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ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

How Office-Based Gynecological Procedures are Changing Patient Care

Dr. Mennen:
Welcome. I am your host, Dr. Barry Mennen, and I would like to welcome my guest, Dr. Francis Gardner, to the program. Dr. Gardner is a former Clinical Director at the Queen Alexandra Hospital in Portsmouth, England, and is a Senior Consultant for Gynecology and Gynecological Oncology there. He is actively involved in the development of office-based ambulatory services, both in Portsmouth and in London, and advocates the use of minimal-access surgical techniques to improve postoperative patient recovery and patient care. Dr. Gardner joins us to share his insights on office-based gynecological procedures. Welcome to the program, Dr. Gardner.

Dr. Gardner:
Thank you so much for inviting me. It's a real pleasure being here.

Dr. Mennen:
Pleasure to have you here, sir. To start, can you tell us how you went about bringing gynecological procedures to outpatient settings at your hospital?

Dr. Gardner:
Well, I work in a brand new hospital. It was opened in 2009 and I was the newly-appointed clinical director at that time and we wanted to restructure our services within the hospital and we had to make certain changes with a financial driver. So we wanted to cut down costs, but actually, we actually wanted to improve patient care and patient safety and patient choice. So, we actually looked at a number of our services, and there are a number of key areas that we felt that we could bring patients from the OR into the outpatient setting, and provide very effective treatment, in an awake setting, with no general anesthesia or sedation, so that we could actually move the care of the patient forward in a very cost-effective way.

Dr. Mennen:
So, which types of procedures, specifically, have been ushered into office-based settings?

Dr. Gardner:
So, we've had colposcopy in our service as an awake outpatient setting for many years. You know, we've been doing colposcopy for probably 20 years and actually even doing loop biopsies for quite some time, but what we actually wanted to do was look at the other areas. So, we've looked at hysteroscopy. So, now our standard is that all patients having diagnostic hysteroscopy will have their procedure in the outpatient setting. And when there's a contraindication or a clinical indication to bring the patient into theatre, that's absolute fine; it's not an issue, but that's our standard. For the treatment of menorrhagia, we're offering an ablation service, and we routinely offer ablation in the outpatient setting with absolutely minimum pain. In addition to that, we're treating polyps and we're treating fibroids, type 0, type 1, and type 2 in our outpatient facility. In addition to that, we're offering hysteroscopic sterilization and we're also offering treatment of chronically retained products of conception. So there's quite a diverse service we're offering, but it's a comprehensive service.

Dr. Mennen:
And you did this in a step-wise manner with the less complex issues first, I would assume.

Dr. Gardner:
Absolutely. We trialed all of our new techniques in the operating theatre where there's appropriate safety and support, and when we were happy with our techniques, then we then moved them into the outpatient setting.

Dr. Mennen:
How do you define success in terms of performing ablation procedures within an outpatient setting?

Dr. Gardner:
Well, with regards to actually performing the procedure, the actual key points are giving the patient a really good experience. So, we don't want to subject the patient to any significant discomfort and certainly not any pain. We want to provide a very slick and swift service. They have a very short treatment, both from the preparation, right the way through to leaving the room, and we want a short recovery time with no side effects from any medications that we give so that the patients can potentially return to normality with almost immediate effect.

Dr. Mennen:
If we consider the perpetual goal of gaining low postoperative pain scores on a VAS scale, do you incorporate paracervical blocks and fundal blocks into outpatient settings to help achieve this?

Dr. Gardner:
Yes. When we set up our service, we used a traditional method of analgesia. So, we provided oral pain relief with simple medication; no opiate analgesia, and then we used an intracervical block with local anesthetic. At that time, we had pain scores averaging at 5.7 with a range of 0 to 10. With the introduction of a paracervical block, with a fundal injection, we consistently get pain scores of between 0 and 2. So, that's now become our standard, and I'm very proud to say that the overwhelming majority of patients get absolutely minimum discomfort.

Dr. Mennen:
It sounds, with numbers like that, if N were 5, it would be a P value that was significant.

Dr. Gardner:
Yes, absolutely, absolutely. We presented our data at the Royal College of Obstetricians and Gynaecologists, World Congress, in Birmingham this year, and we compared 30 consecutive patients with our traditional block, intracervical with the paracervical block and the fundal injection, and I think that had a major impact. We had so much interest in our technique; so many people continue to contact me because they want to gain more information about the technique. It's been really, really impressive.

