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the diameter of the hysteroscope, which often helps alleviate any anxiety. In rare cases, if a patient is very anxious and worried about her tolerance for the procedure, or if the procedure is expected to be unusually long, I will prescribe Valium (diazepam). Usually such patients are young and have never experienced a gynecologic procedure before. In practice, however, I have almost never needed to use any local anesthetic.

I do premedicate patients—especially nulliparous patients and postmenopausal patients with stenotic cervixes—with Cytotec (misoprostol) to facilitate an easier entry of the hysteroscope into the cervix.

I use a 3-mm single-flow rigid hysteroscope for diagnostic purposes and can quickly add the operative sheath, making the hysteroscope a 5-mm operative rigid hysteroscope, when I need to perform a minor procedure. If I anticipate performing a procedure, I will directly enter with the 5-mm hysteroscope. I prefer using the Bettocchi hysteroscope system (Karl Storz Endoscopy-America Inc.) because of its oblong shape that, when rotated horizontally with the light cord, easily slips into the slit-shaped external cervical os.

Rigid hysteroscopes have a camera lens angle of 0-30 degrees. I most often use scopes with a 30-degree angle to optimize visualization with minimal manipulation. With this angle, the hysteroscope can be brought to the midline of the uterine cavity and simply rotated about 90 degrees to the left or right with the light cord without much movement of the hysteroscope to visualize the cornu.

In contrast, visualizing the cornu with a 0-degree scope would require manipulation of the entire hysteroscope, potentially increasing patient discomfort. A 12-degree scope offers similar advantages to the 30-degree scope, and either one can be chosen based on physician familiarity and preference.

After placing the hysteroscope into the lower vagina, I guide it into the posterior fornix of the vagina so that I know I'm at the end of the vaginal canal. Then, I slowly pull back while observing anteriorly and visualizing the external cervical os. I then introduce the hysteroscope through the cervical os, and based on an understanding of the anatomy and the scope's angled view, I guide the hysteroscope through the endocervical canal and into the uterus. If I am not getting good distention of the vaginal walls, I will gently pinch the labia together to minimize fluid leakage.

Insertion of the hysteroscope without a tenaculum requires a great deal of dexterity and comfort with the in-

strument. The surgeon needs to understand the correlation between what is seen on the screen and the exact position of the hysteroscope so that the instrument does not rub against the cervix or the uterine tissue and cause trauma and pain.

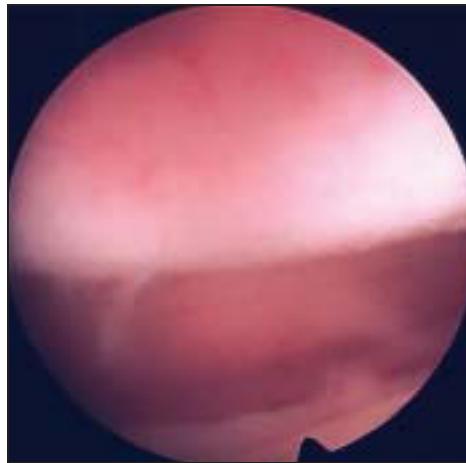
With an angled hysteroscope, the image displayed on the screen reflects what is actually above the tip of the instrument. If the opening to the cervical os looks like it's straight ahead, for instance, it is actually above the direction in which the scope is being guided, and the scope must therefore be angled to enter the canal. Understanding the correlation and being comfortable with this 12- or 30-degree fore-oblique view takes some practice, as does visualizing the cervix correctly when pulling back from the posterior fornix. For most gynecologic surgeons, the necessary skills and comfort levels fall into place after just a few vaginoscopic procedures.

I have not found any difference in difficulty based on the axis of the uterus. In fact, I have found that utilizing a vaginal speculum in conjunction with a cervical

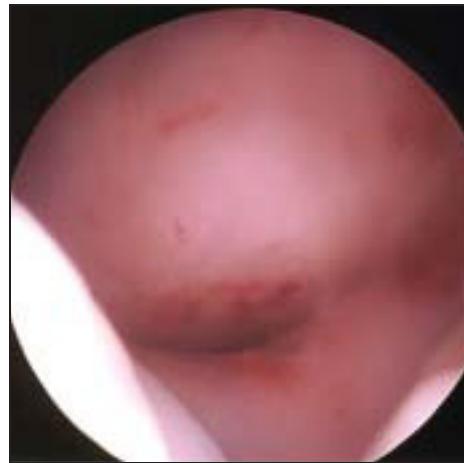
operative hysteroscopy especially. I generally monitor fluid outflow in my practice, with a nurse checking fluid levels and monitoring the deficit while I explain to the patient what I am doing and visualizing. Because diagnostic procedures are fairly short, the likelihood of fluid intravasation at high volumes is low, however.

Vaginostomy can be extremely helpful for evaluating patients who are morbidly obese and for whom standard office instruments are not adequately sized for visualization of the cervix. I recently tried to obtain a Pap smear and do an endometrial biopsy in a patient who was morbidly obese and had a large fibroid uterus, but with conventional methods I was unable to do so using our instruments. I brought the patient to the operating room to use larger instruments, but even these were insufficient. I finally performed the Pap smear successfully by palpating the cervix and os, and used vaginostomy to visualize the entire cervix. I then continued with the hysteroscopy and endometrial biopsy.

After the diagnostic—and sometimes operative—



The hysteroscope is guided into the posterior vaginal fornix.



Then it is pulled back while the external cervical os is visualized anteriorly.



Then the scope is guided through the endocervical canal.

IMAGES COURTESY DR. AARATHI CHOLKERI-SINGH

tenaculum to straighten the uterine axis has limited my hysteroscope manipulation for extreme ante- or retroversion, increasing patient discomfort.

Just as with traditional hysteroscopy, operative hysteroscopy is possible right after or even at the same time as a diagnostic hysteroscopy performed with a vaginostomy approach. The gynecologic surgeon can remove polyps that are visualized during a diagnostic procedure, for instance; perform adhesiolysis for Asherman's syndrome and tubular cannulation for blocked proximal tubal obstruction; retrieve lost IUDs; and perform tubal occlusion using the Essure system. My most recent tubal occlusion procedure took less than 5 minutes from start to finish, and the patient drove herself home within 15 minutes after completion of the procedure.

I do nothing differently when performing an operative hysteroscopy utilizing the vaginostomy approach than I would using the traditional approach, except for not using the speculum and tenaculum.

I recommend fluid monitoring when performing op-

procedure, our nurses will check patients' vital signs and ensure that they are feeling well and are ambulatory. Most of the time, patients leave the office within 15 minutes or so, happy to have had their procedure done in the office as opposed to the hospital.

Vaginostomy also has been shown to be effective, fast, and easy for managing gynecologic problems in pediatric and adolescent patients. In a report published in 2000, Dr. Abraham Golan and his colleagues in Israel reported that they were able to complete the procedure successfully in 22 patients aged 3-16 years who were evaluated for vulvovaginitis, vaginal trauma, bleeding, or genital malformation (*J. Am. Assoc. Gynecol. Laparosc.* 2000;7:526-8). Gynecologic surgeons who build skills and experience with the vaginostomy approach to hysteroscopy could also serve the pediatric/adolescent community well. ■

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Uterosacral Nerve Ablation Failed to Help Chronic Pelvic Pain

BY MARY ANN MOON

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 electrodiathermy, 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 transection of the ligaments was achieved bilaterally with laser or electrodiathermy, according to the surgeon's preference."

Median follow-up was 69 months. The patients assessed their pain and health-related quality of life at 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 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. ■