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Minimally Invasive Hysteroscopic Surgery: A “Start-Up Guide” for the Office Setting

Announcer Introduction:

Welcome to CME on ReachMD. This Omnia Education activity is titled Minimally Invasive Hysteroscopic Surgery: A “Start-Up Guide” for the Office Setting.

Your host is Dr. Robert K. Zurawin. Dr. Zurawin will speak with Dr. Charles E. Miller, Founder, President and Medical Director at the Advanced IVF Institute and the Advanced Gynecologic Surgery Institute, Charles E. Miller, MD & Associates in Naperville, IL.

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Dr. Zurawin:

There are a number of variables to consider when adding in-office minimally invasive surgery to a physician’s practice. This activity will discuss the benefits for both patient and physician in office surgeries versus hospital-based procedures, how to obtain the needed clinical training and hysteroscopic case experience, staffing and facility needs, and recommended approaches to cultivating a patient base. Dr. Miller, welcome to the program.

Dr. Miller:

Well, thank you very much, Dr. Zurawin. Very glad to be here.

Dr. Zurawin:

Well, let’s get started. Minimally invasive hysteroscopic surgery occurs both in office and in the hospital setting. What are the benefits for the patient, as well as for your practice, to consider office-based minimally invasive surgery?

Dr. Miller:

From a standpoint of the patient, it’s not only the convenience of being in an in-office situation, but it’s also the comfort of being in an environment that she is used to being in. From a standpoint of a physician’s practice, I think that there are also some excellent benefits. Number one, it allows that physician to stay focused, stay in an environment that he is most productive in. And there is the added benefit, especially with the change this year, of the Medicare fee schedules from a standpoint of reimbursement.

Dr. Zurawin:

It’s also, of course, very beneficial for the patient because she feels more comfortable. And, not only does the patient not have to go to the hospital, you don’t have to go to the hospital, change into scrubs, dictate the cases, and so on. So, here’s a good followup. If your practice is not like ours, if it’s primarily in obstetrics, and you want to incorporate a mix of GYN procedures, or even work towards exiting from obstetrics, how can the addition of an office-based MIS practice help you achieve this?

Dr. Miller:

Well, first of all, it creates a whole new population of patients. And along the way, it gives you cred. Not only the credibility with your patients that this is an important area that you are focusing on, but also with your referral base as well. The other part, particularly looking at many physicians who are now part of multi-specialty groups, you can look to your physician partners, who are in other

specialties referring to you, that you are doing this very complete evaluation of the patient, and doing it in an atmosphere that saves the system. Because we all know that despite the fee increase within the office, it certainly is nowhere near the amount of money that this same procedure would cost in a hospital or an ambulatory type of setting. I think both of those can lead to a really thriving practice, away from obstetrics.

Dr. Zurawin:

Well, it's a no-brainer that if you think about it, everybody should be doing hysteroscopy and procedures in the office, but all of our listeners don't have the necessary training. You and I have been doing this for years, but we both know that residency programs don't have enough training in hysteroscopy, hardly any in-office procedures, and so, the graduates don't have the confidence to do these procedures. So, how does one obtain the needed clinically training in hysteroscopic case experience to be successful in the office?

Dr. Miller:

one of the keys to being successful in office is to be able to do a procedure that leads to minimal pain. For example, this morning I did a case of a lady with a polypectomy where I did vaginoscopy. Now, for those who don't know vaginoscopy, this is basically taking a small scope, going into the vagina without a speculum, finding the cervix, and moving into the exocervix, the endocervix, and on into the uterus without the use of a speculum, without the use of a single-tooth tenaculum. And it is a much more comfortable way of approaching this. Many of our residents have had no experience with this therefore, people in their private practices, or their hospital-based practices, do not have this type of experience. But this is something that can easily be learned if one is doing hysteroscopy in an operating room setting. So, begin to do this procedure when your patient is asleep and get comfortable with going into the vagina and finding the cervical os, and moving that into the uterine cavity. So, that is one. The physician who does not even do that many hysteroscopic procedures, I am sure that they have someone in around them, reproductive endocrinologist, for example, who may do a lot of these procedures. And I'm sure that reproductive endocrinologist would love to gain their referrals for infertile couples and be glad to show them how to do a vaginoscopy procedure. So, I do think that there are ways of being able to gain this type of training, and do so in an environment that the physician is comfortable in.

