

Transcript Details

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Abnormal Uterine Bleeding (AUB): Impact of Direct Visualization for Earlier Diagnosis

1st Part of 2-Part Discussion with Drs. Feathers, Lee & Volin

Title: *Abnormal Uterine Bleeding: Impact of Direct Visualization for Earlier*

Diagnosis

Narrator:

You are listening to this week's medical industry feature entitled, *Abnormal Uterine Bleeding: Impact of Direct Visualization for Earlier Diagnosis*, sponsored by CooperSurgical's Endosee office hysteroscopy system, a new and better standard of care than blind biopsy alone for the diagnosis of AUB. The following panel discussion is the first in a 2-part series. We encourage you to listen to the second part of this program at reachmd.com/endosee.

Dr. Allen:

Endometrial biopsy, or EMB, has limitations in diagnosing abnormalities within the uterine cavity. If cancer occupies less than 50% of the surface area of the endometrial cavity, the cancer can be missed by a blind EMB alone, and EMB alone could potentially miss the diagnosis of focal lesions in up to 18% of patients. Today, we will be discussing the first in a 2-part series. And, in today's discussion we will discuss the benefits of direct visualization of the uterine cavity at the point of care and its benefits to both you and your patients.

This is ReachMD, and I am your host, Dr. Renee Allen. Joining me today are Dr. Abigail Feathers, Dr. Kevin Lee and Dr. Steve Volin. Doctors, welcome to ReachMD.

Let's start off our discussion with taking a moment for each of you doctors to tell our listening audience about yourself, about your practice and about how many Endosee procedures you have performed. Dr. Volin, let's start with you.

Dr. Volin:

Thanks. I'm Steve Volin. I'm a founder and managing partner of the Women's Health Group here in Denver, Colorado. We're a 17-provider group with offices throughout the North Metro area. We acquired Endosee in several of our offices after it was initially released at the end of 2015, and over the last 6 months, I've done about 40 of the procedures myself. Because of its ease of use, Endosee represented a significant improvement over our previous algorithm, and so I'm pleased to support it here.

Dr. Allen: Dr. Feathers, how about you?

Dr. Feathers:

I am Dr. Abigail Feathers, and I am in a solo, part-time, gynecology practice only. I am hospital employed, and I have been using Endosee, actually, since July 2015. I do approximately 2 to 4 Endosee procedures a week -- again, that's only seeing patients 2 days a week in the clinic -- for a total of probably 50 or 60 Endosee procedures that I have personally performed thus far.

Dr. Allen: Dr. Lee?

Dr. Lee:

I'm Dr. Kevin J. Lee, and I work in Baltimore, Maryland. I work for MedStar Medical Group Women's Health at MedStar Good Samaritan Hospital, which is a hospital-owned practice. I'm the minimally invasive GYN surgeon in my practice, and so I perform about

90% of my cases with a laparoscope or hysteroscope. I have performed about 40 Endosee procedures to date.

Dr. Allen: So, doctors, prior to Endosee, can you describe your approach to diagnosing abnormal uterine bleeding, or AUB? Dr. Feathers, let's start with you.

Dr. Feathers:

Abnormal uterine bleeding is a very common complaint that I see in my general gynecology practice. I would say it's the number one complaint that I see patients for. So, after seeing and evaluating the patients, for my workup I generally do some sort of imaging, and prior to Endosee, that involved the transvaginal ultrasound, either bedside done by myself in the office, or I would send the patients to the hospital for a formal transvaginal ultrasound in radiology. In addition, based on their risk stratification, I would also do endometrial sampling if it was indicated.

Now, what was lacking in my workup previously was direct visualization of the uterine cavity. I rarely did it in the office just because of the cumbersome nature of setting up hysteroscopy in your office, fluid management, sterile equipment, all those things, so I would only do that for patients who I either saw something on transvaginal ultrasound suggestive of a polyp, which is not the ideal way to image the uterine cavity, or if I had biopsy evidence that there was a portion of a polyp or a fragment of a polyp. And even then I would then take those patients directly to the operating room.

So, what I've found since I've had Endosee is, I have a much, much lower threshold to directly visualize the uterine cavity because it's so easy to do in the office. So, in my algorithm, I have now incorporated it to any woman who's had a change in the frequency of their bleeding, because those people could possibly have an endometrial polyp

Dr. Allen: Thank you, Dr. Feathers. Dr. Lee?

Dr. Lee:

Sure. My approach is very much like Dr. Feathers' approach. After obtaining a good history and physical, usually I would order a transvaginal ultrasound, labs, do a Pap smear. Depending on the age and the other circumstances or risk stratification, I would also perform a blind endometrial biopsy. Much like Dr. Feathers, after I started performing Endosee, I found that I was missing many polyps or small fibroids that otherwise would not have known about, and that's the way that I generally have approached my patients with abnormal uterine bleeding.

Dr. Allen: Dr. Volin, how about you?

