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1

ESYMA usage and the effect on liver function at Nottingham City Hospital

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Abstract

Esyma (ulipristal acetate) has been used successfully in the management of uterine fibroids. However, in August 2018 the Medicines & Healthcare products Regulatory Agency (MHRA) released an alert due to cases of liver injury related to Esyma usage. They advised clinicians not to initiate Esyma treatment in patients and to perform liver function tests (LFTs) in patients currently, or recently, prescribed Esyma. At Nottingham City hospital 99 patients were found to have been prescribed Esyma since January 2017. All these patients were invited for LFTs. We found 19 patients had deranged LFTs. These underwent repeat testing and 9 normalised; in 5 patients no further action was taken as their results were at baseline prior to starting Esyma, or only mildly deranged; 3 patients underwent further investigation of their liver, this included a viral and autoimmune screen and ultrasound. 2 patients were found to have fatty liver, in one patient all other tests were negative. No patients were found to have liver injury secondary to Esyma. Our figures were in keeping with the prevalence of fatty liver and deranged LFTs in the general population. To conclude, we found no cases of liver injury associated with Esyma usage in patients at Nottingham City Hospital and we will now prescribe Esyma following the latest government guidance.



2

Laparoscopic oophorectomy for ovarian torsion of a borderline ovarian tumour during pregnancy. (A case report)

Aiman Aref[1], Muhammad Wali[2]

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[2]Jahraa Hospital, Jahraa, Kuwait

Abstract

Background:

Borderline malignant ovarian neoplasm account for approximately 15% of all epithelial ovarian cancers and are of low malignant potential.

Case:

We reported a 34-year-old pregnant female with single intrauterine viable pregnancy. At 6 weeks gestation, she presented with acute abdominal pain. Ultrasonography identified a left ovarian unilocular cyst measuring 10 cm × 6 cm with solid papillary projections and showed normal ovarian Doppler blood flow but with tenderness on probe manipulation.

Laparoscopic left oophorectomy was performed using laparoscopic retrieval bag with no peritoneal spillage. Histology showed borderline ovarian serous cyst adenoma of micro-papillary variant.

She continued pregnancy under multidisciplinary expert team (MDT) , where she is planned for a full staging laparotomy at the time of planned caesarean section delivery at 36 weeks gestation with steroid coverage for fetal lung maturity.

Discussion:

Diagnosis of adnexal torsion in borderline tumours during pregnancy can be difficult, because of their rare incidence of 1 per 100,000 pregnancies. There is no guidance on the management of ovarian torsion during pregnancy, but laparoscopic oophorectomy has been reported safely in some case reports.

These neoplasms are still of low malignant potential. Most gynaecologic oncologists recommend a full staging laparotomy, with conservative therapy in the form of oophorectomy in patients who desire further childbearing and have stage IA disease. Whilst total hysterectomy with bilateral salpingo-oophorectomy for those not desiring childbearing or with more advanced disease.

Conclusions:

This rare conditions during pregnancy needs to be managed by an expert gynaecological endoscopic team to achieve optimal outcome.

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4

Endometrial ablation outcomes after 10 years following the procedure in Royal Gwent Hospital, Newport.

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Abstract

We reviewed local outcomes of endometrial ablation in relation to patients' age and histopathological reports after hysterectomy performed following failed endometrial ablation. Having this information would be very useful in counselling process and selection of patients for the procedure.

Endometrial baloon ablation done with Thermachoice device has become obsolete as it was withdrawn from the market. However, head to head studies with currently used Novasure conclude similar outcomes for both. We therefore retrospectively reviewed outcomes following Thermachoice ablation performed in 2008 and divided them into four age groups: women between 30-45, 36-40, 41-45 and 46-50 years of age. Histopathological reports of all hysterectomies were reviewed.

A list of 215 patients who undergone endometrial ablation or Thermachoice was obtained from ORMIS theatre system. There were 28, 34, 67 and 55 women in 30-35, 36-40, 41-45, 46-50 year old groups respectively.

There were nine (32%), eight (23%), 15 (22%), and six (11%) hysterectomies performed in 30-35, 36-40, 41-45, 46-50 year old groups respectively. 15 (53%), 23(67%), 44(65%) and 45 (81%) women had no further interventions for heavy menstrual bleeding in 30-35, 36-40, 41-45, 46-50 year old groups respectively. There were four pregnancies reported in 3 women in the youngest gropu. Out of 38 histopathological reports, 24 (63%) reported adenomyosis and/or fibroids.

Adenomyosis and fibroids might be responsible for the failure of endometrial ablation. Women with above diagnoses should therefore be considered for hysterectomy rather than endometrial ablation. Larger studies are needed.



6

Endometriosis on finger tips!! A review of endometriosis mobile apps.

Smriti Kuntal
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Abstract

Mobile apps are engaging, informative, and have an increasing use with data showing an average American spends 2 hours on social media

An app search with "endometriosis" on apple store revealed 9 unpaid and 5 paid apps ranging between £1.99-£4.99. Each app was evaluated on version history, public rating and age appropriateness, developer background, GDPR encryption and privacy policy, terms and conditions and data protection. A mobile app rating scale was used to evaluate and a score was assigned based on recommendation based on content, usage count, cost effectiveness and overall rating.

80% apps required an email to log in/raise a query/interact but only 8% apps had information regarding data storage. Only 60% had a bespoke privacy policy. No app offered evidence based medical information or had a developer with a medical degree which was apparent only after purchasing the app. Quality of paid apps appeared better and only 40% had a complaints procedure incorporated. Apps sold as endometriosis were more like period recording log

An ideal endometriosis app would be an NHS app (reliable and authentic), evidence based, free, secure, encrypted patient information, illustrative, interactive and easy to download on any device.

It would aim to reduce clinic time by discussing treatment options and explain risks and benefits, side effects and expected outcomes

It would help to prevent delay in diagnosis-patient/GP information regarding when to seek help, when and where to refer.Existing apps are not evidence based -with a scope of improvement and use within NHS



7

USE OF VISUAL ABSTRACT IN GYNECOLOGY TO DISSEMINATE SCIENTIFIC RESEARCH-SEEING IS BELIEVING

Samina Elahi
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Abstract

Aim/Objective:

To learn best methods to disseminate research in an effective way in Gynaecology. One approach is visually summarising the key points from a research article as "visual abstracts".

Background:

To date, more than 75 journals and institutions have adopted the visual abstract in their dissemination strategy including the CDC, BMJ, JAMA and NEJM. This will also allow the fast transmission of information through rapidly growing social media. However, the gynecology specialty is very laid-back in adopting this new innovative approach.

Material/Methods

Few hypothetical examples of this approach are as follows.

Examples of at least 2-3 visual abstracts

Conclusion

This approach will allow the reader to gain an understanding of main take home message and help readers to identify which papers are more relevant to their research. It attracts the reader at a glance with temptation to read this article. When prepared correctly can hold more information than the amount of text and the results can be captivating to explain one's work.

References

1: Nikolian VC, Ibrahim AM. What does the future holds for scientific journals? Visual abstracts and other tools for communicating research. Clin Colon Rectal Surg.2017 Sep;30(4):252-258.

2: McCormack L, Sheridan S, Lewis M et al. Communication and dissemination strategies to facilitate the use of health-related evidence. Evid Rep Technol Assess (Full Rep).2013 Nov;(213):1-520.

8

Laparoscopic Hysterectomy as a day-case procedure in a district hospital

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Abstract

Objective:

To demonstrate that total laparoscopic hysterectomy (TLH) performed at a district hospital continues to have a low rate of complications and remains feasible and safe to perform as a day-case surgery.

Design:

The low rates of complications and short hospital stays suggest that TLH as a day case is, not only safe, but potentially cost-effective. We report a retrospective case series between May 2013 and December 2018 conducted at district gynaecology department to discern quality improvement and treatment efficacy.

Methods:

142 patients met pre-defined pre-operative criteria, based on the BMI, age, ASA score and indications. Records for TLH performed between May 2013 and December 2018 were analysed for adverse events, length of in-patient stay and patient satisfaction.

Results:

The mean estimated blood loss was less than 300ml, with the average uterine weight being 720g. There were no intra or early post-operative complications. Operating times reduced from a mean 120 minutes to approximately 45-90 minutes over the series duration. The average length of stay was 1.5 days.

Conclusions:

TLH is associated with favourable intra-operative and post-operative outcomes, supporting the notion of performing TLH as a day-case procedure. TLH was associated with a shorter recovery period and increased patient satisfaction. Offering TLH with a '1-day stay' policy will mean the higher initial costs of TLH are compensated by the shorter hospital stay. This relies on optimized patient and surgeon selection, potentially with a selection criteria. It is likely that we will see day-case laparoscopic hysterectomies as the default across the UK.

9

Experience of Myosure in NHS Lanarkshire

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Abstract

Objective

Hysteroscopic removal of endometrial polyp and submucous fibroids with myosure was introduced in NHS Lanarkshire in 2015.

Design

Retrospective study to assess management of endometrial polyps and submucous fibroid with myosure over one year (2017).

Method

Data was collected from electronic patient record. Total number of cases was 18. Analysis was done in form of mean and percentages.

Results

Average age of the women who underwent myosure was 61.5 (range-43-74). 8/18 (45%) were in the age group of 60-70 years. About 60% (n=11) were obese with 17% (n=3) being overweight. Average operating time was 140.6 sec (range-13-589sec). 45% (n=8) were operated within 1 min. The average fluid deficit was 1025 ml (range-260-2562ml). In 2 procedures fluid deficit was >2500.

13/18 had previous failed polypectomy. Perioperatively 10 were documented as polyps and 8 as submucous fibroids (all Type 1). Out of 10 polyps, 9 correlated on histology while 1 was reported as submucosal fibroid. Of the 8 documented fibroid polyp/submucosal fibroid, 4 correlated appropriately, 2 were reported as polyps,1 was endometrial carcinoma and 1 was reported as benign adenofibroma.

Myosure was successful in 16 cases (89%).

Conclusion

Having ruled out malignancy in women presenting with polyps/fibroid, myosure appears to be ideal, especially in cases of those who are unfit for major surgeries due to high BMI/co-morbidities or have had failed blind polypectomy. These women would otherwise have ended up having hysterectomy.

11

Outcomes & complications from 6 months of Laparoscopic Hysterectomy

Michael Magro, Guy Fisher
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Abstract

Background

Laparoscopic hysterectomy now commonly seen as preferred route

No national/local audit standards exist to compare practice to.

Aim was to audit current practice to identify if we could create local standards

Methods

All cases of laparoscopic hysterectomy at our hospital identified between 1/3/18 to 30/9/18 (6 months)

Results

44 cases conducted.Full notes available for 39 patients.

36 TLH with 3 Subtotal

36 Had BSO, 1 unilateral salpingoophorectomy and 2 had ovarian conservation

Additional procedures: (11 had adhesiolysis, 4 had other procedures)

43.6% done by Benign gynaecologists, 56.4% by Gynaeoncologists

Indication: Majority (38%) done for suspected cancer, 13% for endometriosis, 10% due to menorrhagia, 8% due to fibroids, 8% due to adnexal pathology and 3% due to adenomyosis

Pre-op complications: 18 had no pre-op complications, 7 BMI >35, 6 previous laparotomy, 6 previous appendectomy

Intra-op findings: 28% Normal, 43% Bowel or omental adhesions, 26% fibroids, 10%endometriosis, 18% ovarian cysts, 8% bladder adhesions

Complications: 2 converted to open due to significant adhesions. 1 had a return to theatre for laparotomy secondary to bleeding from peddicle, 1 had vaginal wall tear & 2 had post-op haematuria. No bladder/bowel/ureter injuries.

Blood loss: Median 200ml, 75% <100ml. Post op Hb done in 90% with Median drop of 15g/L (0-40g/L). 1 had Blood transfusion, 1 had FeSO4.

Length of stay: Day 1 (20), Day 2 (17), Day 3 (1),Day 7 (1)

Recommendations

To use data to create local standards

Set up enhanced recovery service to improve discharge time

No FBC if EBL<100mls

13

Major vascular injury during gynaecologic laparoscopy; case report and literature review

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[4]Consultant at Dudley Group NHS trust, Dudley, United Kingdom

Abstract

Objective:

We are presenting a case of Aortic and Left iliac vein vascular injury caused by trocar during primary entry at a diagnostic laparoscopy.

Design: We are presenting a case report and performing a literature review of vascular complications in laparoscopic surgery as well as approach to management.

Case:

A 42-year-old patient with history of chronic pelvic pain and menorrhagia . It was agreed her symptoms likely are due to deep infiltrating endometriosis and diagnostic laparoscopy were arranged for confirmation.

Standard closed entry was used ,When the primary port was inserted, a pool of fresh blood was noted. A second port was inserted under direct vision. There was no visible injury, however the bleeding was increasingly rapidly. Midline laparotomy was performed as the patient became haemodynamically unstable. The vascular surgeons attended and identified an injury to the aorta and Left iliac vein from the trocar. The aorta was repaired with a Dacron graft .

Conclusions:

Given morbidity and mortality rates (6-13%) associated with major vascular injury; its incidence in laparoscopic gynaecologic procedures with the most used technique being closed technique leads us to suggest using open technique which may decrease vascular injuries. A systematic approach to manage these injuries include rapidly recognising the injury, communicating with theatre team, resuscitation and controlling the haemorrhage according to the location and severity of the injury. Major vascular injuries require immediate massive haemorrhage protocol activation, multidisciplinary communication, midline laparotomy, and vascular surgeons urgent help. Timely intervention in such cases could prove to be life saving.

18

Demand for a Unified Surgical Consent Process at North Bristol NHS Trust

Jessica Preshaw, Susie Hogg, Sanjay Vyas
Southmead Hospital, Bristol, United Kingdom

Abstract

Aim

To determine surgical consent processes adopted by clinicians across the largest NHS trust in the South West, UK.

Method

A cross specialty online survey to consultants focusing on elective surgeries performed under general or regional anaesthesia within an operating theatre. Ambulatory procedures excluded.

Results

132 responses received, 64% performing procedures requiring written consent.

76% routinely take surgical consent on day of admission. 9% utilise a separate consent clinic. Consultants undertake most consent, especially major procedures. Trend identified for more junior operators consenting for more minor procedures. Few specialties use prepopulated consent forms including O&G, gastro/hepatology, anaesthetics. 58% utilise pooled operating lists. 'Request for treatment' forms are sparsely used (5%) adopted in general surgery, urogynaecology, T&O. The majority (77%) supports an online, mobile consent process and resource. The majority (71%) supports a trust-wide policy on timing of consent.

Themes detected include: desire for consent prior day of surgery; consent is a process; consent clinics favoured; geographical difficulties related to tertiary centre status; anaesthetic considerations; standardised processes; online information and consent supported; pre-populated consent forms controversial.

Conclusions

The high response rate with cross specialty input illustrates consultant body engagement and topic importance. Consent is recognised as a process beginning at initial consultation until surgery, but this journey varies widely depending on specialty. Most consent is executed by consultants, finally undertaken on admission for surgery though some specialties utilise separate consent clinics. Despite controversies there is demand for a unified process pertinent at local level but also nationally.