Dr. Zurawin:

And there are also some courses that perhaps ACOG gives, or some of the companies, actually, offer training the clinician can contact their rep to get training for specific procedures. So, you've described the diagnostic procedures very well, but there are also many procedures, like you mentioned, polypectomy, myomectomy, endometrial ablation. those can't really be done just vaginoscopically alone. They need patient pain and discomfort relief. can you explain how you ensure patient comfort during these more invasive and potentially painful operative procedures?

Dr. Miller:

I do many of these patients without analgesia or anesthesia. So, many of these patients, like a single polyp, we can certainly do with a vaginoscopy procedure and do it with minimal types of analgesia. But, at the end of the day, one balances nonsteroidals, narcotics, anxiolytics, and even local, with doing a paracervical block. We'll go ahead, with many of our patients, and go ahead and give them ibuprofen the night before and the morning of, and then, also, go ahead and at times use a paracervical block. I use a 1% lidocaine solution. We will go at about 7 o'clock and at 5 o'clock and do a paracervical block. Some people will do an intracervical block as part of this. There are different regimens that one can use, but most of the time one can do a number of these procedures with the use of simply using ibuprofen and a paracervical block. If someone wants to do a more extensive procedure, one can go ahead and give Toradol intramuscularly 30 minutes to 60 minutes prior to the procedure and use a paracervical block. And quite honestly, one can also use types of sedation. But Rob, if someone is going to use sedation, then they really want to go ahead and take that training to make sure that they are very comfortable with it, or to use nurse anesthetists or anesthesia groups that can provide the sedation during the case

Dr. Zurawin:

There's one thing that I might add to what you're saying and I've noticed with many physicians I've observed and trained myself, is that they don't give enough time after the injection of the lidocaine or whatever anesthetic that they use, before they start the procedures. You need to give at least 5 minutes, at least, for the anesthetic to sit.

Dr. Miller:

I oftentimes say 10. Go out, see a patient, and then come back.

Dr. Zurawin:

That's exactly right.

Dr. Miller:

Before we leave the discussion of comfort, patients and comfort, we do have to understand that we like to soften the cervix with

misoprostol. I use Cytotec 200 mcg the night before and the day of the procedure. It can be used orally or vaginally. The other thing, and from a standpoint of patient discomfort, that one must have to recognize is that you move your instruments slowly. You talk to the patient. Let them know exactly what's going on and what level of pain they might be anticipating. you really have a dialogue with your patient.

Dr. Zurawin:

That's an excellent point, Chuck. I think it also involves finesse. Because patients who are nulliparous or who have cervical stenosis, definitely benefit from the misoprostol, and especially those patients who have instrumentation that needs more dilation; however, misoprostol for some patients will dilate or soften the cervix too much, and then the instrument will wiggle around and you're not going to get a good seal with the distention medium.

Okay. Well, Chuck, not only the procedure, but the anesthetic algorithm that you've described are both key to encouraging physicians to do in-office procedures. So, I think that they really need a little bit of reassurance to know that this is not difficult or impossible to learn and that with the proper instruction, that they should be able to feel comfortable doing these in the office. What do you think?

Dr. Miller:

I totally agree with you, Rob. you also have to remember: walk, don't run. Make sure you have a patient that is comfortable with the possibility of having an office-based procedure. Make sure that they're not adverse and anxious about the whole process. Make sure that they are a healthy patient.

Dr. Zurawin:

I think that's a brilliant point to add to our previous discussion.

if you're just tuning in, you're listening to CME on ReachMD. I'm your host, Dr. Robert Zurawin, and with me is Dr. Charles Miller. We're speaking about adding in-office minimally invasive surgery to the physician's practice.

So Chuck, you have a very efficient office that does a wide range of procedures, but for the average OB/GYN, what are the staffing and facility needs that are faced when building out one's MIS practice in the office?

