Go Minimally Invasive for Most Hysterectomies

Taking a vaginal or laparoscopic approach is best, except in a few specific, defined circumstances.

By Miriam E. Tucker

Minimally invasive approaches should be the "procedures of choice" for nearly all women undergoing hysterectomy to treat benign uterine disease, according to a new position statement from AAGL.

Currently, more than two-thirds of the 600,000 hysterectomies performed annually in the United States are done through an abdominal incision, despite the availability of less-invasive vaginal and laparoscopic approaches, which are associated with reduced morbidity, faster recovery, and lower costs.

The AAGL Advancing Minimally Invasive Gynecology Worldwide (formerly known as the American Association of Gynecologic Laparoscopists) has now issued a strongly worded statement advising that abdominal hysterectomies be limited to only a few specific, defined circumstances.

"When hysterectomy is necessary, the minimally invasive procedures, AAGL said. Obesity may be associated with longer operative times but otherwise does not impair safety or efficacy of minimally invasive procedures, and the risks of inadvertent cystotomy and other complications with LH in women with previous Cesarean section is low (J Minim. Invasive Gynecol. 2010;17:186-91).

The statement is aimed at several constituencies, AAGL executive vice president and medical director Dr. Franklin Loffer said in an interview. "We want patients to know, insurance companies to pay attention, and we want doctors to either learn how to do the procedures, get someone to help them, or just refer. I don't think it's justified doing an abdominal hysterectomy simply because you can't do anything else. That's not in the patient's best interest."

He added, "We wish to point out that our specialty needs to do a better job of educating people to do these procedures."

In calling for a dramatic reduction in the number of abdominal hysterectomies, the AAGL position is in line with that of the American College of Obstetricians and Gynecologists, issued in a committee opinion paper "Choosing the Route of Hysterectomy for Benign Disease" in November 2009 (J.A.M.A.). But ACOG differed from AAGL in that it deemed the vaginal approach as the procedure of choice, with the laparoscopic approach second and abdominal approach as a last resort. Also, ACOG did not recommend referring patients to specialists at AAGL did.

"Developing something similar for gynecology is one of the AAGL's current initiatives," Dr. Loffer said. "We wish to point out that far apart."

Indeed, both AAGL and ACOG – as well as the American Board of Obstetrics and Gynecology – are exploring ways to improve training at the residency level, where currently the amount of exposure to minimally invasive hysterectomy procedures varies considerably from one program to the next, and is often quite low. This contrasts with general surgery, where completion of a didactic and clinical program "Fundamentals of Laparoscopic Surgery" is now a requirement of residency training.

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Movement also could come from the payer side. AAGL has had discussions with private insurers expressing interest in such approaches as "incentivizing" patients via lower co-pay to choose surgeons who do minimally invasive procedures. The AAGL provides a registry of qualified surgeons, the Council of Gynecologic Endoscopy (www.aagl.org/CGE), but it is relatively recent.

Dr. Iglesia noted that on the Medicare side, a recent change in the hysterectomy CPT codes giving a greater relative value unit for removal of uterus greater than 250 grams either vaginally or laparoscopically means higher payment. "That should incentivize a bit. ... They are trying."

According to the AAGL statement, the 66% abdominal hysterectomy rate in the United States contrasts dramatically with some European countries in which the proportion is less than 25%. Some insight to the attitudes of American practitioners can be found in the results of an online/paper survey conducted by Dr. Jon I. Einarsson of Brigham and Women's Hospital, Boston, and his associates (J. Minim. Invasive Gynecol. 2010;17:167-75).

Of the 1,500 randomly sampled practicing obstetrician-gynecologists surveyed, 376 responded. Among those, the most commonly performed hysterectomy procedure in the previous year was AH (84%), followed by VH (76%). But when asked to rank which hysterectomy approach they would prefer for themselves or their partner, 56% ranked VH as their first choice and 41% ranked LH as their first choice, with only 8% opting for AH.

When asked about barriers to performing minimally invasive procedures, the most common ones reported for VH included technical difficulty, potential for complications, and personal case-load. For LH, respondents cited lack of training, technical difficulty, personal surgical experience, and operating time as barriers.

Nonetheless, when asked about their ideal goal for mode of access, the respondents felt on average that minimal-ly invasive techniques should comprise 79% of all hysterectomy procedures. Not surprisingly, the survey also revealed that gynecologic surgeons who had a high surgical volume were more likely to feel comfortable offering a minimally invasive hysterectomy to their patients.

"This suggests that more emphasis needs to be placed on training opportunities ... given the desire among prac-tising gynecologists to change their surgical mode of access," Dr. Einarsson and his associates concluded.

Dr. Loffer declared that he owns stock in Johnson & Johnson and Interlace Medical. Dr. Iglesia, and Dr. Loffer and his coauthors all stated that they had no disclosures.