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A New Independent Risk Factor for Ectopic Pregnancy: Presentation at very early gestational age has higher rates of ectopic pregnancy.

Alison Montgomery, Lauren James, Gayle Brittain, Catherine Rothon, Kevin Hayes
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Abstract

The average gestation of ectopic pregnancies is 6 weeks. We have hypothesised that there is a group of patients that present with very early gestational dates of between 0 – 4 weeks' and that they have a higher rate of ectopic pregnancy. This strata of patients presenting with very early gestational dates and the association with higher rates of ectopic pregnancies has previously been unreported. It is unclear why patients present with these early dates and it is most likely related to irregular bleeding from the pregnancy that is felt to be their last menstrual period. Therefore we present the evidence of a new independent risk factor for ectopic pregnancies.

A pilot study was carried out looking at all patients presenting to our early pregnancy unit between 1stjanuary 2016 to 31stdecember 2016. There were 4727 pregnancies scanned in total. The proportion of ectopic pregnancies at different gestations was analysed. Patients presenting at less than or equal to 4 weeks' gestational age have a risk of having an ectopic pregnancy of 10%. However, those presenting greater than 4+0 weeks have only a 1.45% risk of having an ectopic pregnancy.

This research represents a new independent risk factor for ectopic pregnancies. We have demonstrated that patients presenting at earlier gestations are at higher risk of ectopic pregnancy. This is hugely important new information that can help triage and diagnose patients in an early pregnancy setting and all trainees in gynaecology should be aware of this new risk factor.



21

EFFECT OF SALPINGECTOMY VERSUS EXPECTANT MANAGEMENT FOR TUBAL ECTOPIC PREGNANCY ON OVARIAN RESERVE: A Prospective Study.

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Abstract

The primary objective of this research is whether ectopic pregnancy and its' treatment by salpingectomy affects ovarian reserve.

This is a prospective observational study. Patients were eligible for inclusion if they had a tubal ectopic pregnancy diagnosed between 1stOctober 2017 and 30thSeptember 2019. Therefore, this study is ongoing and 28 patients have been recruited thus far. At the time of diagnosis, FSH and AMH were taken along with ultrasound measurements of antral follicle count and ovarian volume in 2D and 3D and ovarian blood flow in 3D. These serum and ultrasound measurements have then been repeated at 4-6, 12 and 24 months after the initial diagnosis.

28 patients have been recruited thus far in this prospective study with at least double these numbers expected by the completion date. 24 patients had salpingectomies for their ectopic pregnancies, whilst 4 had expectant management. Initial analysis has shown an average AMH in the conservatively managed group of 11.75pmol/L at time of diagnosis versus 24.3pmol/L in the surgically managed group.

No studies have examined surgical versus conservative management and ovarian reserve in women with ectopic pregnancies before. This preliminary data is surprising given the difference in AMH between the expectant and surgically managed group even before management. This study is being rolled out as a multicentre study and so many more patients will be able to help substantiate whether this is a true difference or not.



23

Endometrial ablation – can an outpatient approach avoid hysterectomy?

Helen Clarke, Satthiyabama Arutchelvam
Mid Cheshire Hospitals NHS Trust, Crewe, United Kingdom

Abstract

Objective:

To evaluate inpatient and outpatient endometrial ablation procedures in terms of clinical success, patient satisfaction and further treatment.

Design:

Prospective audit of endometrial ablation patients over a two-year period and follow-up at six months post-procedure to evaluate symptom profile and patient satisfaction.

Method:

Audit points included TVUS pre-procedure, endometrial sampling, cavity documentation, procedural success, 6-month follow-up of patient symptoms and satisfaction.

Results:

60 patients included; 29 outpatient ablation, 31 inpatient. 100% of patients had a TVUS pre-procedure and 100% had normal histology. One case of failure within the inpatient cohort. Three patients (5%) were dissatisfied with the outcome at 6-month follow-up; two inpatient, one outpatient. Of those, one had a TLH. One patient required repeat ablation within twelve months.

Conclusions:

We had a very high success rate (98%) within our cohort of patients. Only one procedure failed owing to a large cavity. One patient went onto require definitive treatment in the form of a laparoscopic hysterectomy and one required a repeat procedure within twelve months. We had a patient satisfaction rate of 95% overall, with slightly higher satisfaction within the outpatient group (97% vs 94%).

Within our cohort we have demonstrated that endometrial ablation is a successful alternative to major definitive surgery for selected patients with heavy menstrual bleeding and an outpatient approach has a low failure rate with high satisfaction. The effects of this can decrease pressures on inpatient surgical lists and therefore cost savings can be generated whilst maintaining good patient care.

24

A Rare Case of Haemorrhage due to Arteriovenous Malformation

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Abstract

Introduction:

Uterine arteriovenous malformation (AVM), whilst rare, can cause catastrophic bleeding. Diagnosis can be difficult, and surgical intervention could make bleeding worse, leading to increasing morbidity.

Case Description:

A 25 year old, who had undergone an early medical abortion (EMA) at 9 weeks gestation 3 months previously. She started the progesterone only pill (POP) at this time. She stopped the POP 3 days prior to presentation. She started bleeding, and gave a history of extremely heavy menstrual bleeding. She presented to A&E 2 days following this as she was feeling unwell. She was haemodynamically unstable on presentation to A&E. A blood gas was taken showing that she was severely anaemic. HCG was negative. She was resuscitated with red blood cells and fluids. Pelvic ultrasound showed a large AVM with a high flow feeder vessel direct from the left internal iliac artery. She had a CT scan which confirmed these findings. Conservative management was planned as the bleeding stopped with medical management. However, she then had another 1700ml blood loss on the ward. She underwent uterine AVM embolisation with success the following day.

Discussion:

Uterine arteriovenous malformation is a rare cause of heavy menstrual bleeding. It must be considered in any woman who presents with bleeding and a negative pregnancy test. There is an association with AVM development following a pregnancy, particularly following MTOP or miscarriage. A multi-disciplinary approach must be used, including gynaecology, vascular radiology and haematology to ensure the morbidity of haemorrhage of this aetiology is reduced.



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The Cost of Living: A cost-benefit analysis of instrument choice when performing laparoscopic salpingectomy for ectopic pregnancy

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Abstract

There are 11,000 ectopic pregnancies in the UK annually with 60 – 75% managed surgically. Reducing cost without compromising patient care would allow for significant redistribution of finances.

Our unit performed 50 laparoscopic salpingectomies over 12 months. We analysed instrument use, operator experience, operative time, case complexity, procedure timing, and complications.

The majority of operators at all levels(64%) preferred the disposable Voyant advanced bipolar cutting diathermy. Trainees operating alone showed greatest affinity. This was especially true for complex or out of hours procedures. The mean operating time was 56minutes - 35% faster than multiple instrument techniques - for a total cost of £1518.50per case.

Disposable bipolar diathermy and scissors which forms the RCOG standard assessment of competency was used by 29% of surgeons, had a mean operation length of 76 minutes and a total cost of £1794.00 as extended operating times offset lower instrument cost. Reusable bipolar diathermy would cost £1672.50, and less each time it is re-used.

The remainder of cases were performed using BiCoag bipolar cutting diathermy or endoloop with similar median operating times of 65 minutes and a cost of £1488.50 and £1444 respectively.

Consideration was given to patient outcomes, ease of use, safety, infection risk, operation length and time of day, need for skilled assistants, staffing levels, equipment failure rates, training, environmental concerns and lack of product cost transparency leaving leeway for negotiation of purchase price.

Advanced bipolar cutting diathermy is recommended based on analysis of these factors unless training in multiple instrument technique can reduce operative time.



28

A Review of the Accuracy of Transvaginal Ultrasound Scan in Investigating for Endometrial Polyps in symptomatic women undergoing hysteroscopy at a District General Hospital.

Helen Stevenson, Manjula Subramanian, Farah Naz
Russell's Hall Hospital, Birmingham, United Kingdom

Abstract

Background:

Women presenting with symptoms including postmenopausal or irregular vaginal bleeding undergo pelvic ultrasound as first line investigation. If an endometrial polyp is suspected from scan this is removed at hysteroscopy, however, in our hospital this requires a general anaesthetic. Newer outpatient devices mean endometrial polyps can be removed via hysteroscopy in outpatients.

Methods:

465 notes were reviewed of patients who underwent both ultrasound and hysteroscopy January-October 2018.

Results:

The most common indications for hysteroscopy were postmenopausal bleeding in 148 (31%), Intermenstrual bleeding in 107 (23%), menorrhagia in 150 (32%), and incidental finding of polyp on scan in 26 (5.6%). The most common procedure was hysteroscopy and endometrial biopsy in 175 (38%) and hysteroscopy with polypectomy in 108 (23%). Histology showed either hyperplasia or malignancy in 29 patients.

In 76 patients a polyp was seen on both scan and at hysteroscopy. In 74 patients a polyp was seen on scan but not present at hysteroscopy. In 32 patients a polyp was removed at hysteroscopy which wasn't identified on scan.

Discussion:

Despite symptoms and abnormal scan appearance, the incidence of abnormal histology was low at 6.2%. The incidence of polyp at hysteroscopy was 26% overall and 51% of those with an abnormal pre-operative scan. Patients should be offered outpatient hysteroscopy to confirm the presence of polyp prior to listing for GA. This will reduce anaesthetic and operative complications. Investing in devices to see and treat polyps in outpatients will mean more patients undergoing smaller procedures with quicker recovery time.

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Laparoscopic Excision of Rectovaginal Endometriosis at Croydon Endometriosis Centre: a single centre prospective cohort study

Marianne Wild, Emmanuel Ofuasia, Heather Allen-Coward, Elaine Williams-Brown, Ian Swift, Babbin John, Shikha Pandhi, John Rendle

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Abstract

Women undergoing laparoscopic excision of rectovaginal endometriosis requiring dissection of the pararectal space at Croydon Endometriosis Centre completed a BSGE Pelvic Pain Questionnaire at first presentation, 6 months, 12 months and 24 months following surgery. Data was collected prospectively on the BSGE database. Secondary analysis of quality of life (QoL) and symptom severity responses was performed. Patient-reported QoL data was collected using the EuroQol-5D-3L questionnaire and EuroQol Visual Analogue Score. Symptom severity was graded on a 0-10 Likert scale, and bowel symptoms were graded 0 to 4, depending on frequency of symptoms.

37 women underwent surgery between 1.1.15 and 31.12.16. 2 were excluded due to inadequate follow-up data. The reduction in pain and increased QoL observed at 6 months following surgery was maintained at 24 months. All types of pain and bowel symptoms improved following surgery, but particularly premenstrual and menstrual pain. There was a significant reduction in the overall need for analgesia. When comparing the figures to the BSGE's recently published national data1, Croydon Endometriosis Centre had a greater improvement at 24 months for: premenstrual, menstrual, and lower back pain, faecal frequency, urgency and incomplete emptying sensation. Croydon patients self-reported a higher standard of health at presentation, and a similar standard of health at 24 months. Using the EQ5D Index (calculated from the EuroQol-5D-3L), patients from Croydon had greater improvement in QoL at 24 months postoperatively. We attribute this success to excellent multidisciplinary team working.

1Byrne D et al.Laparoscopic excision of deep rectovaginal endometriosis in BSGE endometriosis centres.BMJ Open 2018;8:e018924.doi:10.1136/bmjopen-2017-018924



30

Laparoscopic Power Morcellation: Successful pre-operative screening in a high risk population

Marianne Wild, Emmanuel Ofuasia
Croydon University Hospital, London, United Kingdom

Abstract

Background

Following the FDA's controversial 1 in 350 estimated risk of leiomyosarcoma (LMS) in 2014, the BSGE released a statement supporting the continued use of laparoscopic power morcellation in selected cases. Our aim was to audit compliance with the BSGE's recommendations.

Methods

Case note review of women who underwent laparoscopic subtotal hysterectomy or myomectomy using a power morcellator at Croydon University Hospital over the last 10 years.

Results

28 laparoscopic myomectomies were performed. 17 women were black race and 14 were over 35 years old. Four women had more than one risk factor for LMS. 26 had a preoperative pelvic ultrasound and 15 had MRI. One patient was not imaged as she had a recent laparoscopy. 25 laparoscopic subtotal hysterectomies were performed – nine had fibroids and at least one risk factor for LMS. 14 women were over the age of 45.

50/53 women had adequate investigations to exclude malignancy. Median length of stay was one day for both procedures and there were no major complications. One woman had complex atypical endometrial hyperplasia despite normal hysteroscopic biopsy. There were no cases of LMS and all morcellations were performed by an appropriately trained surgeon. Despite this, women were not given adequate written information or specifically consented for morcellation.

Conclusions

Awareness of LMS and the risks of power morcellation are essential for preoperative counselling. Specific patient information leaflets and consent forms have now been implemented. Trial of in-bag morcellation is in progress and a re-audit in 2 years time is planned.

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Comparison and validation of various Hysteroscopic polypectomy techniques used in our department (Tissue removal kelly forceps versus Myosure) – An Observational cohort study

ARUMUGAM JAYANTHI, Gudrun C Rieck
Ysbyty Gwynedd, Betsi Cadwaladr University Health Board, Bangor, United Kingdom

Abstract

Back ground:

Endometrial polyps are one of the most common causes of abnormal uterine bleeding accounting for 7.8 – 34.9% of gynecological referrals across studies.

Our unit uses the following techniques for intrauterine polyp removal,

- Hysteroscopy directed polypectomy using grasping forceps or microscissors
- Hysteroscopy followed by polypectomy using tissue removal Kellys forceps
- Myosure – intrauterine morcellator.

Aim:

In this study, we compare outcomes of the Myosure group with the mechanical polypectomy group, outcome parameters are: the type of polyp, age group, BMI, menopausal status, complication rates, Visual pain score and resolution of abnormal uterine bleeding.

Method:

An observational retrospective cohort study of 247 consecutive patients who underwent polypectomy between Jan 2014 to Jan 2019.

Setting:

Outpatient Hysteroscopy suite at Ysbyty Gwynedd, Bangor

Data Collection & Analysis:

Data were collected prospectively during the procedure and retrospectively from the hospital computerized result system. The data was analyzed using Descriptive statistical analysis technique

Interventions:

Out of 247 patients 138 underwent hysteroscopy under local anesthesia, followed by polyp removal using mechanical polypectomy. Alternatively, 79 patients underwent Myosure technique under local anesthesia.

Main results: In the mechanical polypectomy group, 18% had a failure to remove a polyp, 26% had incomplete removal due to pain, VAS for pain was average 6-8 and one perforation.

In the Myosure group, the VAS score was 1-2, 98% had complete removal of the polyp with 2 patients needing a blood transfusion and one patient underwent Hysterectomy. Postmenopausal women seemed to tolerate Myosure well and resolution of Abnormal uterine bleeding was more than 80%.

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Is it time for established Fibroid Centres? Analysis of uterine fibroid surgical management in a London Teaching Hospital. A 4-year retrospective view, towards a responsive approach to the management of fibroids.

Sophie Strong, Zwelihle Magama, Shahrazed Rouabhi, Funlayo Odejinmi
Whipps Cross Hospital, London, United Kingdom

Abstract

Objectives:

To review surgical interventions women with fibroids underwent across 4 years at a busy London hospital. To act as a driver for change towards holistic management for these women.

