Complications Are Rare With Laparoscopic Myomectomy

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SAN DIEGO — Complications occurred in 11% of 2,051 patients who underwent laparoscopic myomectomy, which compares favorably with a complication rate of 35% for myomectomy performed by laparotomy — a figure that has been reported in the literature. Rocco Spagnolo, M.D., said at an international congress of the Society of Laparoendoscopic Surgeons. The new data come from the first large series of cases studied with a focus on complications from laparoscopic myomectomy. The multicenter Italian study reviewed patient records retrospectively and recorded complications prospectively, he said. Experienced surgeons who had completed the learning curve for the procedure performed the surgeries using the same techniques.

Patients underwent single or multiple myomectomies for symptomatic myomas measuring at least 4 cm in diameter to treat abnormal bleeding in 45% of cases, pain or a pelvic mass in 28%, and infertility in 27%.

Minor complications such as fever, cystitis, and ileus due to uterine manipulation occurred in 9% of cases. Major complications were seen in 2%, according to Dr. Spagnolo of Rome.

Among the most serious complications were hemo- morrhages in 14 patients (0.7%), 3 of whom required transfusions (0.1%). Postoperative hematomas occurred in 0.5% of patients, one in the broad ligament and the others in the myomectomy scar. One patient suffered a bowel injury. Constant hypotension during surgery led to postoperative acute renal failure in one patient.

Surgeons found unexpected sarcomas in two patients. In one of these cases they immediately converted to laparotomy. In the other case, although the mass looked like an adenomyoma and a frozen section was negative for malignancy, the cancer was diagnosed later upon histologic examination. Dr. SPAGNOLO

Five other cases were converted to laparotomy: three due to anesthesia problems, one because of a lack of space and limited mobility. One was converted to laparoscopic hysterectomy due to a large intraligamentous myoma occupying most of the lateral part of the uterus.

Two patients were readmitted for surgery. One with severe hemorrhage underwent laparoscopic hysterectomy, and the other had a hematoma in the broad ligament drained. Among the 185 pregnancies that occurred, the surgery led to a second surgery to remove the cervix, said Dr. Chung, who has a private practice in Toledo, Ohio.

He reported on 42 laparoscopic supracervical hysterectomies he performed for menometrorrhagia from 2002 to 2004. Of the 42 women, 13 also presented with abdominal pelvic pain and dyspareunia underwent potassium sensitivity tests, which were positive in 12 patients, pointing to bladder problems as the cause of the pain. He treated all 13 medically for bladder problems until they were pain free before proceeding to laparoscopic supracervical hysterectomy.

Thirteen of the 42 patients had adenomyosis, and 6 of those had symptoms of abdominal pelvic pain or dyspareunia, in addition to menometrorrhagia. Five of the six had positive potassium-sensitivity tests, and medical treatment resolved their pain before proceeding to surgery.

The laparoscopic supracervical hysterectomies included endoscopic suturing of the bilateral ascending uterine arteries at the mid-cervix. Patients were followed for 6 months to 2 years.

In general, about 10% of women who undergo laparoscopic supracervical hysterectomy report postsurgical spotting or bleeding. Twelve women in the current study underwent concurrent bilateral salpingo-oophorectomy. No bleeding or spotting would be expected after this surgery unless the patient started hormone therapy.

None of the 42 patients reported any postoperative bleeding or spotting, which Dr. Chung said was most likely due to a careful selection of patients. Selecting patients for surgery who have only menometrorrhagia will increase the rate of amenorrhea, he said.

—Sherry Boschert