EDITORIAL OPEN ACCESS

Stop unnecessary gynecologic endoscopic surgery

Atef M. Darwish

Thanks to the marvelous developments in illumination and instrumentation, the indications of endoscopic surgery in gynecologic practice have been expanded to cover most of gynecologic subspecialties. Some gynecologists, after gaining basic knowledge following a training course or a three-day workshop, use endoscopy frequently whether or not indicated. This can be attributed to a desire to get hands-on-experience before being engaged in busy heavy clinical work, self satisfaction after gaining this limited experience, over-enthusiasm with the technology, propagandism for the doctor or as a trial to gain money. Some doctors decide to perform an endoscopic operation and get the patient's consent but after starting the procedure they fail to detect an indication for the surgery, so they do any procedure to convince the patient that she got some benefit.

Myolysis in infertile women is a good example of a harmful unneeded laparoscopic procedure. Since a long time ago, it has been well known that this procedure is reserved for women over 40 years who completed their families [1]. If it is done for women seeking fertility, extensive adhesions are invited.

The ovaries are the organs that are most exposed to unneeded and even harmful maneuvers. Laparoscopic ovarian drilling (LOD) is commonly performed in many parts of the world particularly in low resource countries that do not cover the expenses of HMG therapy and ICU management of its possible complications. Due to lack of sufficient sonographic experience, some cases of LOD are done for multicystic ovaries (multiple cysts of 25 mm) which are considered a variation of normal physiology. Some gynecologists do not follow any diagnostic criteria, despite being many and famous like the New Rotterdam criteria [2].

Recent evidence supports the limited use of LOD as a second line therapy for women not responding to HMG [3]. Few studies considered it as a first line therapy of CC-resistant polycystic ovary syndorms (PCOS) [4].

LOD is not always easy and not always safe. In addition to uncontrolled bleeding up to sutures or transfixation perforation, unexpected sliding of the unipolar cautery causing an iatrogenic laceration on the external iliac artery and a massive bleeding was reported in one case study [5]. Other serious complications were also reported like internal iliac vessels, ureteric or intestinal injuries.

Doctors should be aware of serious long-term complications of LOD like adhesion formation and induction of premature ovarian failure. Some women lost their fertility due to unneeded or overdone LOD. It should be mentioned that premenopausal LOD is a crime as it accelerates ovarian failure.

Hemorrhagic corpus luteum cyst is not an uncommon indication for laparoscopy for acute abdomen. Some laparoscopists courteously puncture or incise it with subsequent excessive resilient bleeding that may require extensive coagulation or even suturing. Some cases of ovarian hyperstimulation syndrome may be subjected to laparoscopy. A great mistake is to try to evacuate the cysts which would eventually lead to excessive bleeding with possible oophorectomy.

Concerning hysteroscopy, many gynecologists perform unneeded hysteroscopic operations that may harm the uterine cavity. A good example is metroplasty for any case with fundal bulging by diagnostic hysteroscopy. This overtreatment is enhanced by the recent ESHRE-ESGE classification that considered a uterine septum if internal fundal indentation is >50% myometrial thickness (uterine wall). Relative over-diagnosis of septate uterus by ESHRE-ESGE in these cases may lead to unnecessary overtreatment without the expected benefit.

A recent study [6] diagnosed septate uterus in 44 (16.9%) and 16 (6.1%) patients among 261 cases based

Atef M. Darwish
Affiliations: Woman's Health University Hospital, Assiut University, Assiut, Egypt
Corresponding Author: Dr. Atef M.M. Darwish, MD PhD, Professor, Department of Obstetrics & Gynecology, Woman's Health University Hospital, 71111 Assiut, Egypt P.O. Box: (1) Assiut; Fax: 02 088 2368377; E-mail: atef_darwish@yahoo.com

Received: 05 May 2015
Published: 06 July 2015

on ESHRE-ESGE and ASRM classifications respectively. They concluded that septate uterus should not be diagnosed using this classification system and it should not be used as an eligibility criterion for hysteroscopic metroplasty. Moreover, The ESHRE-ESGE criteria may cause greater frequency of recognition of residual septum than the ASRM >1 cm criterion, which could result in more frequent reoperations with use of the ESHRE-ESGE criteria, possibly without any significant effect on reproductive performance. In addition to risks of perforation and implantation site destruction, there is a possible risk of intrauterine adhesion formation particularly if the fundus is broad [7].

Another potentially dangerous operation commonly practiced by some hysteroscopists is lateral uterine wall release incisions aiming at widening of the uterine cavity to enhance fertility. It should be mentioned that normal implantation site is located on the posterior endometrium at midline 10–15 mm from the fundus so lateral release incisions would add just adhesions. The same concept is used to treat T-shaped uterus without sufficient scientific evidence.

Overuse of endoscopic surgery adds little to the fertility potential of women. The possibility of complications should restrict unneeded procedures. Lastly, an advice to every endoscopist; if you cannot help your patient, do not be a cause of harm to her (primum non nocere).

How to cite this article

Darwish A. Stop Unnecessary Gynecologic Endoscopic Surgery. J Case Rep Images Gynecol Obstet 2015;1:8–10.

Article ID: 100003Z08AD2015

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doi:10.5348/Z08-2015-3-ED-3

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Author Contributions

Atef Darwish – Substantial contributions to conception and design, Acquisition of data, Analysis and interpretation of data, Drafting the article, Revising it critically for important intellectual content, Final approval of the version to be published

Guarantor

The corresponding author is the guarantor of submission.

Conflict of Interest

Authors declare no conflict of interest.

REFERENCES

1. Donnez J, Squifflet J, Polet R, Nisolle M. Laparoscopic myolysis. Hum Reprod Update 2000 Nov-Dec;6(6):609–13.
2. Geisthövel F. A comment on the European Society of Human Reproduction and Embryology/American Society for Reproductive Medicine consensus of the polycystic ovarian syndrome. Reprod Biomed Online 2003 Dec;7(6):602–5.
3. Abu Hashim H, Al-Inany H, De Vos M, Tournaye H. Three decades after Gjönnaess's laparoscopic ovarian drilling for treatment of PCOS; what do we know? An evidence-based approach. Arch Gynecol Obstet 2013 Aug;288(2):409–22.
4. Cleemann L, Lauszus FF, Trolle B. Laparoscopic ovarian drilling as first line of treatment in infertile women with polycystic ovary syndrome. Gynecol Endocrinol 2004 Mar;18(3):138–43.
5. Seda A, Osman S, Özsoy Bestami, Ali Galip Z, Atilla K. External Iliac Artery Injury During Ovarian Drilling Procedure: A Case Report. Haseki Tip Bulteni 2014;52(2):p120.
6. Ludwin A, Ludwin I. Comparison of the ESHRE-ESGE and ASRM classifications of Müllerian duct anomalies in everyday practice. Hum Reprod 2015 Mar;30(3):569–80.
7. Ludwin A, Ludwin I, Pitynski K, Banas T, Jach R. Role of morphologic characteristics of the uterine septum in the prediction and prevention of abnormal healing outcomes after hysteroscopic metroplasty. Hum Reprod 2014 Jul;29(7):1420–31.