Method:

All myomectomies, Uterine Artery Embolisations (UAE), Transcervical Resection of Fibroids (TCRF) or hysterectomies for fibroids were analysed (n=236); demographics and outcomes were reviewed.

Results:

The 236 women; 92 (39%) laparoscopic myomectomy, 9 (4%) open myomectomy, 28 (12%) UAE, 29 (12%) TLH, 30 (13%) LASH, 43 (18%) TCRF, 5 (2%) open hysterectomy. Minimally invasive techniques were used in 94% of cases. Mean ages ranged from 37 (laparoscopic myomectomy) to 49 (open hysterectomy).

Mean clinical size of uterus was greatest for open surgeries; 31/40 (Hysterectomy) and 25/40 (Myomectomy) compared with the minimally invasive group 11/40 (TCRF) and 21/40 (LASH). Blood loss for open surgery was higher; myomectomy (μ=756ml) vs. TLH group (μ=165ml).

Days to discharge for laparoscopic group (μ = 1) vs. open group (μ = 3), all embolisations discharged <24hours. Only 7% who underwent open myomectomy (uterine size <16/40) were suitable for laparoscopy.

Conclusions:

Our figures demonstrate that minimal access interventions are possible for most women. However, when selecting an intervention, demographics and outcome desires should be considered. Gynaecologists should share their figures to facilitate women's decision making to ensure that patients receive the best intervention by the most appropriate surgeon and can make an informed choice about their care. We suggest an 'MDT approach' for difficult cases to ensure minimal access techniques as gold standard.

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Route of Hysterectomy at Croydon University Hospital: a retrospective audit

Marianne Wild, Joseph Hogan, Emmanuel Ofuasia
Croydon University Hospital, London, United Kingdom

Abstract

Background

Since the publication of the RCOG's Patterns of Benign Gynaecology Care Report 2015-16, there has been a significant onus on Trusts to audit route of hysterectomies, length of stay and readmission rates locally. Our aim was to follow these recommendations and identify opportunities to improve clinical care and patient choice.

Methods

Retrospective case review of all hysterectomies performed at Croydon University Hospital between July 2017 and July 2018.

Results

Out of 223 hysterectomies, 32.3% were laparoscopic, 22.9% vaginal and 40.4% abdominal. 4.5% of surgeries were converted from laparoscopic to abdominal. 16.7% of abdominal hysterectomies had a normal sized uterus and 26.7% had a ≤12 week size uterus. Median length of stay was one day for laparoscopic, two days for vaginal, and three days for abdominal surgery. Complication and readmission rates were low.

Conclusions

The national laparoscopic, vaginal and abdominal hysterectomy rates in 2017 were 47.2%, 3.5% and 46.5%1. Our high rate of vaginal hysterectomy is likely two fold – we have a prominent urogynaecology unit and perform more hysterectomies for benign indications. Although there are six consultants capable of performing laparoscopic hysterectomy, 42% of women did not have a normal sized uterus and 4.5% had contraindications to laparoscopic hysterectomy. To increase our laparoscopic rate, women opting for hysterectomy with a uterus ≤12/40 size should be offered referral to a consultant trained in performing minimal access surgery.

1Madhvani K, Curnow T and Carpenter T. Route of hysterectomy: a retrospective, cohort study in English NHS Hospitals from 2011 to 2017.BJOG 2018;doi.org/10.1111/1471-0528.15539



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200 cases of Endometrial cancer in the Southern Health and Social Care Trust

Christopher Skelly, Susan Wilson, Geoff McCracken
Craigavon Area Hospital, Craigavon, United Kingdom

Abstract

Objective:

To investigate the outcomes of 200 women with early stage Endometrial Cancer managed at a District General Hospital over a 10 year period.

Methods:

Retrospective audit of 200 patients with confirmed endometrial cancer, within one Trust in Northern Ireland, from 2009-2018.

Patients were identified from a database of recorded cases, with information collected from Northern Ireland Electronic Care Record. Data was subsequently analysed using Microsoft Excel.

Results:

88% were overweight or obese

74% presented with postmenopausal bleeding

54% women underwent total laparoscopic hysterectomy (TLH), 28.5% abdominal hysterectomy, 13.5% vaginal hysterectomy (VH), 3.5% Laparoscopic assisted vaginal hysterectomy (LAVH), 0.5% transcervical resection and mirena

Complication rate was 5% for both laparoscopic and abdominal hysterectomy groups, 1% for vaginal and LAVH.

Conversion rate from laparoscopic to open hysterectomy was 3.6%

Pre-operative histology compared with hysterectomy specimen matched in 78% cases. 3% were significantly upgraded from low to high grade.

Pre-operative radiological staging matched the hysterectomy specimen in 69% of cases. 6% were upstaged from Stage 1, to Stage 2 or 3.

Overall confirmed recurrence rate was 2.5%. None were detected through standard follow-up pathways.

(Further results available)

Conclusions:

This study supports the strong association between high BMI and endometrial cancer. Laparoscopic hysterectomy is the most common mode of surgery. Complication rates are low considering the patient demographic. The shortest median length of stay was with vaginal and laparoscopic hysterectomy. Preoperative grading and staging are relatively accurate. Confirmed recurrence rates are low. Clinical follow-up is not useful in detecting recurrence in the majority of patients.

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Haemoperitoneum and the natural history of deep endometriosis (DE): An ultrasound study

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Abstract

Objectives:

The aim of this study was to test the hypothesis that significant haemoperitoneum that is managed conservatively precipitates the development of DE.

Methods:

This was a prospective observational cohort study conducted over 18 months at University College London Hospital. We included consecutive pre-menopausal, non-pregnant women who attended our dedicated gynaecology unit with acute severe lower abdominal pain and underwent clinical assessment including pelvic ultrasound examination. Presence of significant haemoperitoneum was defined by ultrasound findings of blood clots within the pelvis. Women were managed surgically or conservatively, depending on the severity and cause of symptoms. Those who had conservative management were invited for follow up scans. The primary outcome of interest was evidence of newly developed DE at follow up.

Results:

During the study period, 118 non-pregnant pre-menopausal women attended our gynaecology unit with acute severe lower abdominal pain. 17% had emergency surgery and 83% were managed conservatively. 17 women were excluded from the study due to a previous history of endometriosis or findings of DE on pelvic ultrasound at initial assessment. Of the 81 women included in the study, 8(10%, 95% CI 3-16) had evidence of significant haemoperitoneum. Of the 35 women that attended for follow up, 4/6(67%, 95% CI 22-96) women with initial presentation of haemoperitoneum have developed new evidence of DE compared to 1/29(3%, 95% CI 0-18) without haemoperitoneum [RR 19.3 (95% CI 3-144) P <0.001)]

Conclusions:

In some women, the presence of significant haemoperitoneum that is managed conservatively precipitates the development of DE.

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Abdominal ectopic pregnancy after caesarean hysterectomy: a case report and review

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[2]Glan Clwyd Hospital, Rhyl, United Kingdom

Abstract

Ectopic pregnancy occurring after hysterectomy is very rare. A 38-year-old woman presented with suprapubic pain, dysuria and fever. Nine years earlier she had a total abdominal caesarean hysterectomy with conservation of ovaries at the time of her 3rdcaesarean, due to placenta percreta. At presentation her urine pregnancy test was positive and serum hCG was 2409 mIU/mL. Emergency laparoscopy was carried out due to pain and deterioration. A haemorrhagic lesion attached to the sigmoid colon was removed with histology confirming an extra-uterine gestation. We consider the possible aetiologies, including method of hysterectomy as a causative factor, as well as management strategies to reduce incidence both at the time of, and following, hysterectomy. We also discuss the role of contraception in women that have had a pregnancy after hysterectomy. Although this phenomenon is a rare event, all women presenting with abdominal or pelvic pain with a history of hysterectomy and conservation of ovaries should have pregnancy ruled out.



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An Unusual Late Complication of Endometrial Ablation

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Abstract

An Unusual Late Complication of Endometrial Ablation

A 52 year old, normally well lady presented 15 years post microwave endometrial ablation with a small PV bleed. She was post-menopausal. She had a background of endometrial ablation, TVT and caesarean section.

She was seen in post-menopausal bleeding clinic. TV USS showed a simple cystic structure of 7.4cm max diameter – which was thought to be Para ovarian and a slightly thickened endometrium of 6.5cm. On examination she had a normal appearing cervix with a stenosed external cervical os.

She was listed for hysteroscopy, endometrial biopsy and diagnostic laparoscopy +/- bilateral salpingo oophorectomy and removal of cyst.

On dilation of her stenosed cervical os for hysteroscopy at the time of surgery, a copious quantity of cervical mucous was drained. On hysteroscopy there was a large cervical cavity. It was not possible to enter the uterine cavity. Laparoscopy showed normal uterus,tubes and ovaries, and adhesions in the RIF.

Post operatively she continued to pass excessive PV discharge. She suffered with left sided abdo pain. This was treated with an uncomplicated LAVH. On examination of the cervix post operatively there was a very enlarged cervical cavity, with a stenosed internal cervical os. Histology showed a partially obliterated endometrial cavity and a dilated cervix consistent with mucocele. Microscopically the cervix had evidence of chronic inflammation and epithelial denudation.

Conclusions:

It is possible to form a mucocoele in the uterine cervix as a late complication of endometrial ablation, which may lead to definitive management with hysterectomy.



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A study into the management of ectopic pregnancy in a district general hospital

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Abstract

Introduction:

Ectopic pregnancy (EP) is a common early pregnancy complication which results in maternal morbidity and mortality. Its optimal management is of paramount importance.

Methods:

The aim of this study was to determine whether our hospital adhered to RCOG standards for the management of EP, as published in Green-top Guideline 21 (2016). We retrospectively reviewed all surgically managed cases of EP from 01/05/2018 until 30/11/ 2018.

Results:

We identified 24 surgically managed cases of EP, of which 20 (83%) were histologically confirmed. Of the remaining 4 cases, 2 were clinically felt to be tubal abortions, 1 was a salpingectomy where the histology did not confirm chorionic villi and 1 was a negative diagnostic laparoscopy for a pregnancy of unknown location. The negative laparoscopy rate following ultrasound diagnosis of EP was 0% (RCOG standard: 0%), 75% were offered all relevant management options (RCOG standard: 100%), 96% of women suitable for laparoscopic management went on to have laparoscopic surgery (RCOG standard: 100%), 0% of women received methotrexate for a false-positive diagnosis of EP (RCOG standard: 0%), 0% of non-emergency cases were taken to theatre at night (8pm - 8am; RCOG standard: 0%) and 0% were offered information on support groups (RCOG standard: 0%).

Discussion:

We have identified that patients who are candidates for methotrexate are not always offered it and that although patients may receive written information on support groups this is not clearly documented. These points were addressed by focussed departmental teaching sessions and highlighting the findings at the local governance meeting

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To study the correlation between ultrasound scan findings, pipelle biopsy results and final histology at definitive surgery in women presenting with post-menopausal bleeding per-vaginum.

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Abstract

Background:

OPH is the gold standard investigation in women with PMB versus pipelle biopsy alone. We conducted a retrospective cohort study looking at the correlation between ultrasound findings, endometrial biopsy results and final histology in patients with endometrial cancer/pre-cancer.

Methods:

Retrospective analysis of women from weekly Gynaecology-oncology MDT meetings with a confirmed histological diagnosis of endometrial cancer/pre-cancer from 07/01/2019-25/02/2019. Scan findings were recorded, and compared with pipelle biopsy results and final diagnosis.

Results:

A total of 26 women were included. 20 (77%) presented with PMB. 25 (96%) had ultrasounds prior to obtaining a tissue diagnosis. 7 (27%) had an endometrial thickness between 10- 15mms, 2(8%) between 16-20mms, 6 (23%) between 21-30mms, and 9 (35%) had uterine mass/ polyps. 2(8%) had only pipelle biopsy, 23(88%) hysteroscopy and biopsy and 1 diagnosed on emergency hysterectomy. ET of 21-30 mms - 3 (50%) had clear cell cancer on pipelle however clear cell element only confirmed in 1 on final histology at hysterectomy, 2(33%) had carcinosarcoma and 1 high grade serous cancer. 16-20 mm - 1 had clear cell cancer and 1 grade 2 endometrial adenocarcinoma. 10-15mms group- 1 had atypical hyperplasia confirmed as invasive adenocarcinoma on final histology, 1 suspicious hysteroscopy but histology normal.

Conclusions:

Thicker endometriums are associated with high grade endometrial cancers. In patients who had pipelle only versus pipelle and hysteroscopy chances of missing endometrial cancer with pipelle alone were negligible. Final histology did not always co-relate with the biopsy histology especially with clear cell cancers.

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Comparing Laparoscopic and Open hysterectomy in a minimal access unit- Should all abdominal hysterectomies be started laparoscopically?

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Abstract

Introduction:

Open Hysterectomy (OH) rates have declined partially due to the national push to increase laparoscopic hysterectomies (LH) and the BSGE's national LH training program (Madhvani et.al,2018). This study assess the rate of LH performed in a tertiary London hospital where a laparoscopic approach is encouraged for all women with a mobile uterus <20/40 size.

Methods:

A retrospective analysis of hysterectomies between 2017-2018. Demographic data, indication, past surgical history, operative findings, operating time, length of stay (LoS), and complications were recorded and statistically analysed.

Results:

115 hysterectomies were performed of which 87 (76%) were LH and 28 (24%) were OH. Women having OH had higher BMI's than those undergoing LH (p=0.02) but there were no other demographic differences between the groups. Fibroids and endometriosis were the most common indications for hysterectomy. There was no difference in mean operating time but blood loss was significantly higher with OH(p=0.0001). 3% (3/87) LH were converted to OH. 25% of OH were amenable for an attempt at laparoscopic approach. The median specimen weights were 301g (IQR:192-471g) for LH and 1513g (IQR:1245-2258g) for OH. Median LoS was 1 day (IQR:1-2) for LH and 3.5 days (IQR:3-6) for OH. OH had significantly higher complications and readmissions (p=0.008).

Discussion:

In our minimal access unit a higher proportion of hysterectomies are performed laparoscopically however there is room to safely do more including for large uteri, with shorter LoS and fewer complications. There is an argument that all surgically feasible hysterectomies should be started laparoscopically.

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Impact of the Olympus/ BSGE + Immersion Training Programme on laparoscopic suturing skills; a prospective cohort study

Krupa Madhvani[1,2], Zaid Hasafa[3]

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[2]Blizard Institute, Barts and the London School of Medicine and Dentistry, QMUL, London, United Kingdom.
[3]Royal Cornwall Endometriosis Centre, Truro, United Kingdom

Abstract

Objective:

To assess the change in laparoscopic suturing skills in candidates of an intensive laparoscopic training programme.

Design:

Prospective cohort study.

Setting:

24 Candidates in the Olympus & BSGE ST5+ Immersion Training Programme 2018.

Methods:

Using a worldwide validated Suturing and Knot Tying Training and Testing Method (SUTT1), candidates' laparoscopic suturing skills were evaluated before and after the above training programme by examiners independent of the programme faculty. Candidates were asked to perform five stitches and an intra-corporeal knot.

