

UAE Edges Myomectomy in Terms of Recovery

BY KERRI WACHTER
Senior Writer

CHICAGO — Uterine artery embolization appears to have a slight edge over myomectomy in terms of recovery after treatment of uterine fibroids, according to data presented during the annual meeting of the Radiological Society of North America.

Uterine artery embolization (UAE) was “superior in terms of adverse events, time off from work, time until the resumption of normal activities, and hospital stay,” said Scott C. Goodwin, M.D., who is the chief of imaging services at Greater Los Angeles Veterans Affairs Medical Center.

UAE was superior for hospital stay, time off, and time to resume activities by a roughly three to one margin.

In the prospective study, 149 patients underwent UAE and 60 underwent myomectomy. Embolization was performed with Contour PVA particles.

Patients were included in the study if they were older than 30 years and had symptomatic fibroids. Women in the UAE group did not desire to become pregnant. The researchers collected overall and fibroid specific quality of life scores (QOLs) before the procedures were undertaken.

Women in the UAE group

were older, more likely to have been previously pregnant, and to have had longer periods than those in the myomectomy group. Myomectomy patients were more likely to have a miscellaneous pelvic abnormality or a tubal ligation and to have had more fibroids than UAE patients.

“In terms of the QOLs, we did not find an overall difference [between the two groups], though if you look specifically at the 36-40 age group, there were some differences in terms of sleep, mental health, and restricted activity in favor of the UAE group,” Dr. Goodwin said at the meeting.

There was also no significant difference in terms of reduction of uterine volume or in bleeding score reduction.

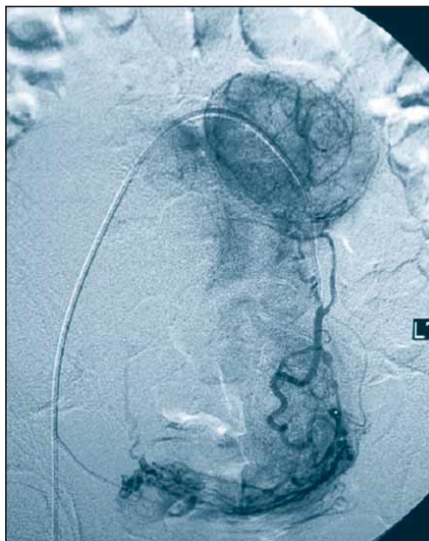
Though the major efficacy outcomes were similar between the two groups, the study was not powered sufficiently to determine whether there were actually any statistically significant differences between groups in terms of efficacy, Dr. Goodwin said.

The adverse event rate (UTI

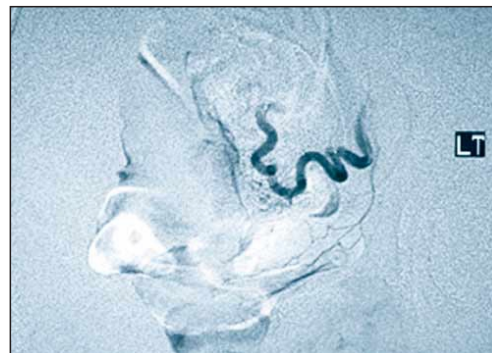
and vaginal discharge, among others) in the UAE group was 22%, compared with 40% in the myomectomy group (UTI, hemorrhage, and others).

The major adverse event rate was 4% in the UAE group, compared with 1.7% in the myomectomy group.

Major adverse events included significant postembolization syndrome—described as flu-like symptoms—enlargement of a multicystic adnexal mass, excessive vaginal discharge, and a ruptured appendix (not related to the procedure).



The uterine artery is shown before UAE.



This angiogram shows the same artery after UAE.

Due to study design, among the women in the UAE group, 19% were considered failures (including 4 patients who withdrew consent, 10 who were lost to follow-up, and 8 who failed to meet QOL

criteria, among others).

In comparison, the failure rate was 25% in the myomectomy group (including five patients who failed to meet QOL criteria, one patient requiring a hysterectomy, and three patients who were lost to follow-up, among others).

Despite the findings, not all women are good candidates for UAE.