Dr. Volin:

Like Dr. Feathers and Dr. Lee, I've performed similar workup. Depending on the ultrasound findings, we would also bring patients back for separate visits for either sonohysterography and sometimes order an MRI to further delineate any structural abnormalities that we found on ultrasound. Since utilizing the Endosee, we've been able to eliminate both the sonohysterography and sometimes the MRI as part of the diagnostic workup.

Dr. Allen: Dr. Volin, prior to Endosee, how many patient visits and over what period of time was necessary for diagnosing AUB, and were multiple locations required?

Dr. Volin:

With the Endosee, we're able to do an ultrasound, a biopsy, and visualize the endometrial cavity during one single patient visit, and for the most part, by doing this we've been able to minimize or even eliminate the use of sonohysterography. This eliminated the need for further preauthorization and additional office visits and, thus, when we utilized the Endosee hysteroscopy at the time of the transvaginal ultrasound and biopsy, we often were able to save patients 1 or 2 visits.

Dr. Allen: Dr. Lee, how about you?

Dr. Lee:

Sure, Dr. Allen. Definitely more than one visit was always required prior to Endosee, and usually those visits happened over the course of a couple of weeks or maybe even a month depending on patient scheduling. If I really suspected that something was in the endometrial cavity based on imaging or based on the patient's history or physical, I would schedule the patient for hysteroscopy in the operating room, and based on operating room scheduling, it was always difficult to tell when that could happen, so the process could easily take several weeks, usually the locations being my office and the operating room. Of course, now with Endosee the number of visits required has drastically reduced and I'm able to streamline which patients need to be in the operating room versus the ones that

don't.

Dr. Allen: Dr. Lee, what is the value of performing an Endosee exam during the same visit that an endometrial biopsy or EMB is performed?

Dr. Lee:

Well, for me, as a gynecologic endoscopic surgeon, to see is to believe. So, why be blind when you can actually see? And that's what Endosee helps us to do. It helps us to gather additional information immediately. Additional knowledge without office hysteroscopy has to be gathered later in the operating room, which can lead to a delayed diagnosis. So, I believe that performing Endosee at the same time that an endometrial biopsy is performed is best for patient care, just because to see is to believe. When you see, you know what's there, and you can send the patient where she needs to go, whether it's home, whether it's to the pharmacy for medication or whether it's to the operating room. So, that's the value that I see in performing Endosee during the same visit that I would perform endometrial biopsy.

Dr. Allen: I can just imagine that it would be very helpful to eliminate blind biopsy alone. Dr. Lee, would you agree?

Dr. Lee:

Absolutely. I almost never perform blind biopsies anymore since acquiring Endosee. I don't know what the purpose is in performing a blind procedure when I can see first prior to doing the biopsy. I've had several cases where I decided to look with the Endosee and decided an endometrial biopsy is not the correct thing to do. There's a large polyp, or a large fibroid, that an ultrasound did not see, and so I can eliminate the discomfort from the endometrial biopsy and proceed directly to OR scheduling just based on taking a quick look prior to my plan to perform a blind endometrial biopsy.

Dr. Allen: Can I then surmise that the Endosee procedure allows you to get to the diagnosis a lot quicker?

Dr. Lee:

Absolutely. Sometimes you look inside the cavity and you see nothing, and maybe the diagnosis is not as clear, but if there's pathology to be seen, well, the only way that you're going to see it is to put a scope inside the uterus and look around, and so the diagnosis can be made much faster with Endosee.

Dr. Feathers:

I agree with Dr. Lee. This really aids -- and he kind of touched on this -- on my surgical planning. Because some of these patients at the initial consultation, we've gone through all the options assuming a normal endometrial biopsy, assuming a normal cavity, and some of these women are saying, "Well, if everything is okay, then I don't want to do anything." Well, if I find a large polyp, that's changed our plan right then and there, so not only is it generating more OR revenue, it's actually finding a source of this bleeding and treating this bleeding for women. So, I really can then plan my surgery accordingly, not having to be surprised when I go into the operating room if a hysteroscopy is part of their surgical plan.

I had a case a couple weeks ago. This woman was planning on an ablation. I put my Endosee in there, and she's got either a septum or some sort of anomalous uterus, a bicornuate uterus. Now, prior imaging, that doesn't show up on a transvaginal ultrasound. Had I found that on the day of surgery, I would have not been able to do her ablation. So, I actually had to do further pelvic imaging in the form of an MRI to really delineate what her uterine abnormality was and whether or not I was still safely able to complete the ablation. I would have had no idea about that had I not done the Endosee in the office there. So, I have found great value in Endosee in surgical planning.

Dr. Allen: Dr. Feathers, what, if any, do you do regarding pain management for Endosee procedures?

Dr. Feathers:

Yes, so before I perform an Endosee procedure on my patients, I recommend that they take up to 800 mg of oral ibuprofen, and that is the only pain management or the pain treatment I give them. Obviously, we all know every patient is different and every patient tolerates procedures differently. With some women they said, "I barely even noticed it." Some women show up and they have forgotten to take their ibuprofen. I don't cancel the procedure, and generally it goes fairly well. So, it's really, it's slightly uncomfortable, but the addition of Endosee, especially when you're already doing endometrial sampling, usually the Endosee is less painful than even an endometrial biopsy I've found in my experience.