The online scoring platform for the European Academy of Gynaecological Surgery was used to calculate the overall score for each participant considering their previous psychomotor training, in three categories; “excellent”, “fair” or “room for improvement”. Individual components assessed within the score were: time to complete the task, the number of correct sutures placed, knot security, precision and no trauma, scored in three categories; “no trauma”, “some trauma” and “excessive trauma”.

Results:

The number of candidates scored overall as “room for improvement” at the assessment improved from 20 to zero after the programme ($p<0.000$). The median number of sutures improved from 1/5 to 4/5 after the programme ($p<0.000$). The number of candidates who were able to place a secure knot laparoscopically improved from 11 to 20 ($p<0.000$). Precision improved from a median score of 4/10 to 8/10 after the programme ($p<0.01$). Eight candidates "no trauma" score improved, six worsened and nine did not change.

Conclusion:

Laparoscopic suturing skills significantly improved after participation in the Olympus & BSGE ST5+ Immersion Training Programme.

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Correlation between ultrasound and hysteroscopy findings in premenopausal women with abnormal uterine bleeding (AUB): a retrospective cohort study.

Pedro Melo, Nidhi Shandil Singh
Milton Keynes University Hospital, Milton Keynes, United Kingdom

Abstract

Background:

AUB affects 25% of premenopausal women and has a significant impact on their quality of life. Recent guidance from the National Institute for Health and Care Excellence (NICE) advises outpatient hysteroscopy (OPH) as the first-line diagnostic test in women with AUB in whom endometrial pathology is suspected. The aim of this study was to investigate the correlation between transvaginal ultrasound (TV-US) and hysteroscopy findings in premenopausal women with AUB.

Methods:

We conducted a retrospective analysis of all premenopausal women presenting to our OPH clinic with AUB between March and June 2018. Demographic data, TV-US details and hysteroscopy findings were retrieved from electronic hospital records.

Results:

A total of 63 consecutive women presenting with AUB were included. Median age was 41 years (range 22-49) and median parity was 2 (range 0-6), with 22% being nulliparous. Heavy menstrual bleeding was the most common presenting complaint (65%) followed by intermenstrual bleeding (16%). Of the 59 women in whom a pre-hysteroscopy TV-US was performed, 23 (39%) had findings indicating endometrial polyps and 4 (7%) submucous fibroids. At hysteroscopy, the majority (60%) were found to have a normal endometrium, followed by polyps (29%) and submucous fibroids (11%). All women with a normal TV-US were found to have a normal endometrium at the time of hysteroscopy (10/10), while 51% (25/49) of women with suspected endometrial pathology on TV US were found to have a normal endometrium.

Conclusion:

TV-US is a poor predictor of endometrial pathology in premenopausal women, with a specificity of only 51%.

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Tolerability of therapeutic outpatient hysteroscopy (OPH) in women with postmenopausal bleeding (PMB) due to endometrial polyps: a prospective cohort study.

Pedro Melo, Nidhi Shandil Singh
Milton Keynes University Hospital, Milton Keynes, United Kingdom

Abstract

Background:

OPH is a first-line investigation in women with PMB due to its safety, convenience and avoidance of risks associated with general anaesthesia. Although OPH was first introduced as a diagnostic test, its therapeutic use in benign endometrial conditions (e.g. polyps, submucous fibroids) has recently become widespread. Nevertheless, there is a paucity of data regarding the tolerability of therapeutic OPH in postmenopausal women. This study aimed to evaluate the experiences of women undergoing OPH for PMB due to endometrial polyps.

Methods:

Prospective analysis of all women presenting to our OPH clinic with PMB due to endometrial polyps between December 2018 and February 2019. OPH was performed with a vaginoscopic technique following administration of intracervical block. Demographic data and hysteroscopy findings were recorded, and women completed a questionnaire about their experience of therapeutic OPH regarding different parameters (e.g. cleanliness, pain) using a numerical scale between 0 (very poor) and 5 (excellent).

Results:

A total of 23 consecutive women presenting with PMB were included. Median age was 56 years (range 46-84). Average score was 5/5 for explanation of the procedure, attentiveness of staff and respect for patients' dignity/privacy. Moreover, an average score of 4.9/5 was recorded for efficacy of local anaesthesia/pain relief. Out of a scale of 0-100, average pain score was 41. The average score for waiting time was 3.8/5. All women (100%) stated they would recommend the procedure to family and/or friends.

Conclusion:

Therapeutic OPH is well tolerated by postmenopausal women requiring removal of endometrial polyps.

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Psychological Intervention of Endometriosis

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[2]St George's, UOL, London, United Kingdom

Abstract

Altered mood and perception are present in women suffering from endometriosis, with depression and anxiety being the most common mental health issues observed in patients with endometriosis. These can contribute to pain perception in women with endometriosis. We conducted a literature review to identify alternative and complementary interventions and their role in alleviating physical and psychological symptoms found in women with endometriosis.

In our study, we reviewed studies looking at the effects of Acupuncture; Hatha Yoga; Progressive Muscle Relaxation, combined Psychotherapy and Somatosensory stimulation, and Transcutaneous Electrical Nerve stimulation on endometriosis symptoms.

Our research demonstrates the positive effect of psychological interventions for psychosomatic symptoms of endometriosis, including chronic pelvic pain, mood disorders, and dyspareunia. We appreciate that the sample size of studies does limit the validity of our conclusion. However, the papers that we analysed support the importance of addressing psychological factors in clinical management of endometriosis.



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Trends in laparoscopic versus open approaches to benign hysterectomy over the last 5 years

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Abstract

Background:

The laparoscopic approach to hysterectomy improves patient outcomes including reduced morbidity and mortality, amongst other benefits. Factors which determine the uptake of minimal access surgery for hysterectomy include surgeon skill, training and preference, local population, uterine size, surgical history and indication.

Aim:

To assess the uptake of minimal access surgery for benign hysterectomy over a five-year period at a London teaching hospital.

Method:

A retrospective study of all benign hysterectomies at a large teaching hospital between 2013-2018 was conducted. Data was collected from electronic hospital records regarding route of surgery (open, vaginal or laparoscopic) and type of operation (total or subtotal).

Results:

A total of 944 benign hysterectomies were performed over the 5-year period. The number of cases decreased from 232 to 163 per year. Open total hysterectomy rates have reduced from 51.7% of all benign hysterectomies to 35% ($p=0.001$), with open subtotal operations showing a trend towards reduction from 18.5% to 12.9% ($p=0.133$). Laparoscopic total hysterectomy rates have increased from 1.7% to 13.5% of cases ($p < 0.001$) and laparoscopic subtotal operations have remained largely unchanged from 4.3% to 3.7% ($p=0.75$).

Conclusions:

Between 2013 to 2018 the total numbers of hysterectomies per year has decreased. This may be due to a range of factors including increased waiting lists, improvements in alternative therapies such as uterine artery embolization and changes in patient choice. Rates of laparoscopic methods for hysterectomy have increased. However, further effort is needed to offer the benefits of laparoscopic surgery for all eligible patients.

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The Effective Role of Laparoscopic Ovarian Cystectomy in NMDA-R Encephalitis Related Ovarian Teratoma

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[2]Queen Elizabeth Hospital, Newcastle, United Kingdom

Abstract

Background

Anti-N-methyl-D-aspartate receptor (NMDA-R) encephalitis is a rare, life threatening condition associated with ovarian teratoma. Expeditious removal of the ovarian teratoma is paramount in the treatment. We present 2 patients who had successful laparoscopic ovarian cystectomy for this condition.

Case 1

KL, a 29-year-old presented with 1 month history of deteriorating mental status, unusual behaviour and headache. Her cerebrospinal fluid (CSF) and serum samples were positive for NMDA antibodies. A pelvic MRI showed a 2cm right ovarian teratoma. Within 24hours, she underwent an uncomplicated laparoscopic right ovarian cystectomy and histology confirmed mature teratoma with no evidence of malignancy. The following day, her neurological status improved significantly. She was reviewed 3 months following surgery and her repeat ultrasound scan was normal.

Case 2

KA, a 36-year-old who was previously fit and well, presented with altered mental status, headache and blurred vision. Her CT venogram excluded venous sinus thrombosis. Serum results for NMDA antibodies were positive in keeping with NMDA-R encephalitis. CT scan confirmed a small right dermoid cyst. She had laparoscopic right ovarian cystectomy and histology showed mature teratoma with foci of immature element. Following surgery, she was discharged home and made significant improvement in her symptoms.

Discussion

Recently, there is a heightened appreciation of young women who develop abnormal neurological behaviour to recognise the significant likelihood of NMDA-R encephalitis in the differential diagnosis. Prompt recognition of this condition as gynaecologists is paramount. From this experience, we recommend that laparoscopic cystectomy is the preferred surgical approach.

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Hysteroscopic Morcellation in the Management of sub-mucous leiomyomas: A retrospective cohort study

Lina Antoun[1], Honest Honest[2]

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[2]Good Hope Hospital, Birmingham, United Kingdom

Abstract

OBJECTIVE:

To compare the MyoSure intrauterine mechanical morcellator device for removal of intrauterine pathology with the TRUCLEAR system in terms of procedure time, peri- and postoperative adverse events, tissue availability, and short-term effectiveness.

INTERVENTION:

This study was performed at Good Hope Hospital. All women undergoing hysteroscopic removal of intrauterine pathology with polyps larger (≥2 cm) were included. Hysteroscopic morcellation was performed using TRUCLEAR Tissue Removal System, or MyoSure device between January 2015 and January 2019.

RESULTS:

A total of 135 MyoSure and 76 Truclear procedures were performed, with 72% performed by trainees. In majority of the cases the procedure was feasible in out patient settings. Resection of leiomyomas occurred in 52% or cases, polyps in 38%, combination pathology in 10%. Complete resection of pathology was achieved in 96% of polyps, 92% of leiomyomas. There was no statistically significant difference in clinical outcomes. One patient had hyponatremia following Myosure. Using Truclear System showed significant reduction in operative time compared to MyoSure with the minimum average time (11m), and the maximum time (45m). Postoperative outcomes included symptom resolution in 70%, further surgery (repeat hysteroscopy or hysterectomy) in 15%, pregnancy in 4%.

CONCLUSION:

MyoSure device is as effective as the TruClear when used to resect endometrial polyps. Similar clinical outcomes were obtained however, operating time was less when using TruClear System. Available data is not enough robust to draw firm conclusion about intrauterine morcellation. Future randomized controlled trials and long-term follow-up are required to further investigate the efficacy of different Hysteroscopic Morcellation systems.

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An Audit Examining the Usefulness of Ca-125 in Referrals to the Suspected Ovarian Cancer Clinic

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Abstract

Objective:

Large numbers of patients are referred on the two-week wait pathway based on their Ca-125 result for suspected ovarian cancer despite it not being an evidence-based test for community screening. This is particularly true with patients presenting with pain or bloating.

Design:

A retrospective observational study was conducted using electronic documents. The study was conducted using data from the one stop clinic at Northampton General Hospital.

Method:

Data was collected from all patients referred by their GP to the two-week wait clinic for suspected ovarian cancer over a two year period (n=286). This study focussed on symptomatic patients with a raised Ca-125 (n=225). Patients with a mass prior to referral were excluded. Data was also collected on their ultrasounds scan results, whether surgery was required and the final outcome.

Results:

We found a 38% increase in referrals in the second year of the study and 126 patients were discharged after initial assessment. Only 12 patients were diagnosed with a primary ovarian malignancy.

Conclusion:

A raised Ca-125 result should not be the sole basis of referral to rapid access clinic for suspected ovarian malignancy. Raising the cut-off value from 35 U/mL to 70 U/mL may increase the efficiency of the two week wait pathway. The one stop clinic, with ultrasound scanning facilities, significantly improved the efficiency of the service as many patients were able to be reassured and discharged following one appointment.

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Trend of laparoscopic hysterectomies at District General Hospital

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Abstract

Background:

Laparoscopic hysterectomy is the preferred route for hysterectomy in the 21st century. This route is attractive to service providers and clients due to reduction in morbidity, length of stay (LOS) and women can return to work earlier due to enhanced recovery.

Aims:

To evaluate all laparoscopic hysterectomies (LH) carried out in 2018 and to compare with the data from 2016 & 2014.

Methods:

Retrospective review of 94 cases of LH between 1/1/18 and 31/12/18.

Results: Age ranged between 27 and 92 years with mean age of 55. More LH compared to 2016 (N=77) & 2014 (N=64). Higher number of total laparoscopic hysterectomies (TLH) (69.2%) performed in 2018 as compared to (46.8%) in 2016 and (10.9%) in 2014. Laparoscopic assisted vaginal hysterectomy (LAVH) (30.8%) was carried out for utero-vaginal prolapse (UVP) and when oophorectomy was required, much less than those performed in 2016 (53.2%); and in 2014 (89.1%). Main indications remained heavy menstrual bleeding (32.9%) and UVP (22.3%). Mean LOS (day) for both TLH & LAVH was 1.16 (similar to the LOS in 2016 & 2014). Intraoperative complication rate was 3.2% and readmission rate was 4.3% in our study which were less as compared to the rate in 2016.

Conclusion:

Higher number of total LH compared to previous years. We performed more TLH than LAVH as compared to 2016 & 2014. Most of the cases were carried out by the consultant level which might reflect less complication rate.



69

The potential for increase in uptake of the laparoscopic approach to hysterectomy for benign indications in a major teaching hospital.

Rhian Gisby Gisby, Matthew Denham, Tom Holland
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Abstract

Background:

Laparoscopic hysterectomy (both total and subtotal) LH has been reported to have many patient benefits. Factors which determine the uptake of minimal access surgery for hysterectomy include surgeon skill, training and preference, uterine size, surgical history and indication.

Aims:

To review all benign hysterectomies over a one year period to evaluate the potential to increase the uptake of the laparoscopic approach.

Methods:

Retrospective review of all hysterectomies carried out for benign pathology in the period of May 2017- May 2018 at Guys and St Thomas's Hospital, London. Data collected included admission duration, type of hysterectomy, uterine weight and complications.

Results:

In total, 154 hysterectomies were performed; 47.4% were open, 17.5% laparoscopic and 35.1% were vaginal. Mean EBL was 248ml for laparoscopic approaches compared to 455ml for open (P=0.0487). The complication rate was 7.4% and 26.0% for laparoscopic and open procedures respectively (p=0.00096). Admission duration was 2.41 days on average for laparoscopic procedures, compared to 3.93 days for open procedures (P=0.091). 37.0% of laparoscopic cases were discharged on day 1, compared to 1.4% of open cases (p<0.001). Uterine weights were 48-981g for laparoscopic compared to 24-6700g for open hysterectomy. 18/50(36%) of open hysterectomies had uterine weights <500g, and 9/50(18%) from 500-1000g, which could potentially have been done laparoscopically.

Conclusions:

The laparoscopic approach to hysterectomy was associated with less blood loss, a reduced rate of complications and a reduced admission duration. More than half of the current open hysterectomies could be performed laparoscopically given current skill sets.

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Vaginal vault evisceration: A rare but serious complication following laparoscopic hysterectomy.

