Hysteroscopic Myomectomy Safe and Easy

One protocol worth serious consideration is the routine oral administration of 200 mcg of misoprostol (Cytotec) 8-12 hours before surgery for all patients, with high-risk patients receiving an additional dose 2 hours before surgery. The protocol will result in a cervix that is softer, significantly less likely to tear, and certainly more easily dilated. This can be achieved with few and infrequent side effects, sometimes including some cramping, fever, or vaginal bleeding. Some, but not all, pharmacies will dispense the drug in single or double tablets; it is worth knowing where to refer patients.

Hysteroscopes and Fluid Management

Diagnostic hysteroscopy, sonohysteroscopy, transvaginal ultrasonography, and—in some cases—MRI may be used for this evaluation. Just Before Surgery

Some institutions and physicians will administer a cervical-ripening agent to women deemed to be at high risk of having cervical stenosis, such as patients who are nulliparous or who have had a c-section. In other institutions, every patient undergoes a preparative cervical-softening procedure.

Surgical Technique

Some surgeons prefer to insert the hysteroscope into the cervix blindly, whereas many prefer to advance it under direct visualization. Some prefer mono- or bipolar scopes with a 12-degree angle, whereas others like to use a 70-degree angle. Myomectomy is performed using an isotonic, electrolyte-containing solution like saline or Ringer’s lactate solution. The rotating resectoscope requires normal saline. In any case, regardless of the chosen modality, fluid management is critical for intraoperative safety. It demands meticulous attention and vigilance. The exact inflow and outflow of any fluid must be monitored to prevent the complications that can result from excess fluid absorption and subsequent hyponatremia (with an electrolyte-free solution) or fluid overload.

A good fluid management system, which is essential to all operative hysteroscopy, will rapidly and continuously measure fluid input and output, and will provide a real-time assessment of the fluid deficit. Each hospital should have a protocol of management that is specific. If, among other things, a fluid deficit at which surgery using each modality should be stopped. We should be operating, in other words, with a set maximum allowable limit of fluid absorption. If we discontinue surgery when the fluid volume reaches this predetermined level, we can avoid major fluid-related complications.

As a general rule of thumb, monopolar systems using nonelectrolyte solutions must be stopped earlier to avoid hyponatremia. There are variations in practice, particularly among gynecologists with significant hysteroscopy experience, but experts typically recommend a threshold of no more than 1,000 cc for monopolar systems, and a threshold of no more than 2,000 cc when electrolyte solutions are used with a bipolar system.

Particularly with larger fibroids, which require more time and more fluid, consider injecting dilute vasopressin into the cervical stroma at the start of the surgery. Some specialists have shown that vasopressin reduces intravasation of the fluid, makes the cervix easier to dilate, and decreases intraoperative bleeding.

Some surgeons may opt at this point to proceed laparoscopically to retrieve the remaining intramural portion of the fibroid. If, as some have argued, the remaining intramural portion of the myoma cannot be safely retrieved, then there is the additional practical issue of the myometrium being left behind. If you cannot safely retrieve the fibroid, it is time to stop the surgery.
If Fertility Is a Consideration, Choose Myomectomy Over UFE

BY GIANCARLO LA GIORGIA
Contributing Writer

TORONTO — Fibroid patients who want to preserve or improve their chances of having children should undergo uterine fibroid embolization only if they are not good candidates for myomectomy. Dr. Gary P. Siskin told his colleagues at the annual meeting of the Society of Interventional Radiology that minimal invasiveness is a procedure that can help patients with fibroids have a child. In my opinion, this remains the preferred first option for these women,” said Dr. Siskin, chief of vascular and interventional radiology at the Albany (N.Y.) Medical Center.

The anatomic and physiologic effects of fibroids on the uterine cavity include distortion of the endometrial cavity and reduction of uterine contractility, both of which interfere with placental implantation, thereby increasing the risk of spontaneous abortion and preterm delivery. Nevertheless, Dr. Siskin said the direct impact of fibroids on fertility remains a controversial issue.

“Fibroids are present in about 5%-10% of patients who are considered to be infertile and have been identified as the sole cause of infertility in 2% of these patients. In addition, the incidence of fibroids increases as a woman approaches menopause—when her fertility is in sharpest decline. However, many women with fibroids do achieve conception, through which there may be complications.”

Dr. Siskin pointed to the significant amount of postmyomectomy data suggesting a connection between fibroids and fertility. In particular, one comprehensive review of 23 studies in 1998 found an overall postmyomectomy conception rate of 57%—a figure that rose to 61% in no other well-known infertility risk factor. Fibroids are present in at least two deaths have been reported.

In general, patients’ symptoms tend to continue after uterine artery embolization, and patients often ultimately require hysterectomy.

Hysterectomy, on the other hand, has all for most patients: low invasiveness, high efficiency, extremely low recurrence, and excellent patient safety.