over the past several years, the number of office-based gynecologic surgical procedures has skyrocketed. Factors cited in this trend toward in-office surgery are better reimbursement, greater efficiency for both patient and physician, as well as the ability to provide a familiar environment for the patient. Both diagnostic as well as operative hysteroscopy are two such procedures that easily can be converted to the office setting.

Key Studies

Vaginoscopy has been described in the literature as far back as the 1950s and continues to be used for diagnosing vaginal endometriosis, pelvic floor dysfunction, and cervical lesions. A recent study evaluated the use of vaginoscopy in patients with endometriosis and found that it is a safe and effective procedure with minimal complications.

Vaginoscopy in Practice

A common concern from the inception of in-office surgery is patient comfort. With the use of anesthetic agents, convalescence both in the office setting as well as at home may be extended. Furthermore, the cost of the procedure will be increased, thus affecting overall reimbursement. Physicians report that most gynecologists are uncomfortable providing even conscious sedation for their patient in the office. Thus, the key to successful transition to surgery in an office setting would be to modify the procedures to minimize pain. Vaginoscopy allows such an approach to both diagnostic and operative hysteroscopy.

I am especially pleased that my associate, Dr. Aarathi Chokkeri-Singh, has agreed to write this edition of the Master Class in Gynecologic Surgery on vaginoscopy. After completing her residency at Advocate Lutheran General Hospital, a large teaching hospital in a Northern suburb of Chicago, Dr. Chokkeri-Singh went on to complete an AAGL/American Society for Reproductive Medicine Fellowship in minimally invasive gynecologic surgery at Harvard Medical School and Brown University hospital affiliates. It was during her training that Dr. Chokkeri-Singh gained experience with in-office vaginoscopy under the watchful eye of noted hysteroscopic guru Dr. Keith Isaacs.

Now the associate director of minimally invasive gynecologic surgery at Advocate Lutheran General Hospital, Dr. Chokkeri-Singh’s practice is concentrated on minimally invasive gynecologic surgery and office gynecology. She will be a featured speaker at the AAGL’s 38th Global Congress of Minimally Invasive Gynecology this month in Orlando.

Dr. Miller is clinical associate professor, University of Chicago and University of Illinois at Chicago, immediate past president of the AAGL, and vice president of the International Society for Gynecologic Endoscopy. He is a reproductive endocrinologist in private practice in Schaumburg, Ill., and Naperville, Ill., the director of minimally invasive gynecologic surgery at Lutheran General Hospital in Park Ridge, Ill., and the medical editor of this column.

Continued on following page
Uterosacral nerve ablation via laparoscopy failed to improve chronic pelvic pain, dysmenorrhea, dyspareunia, and quality of life in a clinical trial four times larger than any previously published study of the issue, according to a report in JAMA.

Laparoscopic uterosacral nerve ablation (LUNA), using either lasers or electrodes, has become increasingly popular for chronic pelvic pain, even though systematic reviews of the evidence have been “inconclusive” as to the procedure’s benefit. “Clinicians’ beliefs about LUNA’s effectiveness vary widely,” and LUNA remains a controversial procedure, reported Jane Daniels of Birmingham (England) Women’s Hospital, and her associates.

The investigators performed a randomized study of 487 women with chronic pelvic pain undergoing laparoscopy for a differential diagnosis at 18 British hospitals. Intraoperatively, the women were assigned to undergo immediate LUNA or no nerve ablation. The women were blinded to their treatment assignment.

“The ablation was performed as close to the posterior aspect of the cervix as possible and continued for a minimum of 1 cm posterolaterally on either side with the intended aim of destroying the sensory nerve fibers and the secondary ganglia as they left the uterus and lie within the uterosacral ligaments,” Ms. Daniels and her colleagues noted. “Full or partial transaction of the ligaments was achieved bilaterally with laser or electrodethery, according to the surgeon’s preference.”

Median follow-up was 69 months. The patients assessed their pain and health-related quality of life at 1, 3, and 6 months and 1, 2, 3, and 5 years post procedure. The investigators found no differences between women who had LUNA and those who did not in terms of severity of chronic pelvic pain, dysmenorrhea, or dyspareunia at any of those time points, Ms. Daniels and her colleagues reported (JAMA 2009;302:955-61).

There also was no difference in health-related quality of life. One year after the procedure, the two groups reported a similar number of visits to their general practitioners and a similar number of days off work from work.

There were eight cases of minor hemorrhaging during the LUNA procedure and one case that required conversion to an open surgery.

The investigators reported no financial conflicts of interest.

BY MARY ANN MOON

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