Dr. Mennen:
Dr. Gardner, you just spoke a bit about fundal block usage in the outpatient setting. How has providing fundal block changed your outpatient practice?

Dr. Gardner:
Well, the key to our practice is that previously we warned the patient that they would have significant discomfort, but that it was a very short duration, and the overwhelming majority of patients felt that it was acceptable. However, there was a group of patients that said, actually, "This wasn't for me," and they chose to move into the OR and have their procedure with general anesthesia. However, since the introduction of our new technique we've had no patients making that choice. And so, from a cost-effective point of view, the operating theatre is the most expensive resource we have in our hospital, and by avoiding its usage for this type of procedure, it streamlined the process, it's allowed us to one-stop see-and-treat, and we have very low conversion rate to the inpatient setting.

Dr. Mennen:
Do you have to allocate extra time to your procedure to perform these paracervical and fundal blocks?

Dr. Gardner:
No, it's actually very easy to do. The actual concept is actually quite simple, but there are certain safety things that we have to incorporate in our protocol to ensure that we're not giving any intravascular local anesthetic injections. So, the actual procedure itself, from start to finish, including the ablation and the paracervical and fundal block, is always performed in less than 15 minutes, and in the majority of patients, between 5 and 10 minutes. And if you compare that to either giving sedation or to giving a general anesthesia, you'd need to allocate probably at least another 30 minutes. So, it's very, very effective and it allows us to actually treat a good number of patients in a 4-hour clinical session. And so, actually, it makes our clinical activity very cost effective.

Dr. Mennen:
Can you explain how your technique differs from other notable approaches and what the advantages are with this technique?

Dr. Gardner:
Well, I actually visited Henrik Skensved in Hillerød, in Denmark, because he had the original concept of a paracervical block with a fundal injection. So, in his protocol, he injects at 9 o'clock, 3 o'clock, 7 o'clock, and 5 o'clock and he injects 10 mL of ropivacaine as a

reservoir into those tissues. He then waits 10 minutes; he then does his fundal block and then does his ablation. So, in our clinics, our clinics are very busy. We would treat, on average, 6 patients in a 4-hour session, so we'd actually lose an hour of clinical activity by using that technique. So what I've done is I've taken his take and I've adopted it and improved it, so that we actually inject a very small amount of local anesthetic into the anterior lip of the cervix, only about 1 mL, and that allows me to apply a tenaculum without any pain or discomfort. And then, we can manipulate the cervix so that we can get our paracervical block very accurately placed, so we'reusing the same volume, 40 mL, but the distribution around the cervix is different and also the depth of the infiltration of the local anesthetic is deeper, and we also inject down a greater depth of tissue, throughout the actual injection course of the needle, and so we don't have to wait for the local anesthetic to permeate the paracervical tissues. And that's why we don't need the 10 minutes. We then proceed straight on to performing a fundal injection which is similar to Henrik. We inject just lateral to the tubal ostia and around about 1 cm medial into the fundus of the uterus; around about 2 mL at each injection point, and our volume total is only 48 mL for the whole procedure, and we use just 0.25% of local anesthetic. And we've chosen to use a drug called levobupivacaine, and the reason being is it's less cardiotoxic than other local anesthetics. So, that brings in another level of safety. Not only are you checking your not injecting intravascularly, but also the actual local anesthetic is safer. So, that, although this technique sounds more involved, actually, you can become very slick and quick at it, and the whole paracervical block and fundal injection usually takes less than 5 minutes. And then, with a 2 minute ablation cycle and then just getting the patient cleaned up and so forth, the whole treatment cycle, as I say, takes between 10 and 15 minutes.

Dr. Mennen:
Before we wrap up this discussion, are there any parting comments that you'd like the audience to take away from the topic of office-based procedures?

Dr. Gardner:
Well, I think people need to acknowledge that, you know, there are financial pressures in healthcare, but actually, we need to actually address the needs of the patient as well. So we need to offer patient good choice. We need to avoid major surgeries when we can, but we need to have very effective treatments and I believe that office-based gynecology has a real future in healthcare, both in the USA and also in the rest of the world, because we can offer these treatments now that are very effective and with absolutely minimal patient discomfort, and with producing such highly effective care that actually we can offer so many more patients treatment within any defined treatment clinical session, but at a very much reduced cost. So, it's win-win for the healthcare system and it's win-win for the patients.

Dr. Mennen:
Dr. Gardner, it was great to have you here.

Dr. Gardner:
It was a real pleasure. Thank you so much.

Dr. Mennen:
Thank you.