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Abstract

A 66-year-old woman presented, six weeks post laparoscopic hysterectomy, with small bowel protruding from the vagina following an episode of sexual intercourse and straining to pass stool. Following the immediate management of this acute gynaecological emergency the vaginal defect was repaired, using a combined laparoscopic-vaginal approach.

Vaginal vault evisceration is the breakdown of the vaginal vault with extrusion of intraperitoneal contents. It is a rare but serious post-operative complication of a hysterectomy. It should be recognised and managed urgently to prevent significant morbidity and mortality.

The incidence of vaginal vault evisceration is approximately 1 in 1000 with the most common risk factors including postmenopausal atrophy, previous vaginal surgery and enterocele. In post-menopausal women the most common precipitating factors include activities that increase intra-abdominal pressure such as straining and coughing. Total laparoscopic hysterectomy has been suggested to increase the risk of vaginal vault dehiscence when compared to other methods2.

Advances in minimally invasive surgery have led to a significant increase in the number of hysterectomies being performed laparoscopically worldwide. An understanding of preventative measures and emergency management of this serious complication is essential.

This case report discusses the risk factors, prevention methods and management of vaginal vault evisceration. In addition to exploring the differing surgical approaches for its treatment, including abdominal, vaginal and combined laparoscopic-vaginal.



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Nurse led follow-up clinics: the successful development of a new service.

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Abstract

The benefits of nurse led follow-up are well documented in the literature and include high patient satisfaction rates and improved information delivery. Unfortunately there is a paucity of data when it comes to gynaecology, particularly with regards to post-operative follow-up where the much-needed continuity of care a clinical nurse specialist (CNS) can offer is often underutilised.

Following on from initial positive results, we developed a CNS led follow-up clinic with fixed clinical review criteria and undertook a prospective patient satisfaction survey. All clinically suitable post-operative patients requiring follow-up were reviewed by our CNS and asked to complete a satisfaction survey.

Over an 8-month period 40 post-operative patients were reviewed. 42.5% had undergone laparoscopic endometriosis surgery, 35% a laparoscopic myomectomy, 15% a laparoscopic hysterectomy and 7% other major gynaecological surgery. The average review period was 3 months (range 3-12) postoperative. 100% of patients had a documented wound review and histology check. Symptom resolution, bladder/bowel function and fertility plans were discussed in 100% of cases. 85% of patients were successfully discharged following 1 visit after a mean of 3.5 months (range 1-12). The mean patient satisfaction rate was 9.45/10.

Our results highlight a productive extension of our endometriosis CNS's role. The development of such clinics allows both valued continuity of care for the patient and with pre-determined clinical criteria a safe, high quality, standardised follow-up pathway. Not only is the service well received by patients, it is also efficient and cost effective with 85% of patients discharged after 3.5 months.



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HYDROLAPAROSCOPY A new technique for difficult laparoscopy

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Abstract

Introduction:

Laparoscopic options are not available for all patients. Failure to obtain a good view at laparoscopy can be more common in those high BMI patients, when tilt of operating table is not possible to obtain a view of the pelvis.

Rates of conversion to laparotomy vary but in high risk patients can be as high as 10-20%.

Hydrolaparoscopy involves using saline infusion after CO2 insufflation to provide clearer vision and easier access to the operating site and minimise the technical difficulties.

Cases:

We describe 2 cases where underwater laparoscopy was used successfully.

The first case involved a pregnant patient who had gravid uterus of 19 weeks gestation. She underwent laparoscopic ovarian cystectomy.

At laparoscopy, the gravid uterus made visualisation of pouch of Douglas difficult and the ovaries could not be seen, manipulation of the soft, large uterus was impossible. Several litres of saline were infused. The gravid uterus gradually partly floated within the fluid allowing easier manipulation of the pelvic organs and exploration with clearer views of tubo-ovarian structures. The cyst was then easily identified and excised.

On a second occasion during an LAVH, the pelvic anatomy was difficult to visualise due to bowel distension. Hydrolaparoscopy was again tried allowing the bowel to be displaced to the top better visualisation facilitating a successful continuation of the laparoscopic procedure.

Discussion:

We propose that saline infusion at laparoscopy may provide better visualisation and reduce technical difficulties lowering the rates of conversion to laparotomy.

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An intra-abdominal lens-cleaning device reduces operative duration in laparoscopic excisional surgery for DIE: initial results of an in-service evaluation study

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Abstract

Background

Laparoscopic excisional surgery for deep infiltrating endometriosis relies on good endoscopic views of the operative field deep within the pelvic spaces. Blood spatter, ultrasonic plume, electrosurgical smoke and fat smears affecting the laparoscopic tip obscures the surgical view requiring removal of the laparoscope for extra-abdominal cleaning, reinsertion and reorientation of the view eating up valuable operating theatre time and prolonging anaesthesia duration. Various techniques and products exist to tackle this problem.

Methods

In this prospectively evaluated in-service pilot study of a proprietary device for intra-abdominal lens cleaning (OpClear, Cipher Surgical, UK), we present initial results of the operative time saved by using the device, compared to cases prior to the pilot study without the device. All cases involved deep infiltrating endometriosis requiring rectovaginal septum and pararectal dissection. The device comprises a thin disposable sheath attached to the laparoscope delivering intrabdominal surgeon-activated CO2/saline lens tip cleaning.

Results

Without the device, the laparoscope was removed from the abdomen 12 times per case ([median], range 9-18), requiring 13 minutes 34 seconds of operative time for extra- abdominal lens cleaning ([mean], range 7m45s - 15m12s). After introduction of the device, all cases were completed without the need for removal of the laparoscope for the duration of the procedure.

Conclusions

In this study, the evaluated lens-cleaning device reduced operative duration. A cost- effectiveness evaluation is in progress.

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An unmet need to target mood disorders in women with Endometriosis

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Abstract

Endometriosis adversely influences the psychological wellbeing of women. The relationship between chronic pain and mood disorders is complex. Studies have shown that low mood can exacerbate pain perception (Wiech et al., 2009) and at the same time the perception of pain can cause mood disorders (Facchin et al., 2015).

Objective

We reviewed the prevalence of anxiety and depression in a cohort of 250 women all presenting to the Endometriosis clinic between 1/6/17 and 1/12/18 to ascertain the relationship, if any, between mood disorders and chronic pain.

Results

Preliminary results reveal that 69 patients (27.6%) were suffering from anxiety, depression or both (95% CI 22.4 - 33.5%). This is compared to a prevalence of anxiety and depression in women in England of 19.1% (95% CI 17.8-20.5%) (Stansfeld et al., 2016). The lack of overlap between these confidence intervals suggests there is a significant statistical difference between the prevalence of anxiety and depression in endometriosis sufferers and the general population. The odds ratio is 1.61 with a 95% CI of 0.83 - 3.14; this suggests that although patients with endometriosis are 1.61 times more likely to experience anxiety and depression, there is no significant difference between these two groups. A larger study is therefore needed to establish statistical significance.

Conclusion

Irrespective of whether the disease causes anxiety and depression or mood disorders increase sensitivity to pain, this aspect of care which is presently being ignored by the endometriosis service providers needs to be addressed to achieve better pain control for these patients.



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A very unusual case of primary inguinal endometriosis: a case report and review of the literature

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Abstract

Introduction

Inguinal endometriosis remains a rare occurrence with a reported incidence of >1%. It was first described in 1896 and is thought to arise due to the presence of endometrial tissue within the extra-peritoneal portion of the round ligament. We present the unusual case of 25-year-old, with no previous gynaecological or surgical history, who presented with a 2cm endometriotic nodule in her right inguinal region, which was successfully treated with complete surgical excision.

Case Report

A 25-years old nulliparous patient presented to the gynecology clinic with a cyclically painful right-sided groin lump. Symptoms were worsening despite the COCP and examination revealed a 2cm tender groin lump.

US scan confirmed a 2cm hypoechoic lesion and subsequent MRI described a low intensity speculated mass likely to represent an endometriotic nodule. US-guided biopsy confirmed endometriosis and excision under GA was offered in view of her worsening symptoms.

A linear incision was made over the nodule and the overlying superficial tissue dissected off to reveal the full nodule arising from the right round ligament. This was fully excised using diathermy and a 3-layer closure was undertaken. Histology confirmed endometriosis and the patient made a good post-operative recovery.

Conclusion

Inguinal endometriosis remains a rare phenomenon, but the diagnosis must be considered in those presenting with a painful groin lump. Although there is no standardised management plan, the generally accepted approach is complete surgical excision as medical management is rarely curative. Meticulous surgical technique is essential to ensure complete resection with adequate margins to avoid recurrence.

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Endometriosis "Gone but not forgotten"

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Abstract

The definitive treatment for endometriosis is universally considered as Hysterectomy and bilateral salpingo –oophorectomy (TLH/BSO). Both the medical team and the patient expect complete resolution of the disease after this procedure.

A 45 year old patient with stage 4 endometriosis underwent TLH /BSO in June 2017. She experienced initially complete resolution of her pain and was pleased with the result of surgery. However, 4 months later to her dismay she began to experience a recurrence of the pelvic pain..

She was referred by her GP after surgery for recurrence of the pain predominantly right sided.Her blood markers confirmed menopausal status. MR in July 2018 showed no morphological evidence of endometriosis. She was reassured that eventually she should expect resolution. Unfortunately her pain worsened.

As a result in September 2018 she underwent laparoscopy, there was deep scarring on the right pelvic side wall into the obturator fossa. This was resected after right uterolysis. Histology of the resected pelvic peritoneum noted active endometriosis.

Her pain settled temporarily, however 3 months later she relapsed. She was offered a trial of pregabalin and an aromatase inhibitor (letrozole 2.5mg) , this proved to be effective in easing her symptoms. Up to the present her quality of life has improved.

This case highlights the presence of recalcitrant endometriosis persisting clinically and histologically even after surgical menopause. The importance respecting the patient's symptomatology, laparoscopic re-evaluation for occult retroperitoneal disease and the use of the aromatase inhibitor to negate the extra ovarian oestrogenic stimulus is underscored.



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RAISING THE BAR IN MINIMAL INVASIVE GYNECOLOGY SURGERY- Training Pathways for Robotic Laparoscopic Hysterectomy (RA-TLH) and Proficiency Scoring Tool.

Samina Elahi

University College London .Division of Minimal Invasive Surgery, London, United Kingdom

Abstract

Aims

The aim of this abstract to look into the training pathways for the Robotic Total Laparoscopic hysterectomy and use of proficiency scoring system to achieve competencies. (1)

Background

Hysterectomy is the second most common surgical procedure in world. Data from the UK suggest a hysterectomy rate of 42/100,000 population, with higher-rates in the United States (143/100,000) and Canada (108/100,000). There is increasing trend towards minimal invasive approaches. The increase has been even steeper for robotic-assisted hysterectomy, with 0.5% of all hysterectomies performed robotically in 2007 compared with 9.5% in 2010. (2)

Material and Methods

To look into literature retrospectively for the training analysis and available tools with scoring system for the validity of evaluation process. A training model was designed and proficiency scoring tool robotic assisted hysterectomy was proposed with defined outcome measures.

Conclusion/Summary

References

1: Schruder HW, Wolswijk R et al. Training and learning robotic surgery, time for a more structured approach: a systematic review. BJOG. 2012 Jan;119(2):137-49.

2: Wright, Jason D. MD; Herzog, Thomas J.MD et al. Nationwide trends in the performance of inpatient hysterectomy in United States. Obstet Gynecol 2013 Aug; 122(2 0 1): 233–241.

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Uterine artery embolisation for fibroids: our experience

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Abstract

Introduction:

Uterine fibroids can cause a multitude of symptoms including heavy menstrual bleeding and pain. Uterine artery embolisation (UAE) is a radiological procedure which can be used to manage symptomatic fibroids. A Cochrane systematic review demonstrated patient satisfaction with UAE to be comparable to surgical intervention.

Methods:

We aimed to review UAE requests at our hospital from 1/01/18 until 31/08/18 to determine a) whether patients received full counselling regarding the management of symptomatic fibroids, b) whether UAE was performed and how successful it was at 6 months follow-up and c) if not performed, the reasons why and the subsequent management instituted.

Results:

We identified 29 requests for UAE, of whom 15 (52%) received full counselling regarding treatment options. Twenty four patients (83%) were eligible for UAE and 15 (52%) were carried out, with all patients not requiring surgical intervention within 6 months of follow-up. Satisfactory radiological response was demonstrated in all patients who had post UAE imaging. Of the 14 patients who were eligible but did not have UAE, 5 were due to patient choice, 3 experienced symptomatic improvement, 4 were advised surgical management by the MDT, 1 was ineligible and 1 was lost to follow-up.

Discussion:

UAE is an effective alternative to surgical intervention for the management of uterine fibroids, making it a good alternative for patients who are surgically high-risk. A notable exception would be suspicion of malignancy.

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TORSIONS WITH A TWIST

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Abstract

Ovarian torsion is a gynaecological emergency requiring accurate diagnosis and timely management. Diagnosis is not always straight forward; often either mis-diagnosed or diagnosed late. We discuss the diagnosis and management of 4 different cases.

A 25yr old patient presented with sudden onset of pain with vomiting on a background of a known ovarian cyst.

She was taken to theatre and the findings were of a large right paratubal serous cystadenoma that had torted and she had a right salpingectomy with ovarian preservation.

An 18 year old patient presented with a history of abdominal pain and vomiting. Imaging revealed a 12cm cyst and the diagnosis of ovarian torsion was made.

It was revealed to be ovarian torsion, the cyst was untwisted and a cystectomy carried out. The subsequent histology was of a borderline serous cyst and a further adequate staging operation had to be carried out.

A 37 year old patient presented with a 3 week history of RIF pain which suddenly got worse over one day. The findings on imaging were of a large 12cm mucinous cystadenoma that had likely torted.

Operation revealed a large cyst that was not torted and a salpingo-oophorectomy was carried out.

A 36 year old patient presented with RIF on a background of having had a hysterectomy the year previously for endometrial carcinoma. USS revealed a normal right ovary and a possible polycystic left ovary. Surgery for presumed appendicitis revealed a torted left ovary, but with no cyst.



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Title: Heterotopic pregnancy and laparotomy: are these both rare? A systematic review of literature

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University Hospitals of Leicester, Leicester, United Kingdom

Abstract

Objective:

Review of evidence for heterotopic pregnancy after assisted reproduction techniques (ART) and management trends.

Background:

Heterotopic pregnancy is traditionally quoted with incidence of 1 in 30,000 pregnancies, however with ART the numbers have risen to 1 in 100. Management varies depending upon presentation at diagnosis and expertise.

Methodology: Electronic database were searched from 1974-2018. Inclusion criteria included all case studies and case series of heterotopic pregnancies in women with ART.

Literature review was performed and management trends compared from 1974 to 1990 with those from 2013 to 2018.

Results:

11 articles (n=21 cases) reported heterotopic pregnancy after ART between 1974 to 1990 and 22 articles (n=488 cases) from 2013 to 2018. All reported cases were less than 15 weeks of gestation. The reported patient symptoms varied from pelvic pain, PV bleed to hypovolemic shock. Treatment was with laparoscopy or laparotomy depending on the stability of the patient. There were 7/22 case reports from year 2013-2018 that reported laparotomy as the management option and only one of them reported rupture and haemoperitoneum.

