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SURGICAL SHORTCUTS

**Madalinska JB, van Beurden M, Bleiker EM, Valdimarsdottir HB, Lubsen-Brandsma L, Massuger LF, Mourits MJ, Gaarenstroom KN, van Dorst EB, van der Putten H, Boonstra H, Aaronson NK**

**Predictors of prophylactic bilateral salpingo-oophorectomy compared with gynecologic screening use in BRCA1/2 mutation carriers**

**J Clin Oncol. 2007;25:301–307**

**OBJECTIVE:** Women with BRCA1/2 gene mutations who have completed their childbearing are strong candidates for risk-reducing prophylactic bilateral salpingo-oophorectomy (PBSO). The aim of the current study was to identify baseline predictors of PBSO versus gynecologic screening (GS) in this group of high-risk women.

**METHODS:** Baseline questionnaires were available from 160 BRCA1/2 carriers who participated in a nationwide, longitudinal, observational study of the psychosocial consequences of prophylactic surgery versus periodic screening. Topics addressed by the questionnaire included generic quality of life, cancer-specific distress, risk perception, knowledge of ovarian cancer, and perceived pros and cons of surgery versus screening. PBSO use during the 12-month period after the first gynecologic consultation was determined on the basis of medical record data.

**RESULTS:** During the 12-month follow-up period, 74% of women had undergone PBSO, and 26% opted for screening. Statistically significant multivariate predictors of PBSO included education, general health perceptions, perceived incurability of ovarian cancer, and perceived benefits of surgery.

**CONCLUSION:** Women with lower educational levels, with poorer general health perceptions, who view ovarian cancer as an incurable disease, and who believe more strongly in the benefits of surgery are more likely to undergo PBSO. Clinicians should ensure that high-risk women are well informed about the low predictive value of GS techniques and about the lethal threat posed by ovarian cancer because of its limited curability.

**Frenna V , Santos L , Ohana E, Bailey C, Wattiez A**

**Laparoscopic management of ureteral endometriosis: Our experience**

**J Minim Invasive Gynecol. 2007;14:169–171**

**OBJECTIVE:** Ureteral endometriosis is rare, accounting for less than 0.3% of all endometriotic lesions. The aim of our study is to evaluate the prevalence of extrinsic ureteral endometriosis in women undergoing laparoscopic surgery for severe endometriosis and to suggest that laparoscopic ureterolysis represents a mandatory measure in all cases to avoid ureteral injury.

**METHODS:** A retrospective analysis was performed of all cases of patients who underwent laparoscopic surgery for severe endometriosis at the Departments of Obstetrics and Gynecology at CMCO-SIHCUS and Hautepierre Hospital, Strasbourg, from November 2004 through January 2006. Measurements and main results: We recorded 54 patients with a mean age of 31 years and a mean body mass index of 21.9. Reported symptoms were dysmenorrhea (88%), severe dyspareunia (88%), severe pelvic pain (38.8%), and infertility (74%). Five women presented with dysuria, frequency, recurrent urinary tract infections, and pain in the renal angle, and two patients had hydronephrosis. We observed 3 patients (5.6%) with ureteral stenosis, 35 (64.8%) with adenomyotic tissue surrounding the ureter without stenosis, and 16 (29.6%) with adenomyotic tissue adjacent to the ureter. It was on the left side in 47.4% of cases, on the right side in 31.6% cases, and bilateral in 21% of cases. In nine patients, ureteral involvement was associated with bladder endometriosis (16.7%). In all patients, ureterolysis was performed. There was one case of ureteral injury during the procedure, two of transitory urinary retention, and one of uretero-vaginal fistula after surgery. During the first year of follow-up, the disease recurred in four patients, with no evidence of the disease in the urinary tract.

**CONCLUSION:** Conservative laparoscopic surgery to relieve ureteral obstruction and remove pathologic tissue is the management of choice. Resection of part of the ureter

should be performed only in exceptional cases. Ureterolysis should be performed in all patients before endometriotic nodule resection to recognize and prevent any ureteral damage.

