

Reroute Laparoscopic Entry in Select Patients

Subumbilical adhesions from previous surgeries are a major cause of complications and visceral injury.

BY KATE JOHNSON
Montreal Bureau

LONDON — Physicians attempting laparoscopic entry in patients who have had previous abdominal surgery should consider an alternative to the traditional umbilical entry port, recommended Colin Davis, M.D., associate clinical director of gynecology at St. Bartholomew's Hospital.

Subumbilical adhesions from previous surgeries are a major cause of laparoscopic entry-related complications and can lead to visceral injury secondary to Veress needle or trocar insertion, he said at the annual congress of the Interna-

tional Society for Gynecologic Endoscopy. "This is an uncommon, but serious complication of laparoscopic surgery and a major cause of [medicolegal] claims," he said, adding that the Palmer's point entry in the left upper quadrant avoids blind entry in the umbilicus—the area most likely to contain adhesions from previous surgery.

"We should all become familiar with an alternative entry point for patients with a history of previous abdominal surgery," he said, specifying that this would include patients who've had one previous Pfannenstiel, suprapubic, transverse, or midline laparotomy.

This approach also should be considered

in patients who are overweight and in patients with whom entry through the umbilicus is difficult, he said.

Dr. Davis' group assessed the prevalence of subumbilical adhesions in a prospective study of 96 women undergoing Palmer's point entry procedures.

Subumbilical adhesions were seen in 57% of those with a history of one Pfannenstiel laparotomy and 66% among those who'd had two previous Pfannenstiels. Women with a previous midline incision had a 92% risk of subumbilical adhesions.

Overall, 32% of adhesions contained bowel, he reported. There were no subumbilical adhesions in women who were considered low risk for adhesions but who underwent Palmer's point entry due to difficult initial insufflation, large ovarian cysts extending to the umbilicus, or patient preference to avoid an umbilical scar.

According to Dr. Davis, Palmer's point entry is well described, but it is not routinely used in high-risk patients, even though it is easy to learn.

To perform the entry, a Veress needle is introduced 3 cm below the subcostal line on the left, and the peritoneal cavity is insufflated.

Then a 5-mm trocar is introduced, followed by the laparoscope, and the secondary points are then made under direct vision.

"The main disadvantage is a slightly altered perspective of the pelvis because you are looking at it from a different angle," he said.

In addition, physicians should be prepared to have to push slightly further to gain entry into the peritoneal cavity, since the tissue is slightly thicker than it is at the umbilicus. ■

Newer Version of Endometrial Ablation Technique Said to Boost Satisfaction

BY KATE JOHNSON
Montreal Bureau

LONDON — A newer version of the Thermachoice endometrial ablation system shows better efficacy and patient satisfaction than one of its predecessors, according to data presented at the annual congress of the International Society for Gynecologic Endoscopy.

New clinical efficacy data on the Thermachoice III balloon ablation system, which was approved in 2003 by the Food and Drug Administration, suggest it is an improvement on the first Thermachoice system, said Fiona Marsh, M.D., who presented two studies that were partially funded by Gynecare, which makes the product.

Thermachoice was launched in the United States in 1998, and Thermachoice II, a revised version of the system, had its U.S. launch in 2000. Thermachoice II was not marketed in England, where Dr. Marsh practices. The two studies she presented at the meeting focused on Thermachoice III.

"My results on patient satisfaction and symptom reduction with Thermachoice III do look better than results that have been published for Thermachoice I," she told this newspaper.

"These are also the first data on the feasibility of performing Thermachoice III in the outpatient setting—information which is imperative for clinicians to be able to counsel women appropriately," she said.

Gynecare data suggest that Thermachoice III achieves greater thermal effect and depth of necrosis than the original version, but to date there have been no studies assessing symptom reduction or pain with the procedure, said Dr. Marsh, a clinical research fellow at St. James's Hospital, Leeds, England.

Her first study found improved patient satisfaction with the treatment in both the office and hospital outpatient settings—with improvements in dysmenorrhea in 87%, improvements in irregular menstruation in 66%, and improvements in quality of life in 84% of the 44 women in the study. Overall, 87% of the women said they were satisfied with the effects of the treatment—an improvement over previous studies showing a 67% satisfaction rate with the original Thermachoice, Dr. Marsh said.