Conclusion:

The trend for heterotopic pregnancy is on the rise and more so because of ART. However, systematic review of literature suggests that there is a hesitancy in suspecting and diagnosing heterotopic pregnancy in woman who have had IVF. Laparotomy was performed in a third of case reports, indicating need for awareness and that earlier diagnosis will help in performing the procedure laparoscopically.

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Initiating an outpatient service for total laparoscopic hysterectomy

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Abstract

Introduction and aim:

Ambulatory total laparoscopic hysterectomy (TLH) has been suggested as a feasible and safe strategy, alleviating bed pressure, reducing costs, and in the right cases improving patient experience. Following introduction in our rural district general hospital, we sought to examine outcomes.

Method:

Retrospective case note analysis of all patients undergoing TLH from November 2018 to February 2019. Cases were identified from the theatre operative diary and data collected from online records.

Results:

27 patients underwent TLH, under three different operating consultants. Two patients were unsuitable for outpatient management due to intraoperative complications (bladder injury, conversion to laparotomy).25 patients were assessed for same day discharge. 16% (4/25) achieved same day discharge. 84% (21/25) had a longer stay, average length of 1.3 days (range 1-3, median 1 day). Of the ambulatory patients: 100% (4/4) had a WHO performance score of 0; average age was 54 (range 37-68); average BMI 25.5 (range 21-29); distance from the hospital was an average of 15 miles (range 2-28). They had minor medical complications or none. No patients were assessed for suitability for outpatient management pre-operatively. Home support was not assessed. Average operating time was 77 minutes (range 58-110). One patient (1/4) presented to the gynaecology assessment unit on day one after discharge, but was not admitted.75% (3/4) did not have unplanned attendance post-operatively.

Conclusion:

Ambulatory management of TLH is safe, however presents challenges. Structured pre-operative identification of suitable patients may increase the cases in whom same day discharge is achieved.

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Reducing open surgery: Reduction of open procedures for abdominal hysterectomy

Aaron McAvoy, Karen Jermy, Helen Nicks
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Abstract

After guidance for "getting it right first time" (GIRFT) to reduce unwanted variation in practice within the NHS was published, SASH hoped to look at opportunities to increase the proportion of laparoscopic hysterectomies compared with open procedures.This was done via MDT retrospective review aiming to highlight missed opportunities.

Results:

N=76. This showed the main indication for open hysterectomy was heavy menstrual bleeding, with fiboids as the sole reason in 12 cases. After MDT review there was a subjective impression that 59% of cases would have been suitable for laparoscopic approach as the intended operation.



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Endometrial Ablation for Heavy Menstrual Bleeding - Does it Increase Diagnostic Hysterectomy?

Thomas Sewell, Sangeetha Nagabushanam
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Abstract

Introduction:

Endometrial ablation (EA) is a common treatment for heavy menstrual bleeding (HMB). However, there is a concern that the formation of intrauterine adhesions secondary to EA can hamper the investigation of abnormal uterine bleeding leading to failed diagnostic hysteroscopy and ultimately diagnostic hysterectomy. This study aims to evaluate long-term outcomes following EA including the rate of diagnostic hysterectomy.

Method:

A retrospective observational study was undertaken involving all women who underwent EA at a single UK hospital over a 5 year period (January 2010 to January 2015). 289 patients met inclusion criteria and data was collected via review of the hospital records alongside a telephone administered questionnaire. Median interval from procedure to follow up was 6.7 years.

Results:

Patients had a mean age of 47.9. 5.2% of patients had intra-operative or early complications and 1.4% had unplanned hospital readmission within 30 days. 16.6% of patients reported long-term complications or treatment failure. The rate of amenorrhoea and patient satisfaction was 31.3% and 63.4% respectively. 15.2% of patients had further HMB treatment with hysterectomy being the most common. Women with treatment failure were more likely to have fibroids ((47.7% vs 24.9%), dysmenorrhoea (54.5% vs 35.5%) and significantly larger uterine sizes (length 10.4cm vs 8.1cm (p=<0.05)). 8.1% of patients required hysteroscopic uterine evaluation during follow up with an overall diagnostic hysterectomy rate of 1.4%.

Conclusions:

EA is a safe and effective treatment for HMB. Despite intrauterine adhesions, subsequent diagnostic hysteroscopy is usually successful meaning the rate of diagnostic hysterectomy remains low.

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Reducing the rate of abdominal hysterectomies – the role of a benign gynaecology MDT?

Samuel Oxley, Sophie Strong, Funlayo Odejinmi, Fredric Willmott
Barts Health NHS Trust, London, United Kingdom

Abstract

Introduction

There is significant variation in the rate of abdominal hysterectomies performed across the UK. The benefits of performing hysterectomy via the vaginal or laparoscopic route are well known, and should be a focus of gynaecology care and training. Here we demonstrate how we have successfully reduced our abdominal hysterectomy rate over a 5-year period, and discuss the challenges and next steps in achieving excellence, particularly with a high prevalence of uterine fibroids.

Methods

Audit of hysterectomy routes and outcomes in one hospital from 2013 to 2018. During this time, additional consultant and fellows with minimal access expertise were appointed, increased laparoscopic training was provided, and enhanced recovery pathway was introduced.

Results

Overall rate of abdominal procedures decreased by 37.7% overall, from 60.4% (32/53) in 2013 to 37.6% (32/85) in 2018. In 2018, the non-abdominal rate was 89% for patients with endometrial pathology, and 47% for patients with benign disease; the majority with a uterine size over 16 weeks. Mean BMI remained high at 29.9kg/m2. From 2013 to 2018, mean intra-operative blood loss reduced from 385 to 275ml, and length of stay from 3.8 to 1.6 days.

Discussion

A significant reduction has been achieved in the rate of open procedures, despite a high average BMI. The major indication for laparotomy remains the large fibroid uterus, and progress is limited by the controversies surrounding morcellation. In order to achieve excellency in fibroid management and consistency in counselling of patients, we have established a benign gynaecology MDT, and a local fibroid database.

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Implementing the RIGS laparoscopy handbook: should regular simulation training be available and mandatory for all trainees?

Samuel Oxley, Elizabeth Egbase, Alice Howell, Fredric Willmott
Barts Health NHS Trust, London, United Kingdom

Abstract

Introduction

Simulation is an increasingly vital component of gynaecological training, and the 2018 RIGS laparoscopy handbook was developed to support units in providing this. We have used this handbook to develop our regular simulation program, alongside a "passport" of training achievements.

Methods

Regular protected afternoon simulation training started in May 2018, occurring every 8 weeks, with local gynaecology consultants as faculty, and simulation equipment provided at a 1:1 or 1:2 ratio per trainee. Sessions were mapped to the RIGS and RCOG curriculum, with modules from the European Academy of Gynaecological Surgery.

Results

Overwhelmingly positive feedback was obtained from all trainees from FY1-ST7. 100% of trainees found the sessions relevant to their needs, and particularly valued the significant time available on box trainers and consultant faculty. Consultants valued the teaching opportunities, and on several occasions trainees performed significantly more live operating after demonstrating their skills during simulation. The 8 weekly whole-afternoon sessions worked well for our department, fitting around other teaching and clinical commitments.

Discussion

Simulation sessions were well received by both consultants and trainees, leading to immediate skill acquisition and benefits during live surgery. Key to this success are protected teaching time, adequate equipment, and consultant faculty.

Given the feasibility and benefits of this programme, we propose that regular laparoscopic simulation sessions should be available for all trainees, and attendance at one or more sessions should become a requirement of the RCOG intermediate curriculum matrix, to better support the provision of high quality surgical care to gynaecological patients.

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Acute pelvic pain due to cystic degeneration of large leiomyoma of uterus- A diagnostic challenge.

Rupali Banzal, Chellappah Gnanachandran
Northamton General Hospital, Northampton, United Kingdom

Abstract

Title-

Acute pelvic pain due to cystic degeneration of large leiomyoma of uterus- a diagnostic challenge.

Background-

Acute pelvic pain is common in young women due to reason such as ovarian torsion, appendicitis but unlikely due to fibroid. Cystic degeneration is uncommon complication of leiomyomas even though they are commonest benign uterine neoplasms. Leiomyomas can undergo variable changes making diagnosis difficult. This is a case of cyst within large leiomyoma presenting with acute pain.

Materials and methods-

33 year old nulliparous woman presented with abdominal pain and palpable mass. The Ultrasound Scan showed 9 x 8 x 6 cms leiomyoma with 8 x 6 x 6 cms cyst attached. MRI showed cyst within leiomyoma. Tumor markers were normal.

Laparoscopy showed 6 x 6 cms cyst within leiomyoma at uterine fundus. The cyst was drained (possible adenomyoma). But it was difficult to reach to the base of the cyst, hence laparotomy was performed. Cyst and leiomyoma were removed together. Both tubes and ovaries were normal. Endometrial cavity was not breached. Differential diagnosis included adenomyoma, endometrioma and degenerative leiomyoma. Histology suggested benign leiomyoma with cystic degeneration. Post-operative recovery was uneventful.

Conclusion-

Acute pain with cystic changes in leiomyoma pose diagnostic challenges. Ultrasound is the first line investigation. Surgical management is appropriate for symptomatic patients.

Keywords- leiomyoma, cystic degeneration, laparoscopy, laparotomy, diagnostic challenge.

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Does Simulation Training Improve Endoscopic Performance In Novice Medical Students? : A Randomised Control Trial.

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Abstract

Aims:

To determine whether endoscopic simulation improves performance in novice endoscopists (medical students).

Materials & Methods:

Students were randomised into two groups: the Control group carried out their training as standard, the Simulator group spent an additional hour per week for 4 weeks using a simulator. Both groups underwent initial and final assessments consisting of a diagnostic shoulder arthroscopy on a dry-lab model. Assessments were recorded and assessed for surgical performance, time to task completion, and number of assists required.

Results:

106 students completed the study with 50 students in the Control group and 56 students in the Simulator group. Initial assessment performance demonstrated no differences between groups. At final assessment, the Simulator group demonstrated a higher Global Rating Scale of the Connecticut Score (CS) (25) than the Control group (23) ($p=0.01$). The Simulator group achieved a 7-point improvement in CS compared to 4 points in the Control group ($p=0.006$). All secondary outcomes showed better performance in the Simulator group than the Control group at final assessment; Global Rating Scale for Shoulder Arthroscopy (GRSSA) ($p=0.03$), time taken ($p=0.0002$) and number of assists ($p<0.0001$).

Conclusion:

The introduction of 4 hours of simulation training improved novice endoscopists' speed and performance and reduced the supervision required in a dry-lab model.

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Uterine artery embolization for the treatment of symptomatic fibroids: who will benefit?

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[1]St Michaels Hospital, Bristol, United Kingdom.
[2]Bristol Royal Infirmary, Bristol, United Kingdom

Abstract

Uterine artery embolization (UAE) is a safe and effective treatment for symptomatic uterine fibroids. However up to one third of women undergoing UAE will require further treatment for symptomatic fibroids by five years. Therefore appropriate patient selection for UAE is important. We aim to evaluate all cases of women undergoing UAE in our unit to establish whether fibroid location, size or vascularity impacted treatment response.

Case of notes of all women undergoing UAE between January 2016 and May 2018 were evaluated. 18 cases were identified. All women had symptomatic uterine fibroids which had not responded to medical therapies. All underwent pre-treatment ultrasound and MRI scans to establish fibroid size, location and post-contrast enhancement. Of the 18 women, 17 underwent UAE. 11/17 women (65%) had complete or partial resolution of their symptoms by 6 months. Fibroid location and size did not significantly impact treatment response. Women with normal fibroid enhancement post-contrast MRI were more likely to have symptomatic improvement following UAE (82% vs 50%.)

We concluded that fibroid size need not be a barrier to recommending UAE as a treatment for symptomatic fibroids. Fibroid vascularity may predict treatment responders however needs further evaluation.



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Striving to achieve best practice in ambulatory gynaecology

Yulia Nicholson, Edward Harrison, Kausik Das
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Abstract

Outpatient hysteroscopy is a cost-effective procedure for investigation and therapeutic purposes, and the most commonly performed in the ambulatory gynaecology service. It is generally well tolerated but can be associated to pain and anxiety impacting in women's satisfaction.

This is a prospective study of 93 women who attended the ambulatory gynaecology clinic between July and August 2018.

The results showed that the largest age group was between 50 and 60 years with 33%; followed by 28% of women under 50 years old, the smallest group was the 70 years old or older with a 6%.

61% of women were postmenopausal, 33% premenopausal and perimenopausal in 11% of the cases.

The most common indication was postmenopausal bleeding (47%), followed by dysfunctional uterine bleeding (28%), thickened endometrium (14%).

Vaginoscopy approach was used in 60% of the cases whilst speculum was used in 40%. Vasovagal episodes were more common when speculum (5%) was used and when there was no local anaesthetic (5%) . Outpatient hysteroscopy was unsuccessful in 9% of cases.

When analysing pain scores, these were higher when there was no allocated support staff with women at the time of the procedure as well as the use of speculum during procedure. In contrast, vaginoscopy approach was associated to lower pain scores.

Conclusions

Appropriate staffing should be provided to support patients during procedures. Vaginoscopy approach should be the default method for outpatient hysteroscopy.



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Hysteroscopic Management of Retained Products of Conception in an Outpatient setting R.Ram, E.Howe, M.E. Connor, P.Madhuvrata

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Abstract

Introduction:

Retained products of conception (RPCs) are associated with short term complications like bleeding and infection while leading to intrauterine adhesions (IUAs) associated with subfertility and pregnancy complications in the long term.

Aim:

The aim is to review the outcome of women with RPC managed using hysteroscopic morcellator in the outpatient setting.

Method:

Retrospective study of women with RPCs treated at Jessop wing of the Royal Hallamshire Hospital in one-stop hysteroscopy clinic under local anaesthesia using a morcellator.

We identified a total of 18 women between 2016 and 2018.Over half (55.5%) were referred via emergency gynaecology admissions, 61% of the women had a preceding term delivery, whilst the remainder were after a miscarriage or termination. The mean age of presentation was 31 years(20-44 range). The mean duration from delivery or miscarriage/termination to treatment was 19 weeks(5-102).Transvaginal USS was carried out in all women prior to treatment and mean size of RPCs was ≥2cms in 5 cases but lesser in the rest. 27% needed second sitting to treat, of which only two required removal under general anaesthesia due to patient discomfort. A check hysteroscopy carried out in 6(33.3%) women revealed IUA s in 2(33.3%) requiring adhesiolysis. Over a third (38.8%) women conceived after treatment with 71% conceiving within 6 months. Histology was available in 10 cases of which 4 had placental site nodule. There were no procedure related complications.

Conclusion:

Hysteroscopic removal in an outpatient setting may be an option for treatment of RPCs.

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Management of chronic retained products of conception (RPOC)- ERPC (evacuation of retained products of conception) under general anaesthesia (GA) or Myosure morcellation under Local anaesthesia (LA)?