**Voney G, Biro P, Roos M, Frielingsdorf B, Shafighi M, Wyss P**

**Interrelation of peri-operative morbidity and ASA class assignment in patients undergoing gynaecological surgery**

**Eur J Obstet Gynecol Reprod Biol. 2007;132:220–225**

**OBJECTIVE:** The aim of this study was to estimate intra- and post-operative risk using the American Society of Anaesthesiologists (ASA) classification, which is an important predictor of an intervention and of the entire operating programme.

**METHODS:** In this retrospective study, 4,435 consecutive patients undergoing elective and emergency surgery at the Gynaecological Clinic of the University Hospital of Zurich were included. The ASA classification for pre-operative risk assessment was determined by an anaesthesiologist after a thorough physical examination. We observed several pre-, intra- and post-operative parameters, such as age, body-mass index, duration of anaesthesia, duration of surgery, blood loss, duration of post-operative stay, complicated post-operative course, morbidity and mortality. The investigation of different risk factors was achieved by a multiple linear regression model for log-transformed duration of hospitalisation.

**RESULTS:** Age and obesity were responsible for a higher ASA classification. ASA grade correlates with the duration of anaesthesia and the duration of the surgery itself. There was a significant difference in blood loss between ASA grades I (113±195 ml) and III (222± 470 ml) and between classes II (176±432 ml) and III. The duration of post-operative hospitalisation could also be correlated with ASA class. ASA class I=1.7±3.0 days, ASA class II=3.6±4.3 days, ASA class III=6.8±8.2 days, and ASA class IV=6.2±3.9 days. The mean post-operative in-hospital stay was 2.5±4.0 days without complications, and 8.7±6.7 days with post-operative complications. Multiple linear regression model showed that not only the ASA classification contained important information for the duration of hospitalisation. Parameters such as age, class of diagnosis, post-operative complications, etc., also have an influence on the duration of hospitalisation.

**CONCLUSION:** This study shows that the ASA classification can be used as a good and early available predictor for the planning of an intervention in gynaecological surgery. The ASA classification helps the surgeon to assess the peri-operative risk profile of which important information can be derived for the planning of the operation programme. 

**Obermair A, Crandon A, Perrin L, Walsh, T, Carrazo M, Nicklin J**

**Randomized trial of skin closure after laparotomy for gynaecological surgery**

**ANZ J Surg. 2007;77:460–463**

**OBJECTIVE:** New suture materials may provide patients with a better cosmetic outcome at similar pain and wound complication rates.

**METHODS:** To assess pain and cosmetic outcome among patients randomized to receive wound closure after laparotomy for gynaecological surgery using staples, polyglecaprone 25 or polyglecaprone 6211 subcuticular sutures.

**RESULTS:** Overall, 90 patients (87.4% consent rate) were randomized. There was no difference in wound complications and pain among the three groups. Patients randomized to polyglecaprone 6211 subcuticular sutures rated the cosmetic result at 1 and 6 weeks after surgery somewhat lower than patients randomized to the two alternative groups; however, at 3 months after surgery, all three groups rated the cosmetic result as similar.

**CONCLUSION:** This study suggests that the three wound closure methods have similar short-term pain and cosmetic outcomes, as well as a similar rate of wound complications, leaving the decision of the most appropriate closure method to individual surgeons. 

**Franchi M, Trimbos JB, Zanaboni F, v.d. Velden J, Reed N, Coens C, Teodorovic I, Vergote I**

**Randomised trial of drains versus no drains following radical hysterectomy and pelvic lymph node dissection: a European Organisation for Research and Treatment of Cancer-Gynaecological Cancer Group (EORTC-GCG) study in 234 patients**

**Eur J Cancer. 2007;43:1265–1268**

**OBJECTIVE:** Drainage, following radical hysterectomy and pelvic lymph node dissection to prevent postoperative lymphocyst formation and surgical morbidity, is controversial.

**METHODS:** To study the clinical significance of drainage, 253 patients were registered and 234 patients were randomised into two arms. In one arm (n=117) postoperative drainage was performed; in the other arm (n=117) no drains were inserted. In both arms closure of the peritoneum of the operating field was omitted. The main exclusion criteria were blood loss of more than 3,000 ml during surgery and persistent oozing at the end of the operation. Clinical and ultrasound or CT-scan evaluation was done at 1 and 12 months postoperatively.