Dr. Allen: Why do you think that that is the case?

Dr. Feathers:

When you're using a pipelle endometrial biopsy -- that's what I'm used to using -- when you put the suction on there and you're kind of moving that back and forth, that really incites a lot of cramping, uterine cramping, from what I can gather; whereas, the Endosee, you've inserted that cannula, you can control how fast you're putting that fluid in through the syringe. If your assistant is slamming that in there, they tend to get a lot more discomfort. So, really, it's a very, very small amount of fluid that you can put in the uterine cavity and it's generally very, very well tolerated. When it's not, I just have my assistant slow down slightly so they're just pushing a little bit less. But with the Endosee you can also control how much fluid is going in, and that does correlate with the amount of pain they have from my experience.

Dr. Allen: Okay. So, basically, patient selection is quite important for this procedure and that based on the vast majority of patients, and based on your experience, patients tolerate it similar to an EMB. Is that correct?

Dr. Feathers:

Correct. I do the Endosee first and then I do the biopsy next, and usually they're more uncomfortable with the biopsy than they are with the Endosee.

Dr. Allen: Dr. Lee, what do you think?

Dr. Lee:

It's very interesting to hear Dr. Feathers say that because my experience mirrors hers. I also have the patient take a nonsteroidal like ibuprofen for naproxen prior to the procedure, and usually I ask them to add *Tylenol* just for a different pain pathway, but I have found with almost every case that extending the uterus with fluid as I'm doing the Endosee procedure almost causes no discomfort. However, the endometrial biopsy procedure where I'm removing fluid from the Endosee and then removing cells from the lining of the uterus is much more uncomfortable. So, the Endosee procedure itself is very well tolerated, and this is a good thing because in the past I would have done a blind endometrial biopsy on patients with abnormal uterine bleeding. Sometimes I put the Endosee into the uterus and look around and find the polyp or fibroid that I think is causing the problem, and I can avoid the discomfort caused by the endometrial biopsy that I would have planned to do had I not looked inside the uterine cavity with my Endosee device.

Dr. Allen: As a simple hysteroscopic direct visualization tool, is there a concern that Endosee will or may be over utilized? So, I'm going to open up that question to Dr. Volin.

Dr. Volin:

Yes, I'm a believer in the future of Endosee because I think it's a better test than blind biopsy or sonohysterography, but like anything, when you have something that's easy to use and there's a favorable reimbursement, it could be tempting to overutilize it in the future in most cases where biopsy is indicated, I think that we are not doing enough hysteroscopies. ACOG recommends hysteroscopy now in the workup of abnormal bleeding. It has higher sensitivity. While there's a potential in the future to overutilize hysteroscopy, right now our main thing that we need to address is how to get more people using this easy and effective tool

Dr. Lee:

You know, Dr. Allen, I don't think there's a real concern. As Dr. Volin so perfectly outlined, ACOG recommends diagnostic hysteroscopy in the workup of abnormal uterine bleeding. And colposcopy, cystoscopy or laryngoscopy are all simple office visualization tools, just like hysteroscopy is, and the practitioner believes that he or she will gain more information in all of those procedures by seeing. This is true for me using Endosee. So, I would be more concerned that Endosee will be underutilized by doctors who don't understand how easy it is to do. There are many indications for hysteroscopy, but it is seldom scheduled for most patients due to inconvenience or need for hospital stay or anesthesia clearance and surgical posting difficulties. Endosee eliminates these barriers. So, I would be more concerned, frankly, Dr. Allen, about underutilization than overutilization.

Dr. Allen: Dr. Feathers, what is your opinion?

Dr. Feathers:

Yes, I agree with Dr. Volin. I mean, a concern that Endosee would be overutilized, so then what would our concern be, risk to the patient? I mean, it's very, very minimal risk. I have not yet had an Endosee complication. Would it be that people are not qualified to be using Endosee? It is a very, very easy thing to use. So, I guess I would think the concern of overutilization is quite small. And, in fact, the bigger concern is underutilization of direct visualization of the uterine cavity, as we have all mentioned multiple cases of patients who we wouldn't have necessarily taken to the operating room and we found significant pathology with the Endosee, so I would say that

would be a bigger concern as opposed to overutilization.

Dr. Allen:

Dr. Feathers, Dr. Lee and Dr. Volin, thank you for participating in the first of this 2-part discussion. We appreciate you sharing your insights on the benefits of direct visualization of the uterine cavity with Endosee and its benefits for both you, the benefits for your office staff, and most importantly the benefits for your patients. And, we look forward to the second discussion. Thank you so much, doctors.

Dr. Feathers:

You're welcome.

Dr. Lee:

Thank you for having me.

Dr. Volin:

Thanks very much. I appreciate being part of this.

Narrator:

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