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Endosee: Changing the Work Up of Abnormal Uterine Bleeding

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

Title: ***Endosee: Changing the Work Up of Abnormal Uterine Bleeding***

Narrator:

You are listening to this week's medical industry feature entitled**,** *Endosee: Changing the Work Up of Abnormal Uterine Bleeding,* 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 program is the 2nd in a 2-part discussion.

Your host is Dr. Renee Allen, an Ob-Gyn hospitalist in Atlanta, Georgia. Your medical guest experts are: Dr. Abigail Feathers, solo practitioner, Medical and Surgical Gynecologist in Oakland, Maryland; Dr. Kevin J. Lee, minimally invasive GYN surgeon, at MedStar Medical Group Women's Health at MedStar Good Samaritan Hospital in Baltimore, Maryland; and Dr. Steve Volin, founder and managing partner of the Women's Health Group in Denver, Colorado

Now here is your host, Dr. Renee Allen…

Dr. Allen: Drs. Welcome back to ReachMD. I am looking forward to the 2nd part of our discussion, where we will be focusing on changing the work up of abnormal uterine bleeding. Dr. Lee, Let's start off with you. Based on your experience, how does Endosee benefit you, how does it benefit your practice, how does it benefit your patients, and overall, the healthcare system?

Dr. Lee:

Well, Dr. Allen, I'll start with the benefit Endosee provides to the patient because to me the patient is most important I can tell my patients that I can gather more information quickly and easily which helps me diagnose them faster using Endosee office hysteroscopy. There are some patients for whom anesthesia is a serious risk, and with my using Endosee in the office to inspect the endometrium, I can avoid cardiac risk and other anesthesia-related risk. So, for the patient there are definite benefits and advantages.

Now, as Dr. Feathers and Dr. Volin both know, operating room time is always limited and it's impossible to schedule every abnormal uterine bleeding patient for hysteroscopy in the operating room whenever you want to schedule them, so you're forced to pick and choose. All of us have had the experience of performing a hysteroscopy in the operating room after a normal ultrasound only to find pathology that suddenly requires operative hysteroscopy, and the operating room staff becomes stressed because the case wasn't posted for myomectomy or polypectomy or endometrial resection or lysis of adhesions. So, with Endosee we can avoid the operating room if we think the case is nonoperative based on the available workup or schedule appropriately for the operating room for operative cases. The most important piece in all of this is direct visualization. Traditional ultrasound nor sonohysterography provide direct visualization.

Now, in terms of the benefit in the practice, in the office, an efficient office can streamline the practice to do Endosee on many patients who meet the criteria for it on the same day. It's quick. It's easy to use. And most of my Endosee procedures take less than 2 minutes. I think that my very first case took me less than 2 minutes. I've had new patients who I thought would benefit from immediate hysteroscopy. It happens occasionally. And before they left, we were able to obtain a piece of the puzzle as to why they have abnormal uterine bleeding or postmenopausal bleeding.

Dr. Allen: Dr. Feathers?

Dr. Feathers:

I agree with everything that Dr. Lee had already said. the reimbursement, obviously, for doing an office hysteroscopy and endometrial sampling as opposed to endometrial sampling alone is, with some of the insurance covers 3 to 4 times as much, okay, and not only that, then the OR revenue that's generated from picking up unsuspected or otherwise unknown pathology. I mean, I can't put a number on it, but I know it's already been significant in my practice.

Dr. Allen: Dr. Volin, I would like to ask you the same question as well, so that our listeners can hear what you have to say with regards to your experience.

Dr. Volin:

We've been doing office hysteroscopy and sonohysterography in our office for several years, and while we got a lot of accurate information, it was always associated with a lot of anxiety and trepidation on the part of patients as they went room to room, and there was a lot of cleanup and preparation time associated from our staff. One thing that's been really nice since we moved the Endosee hysteroscopy to the exam room is that we get the same valuable information with a lot less effort in a lot shorter time. This has decreased the anxiety and trepidation for the patients. And then once we're done with it, we can quickly go to talking about what the pathology is and helping them move towards their treatment options in a more timely fashion.

Dr. Allen: Dr. Feathers, can you share with us a noteworthy AUB case where Endosee really made a difference?