Dr. Goodwin does not recommend that women undergo the procedure if they are not symptomatic. Instead, he advises them to watch and wait, he told

this newspaper.

Fertility is also a consideration. There is some risk of premature ovarian failure following embolization, though this varies with age.

He estimated that a woman under 35 years has very little chance of this occurring, while a woman under 40 has a roughly 1% chance. Over the age of 50 the risk goes up to 30%-40%.

“So if you have a 45-year-old woman—who has not had children—who is really trying to get her last shot at having a baby, she would probably be better served by a myomectomy,” Dr. Goodwin said.

Uterine artery embolization is also contraindicated in women with a severe allergy to the contrast dye used in imaging and in women who have poor renal function, he said. ■

Left Upper Quadrant Called Safe Alternative for Umbilicus Entry

SAN FRANCISCO — The ninth intercostal space in the left upper quadrant provides a safe alternative to umbilicus entry for laparoscopy when the patient has adhesions, Neena Agarwala, M.D., reported in a poster presentation during the annual meeting of the American Association of Gynecologic Laparoscopists.

In a large retrospective study, Dr. Agarwala of the University of Nebraska Medical Center, Omaha, studied all 918 laparoscopies performed over a 6-year period on patients with surgical scars at a university hospital and a community hospital. Of those 918 laparoscopies, 504 (55%) of the patients had umbilical adhesions.

Using the alternate entry position in the left upper quadrant resulted in no trocar-related injuries and only two Veress needle-related injuries.

One was a needle puncture to the left lung margin resulting in transient pneumothorax,

and the other was a Veress needle placement in the stomach, which was recognized and repaired immediately.

Extensive adhesion lysis resulted in two bowel injuries that required additional surgery via laparotomy.

The curvature of the rib together with the rigidity of the peritoneum in this area provides a protected space free of all intraabdominal organs.

The left upper quadrant technique involves the insertion of the Veress needle parallel to the anterior thoracic wall. The needle's course goes along the interior aspect of the ninth rib.

The curvature of the rib together with the rigidity of the peritoneum in this area provides a protected space free of all intraabdominal organs, Dr. Agarwala said.

The umbilical adhesions in these patients resulted from one of three causes. Of the 504 patients with adhesions, 62% had a prior abdominal wall incision, 22% had a prior Pfannenstiel incision, and 16% had a prior laparoscopic incision.

—Robert Finn

Nerve-Sparing Technique Said to Cut Complications in Deep Endometriosis

SAN FRANCISCO — A laparoscopic procedure that preserves the hypogastric and pelvic splanchnic nerves appears to reduce urinary retention after treatment of deep pelvic endometriosis, Paulo Ayroza Ribeiro, M.D., reported at the annual meeting of the American Association of Gynecologic Laparoscopists.

In a prospective, nonrandomized study, Dr. Ayroza Ribeiro of Santa Casa Medical School in São Paulo, Brazil, first treated 25 women with laparoscopic radical excision of paracervical deep pelvic endometriosis using standard techniques. Then, after introducing the nerve-sparing technique, he treated an additional 25 women.

Nine of the 25 who underwent the standard procedure experienced urinary retention on day 1 following the operation, 4 still had urinary retention on day 3, and 2 still had urinary retention on day 30.

By comparison, 2 of the 15 women who underwent the nerve-sparing procedure experienced urinary re-

tention on day 1, but all were better by day 3.

The differences in the number of women experiencing urinary retention were statistically significant on day 1, day 3, and day 7 after the procedure.

“Anyone who gets a patient with urinary retention for 30 days, 6 months, 1 year, knows that this is a really great problem,” Dr. Ayroza Ribeiro said at the meeting. “That’s why we developed these kind of techniques,” which built upon the work of Marc Possover, M.D., currently of the University of Cologne, Germany.

The new technique starts with a paracervical and pararectal space dissection with identification and preservation of the hypogastric and splanchnic nerves.

It continues with the laparoscopic radical excision of deep pelvic endometriosis using traditional surgical techniques such as blunt dissection and bipolar coagulation. ■

—Robert Finn