CHOICES PREVAIL WHEN IT COMES TO HYSTERECTOMIES

by Maryjo Faith Morgan |

Making the decision to have a hysterectomy can be confusing. Which is better—a TAH, LAVH, LSH, or TLH? Robotically assisted laparoscopic or not? Are there alternatives to surgery that are effective? Which procedures require general anesthesia and which can be performed with a spinal or epidural? It is essential that candidates for hysterectomies discuss these questions with their care providers.

First, refer to the sidebar on page 89 for more information for the options currently available. If you are facing the decision for having a hysterectomy, you are not alone! True, there is an increase in the number of hysterectomies being performed, but there is also an increase in the number of women seeking solutions and addressing problems sooner. As well, women are being diagnosed with endometriosis at a younger age. Women are no longer willing to suffer in silence. With effective alternatives to surgery and more advanced surgeries that vastly improve quality of life broadly available, waiting is not necessary.

Last year there were 170 hysterectomies performed at Poudre Valley Hospital (PVH); of those, 65 were abdominal and 105 were vaginal. "Although some of these patients would not have qualified due to anatomy, disease, or something else pertinent in their history, I project that a year from now, for any woman who meets the criteria, the procedure of choice will be a robotic assisted or LSH, and most will avoid full abdominal hysterectomies," says Robin Ramsey, RN and Director of Surgical Services at PVH, the first hospital in Northern Colorado to have a robotically controlled surgical suite utilizing the da Vinci™ Surgical System. (Read more about robotic surgery in "da Vinci in the Operating Room" in this issue.)

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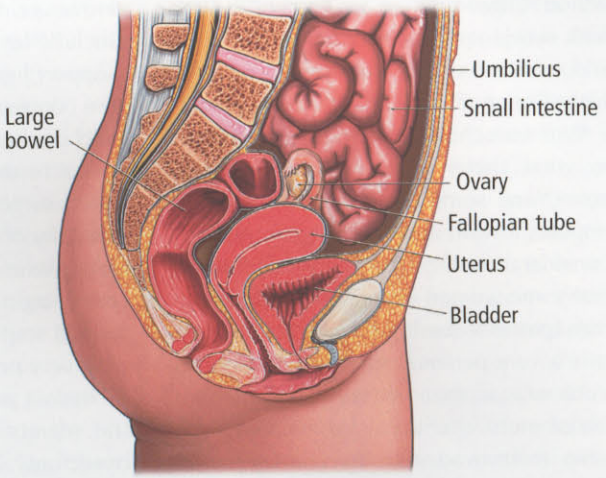
> ***Fort Collins Women's Clinic***

Beverly E. Donnelley, MD of Fort Collins Women's Clinic says women here are savvy, intelligent, and ask good questions. "They tend to be well informed and use the Internet even before they come in to see me." In Dr. Donnelley's mind, the biggest issue is to make sure you do what is best for you. "Don't choose a particular procedure simply because it worked for your mother or sister or a friend. There are many different options to take into consideration when looking at what is best for you individually. In all frankness, I have never had a patient who regretted having a hysterectomy, but you must find the right surgery for the right patient."

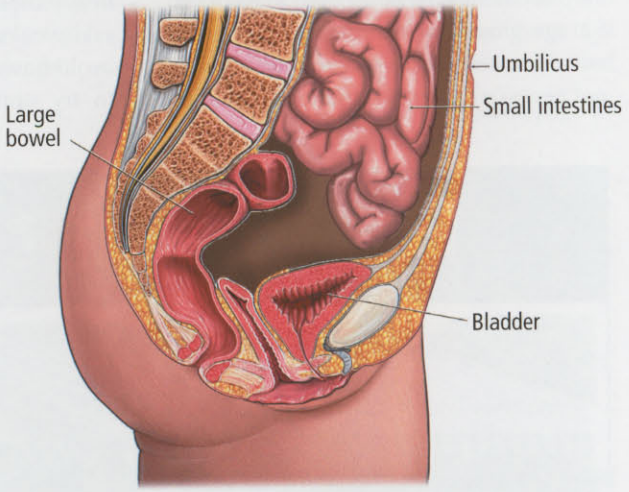
Dr. Donnelley speaks from personal experience, saying that hysterectomies definitely have a real place in medicine. "There comes a point when the uterus is no longer serving you, and a lot can go wrong. Then it's time to seriously consider surgery."

