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

BY KATE JOHNSON
Montréal Bureau

LONDON — Physicians attempting laparoscopic entry in patients who have had previous abdominal surgery should consider an alternative to the traditional umbilical entry, 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 International 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 Pfannenstelts. 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 second and third trocars 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 the original version of the system, according to data presented at the annual congress of the International Society for Gynecologic Endoscopy.

New clinical efficacy data on the Thermachoice III system will reportedly bring those rates to 92% for adhesions, 87% for menorrhagia in 87%, improvements in quality of life in 84% of patients, and use of ibuprofen meant most did not need rescue analgesia.

The second study assessed intraoperative pain with Thermachoice III in 32 women 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 intrahedral 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 0 describing 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 was tolerable for the vast majority of patients, and use of ibuprofen meant most did not need rescue analgesia,” Dr. Marsh said.

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 Conceptus Inc., the device’s manufacturer.

Not a single pregnancy occurred in 29,375 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 dissatisfaction as “satisfied” or “very satisfied.” No women reported persistent pain or bleeding.

—Robert Finn