Dr. Feathers:

Yes, in fact, I do. I had a case a couple of months ago. It was a postmenopausal patient who came to my office for postmenopausal bleeding. I did the standard workup including a transvaginal ultrasound. I didn't do it personally. She went to the hospital to get an ultrasound, a formal scan done for some reason. And then her lining was slightly thickened, so I performed an office endometrial biopsy. Everything was normal or reported as normal, so I did nothing further at that point.

She came back to my office about 6 months later, with persistent postmenopausal bleeding. She really didn't have much improvement and, in fact, was bleeding significantly more than she even had been prior to my sampling and the ultrasound, so I thought I must be missing something, but I had a hard time defending my next step just because I had a stone cold normal ultrasound and a stone cold normal biopsy with no fragment of polyp or anything. So, I thought, well, let's try an office hysteroscopy. I have this Endosee. It's low risk. So, I brought her in, we did an Endosee, and I found a polyp that, honestly, almost took up the entire uterine cavity. I don't know how it was missed on my biopsy or on the ultrasound, but obviously, I then proceeded to the operating room, removed her very large polyp, and now her bleeding has resolved. So, that is a case in which I would have had a hard time defending taking her to the operating room with an otherwise completely normal workup. I didn't really suspect anything there, but I did the office hysteroscopy with the Endosee just because it was so easy and I could and did find significant pathology, and now I've greatly improved her, or essentially resolved her symptoms.

Dr. Allen: I think that's a very good example. Thank you, Dr. Feathers. Dr. Volin, how about you?

Dr. Volin:

I also have an interesting case of a submucous fibroid that was actually picked up on transvaginal ultrasound. In the past I probably would have gone directly from there to operative hysteroscopy, but since the Endosee is so easy to use, I decided to take a look at this fibroid prior to taking her to the OR. It measured about 2, 2.5 centimeters on transvaginal ultrasound, and when we did the Endosee hysteroscopy in the office, it was exactly as it had appeared on the transvaginal ultrasound, but what I found was that it had a broad base coming from the top of the uterine fundus. The way it changed management in this case was instead of just taking a Myosure device for a hysteroscopic morcellator, which I typically would have done, I also used operative hysteroscopy with a loop, and that way we were able to get the entire base off as well. So, in the past I would have gone to the OR prepared for one thing and then had a lot of OR staff running around to get instrumentation ready in the middle of the case, and instead of having problems with organization and everything like that, we were already prepared at the beginning, so what should have been a 10-minute procedure still stayed a 10-minute procedure to do. So, it was only because of doing the initial hysteroscopy prior that we were able to get that kind of information and make adequate preparations for the operating room.

Dr. Allen: Dr. Volin, that's an excellent example. Dr. Volin, let’s know discuss how important is it to have your clinical and office staff on board for Endosee utilization?

Dr. Volin:

Its super important, and these days as a physician I feel like I'm just a member of an entire care team that involves not just me but my entire front and back office. Getting everybody on board makes the process just that much easier. It starts when they're scheduling and when we call patients to remind them of what they're about to go through, because we remind them to premedicate at home with an anti-inflammatory, and that's with my appointment and scheduling front desk people. When the patient financial counselor speaks to the patient, they know that they're going to be getting an exam, the Endosee and an ultrasound the same day, so they can take care of the all the precertification part and tell the patient about what their financial responsibility will be. But probably, the biggest person who needs to have buy-in is the medical assistant, and that's where Endosee really shines. Endosee is simple to set up and easy to use, so with their buy-in, they are able to easily set up the equipment, and we get through the procedure so quickly. There's no sterilization issues. They can set up in advance. In most cases my assistant is the one who's using the syringe to help installation of the saline, so she feels like she's part of the patient's care. And once the procedure is done, since it's done in the exam room, it's even easy for them to turn it over. So, staff buy-in is just natural with the Endosee, from scheduling the procedure to cleaning up and turning the room over. It's easy for our patients and our staff.

Dr. Allen: Dr. Volin, can you discuss the economic impact that Endosee has had on your practice versus other diagnostic procedures?

Dr. Volin:

We added Endosee because we felt that it improved care for our patients, but it's had a really nice positive economic benefit for the practice as a whole. It's an example where doing the right thing results in an economic benefit. When I do an Endosee and a biopsy, we typically bill out procedure code 58558, which is hysteroscopy with biopsy, and in Colorado the Medicare reimbursement for that code is approximately $410 with the commercial payers paying at a greater percentage of that. Blind endometrial biopsy codes at a 58100 and reimburses at approximately $110.