She maintains that it is essential for each woman to thoroughly talk through her options with her care provider, and of course, surgery should not be the first thing to try. "It is common for women to have one or two D&C's (dilation and curettage), endometrial ablation, or to have tried hormonal therapies to cope with any number of uterine difficulties before considering

BEFORE HYSTERECTOMY



AFTER HYSTERECTOMY

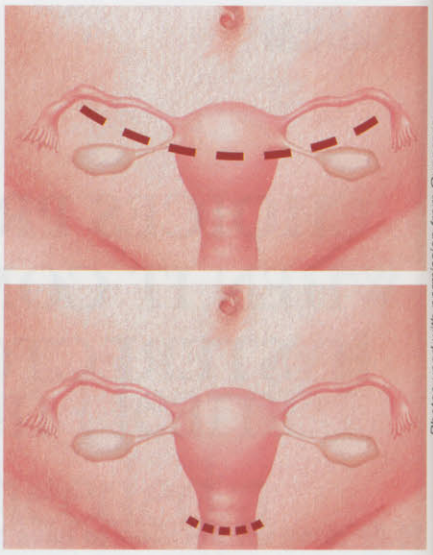


a surgical solution. There are different hormones available now than what we had years ago; they can be a good alternative to surgery. Of course, women may have their own ideas as to what they want. Some come in with their minds made up that they are not having surgery, period. Other women are tired of dealing with symptoms, such as heavy bleeding, and want a hysterectomy just to be done with it once and for all."

Women's choices are sometimes limited to what their insurance providers will cover, and some companies do have an impetus toward avoiding surgery. Another consideration Dr. Donnelley mentions is that some women experience the onset of menopause following a hysterectomy, but it is a very personal response that differs from one woman to another. It is not uncommon, she says, for women who keep their ovaries to have menopausal symptoms for four to six weeks after surgery, then the symptoms disappear. This may not include those women in the 48 to 52 age group, where menopause would occur anyway, simply due to their age and not necessarily in response to the surgery.

There are reasons to remove the cervix, and just as many to allow it to remain. On one hand, it may be prolapsed, or issuing extra discharge, or may have developed pre-cancerous changes, or in the case of a vaginal hysterectomy, physiologically, removal of the cervix cannot be avoided. However, reasons to leave the cervix include less chance of hernia, since many support ligaments to the top of the vagina are connected to the cervix; less bleeding and discharge post-surgery; and the ability to resume sexual intercourse sooner after surgery. Since the neuro-vascular integrity of the pelvic floor remains intact, many women experience continued sufficient vaginal lubrication and undisturbed sexual response after the initial two-week recovery period.

Recent patient, Kim, of Fort Collins, has no regrets about her Supracervical hysterectomy. Although none of the alternative treatments improved her condition nor relieved the constant exhaustion from heavy bleeding she experienced for several weeks every month, Kim wanted to avoid having a hysterectomy. She wanted to try options, but taking iron supplements made her sick, birth control pills made her nervous, and she was just plain tired of being tired all the time. "I had been struggling with symptoms for seven years and had tried everything; I had to do something." When her doctor referred her to Dr. Franco of Columbine Women's



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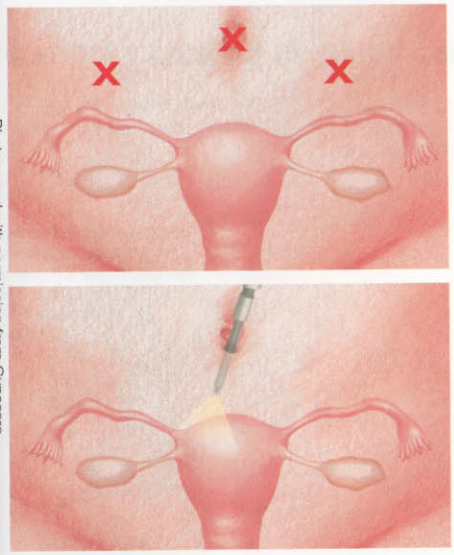
Top: Total Abdominal Hysterectomy
Bottom: Vaginal Hysterectomy.