Engy Morsy, Peggy Khine, Bronwyn Middleton
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Abstract

Introduction:

Myosure is an efficient and safe outpatient hysteroscopic procedure for management of intrauterine (IU) pathology such as polyps, type 0 and type I submucous fibroids. Recently it has been used to remove chronic (RPOC). The term RPOC refers to persistent intrauterine tissue after spontaneous miscarriage, medical and surgical management of miscarriage (MMM or SMM) or termination, and vaginal or caesarean delivery.

Aim:

To evaluate the efficacy and safety of Myosure device in removing RPOC and its feasibility in an outpatient setting.

Methods:

Retrospective case review of 28 women whose USS indicated chronic RPOC between 2016 & 2018.

Results:

Age ranged 17- 40 years, mean age 32, average BMI was 26.1 ± 8.1, and parity between 0-4, (mean = 1). 24 women agreed to be seen at OPH, 4 women opted for GA procedure. All had pelvic ultrasound confirmed RPOC after presenting with persistent bleeding following termination, SMM/ MMM and post-partum (after SVD or LSCS). Oral analgesia & cervical block with LA was used. Average pain score was 3.7. 17 women underwent myosure device for morcellation of RPOC under LA. 88.2% of histology confirmed RPOC. 4 women opted for mysosure morcellation of RPOC under GA, 75% of histology indicated RPOC. No intraoperative complications or re-admissions.

Conclusions:

Removal of RPOC using Myosure under LA in the outpatient setting is a safe, well tolerated procedure with good patient satisfaction and can avoid the potential risks from blind ERPC and should be used as standard for management of all cases of chronic RPOC.

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Endometriosis club – a way to involve patients in healthcare service quality improvement

Temenuga Dacheva, Jennifer Dean, Jamin Kashwa, Christian Barnick
Homerton University Hospital, London, United Kingdom

Abstract

Quality improvement is fundamental for improved patient care. NHS England has made a commitment to become better at involving and supporting the patients in their care.

Endometriosis is a chronic specific disease, which can have a significant negative impact on patients' quality of life. It is a long-term, recurrent condition, which requires long - term support.

A patient support group potentially offers a forum for comfort, information exchange, tips and ideas on how to manage and live with the disease. Often this is a place not only to talk but also to listen.

Last year in our hospital we set up an endometriosis club. The purpose is to organise meetings for endometriosis patients where they have the opportunity to discuss topics important to them, meet other women locally with endometriosis, and exchange their own stories and experiences. Eligible women who want to join the club are added to our mailing list. We facilitate the meetings every 6-8 weeks. With relatively little effort and cost this support group may make a positive impact to the lives of our patients dealing with endometriosis.

The feedback that we have so far received from our patients was excellent and the number of the patients joining the group is rapidly increasing. Discussion in one of the meetings have lead us to organise an Endometriosis Information Day.

Endometriosis club is an important social platform for our patients. It can help them understand their disease better and empower them to make informed choices about their health.



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Diagnostic laparoscopy for investigation of chronic pelvic pain; a review of management and outcomes

Louise Speers, Anita Nargund, Rohini Gonsalves
Royal Gwent Hospital, Newport, United Kingdom

Abstract

Introduction

Increased patient awareness of pelvic pain and endometriosis is potentially attributable to focussed media attention in recent years. Locally, it appeared increasing numbers of women were undergoing diagnostic laparoscopies that were negative; hence this required further investigation.

Aim

Assess the number, intra-operative findings and outcomes of patients undergoing diagnostic laparoscopy for pelvic pain.

Method

Retrospective review of diagnostic laparoscopy cases identified using Operating Room Management Information System (ORMIS) over a six-month period for all gynaecology theatres across a University Health Board in South Wales.

Results

A total of 40 diagnostic laparoscopies were undertaken, of which 52% were negative. Indication for laparoscopy was pain in 64%. No pre-operative treatment was initiated in 31%, with a further 16% declining medical treatment. Of those patients with positive laparoscopy findings the majority received hormonal treatment (37%) post-operatively. Of note, seven cases (37%) were not treated despite positive laparoscopy.

Discussion

The total number of diagnostic laparoscopies was lower than initially anticipated but with higher rates of negative laparoscopy (52%) compared to data quoted in Royal College guidance. Optimising first-line medical management could further reduce the number of diagnostic laparoscopies undertaken. Similarly post-operative secondary management could be improved, aiming to alleviate patient symptoms for potentially longer durations.

Conclusion

Negative laparoscopy is still a majority finding at diagnostic laparoscopy. Medical treatment both pre and post-operatively is key to reducing negative laparoscopies and reducing recurrence of pelvic pain in those surgically treated. Patient comprehension of treatment rationale is the cornerstone to engagement, compliance and improved outcomes.

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TOPIC: Removal of Intrauterine adhesions using mechanical resection under direct vision (MyoSure ®) - a case report.

ARUMUGAM JAYANTHI, Gudrun C Rieck, Zainab Illyas

Ysbyty Gwynedd, Betsi Cadwaladr University Health Board., Bangor, United Kingdom

Abstract

Background:

Bands of fibrous tissue that form in the endometrial cavity in response to any uterine procedures are Intrauterine adhesions (IUAs). IUAs with symptoms are referred to as Asherman syndrome. The prevalence ranges from 1.5% to 21.5 %.

IUAs appear to result from trauma to the basalis layer of the endometrium. It's most susceptible in the first four postpartum or postabortal weeks. Trauma results from intrauterine procedures such as dilation and curettage, although inflammation, infection, and uterine compression sutures can play a role.

Clinical manifestations of the severe intrauterine adhesive disease include menstrual irregularities (amenorrhea, hypomenorrhea), infertility, cyclic pain, recurrent pregnancy loss, and abnormal placentation. IUAs can also be an incidental finding in asymptomatic women. The diagnosis of IUAs is by hysteroscopy.

Case Report:

A 28-year-old patient was referred by GP with a history of secondary amenorrhoea for one year following surgical removal of retained pregnancy tissue. She has had one full term normal delivery and surgical termination of pregnancy in the past.

The investigations for the endocrine cause of secondary amenorrhoea was normal and the scan showed irregular thickening of the endometrial cavity.

Saline Hysteroscopy showed a dense adhesion in the cavity which was removed using a mechanical device under direct vision (Myosure ® equipment). There was no further damage to the endometrium. She was prescribed estrogen tablets and will be reviewed soon.

Conclusion:

Using MyoSure to remove IUAs seems a feasible and safe option, more research is needed to 9look at the long-term outcome of those cases

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Follow up of Endometrial hyperplasia and treatment effect in a large District General Hospital

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Abstract

Background

Endometrial hyperplasia with or without atypia is a common gynaecological diagnosis.

As reversion to normal endometrium is the key to optimal management, vigorous follow up is necessary. We have audited our practice on the follow ups.

Material and methods

We retrospectively analysed the electronic records of 44 patients attending follow up in our hysteroscopy clinic over a year. RCOG/BSGE Green top guidelines used as standard.

Treatment effectiveness and necessity for a separate pipelle biopsy clinic was evaluated.

Results

75% (33/44) of patients were post-menopausal. The body mass index data(BMI) was available for only 26/44 patients, 65% were >35.

At first diagnosis, 77% (34/44) were endometrial hyperplasia without atypia and 23%(10/44) had focal atypia. 68% were managed with intra uterine progestogen (LNG-IUS), 25% had oral progestogen and 7% declined treatment. The interval for the first repeat sample for both the groups was a mean of 8.6 months. 30% patients had a hysteroscopy in this visit. Majority had an adequate sample noting progesterone effect in 86%.

18% of hyperplasias were identified in polyps about 50% of them having focal atypia. Only 20%of the focal atypias had follow up hysteroscopy.100% had regression, one patient had relapse and none had progression.

Discussion

Treatment effectiveness was 100%. Clear documentation on BMI and strict follow up protocols is essential.

In hyperplasia with atypia, follow up hysteroscopy has to be put in practice. Setting up a separate biopsy clinic would reduce the burden on hysteroscopy slots and meticulous follow up can be promoted.

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Clinical hyperthyroidism with a gynae cause: A case of Struma Ovarii with follicular carcinoma.

Victoria Finney, Jennifer Ramage, Jed Hawe
Countess of Chester NHS Foundation Trust, Chester, United Kingdom

Abstract

A 48 year old was referred to the surgeons for a total thyroidectomy for relapsing Grave's disease. Despite this she was still hyperthyroid after the procedure requiring treatment with carbimazole. She also developed palpitations and atrial fibrillation. A provisional diagnosis of ectopic thyroid tissue was considered but both a targeted thyroid uptake scan and SPECT scan did not show any significant thyroid tissue.

A possible diagnosis of struma ovarii was raised and a transvaginal USS was performed showing a 9cm mass in the midline and posterior to the uterus with both solid and cystic areas presumed to be from an ovary. The Ca 125 was slightly elevated at 76.9. She underwent a total body I-131 scan which showed uptake in the ovary.

A unilateral left salping-oophorectomy and right salpingectomy was undertaken with omental biopsy and washings after discussion with the local and regional MDT. Findings at the time of surgery were of normal peritoneal cavity and a benign looking cyst and there was no spillage of contents during the procedure.

Histology revealed follicular carcinoma within a struma ovarii. Onward treatment and monitoring was discussed at the thyroid MDT and monitoring with thyroglobulin was recommended due to the unusual diagnosis which was felt not to be classed as invasive unless it metastasized. Her last reported thyrogloblin levels are normal but she still has paroxysmal AF despite better control of her thyroid function.

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Audit on management of complex endometrial hyperplasia/ carcinoma diagnosed by preliminary endometrial sampling and its prevalence in hysterectomy specimens

Bronwyn Middleton, Irene Ray
WSHFT, Chichester, United Kingdom

Abstract

Endometrial cancer is the most common gynaecological cancer in the Western world and endometrial hyperplasia is its predecessor. Two types of treatment options are recommended for hyperplasia dependent on type of atypia, treatment with progesterone(without atypia) or hysterectomy (with atypia). There is 43%risk of concomitant cancer in patients with atypical hyperplasia.

Objectives:

1. Number of patients with diagnosis of endometrial hyperplasia/ carcinoma diagnosed at preliminary endometrial sampling
2. Management, whether in accordance with RCOG set standards
3. Histology after hysterectomy – to review the rate of concomitant endometrial carcinoma.

Methods:

We collected data for all patients with abnormal uterine bleeding who were diagnosed with endometrial hyperplasia/ carcinoma at endometrial sampling (Pipelle's/ curettage/ polypectomy) from January 2014 to December 2018 (5 yrs) at Chichester (n=39) and Worthing (n=29). We collected relevant data (age/ HRT/ hormonal treatment pre-diagnosis/ Family history of related cancer), method of diagnosis, treatment following initial diagnosis, whether they had hysterectomy and the subsequent histology.

Findings:

68 cases of complex endometrial hyperplasia with atypical hyperplasia in 41 (60%) and a concurrent endometrial cancer at initial diagnosis in 10(15%). Complex hyperplasia within a polyp in 7 cases (10%). 32 cases of endometrial cancer diagnosed at the time of hysterectomy (47%).

Hysterectomy was performed in 90%with Progesterone treatment in 9%, 5 Mirenas and 1 oral progesterones. The cases managed medically were due to hyperplasia confined to a polyp, multiple comorbidities in a BMI of 56, patient choice and one death prior to definitive treatment. All patients counselled appropriately.

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Open vs Laparoscopic Myomectomy: A retrospective cohort study from a multi-site London university hospital

Carina Johnstone-Ayliffe, Nisreen Fahmy, Nicolas Galazis, Magdy Nawar
London North West University Healthcare NHS Trust, London, United Kingdom

Abstract

Aim:

To compare clinical outcomes between laparoscopic and open myomectomies (including conversions and laparoscopic-assisted open).

Methods:

A retrospective cohort study of all myomectomies performed in a London university hospital between January 2016 and December 2018. Data was collected on the number and size of fibroids, length of postoperative stay, surgical technique and complications including blood transfusion.

Results:

A total of 142 myomectomies were performed of which 68 were open, 71 laparoscopic (9 needed conversion to open) and 3 laparoscopic-assisted open. All laparoscopies, with the exception of one case, involved morcellation and histology was benign. Specimen bag was used for a suspicious mass with subsequent histology confirming atypical smooth muscle cell tumour.

Laparoscopy was more commonly performed for single rather than multiple fibroids ($P<0.05$) and open myomectomy was performed for larger fibroids when compared to laparoscopy ($P<0.05$). The average stay after laparoscopy was 2 days compared to 4.4 days after open myomectomy.

Six percent of laparoscopic myomectomies required blood transfusion compared to 31% of open procedures ($P<0.05$). Moreover, blood transfusion was associated with multiple fibroids. A trend towards lower complication rates was observed in laparoscopic myomectomy compared to open (16% and 26% respectively) ($p=0.14$).

Discussion:

The efficacy of laparoscopic myomectomy has been previously established. This study demonstrates that the laparoscopic approach is safe and associated with reduced hospital stay and complication rates. The size and number of fibroids act as limiting factors. Further evaluation is required towards medium and long-term outcomes of laparoscopic myomectomy, particularly recurrence, reoperation, fertility and pregnancy rates.

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Case report of a patient with anterior abdominal wall desmoid tumours and intraabdominal endometriosis

Temenuga Dacheva[1], Jamin Kashwa[1], Christian Barnick[1], Raj Ragoowansi[2]

[1]Homerton University Hospital, London, United Kingdom.
[2]Barts Health NHS, London, United Kingdom

Abstract

Background

Abdominal wall endometriosis is a rare condition. Associations with abdominal surgery are known. Its prevalence varies between 0.01% and 1% after caesarean section.Abdominal wall desmoid tumours are uncommon too.The precise diagnosis may be difficult.

Case summary

A 42 years old P2 patient with severe endometriosis including suspected endometriosis of the anterior abdominal wall was admitted for elective joint surgery with a plastic surgeon.

Past gynaecological history of endometriosis, fibroids and endometrial polyp.

She had a complex past surgical history with 5 previous abdominal operations.

On MRI there was a suspicion of abdominal wall endometriosis with an 8x2x6cm irregular, anterior wall mass, with slightly atypical MRI characteristics.

The patient underwent laparoscopic excision of periureteral endometriotic nodules, followed by a mini abdominoplasty under laparoscopic control, with complete excision of three suspected endometriotic nodules from the anterior abdominal wall- two subcutaneous and one intramuscular. No residual nodules were felt.

The histology result of the abdominal wall masses revealed desmoid tumours and the intraabdominal nodules were endometriotic.

Conclusion

Clinicians should be aware of the possibility of dual pathology- endometriosis and desmoid tumours. The final diagnosis is histopathological.

Abdominal wall desmoids may require abdominal wall resection and reconstruction. As in this case, a multidisciplinary team approach with Plastic Surgery complements our input as it facilitates wider/extensive resection of these tumours in the knowledge that the defects can be reconstructed de novo and/or along aesthetic surgery principles. Consider laparoscopic guidance to ensure adequate excision margins and to reduce operative time and risks.

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Longstanding anterior abdominal wall subcutaneous endometriosis after Caesarean section- a case report

Temenuga Dacheva, Jamin Kashwa, Christian Barnick
Homerton University Hospital, London, United Kingdom

Abstract

Background

Extrapelvic endometriosis has been described in various locations and endometriosis of the abdominal wall is the most common one. However subcutaneous abdominal wall endometriosis is a rarity. It is often related to a surgical scar. The most common surgery associated with abdominal wall endometriosis is Caesarean section. The reported incidence varies between 0.03%-1%.

