneum. The area heals completely on follow-up, and is covered by the peritoneum.

I send excised tissue for histologic examination to verify removal of nerve elements and ganglion.

The Outcomes

In 1992, we described a laparoscopic method of presacral neurectomy, based on Cotte's principles and technique, as part of a report on 52 patients with disabling midline dysmenorrhea and varying severity of endometriosis, all of whom had been unresponsive to medical treatment.

Of the 52 patients who were followed for more than a year, 48 (92%) reported relief of dysmenorrhea, and 27 (52%) reported complete pain relief (BJOG 1992;99:659-63).

In 1998, we reported even longer-term outcomes (up to 72 months) in 176 women with central pelvic pain who underwent laparoscopic presacral neurectomy and treatment of endometriosis. Pain was reduced substantially in 74% of the women, and just as notably, the degree of pain improvement was not directly related to the stage of endometriosis.

A reduction in pain of more than 50% was reported in 69.8% of women with stage I endometriosis (using the revised classification of the American Fertility Society), 77.3% of those with stage II, 71.4% of those with stage III, and 84.6% of those with stage IV endometriosis (Obstet. Gynecol. 1998;91:701-4).

We were discouraged from offering patients treatment in a blinded manner because a randomized trial conducted not long before this had been stopped in an early stage by a monitoring committee when the efficacy of presacral neurectomy became clear.

In this prematurely halted study, Dr. B. Tjaden, Dr. John A. Rock, and associates at Johns Hopkins University found that of 17 patients undergoing the procedure (all had moderate to severe dysmenorrhea and stage III-IV endometriosis), only two had recurrence of pain and the remainder remained pain free at 42 months of follow-up.

Of the nine patients who underwent resection of endometriosis but not presacral neurectomy, none had relief of midline pain (Obstet. Gynecol. 1990;76:89-91).

Although Dr. Rock and his team found that relief of dyspareunia was variable in both groups, we and others have had success in treating this manifestation of pelvic pain.

In our study published in 1998, a reduction in dyspareunia by more than 50% was seen in 32 of 60 patients followed for 24 months or longer.

More recently, Dr. F. Zullo and associates published the 2-year success of laparoscopic presacral neurectomy, reporting significant reduction in the frequency and severity not only of chronic pelvic pain and dysmenorrhea but of dyspareunia as well (J. Am. Assoc. Gynecol. Laparosc. 2004;11:23-8).

Laparoscopic uterosacral nerve ablation is an easier procedure to perform than laparoscopic presacral neurectomy, but it has been proved to provide only temporary re-



Presacral space on second look: The area heals completely on follow-up.

lief and not the longer-term pain reduction that presacral neurectomy can achieve in most cases. I liken it to trimming a weed in your yard versus pulling the weed out by the roots.

The Complications

The most common and urgent intraoperative complication is bleeding, and we must be prepared, in the event of injury, to actively identify the anatomy and determine the feasibility of the repair laparoscopically, or to immediately convert to laparotomy.

We have not had any major complications, but the slight risk of vascular injury and the possible need to convert to laparotomy is something that patients should be informed of.

Long-term complications with presacral neurectomy are uncommon. Urinary urgency, poor bladder emptying, and constipation have been reported occasionally, as has vaginal dryness during sexual arousal.

We have not had any major complications such as vascular injury, gastrointestinal injury, or genitourinary injury in any of our presacral neurectomy procedures. Nor did any of these cases require conversion to laparotomy or transfusion.

Our initial (1992) study revealed no major intraoperative or immediate postoperative complications.

However, of the 52 women followed after 1 year, seven women reported either constipation (three patients), urinary urgency (one), vaginal dryness (one), or "painless labor" (two). These are all among the issues that we routinely cover in our patient counseling.

In conclusion, procedural failure, of course, is an important long-term complication, but the most common reasons for failure—poor patient selection and incomplete neurectomy because of neurologic variability or failure to remove all nerve tissue within the interiliac triangle—can, in most cases, be avoided with proper training and preparation. ■

No Link Found Between IBS and Elective Gynecologic Surgery

BY PATRICE WENDLING
Chicago Bureau

MILWAUKEE — Irritable bowel syndrome did not result from elective gynecologic surgery in a large prospective binational study of 255 women.

There was no significant difference in the development of irritable bowel syndrome (IBS) at 3 and 12 months' follow-up among 132 women who underwent elective gynecologic surgery for disorders not related to pain and 123 age-matched controls who went for consultation at a gynecology clinic but did not undergo surgery. None of the women had IBS at baseline.

However, significantly more surgical patients than controls developed persistent abdominal pain (14% vs. 2%, respectively), Dr. Ami D. Sperber reported at an inter-

national symposium sponsored by the International Foundation for Functional Gastrointestinal Disorders.

The development of persistent pain was predicted by psychosocial factors, but not by sociodemographic or clinical variables, according to an analysis that included surgery type (hysterectomy, tubal ligation, cystectomy); laparotomy versus laparoscopy; surgery duration; amount of postoperative analgesia; and surgical complications.

"One might think—and this is still speculative—that the development of persistent pain could be associated more with central registration and amplification of the afferent signal via cognitive and emotional input, rather than with the degree of the actual peripheral injury per se," said Dr. Sperber, associate professor of medicine, Soroka Medical Center, Ben

Gurion University of the Negev, Beer-Sheva, Israel.

Women who anticipated difficulty in recovering from surgery were more than five times as likely (odds ratio [OR] 5.2) to develop persistent abdominal pain, according to results from psychosocial evaluations that included the Implicit Models of Illness Questionnaire, Client Satisfaction (CSQ) scale, and Sense of Coherence (SOC) scale.

Persistent pain also was more likely to occur among women with a strong personal need for control (OR 1.2), those who perceived their disease as being more severe or constant (OR 1.9), and those who had lower coping skills (OR 1.09), reported Dr. Sperber and coinvestigator Dr. Douglas Drossman, professor of medicine and psychiatry and codirector of the Center for Functional GI & Motility Disorders, Uni-

versity of North Carolina at Chapel Hill.

Although the findings are still preliminary, they could be used to identify women with a similar profile and to conduct interventions before surgery that would improve coping skills or reduce catastrophizing, Dr. Sperber said in an interview.

Prior studies show that patients with IBS undergo more gynecologic operations, particularly hysterectomy, than women in the general population. But it's unknown whether women with IBS undergo more surgery or whether gynecologic surgery can cause IBS or new bowel symptoms such as constipation.

Constipation was increased among the women in the study, but did not differ significantly between groups, said Dr. Sperber at the meeting, which was cosponsored by the University of Wisconsin. ■