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Top: Laparoscopically Assisted Vaginal Hysterectomy. Bottom: Laparoscopic Supracervical Hysterectomy.

Clinic as a candidate for a new procedure, she was willing to consider it. "When I heard about it, Laparoscopic Supracervical Hysterectomy, and realized they could do the whole thing laparoscopically, I decided to do it. Just a week after surgery I was feeling perfectly fine. I am totally back. I have energy, can think and concentrate again, and I even went mountain biking this week, just seven weeks after surgery." For Kim, the change from being near to needing a transfusion almost all of the time to having energy to spare has been amazing. For Kim, LSH was a good solution.

Dr. Franco predicts that in his practice, 85 percent of hysterectomies will be the minimally invasive LHS. "We as gynecologists need to look after our patients' best interests and develop new therapies. LHS is one of them; it provides patients with such benefits as less pain and a six-day recovery versus a six-week recovery period. Many women in the business world, raising children, and who are productive contributors to society just don't have the time to take off six weeks for convalescence. It is a tragedy to use so much time for sick leave when they get so little time off in the first place, a shame to be convalescing instead of vacationing. LHS is a great alternative to traditional hysterectomies." An initial study following patients five to seven years post-surgery revealed far fewer cases of pelvic floor prolapse, bladder prolapse, and urinary incontinence.

Dr. Franco hopes that many of the 600,000 women nationwide who have hysterectomies will look at LHS as an alternative. "Presently it is not available everywhere; this procedure was not taught five years ago. If traditional hysterectomy is all physicians know, they will not recommend LHS. They cannot recommend what they do not know." Dr. Franco says LHS is available in cities like Chicago, Los Angeles, Boston, Denver, and now, Fort Collins. He took his training under Dr. Steven Bush in Aurora, Illinois and also with Dr. Viviane Connor of Cleveland Clinic in Weston, Florida. As when considering any surgery, he insists that each patient needs to have a good discussion with her care provider. "Most patients make good, informed decisions when they receive current information and their questions are answered."

As consumers, whether we are talking about goods, services, or medical treatment, it is important that we educate ourselves and be aware of our alternatives, ask questions of trained professionals, and ultimately make our own decisions in a knowledgeable way. Then peace of mind is ours.

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Total Abdominal Hysterectomy, TAH, is the traditional hysterectomy and requires:
- general anesthesia or spinal.
- "Bikini cut" incision.
- removal of the uterus, ovaries, and cervix through a stretched abdominal wall.
- a three to five day hospital stay.
- a six to eight week recovery period.

Vaginal Hysterectomy requires:
- general anesthesia or spinal.
- an internal incision, (one to three inches) at top of vagina.
- removal of the uterus and cervix through the vagina.
- a two to three day hospital stay.
- a six-week recovery period.

Laparoscopically Assisted Vaginal Hysterectomy, LAVH, requires:
- general anesthesia.
- three small incisions (one hidden in the belly button).
- removal of the uterus through the vagina.
- a two to three day hospital stay.
- a six-week recovery period.

Laparoscopic Supracervical Hysterectomy, LSH, requires:
- general anesthesia.
- removal of the uterus with laparoscopic instruments.
- a same day or one day hospital stay.
- a six to ten day recovery period.
- leaves the cervix & vascular integrity of the pelvic floor.

Total Laparoscopic Hysterectomy, TLH, requires:
- general anesthesia.
- three small incisions (one hidden in the belly button).
- removal of uterus and cervix with laparoscopic instruments.
- one day hospital stay.
- a three to four week recovery period.

Some alternatives to surgery include:
- **Dilation and Curettage**, D&C, is a surgical procedure used for the diagnosis and treatment of various uterine conditions. The cervix is dilated and the uterine lining scraped with a curette.
- **Endometrial Ablation** is a procedure that permanently removes the lining of the uterus and is used to stop abnormal bleeding and subsequent anemia.
- **Hormonal/Estrogen therapy**
- **Exercises** to strengthen the pelvic floor or insertion of a pessary (plastic ring) to support the uterus.
- **Myomectomy** to remove fibroid or benign tumors.

Maryjo Faith Morgan is a freelance writer happy to be living in Loveland.