**RESULTS:** The median follow-up amounted to 13.3 months. No difference in the incidence of postoperative lymphocyst formation or postoperative complications was found between the two study arms. The late (12 months) incidence of symptomatic lymphocysts was 3.4% (drains: 5.9%; no drains: 0.9%). The difference showed a p-value of 0.06 in Fisher's exact test. The operating time was related to the occurrence of postoperative lymphocyst formation.

**CONCLUSION:** It was concluded that drains can be safely omitted following radical hysterectomy and pelvic node dissection without pelvic reperitonisation in patients without excessive bleeding during or oozing at the end of surgery.

**Morgan DJ, Hunter DC, McCracken G, McClelland HR, Price JH, Dobbs SP**

**Is laparoscopically assisted radical vaginal hysterectomy for cervical carcinoma safe? A case control study with follow-up**

**BJOG. 2007;114:537–542**

**OBJECTIVE:** To compare a new surgical approach, laparoscopically assisted radical vaginal hysterectomy (LARVH) with open radical hysterectomy in women with cervical cancer. Can selected women benefit from the minimally invasive approach without compromising safety (recurrence rate) and morbidity (complications)?

**METHODS:** Retrospective case control study. Setting: A tertiary referral unit for gynaecological malignancies. Population: Thirty women undergoing LARVH were included and compared with 30 women undergoing open radical surgery. The control group was matched for age, body mass index and disease stage.

**RESULTS:** Recurrence rates were equal (6.7%). There was one death, in the LARVH group. Follow-up was a mean of 31 months in the LARVH group and 30.9 months in the open group. Blood loss as measured by mean drop in haemoglobin was greater in the open group (2.03 versus 3.01 g/dl, P=0.02). Transfusions were given in 40% of women in the open group and 16.7% in the LARVH group. Hospital stay was significantly less in the LARVH group (5.9 versus 7.8 nights, P=0.003). Mean operating time was longer in the LARVH group (131 versus 187 minutes P=0.0001). Mean nodal counts did not differ significantly (17.4 in open vs 14.8 in LARVH, P>0.05). There were seven perioperative complications in the open group and four in the LARVH group. There have been two recurrences in each group (6.67%) at mean follow-up of 31 (LARVH) and 30.9 (open) months.

**CONCLUSIONS:** The first 30 LARVH procedures performed in this unit are comparable in terms of safety (recurrence rate and complication rate) and economic factors (shorter hospital stay mitigating longer operating time). Further development of this technique is warranted.

**Albo ME, et al. Urinary Incontinence Treatment Network.**

**Burch colposuspension versus fascial sling to reduce urinary stress incontinence**

**N Engl J Med. 2007;356:2143–55**

**BACKGROUND:** Many surgical procedures are available for women with urinary stress incontinence, yet few randomized clinical trials have been conducted to provide a basis for treatment recommendations.

**METHODS:** We performed a multicenter, randomized clinical trial comparing two procedures–the pubovaginal sling, using autologous rectus fascia, and the Burch colposuspension–among women with stress incontinence. Women were eligible for the study if they had predominant symptoms associated with the condition, a positive stress test, and urethral hypermobility. The primary outcomes were success in terms of overall urinary-incontinence measures, which required a negative pad test, no urinary incontinence (as recorded in a 3-day diary), a negative cough and Valsalva stress test, no self-reported symptoms,

and no retreatment for the condition, and success in terms of measures of stress incontinence specifically, which required only the latter three criteria. We also assessed postoperative urge incontinence, voiding dysfunction, and adverse events.

**RESULTS:** A total of 655 women were randomly assigned to study groups: 326 to undergo the sling procedure and 329 to undergo the Burch procedure; 520 women (79%) completed the outcome assessment. At 24 months, success rates were higher for women who underwent the sling procedure than for those who underwent the Burch procedure, for both the overall category of success (47% vs. 38%, P=0.01) and the category specific to stress incontinence (66% vs. 49%, P<0.001). However, more women who underwent the sling procedure had urinary tract infections, difficulty voiding, and postoperative urge incontinence.

**CONCLUSIONS:** The autologous fascial sling results in a higher rate of successful treatment of stress incontinence, but also greater morbidity than the Burch colposuspension.