Dr. Allen: Yeah, that's significant, sir!

Dr. Volin:

Yes, so for several minutes more work and with improvements in both the sensitivity and specificity, we'll have an increase in our reimbursement of approximately $300 before expenses, so it's nice because I feel like we're doing the right thing and we're getting compensated at the same time. Outside the particular office setting, we're finding a lot more cases that turn out to be structurally related rather than hormonal or neoplastic, and so we're going to the OR more as well. So, this improved not only the care for the patient, but going to the OR and doing procedures is a better use of my time. It makes me more efficient and brings more practice revenue in.

Dr. Allen: Dr. Feathers and Dr. Lee, do you have similar experience with regards to your reimbursement using the Endosee procedure?

Dr. Lee:

For me, more OR cases have come about as a result of using the Endosee. Being able to see what I suspect in the office first using Endosee has kept me more busy in the operating room because, as we've talked about, sonohysterography or blind endometrial biopsy don't always provide the answers. Endosee uncovers pathology that requires operative hysteroscopy. For those clinicians who use relative value units in their practices, the work RVUs for a hysteroscopy with or without biopsy is about 3 times the work RVUs given for blind endometrial biopsy. I would say that's not bad for adding 2 minutes or less to a procedure in the office.

Dr. Allen: Dr. Feathers?

Dr. Feathers:

I agree with exactly what Doctors Volin and Lee have said. I'm finding more OR [operating room] cases you can bill more for the procedure you're doing, which you kind of are already doing anyway. I mean, the Endosee adds minimal time if I'm doing endometrial sampling.

Dr. Allen: Dr. Feathers, as we wrap up our discussion, if you can leave your peers, our listeners, with one piece of information regarding this new technology, what would it be?

Dr. Feathers:

I would have to say that I truly believe that Endosee is actually going to revolutionize the workup for abnormal uterine bleeding, as evidenced if you've heard our prior discussion of the simplicity of use, the quality of the imaging you get, the detection of previously unsuspected intrauterine pathology, assistance in surgical planning, financial benefits for your practice. I can't say enough good things about Endosee in my experience. It's very, very well tolerated. It is easy to use. I mean, we are doing 50 times more office hysteroscopy than I would have been prior to the introduction of Endosee. So, it's a new technology and it's something I've wholly

embraced, and I encourage other providers to do so.

Dr. Allen: Dr. Lee?

Dr. Lee:
For me, Dr. Allen, it's pretty simple. It really is straightforward. To see is to believe. Open your eyes. You have the ability to do what very few doctors can do in the office setting. You can quickly and easily look inside the organ that's causing your patient distress, As far as I can tell in my experience in using Endosee, there are absolutely no good reasons to not at least try it. And after I used it the first time, I realized that I wasn't going to be able to stop using it after one time. It's very important in my day-to-day clinical practice

Dr. Allen: And, Dr. Volin?

Dr. Volin:

Well, I like to follow ACOG guidelines, and I was surprised when I read the May 2015 Committee Opinion on the workup of abnormal uterine bleeding, and it had changed, and it was a pretty significant change, when they said in the past that it was an acceptable part and they changed it to it is a recommended part. In the past, hysteroscopy has been kind of difficult to get into because it's pretty expensive to buy a hysteroscopy setup for the office. Endosee hysteroscopy let's you bring hysteroscopy into your office, do what is now part of the recommended ACOG workup, and get into that with, just as the other doctors have said, seeing is believing. It lets you get into that and see with better results at a very low cost point. So, that is why we introduced it in our office, and I'm so excited to be a part of trying to educate other physicians about bringing it into their office.

Dr. Allen: Doctors, thanks again for being with us today and being a part of the 2nd part of this series. Dr. Feathers, Dr. Lee and Dr. Volin, thanks for sharing your insights on educating your colleagues on the benefits of Endosee. And, for our listeners, please visit the first part of this discussion at reachmd.com/AUBdiagnosis. I am your host Dr. Renee Allen, thank you for listening.

Narrator:

You've been listening to ReachMD. The preceding program was the second in a 2-part series sponsored by CooperSurgical. To learn more about Endosee and the diagnosis of AUB, please visit www.endosee.com. And to download this segment and others in this series, please visit ReachMD.com/Endosee. That's ReachMD.com/Endosee.