Uterine perforation is the most common complication of operative hysteroscopy, occurring in 1%-10%.

Stephen M. Cohen, M.D., advised at a conference on gynecological surgery sponsored by Columbia University.

All but the smallest fibroids should be removed in an operating room, according to Dr. Cohen, chief of the division of gynecology and director of women's minimal access surgery at Albany (N.Y.) Medical College. In cases in which a large vascular fibroid is detected, Dr. Cohen also recommended allowing time to shrink it with a GnRH agonist before attempting removal.

He noted that patients should be forewarned that a second operative procedure may be necessary to remove the entire fibroid.

Uterine perforation—usually during cervical dilation—is the most common complication of operative hysteroscopy, occurring in 1%-10% of cases, according to Dr. Cohen. Patients with Asherman's syndrome and cervical stenosis are at most risk.

He advised physicians to prevent perforation by withdrawing the resectoscope as soon as it continues advancing.

"Back out, redilate, and make it go easy. Don't keep pushing ahead if you can't see where you're going," he said.

The hyponatremia risk stems from the pumping of low-viscosity fluids containing sorbitol, mannitol, or glucose to distend the uterus during the procedure. Younger women are at greatest risk for permanent brain damage and death from severe sodium depletion, according to Dr. Cohen.

He cited the theoretical effects of estrogen's possible interference with sodium balance, the decreased effect of vasopressin in the reduction of cerebral edema, and the smaller intracranial space in young women.

Dr. Cohen said intrauterine pressure ideally should be kept to a mean arterial pressure of 75 mm Hg. This pressure is not adequate in some patients, however, so he occasionally starts as high as 120 mm Hg and titrates it down until he sees the uterine beginning to collapse.

Physicians need to have a system for keeping track of the intake and output of fluids, noted Dr. Cohen.

Some patients absorb more fluid than do others, and the amount can increase substantially during a long procedure.

If the uterine volume reaches 1,000 ml, he recommended giving intravenous Laxev (furisomide). If the amount reaches 1,500 ml, the operation should be stopped immediately, he said.

"When they absorb 1,500 ml, that's done—case over. It's better to go back a second time for a fibroid than to be reporting a death," Dr. Cohen said, advising that extreme cases of fluid overload may need to be treated in the intensive care unit.

If the patient under general anesthesia, Dr. Cohen advised watching for decreased oxygen saturation and dilated pupils as the first signs of hypotension.

Should the plasma sodium level fall below 120 mEq/L, he recommended infusion of a 3% saline solution monitored in the ICU.

Under local anesthesia, symptoms of mild hypotension (130-135 mEq/L) include apprehension, disorientation, irritability, twitching, nausea, vomiting, and shortness of breath. As sodium levels drop further, symptoms include pulmonary edema, moist skin, polyuria, hypotension, bradycardia, cyanosis, mental changes, encephalopathy, chronic heart failure, lethargy, confusion, and convulsion.

With sodium less than 115 mEq/L, the patient faces brain stem herniation, respiratory arrest, coma, and death, he said.

Expert Offers Hysteroscopic Myomectomy Pointers

**By Jane Salodof McNeil**

**Contributing Writer**

**SANTA FE, N.M. — Although the complication rate for hysteroscopic myomectomy is relatively low, physicians must guard against uterine perforation and hysterectomy during the procedure,**

**O.B.G.Y.N. News**

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**To avoid perforation, withdraw the resectoscope when advancing becomes difficult.**

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