The second study assessed intraoperative pain with Thermachoice III in patients treated in the office setting without local analgesia or intravenous sedation.

"Since Thermachoice III provides deeper and wider endometrial coverage, compared with the earlier version, we wanted to see if this had an effect on intraoperative pain scores" in patients treated in the office, Dr. Marsh said.

A total of 38 women with menorrhagia were included in the study. For pain prevention, they were given high-dose ibuprofen (800 mg) orally the night before the procedure and again 1 hour before undergoing endometrial ablation.

Intraoperatively, the women were offered rescue analgesia in the form of inhaled nitrous oxide, and after surgery they had the option of having tramadol 100 mg.

A total of 32 women (87%) were able to complete the 8-minute treatment, with 5 requesting it be stopped because of pain.

Using a visual analog scale, with 10 de-

scribing the worst pain possible, 15% women reported scores of at least 7, including 3 reporting a score of 10.

Twenty-nine percent of the patients requested rescue analgesia, compared with the 12% rate in her unit when the original version of the system was used.

"Performing Thermachoice III in the [office] setting is tolerable for the vast majority of patients, and pretreatment with ibuprofen meant most patients did not need intraoperative rescue analgesia," Dr. Marsh said.

"This provides women with an [in-office] option, if they would prefer to avoid general anesthesia," she said.

Most of the patients went home about a half hour after they finished the treatment session.

"None of them came back with complications, and 5% called about cramping. Most of them used ibuprofen for 2-3 days after the procedure," Dr. Marsh said. ■

ThermaChoice III in the office setting was tolerable for the vast majority of patients, and use of ibuprofen meant most did not need rescue analgesia.

Essure Sterilization Safe, Effective at 5 Years

SAN FRANCISCO — Hysteroscopic sterilization with Essure microinserts appears safe and effective for at least 5 years after the procedure, according to a poster presented by John F. Kerin, M.D., at the annual meeting of the American College of Obstetricians and Gynecologists.

Dr. Kerin of Flinders Medical Centre, Adelaide, Australia, and colleagues from the Selective Tubal Occlusion Procedure 2000 Investigators Group followed 643 women for up to 5 years after they underwent the procedure. All women had received bilateral placements of Essure microinserts as part of phase II or phase III clinical trials sponsored by Con-

ceptus Inc., the device's manufacturer.

Not a single pregnancy occurred in 29,357 woman-months of follow-up, Dr. Kerin reported. The age-adjusted cumulative bayesian effectiveness rate at 5 years was 99.74%.

Patient tolerance, comfort, and satisfaction were measured at seven or eight visits during the follow-up period.

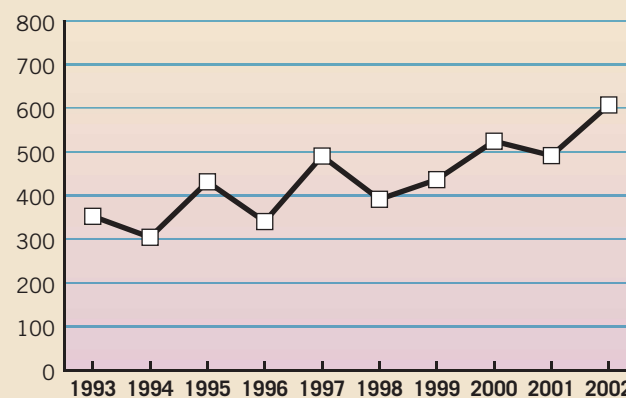
At all visits, 99% of women rated their tolerance of Essure as "good" or "excellent," 99% rated their comfort as "good" or "excellent," and 97% rated their satisfaction as "satisfied" or "very satisfied."

No women reported persistent pain or bleeding.

—Robert Finn

DATA WATCH

In-Hospital Deaths From Postoperative and Posttraumatic Infections Are on the Rise



Note: Based on weighted estimates from the Healthcare Cost and Utilization Project nationwide inpatient sample.
Source: Agency for Healthcare Research and Quality