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Efficacy of Tissue Removal Systems for Intrauterine Pathology

Dr. Mackey:

Welcome to a special edition of Advances in Women's Health. I am your host, Dr. Amy Mackey, and joining me today is Dr. Robert Zurawin, Associate Professor, Department of Obstetrics and Gynecology at Baylor College of Medicine in Houston, Texas. He and I will be discussing the Efficacy of Tissue Removal Systems for Intrauterine Pathology.

Dr. Zurawin, welcome to the program.

Dr. Zurawin:

Thank you very much. It's a pleasure to be here.

Dr. Mackey:

Dr. Zurawin, I am sure our audience understands that in many surgical procedures, tissue specimens need to be removed from the body. Can you please explain to our audience what gynecologic conditions might require specialized tissue removal?

Dr. Zurawin:

Well, actually, you're talking about the entire range of gynecology. Except for ablative surgery like lasering of endometriosis or draining of cysts, any time you take out the uterus or a fibroid or a polyp or an ovary or cancer, you have to take it out of the body, and the challenge nowadays is: How do you get it out safely? There's a lot of controversy about tissue extraction now that's really come up in the last year and a half since this case of uterine leiomyosarcoma was disseminated by morcellation and it reached the newspapers. So, really, the challenge now, whether abdominally or vaginally, just about any method of removal, is: How do you remove it? How do you get new tissue out? And that really covers just about everything we do.

Dr. Mackey:

What are the current methods for removing tissue from the body?

Dr. Zurawin:

Well, of course, the traditional way is an abdominal incision, and it ranges from a vertical incision, from the umbilicus down to the symphysis, or a transverse incision, which is, of course, what we use for a C-section, and that's actually the most common incision still used. I'd like to say that laparoscopic surgery is really more common, and it's gradually getting more, but it's not available for a lot of people, and the skill level of our surgeons is not quite up to it. It doesn't really even matter, because once you even do it laparoscopically, you have to get a piece of tissue out of a 5 or 10 mm port, and so you have to be creative and remove it somehow and safely.

Vaginally is simpler. You already have a natural orifice, and we've done this for over a century, vaginal hysterectomy. The question even is then, is if you have a larger uterus that would fit through the colpotomy incision, how do you get it out? Do you put it in a bag? Do you morcellate it naturally? It's a real challenge. The bottom line is what's best for our patients and what's most accessible for the surgeons that we have out there? So, that's kind of the challenges that we're looking at. The only exception, actually, to this is hysteroscopic surgery. Of course, if you have conditions which are the most common conditions, practically, like abnormal bleeding that have fibroids and polyps, you can go transcervically with a hysteroscope, remove the fibroids and polyps and not enter into any of that problem that we have with abdominal or vaginal tissue extraction.

Dr. Mackey:

Are there other challenges that accompany surgical procedures where organs are removed?

Dr. Zurawin:

Oh, certainly. Besides, obviously, the technical skill that's required in more complicated cases like fibroids that distort the anatomy or endometriosis or previous surgery with adhesions, you have the challenges of complications from energy use or anatomical abnormalities or the skill level of our surgeons. Training now in surgery for gynecologic surgeons has really changed in the last 20 years.

Also, what's the degree of pathology? Is it something that even is extractible? Should it be something that should be medically done? But once that decision has been made to proceed with surgery, you need to have a thorough understanding of the anatomy, normal and abnormal; you have to be able to get good access to the tissue, either abdominally or vaginally, and then be able to remove it safely. It's just that gynecology has so many variations of pathology that requires so many different variations of technique and skill that you really have to be a thoroughly versified surgeon to be experienced enough to handle anything that you come up with.

Dr. Mackey:

If you are just tuning in, you are listening to Advances in Women's Health sponsored by Hologic on ReachMD. I am your host, Amy Mackey, and I am joined by Dr. Robert Zurawin. We are talking about The Efficacy of Tissue Removal Systems for Intrauterine Pathology.

I understand that some people are advocating putting the tissue in bags before removing it from the body. What are your thoughts about that?

Dr. Zurawin:

The whole idea of putting tissue in a bag is to remove it safely without any of the tissue leaking or spilling or spreading throughout the body. In benign conditions that's not so important, but there's always a chance of an occult carcinoma or other kind of tumor that is cut and spread inadvertently in the process of removing it. This is especially important when you're doing it laparoscopically. Like I said before, you're taking out a big piece of tissue through a small hole, so you have to chop it up somehow. Now, the real problem is: Is there a significant difference between survival in cancers where it's been put in a bag, morcellated or not? It's a subject of intense study. And at this point it's not quite sure, but it's better to be safe at this point and bag tissue, especially if there's any question whether it might be cancerous. Now, for many years we've taken out dermoid tumors or endometriosis in a bag because we don't want that to get spread, so I think it's just an extension of what we've done before.

Dr. Mackey:

How does abdominal and laparoscopic tissue removal differ from extracting tissue such as fibroids and polyps from inside the uterus?

Dr. Zurawin:

Well, that's a great question, and it's actually very simple. If you're going to do a hysteroscopic procedure, you're not cutting into anything. You're not opening the abdomen. You're not doing a vaginal incision. You're actually going inside the uterine cavity where the pathology is and you're removing it right there with an instrument, so you don't really have to bag it because there's nothing to bag. You can chop it up or slice it and remove it through the cervix, so it's really radically different.

What's exciting about that is that the newer technologies that we have for hysteroscopic tissue removal are so improved over previous methods, which are cumbersome and difficult for many gynecologists to learn, that we now have an opportunity to treat patients without having to do a hysterectomy or significant tissue removal. This ranges from hysteroscopic myomectomy to polypectomy to endometrial ablation, and that's really probably been a revolution even without the morcellation or tissue extraction controversy.

Dr. Mackey:

Can any of these procedures be performed in the office or outpatient setting?

Dr. Zurawin:

Yes, as a matter of fact, that's the beauty of it. For most polyps or fibroids that are inside the uterus that are removed hysteroscopically, that can be done in the office; at the very most, you can do it in an ambulatory surgical center. You almost never have to do it as an inpatient.

Dr. Mackey:

What information will the gynecologic surgeon want the referring physician to consider before sending a patient for consultation?

Dr. Zurawin:

The most important things for a referring physician to know before sending a patient to the gynecologist are two things. First of all, is the patient symptomatic or not symptomatic? How acute is the problem? Then, more importantly, what is the patient's fertility status? Do they want to get pregnant now? Do they want to get pregnant in the future, or is pregnancy in the future not even a consideration? And so, when you combine those different factors, then you have an idea of what the patient's expectations are and the kind of approach you need. If somebody wants to get pregnant in the future, you're not going to offer them a hysterectomy. If they're having sudden bleeding that's symptomatic, you're not going to give them medical therapy because it would take too long to work. So, knowing those pieces of information are going to be very helpful for the referring physician. Of course, having a complete workup, if possible, blood work and ultrasounds and other radiological studies are important, but I think knowing those expectations of the patient will help the gynecologist make the correct referral in terms of options to offer the patient.

Dr. Mackey:

Dr. Zurawin, thank you for sharing your insights with our ReachMD listeners.

Dr. Zurawin:

You're very welcome. Thank you very much. It was a pleasure.