Dr. Miller:

The first thing is we talk about staffing. I think it is important that one has 2 assistants during the course of the procedure, that there is not only the surgeon there, but there are 2 assistants, one that is helping you with instrumentation to move things along, and one is basically circulating and helping you with fluid, etc., and if instruments have to be brought in for some reason. Obviously, as I mentioned, if you're going to do more complex cases and you want to bring in an anesthesia partner to help with sedation, then that is a group of 4. And if you're doing more complex cases, you should have and your people should have ACLS training, not just basic training. It should be more advanced and you should have the equipment to be able to deal with this in an office situation.

Dr. Zurawin:

And let me jump in for 1 second, Chuck, because every state has different requirements, so for all of our listeners, I would make sure that they check with their state licensing board with any of this.

Dr. Miller:

That's very important, Rob. From a standpoint of the facility itself, the instrumentation can be fairly minimal. For example, one can use the hysteroscopic morcellation instrumentation that not only allows you to have excellent hysteroscopic visualization, but it gives you that ability to remove polyps, retained products of conception, some scar tissue, small fibroid, with ease. The equipment also gives you the opportunity to put scissors through them, to put graspers through them as well. Obviously, we want to be able to visualize, so you have to have a camera and screen. From a standpoint of fluid, we don't recommend that one has to have a system that is very extensive from a standpoint of fluid collection. We simply use a bag to catch the fluid and then measure it at the end of the procedure, so we know our I's and O's. These are procedures, that are very short and if you're looking at doing very extensive procedures, which I certainly don't recommend for most, then I do think you have to have a system where you can have ongoing I's and O's during the course of the procedure. But for our polyps, for our retained products of conception, for looking at endometrial biopsies to rule out hyperplasia; for those types of cases, a simple fluid collection system will work admirably.

Dr. Zurawin:

That's great. Well, on that line of thinking, can you give us some initial thoughts on your considerations and approaches to marketing?

Dr. Miller:

when you get involved in this type of work that one goes ahead and makes sure it is a place of importance on one's website. I would send out notification to your patients that you are doing this type of work. That you are very, very interested in patients with abnormal

bleeding, with intermenstrual spotting, etc., so that you begin to cultivate this patient base within your own population. I would also, as I said, reach out to your referring physicians. The bottom line is, if you build it, they will come.

Dr. Zurawin:

Right, well, I think if you incorporate, as you've alluded to, the workup of abnormal uterine bleeding, to have a hysteroscope done at the same time, so that you don't waste time giving them Provera or birth control pills which will never fix a polyp or a fibroid. If you get in the habit of hysteroscoping anybody with abnormal bleeding or similar kinds of conditions, you're not only doing the patient a service by minimizing their inconvenience and making an immediate diagnosis, but you're helping yourself by building that experience in surgical procedures and your practice.

Dr. Miller:

Rob, I think that is such a strong point.

Dr. Zurawin:

And one thought that you make me think of is with the very high instance of C-sections, we're seeing things that hormones will never treat, which is C-section scars, isthmoceles that can only really be properly diagnosed that way. And if you are not familiar with in-office hysteroscopy, you're going to miss these procedures. I think that there are great needs for all of the practicing OB/GYNs to become familiar with in-office procedures, safe anesthesia, operative techniques, staffing, and facility needs, so that they can—we all better serve our patients.

Chuck, this has been a great discussion. Is there anything else you'd like to add?

Dr. Miller:

I would just like to, say, we as gynecologists are generally a very careful group of physicians. I do believe that office hysteroscopy is absolutely advantageous to the patient, but we have to remember that our patients' safety always comes first. That begins at the way you set up your office; it begins at the way that you select your patient. We always have to remember the Hippocratic Oath: Physician, do no harm. But, saying that, the office can be a tremendous experience for the patient.

Dr. Zurawin:

That's a great point. And on that note, again, I'd like to thank you for your contribution. It's always a pleasure to visit with you.

Dr. Miller:

You as well, Rob, and the same.

Announcer Close:

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