This rare location of abdominal wall endometriotic nodule has a wide range of differential diagnosis.

The treatment of choice is wide surgical excision. It is important not to break the mass during the excision in order to prevent the reimplantation of microscopic endometrial cells.

Case summary

An young patient, G1P1 , who underwent emergency uncomplicated Caesarean section 10 years ago presented to our endometriosis centre with history of a 3 cm 'lump' in the Caesarean section scar which was very painful and increasing in size during her periods.

On examination there was about 3cm palpable nodule in the superior left aspect of the previous Caesarean section scar. The ultrasound scan showed suspected 3cm abdominal wall endometriotic nodule. No other endometriosis.

Surgical exploration revealed a 3 cm solitary subcutaneous mass extending to the anterior lamina of the rectus sheet. The lesion was excised and the histopathology confirmed endometriosis.

Conclusion

Abdominal wall endometriosis should be considered in women with exacerbation of pain and tenderness in the mass during menstruation and history of abdominal pelvic surgery.

The true incidence might be higher than the reported one as sometimes the women can suffer in silence for many years.

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Outpatient Hysteroscopy Service in a District General Hospital: A Patient Satisfaction Survey

Susan Addley, Courtney McMullan, Kristine Steele, Roisin Hearty, Karen Woods
Ulster Hospital, Dundonald, United Kingdom

Abstract

With the average BMI of the gynae population increasing, so too is endometrial pathology. Carrying out the gold standard investigation of hysteroscopy in the context of high BMIs and multiple comorbidities is safer, quicker and more cost effective when performed in the outpatient setting. But how acceptable is this approach to our patients? We asked a cohort of 54 women to complete a patient satisfaction questionnaire after undergoing outpatient hysteroscopy. 91% of patients had received information on the procedure prior to attendance; 73% as written information; and 27% as a verbal explanation. 98% found this pre-procedure information 'clear' and 98% were reassured by it. 34% of patients took analgesia prior to their appointment – most commonly Co-Codamol and on average 92 minutes beforehand. 63% of all women described the procedure as 'painful'; with a mean reported pain score of 4/10. Pain scores were slightly higher (4.2/10) in those who received no pre-procedure information versus women who had been appropriately counselled (3.9/10). Patients with analgesia on board had lower pain scores (3.4/10) than patients taking no analgesia (4.3/10). 94% of women overall, and 91% who reported pain, would undergo outpatient hysteroscopy again. 93% would recommend to a friend. All patients described staff as 'friendly' and the clinical setting as 'comfortable'. We concluded: pre-procedure information is important for patient reassurance and may reduce pain scores; analgesia prior to outpatient hysteroscopy may also reduce the pain experienced; and the vast majority of all women found the experience acceptable and one they would undergo again.



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A Review of the Outpatient Hysteroscopy Service in a District General Hospital

Susan Addley, Courtney McMullan, Kristine Steele, Roisin Hearty, Karen Woods, Leah McGuckin
Ulster Hospital, Dundonald, United Kingdom

Abstract

With the average BMI of the gynae population increasing, so too is endometrial pathology. Carrying out the gold standard investigation of hysteroscopy in the context of high BMIs and multiple comorbidities is safer, quicker and more cost effective when performed in the outpatient setting. We carried out a prospective audit of 35 cases attending for outpatient hysteroscopy in a district general hospital. The clinical areas used appropriately offered changing facilities, a dedicated gynae couch, refreshments area and had access to Entonox, local anaesthetic and a cardiac arrest trolley. The average patient age was 51.1 years. The majority of referrals came via gynae outpatients (91%); with 72% graded 'red flag'. Post-menopausal bleeding was the most common indication (68%). 62% of women had thickened endometrium on ultrasound prior to referral; and 28% a suspected polyp. 76% had not had a pipelle biopsy. 'Red flag' referrals were seen on average within 32 days; and 'urgent' 83 days. 60% of women attending were parous, with 1+ vaginal deliveries. 41% had a BMI>30kg/m2; 18% were diabetic and 9% on HRT. 82% of patients received pre-procedure information and 19% took pre-procedure analgesia. All patients were consented. No cervical priming, antiemetics or antibiotics were used and no patients had fasted. All procedures were chaperoned. In all cases, vaginoscopy was the preferred technique, using a rigid 5mm scope and saline for irrigation. 12% of hysteroscopies failed, being unable to access the uterine cavity due to pain or stenosis. 3% of patients experienced nausea and 3% a vasovagal response.



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What role do "off label" non hormonal medicines have in an endometriosis consultation?

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Abstract

Endometriosis is a chronic and debilitating condition. Current management of endometriosis include NSAIDS, Hormone mediating drugs and surgery, with the latter being the mainstay of treatment. There is widespread practice to use horomone suppressive agents following surgery to minimise disease recurrence. However risk of spontaneous conception following surgery is greatest in the few months after surgery. Therefore hormone suppression appears unacceptable to those women trying for pregnancy. They are mostly offered analgesics as the sole strategy and most live in intractable pain.

We present a selection of "off label" non hormonal medical therapies used in the management of endometriosis which may reduce inflammation, suppress immunity and inhibit growth of endometriosis. Some of those discussed includes Metformin which has shown significant pain reduction and increased pregnancy rates in an a controlled trial. Pentoxyfylline has also shown pain reduction as well as increasing pregnancy rates with minimal side effects. Statins and anti growth therapies have pleitrophic properties which may regress endometriotic deposits.

There is growing interest in endometriosis being inflammation driven and we present the verdict on use of potent immune modulators like infliximab.

Whilst data supporting the use of off label medicines remains indeterminate, we owe it to our women to have a frank discussion and put these options forward as part of an informed discussion. It may give some women the hope they have long lost and give observational data which may increase the chances of more randomised control trial being rolled out in future.



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Contemporary management options for tuboovarian abscess: a systematic review of the literature

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Abstract

Objective:

Tuboovarian abscess (TOA) is a serious acute complication that affects 15-35% of patients with pelvic inflammatory disease. After failure of antibiotic treatment, we sought to review the literature and determine the optimal way of managing TOA with least morbidity and limited hospital stay.

Design:

Systematic review of literature to evaluate effective methods of management of TOA.

Method:

Literature search done using Medline (1950-2018), Embase (1980-2018) and the Cochrane Library for relevant citations. Overall, 11 (10 retrospective and 1 case report) studies were eligible for the systematic review with a sample size of 606 women with TOA.

Results:

There were no RCTs comparing conservative versus surgical treatment and no prospective studies. Of the 11 studies, 5 studies (n=120) demonstrated transvaginal abscess drainage with or without tube drain to be an effective management option. Three studies with largest case series (n=170) compared conservative management versus surgery. All three studies confirmed that the size of TOA of 7 cm and more required surgical intervention (p=<0.05). In most studies, with conservative management or surgery there was no significant difference in hospital stay. There were some reported complications with the different techniques of aspiration drainage (bladder pain and infection).

Conclusions:

This review shows that there is a lack of good quality studies to compare various management options for TOA, however the limited evidence does demonstrate that the size of TOA can determine if surgical intervention is needed. Prospective studies are required to compare transvaginal drainage versus laparoscopic drainage for morbidity, fertility and cost-effectiveness.

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Symptomatic recurrence of endometriomata following PlasmaJet treatment

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Queen Elizabeth University Hospital, Glasgow, United Kingdom

Abstract

Introduction

The current recommended treatment of endometriomata is usually surgical excision. Excisional treatment is associated with decrease in ovarian reserve compared with ablation techniques but also a decrease in recurrence rates.

Methods

64 endometriomata were treated in 49 consecutive patients identified retrospectively from theatre records of a single operating surgeon, from January 2013 to December 2017. Electronic hospital records were used for data collection and to search for re-attendance for imaging or gynaecology review within the whole health board. The maximum time from treatment to clinical review was 66 months. All patients included in study were treated using plasma energy device, PlasmaJet.

Results

Mean age at surgery was 35 year (+/- 5.8) with a recorded BMI of 26 (+/- 3.8). Median recurrence of symptoms of pain was 20 months.

Symptomatic recurrence of endometriomata diagnosed within the health board was 6.2% when looking at total number of cysts treated, with an average time of 19 months from treatment to recurrence. Bilateral endometriomata predicted recurrence compared to unilateral disease with an OR 3.02, RR2.6. Women under the age of 35 years were more likely to be diagnosed with recurrence of endometriomata than women over 35 years with an OR 3.3, RR2.83.

Secondary outcomes recorded were recurrence of pain, dysmenorrhoea and peri-operative complications.

Conclusion

Recurrence of endometrioma in our study is comparable with published rate of recurrence after excisional treatment (14-17%). Plasma energy ablation may have lower recurrence rates than other ablation techniques. Formal studies with long term follow up are required.

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Hysteroscopic tissue removal system (MyoSure) in an outpatient setting: Experience from a large retrospective cohort study

Mihai Gherghe, Konstantinos Papadakis, Aimee McCoubrey, Christina Taggart
Queen Elizabeth University Hospital, Glasgow, United Kingdom

Abstract

Introduction

Hysteroscopic resection has been established as the gold-standard management of endometrial pathology. MyoSure has emerged as a minimally invasive alternative to traditional resectoscopic methods with notable advantages such as office environment setting, use of simple analgesia only and reduced treatment times.

Methods

This was a retrospective cohort study with data collected from May 2015 to January 2019 with¬in a busy Health Board. The primary endpoints of the study were: 1) pain scores, 2) completeness of resection, 3) complications and 4) rate of recurrence.

All procedures were performed with a dedicated team of nurses and by four different Gynaecologists. All patients had endometrial pathology (polyp or fibroid) confirmed at diagnostic hysteroscopy.

Procedure efficiency was evaluated by recording resection time and total procedure time. Pre-procedure endometrial biopsy report was compared with final histopathology of morcellated tissue.

Results

A total 619 patients met the inclusion criteria. The mean age was 57.9 years. 79.7% of patients were post-menopausal, and 20.3% pre-menopausal. Of the initial 241 procedures, 7 were abandoned (2.9%). The mean procedure time was 8.16 mins and mean resection time 40.4 seconds. 5.3% of patients had documented evidence of recurrent polyps after MyoSure. 80.1% of patients reported a pain score of 5 or less.

Conclusion

This is a large cohort study evaluating the outpatient accessibility and feasibility of MyoSure system for treatment of endometrial pathology. The procedure has proven to be safe and efficient and majority of patients found it acceptable with avoidance of regional or general anaesthesia.

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An Audit of Benign Hysterectomy Practice in NHS Fife - are we heading down the keyhole?

Vanishree L Rao, Katherine Hughes, Fiona Smith, Omar Thanoon, Chu chin Lim
NHS Fife, Kirkcaldy, United Kingdom

Abstract

Aim:

To compare benign hysterectomy practice in NHS Fife with that of English NHS hospital-trusts in the key domains identified in the Royal College of Obstetricians & Gynaecologists (RCOG) Clinical Indicators Programme 2015/16; Hysterectomy type, Length of stay and Emergency readmission rates.

Method:

Retrospective audit of electronic records of women who had hysterectomies performed in Fife between January 2017 and May 2018. Patients with malignant pathology and pelvic organ prolapse as primary indication were excluded.

Results:

Hospital theatre records identified 132 patients. 65% of these were Laproscopic Hysterectomies (LH), 33% were Abdominal Hysterectomies (AH) and the remaining 2% were Vaginal Hysterectomy (VH) or Laproscopically Assisted Vaginal Hysterectomy (LAVH). 5 of the 86 planned laparoscopic hysterectomies had to be converted on the operating table to open giving a conversion rate of 5.8%.

Average length of stay for LH, AH and VH was 2.7, 4 and 3 days respectively. Emergency readmission rate was defined by hospital re - admission within 30 days from surgery (6.4% for AH v/s 2.4% for LH) or attendance at emergency gynaecology clinic (2.1% for AH v/s 6% for LH).

Rates of all complications were higher in AHs (38.6%) than in LHs (11.6%).

Conclusions:

Laparoscopic hysterectomy is the main route of hysterectomy in Fife and proportionately higher than English NHS trusts as stated in the ROCG 2015/16 Benign Gynaecology Care report. However, more recent data is needed for direct comparison. LH in Fife was associated with shorter hospital stay, fewer complications and lower readmission rates than AH.

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A Review of an Outpatient Hysteroscopy Service for Two Week Wait (TWW) Referrals with Suspected Uterine Cancer

Geetika Shah, Deepa Nair, Nikki Webb, Sameer Umranikar
Princess Anne Hospital, Southampton, United Kingdom

Abstract

Aim:

To review the outpatient hysteroscopy service for TWW referrals at a University teaching hospital.

Methods:

A retrospective analysis of patients referred to University Hospital, Southampton with suspected uterine cancer via the TWW pathway over a three month period.

Results:

A total of 192 patients were reviewed with a median age of 58 years. Majority of patients (96%) had a transvaginal scan. The cut-off of endometrial thickness (ET) requiring further investigation was taken as 3 mm. Of 101 patients who required a hysteroscopy (ET > 3 mm/ not clearly visualised), 47 were done as an outpatient procedure, 2 declined further investigation and the remaining were done under General Anaesthetic (GA). Pain (33%), cervical stenosis (23%) and patient anxiety (15%) were the most common reasons for unsuccessful outpatient hysteroscopy. Of those who had a successful outpatient hysteroscopy, 5 (10.6%) were nulliparous compared to 13 (21.7%) amongst those who had hysteroscopy under GA.

In this cohort, 13 patients were diagnosed with cancer (1 bladder, 1 ovarian, 1 cervical, 1 ovarian with hyperplastic endometrial polyp and 9 with endometrial cancer). Four cases of endometrial cancer were diagnosed through outpatient hysteroscopy (8.5%) and 5 through hysteroscopy under GA (9.3%).

Conclusion:

Our study supports outpatient hysteroscopy as a useful tool to maximise efficiency of the TWW pathway. A further cultural change within the unit may enable us to increase patient uptake and success rates of out-patient hysteroscopy, enabling quicker diagnosis and better overall patient experience alongside clear economic benefits to the service.

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Abnormal appendix and recurrent ovarian cysts.

Jody Taylor, Oscar Barnick, Elias Kovoor
Darent Valley Hospital, Kent, United Kingdom

Abstract

One in 10 women will have surgery for ovarian cysts in their lifetime and recurrence is common in premenopausal women. When recurrence occurs rapidly one needs to be suspicious of the underlying pathology. We encountered a 40 year old nulliparous woman who presented with abdominal pain with ultrasound revealing bilateral ovarian cysts. She went on to have a laparoscopy where the appendix was deemed abnormal and removed. Her pelvis was frozen and mucinous fluid was drained from the ovarian cysts. Histology for the appendix revealed a low grade dysplasia.

Within a month the cysts had recollected. Ovarian cystectomy was performed with histology confirming low grade appendicular mucinous neoplasm (LAMN) with secondary deposit of pesuodomyxoma ovarii leading to the ovarian cysts. The ovaries are a common site for metastasis for primary appendiceal tumours. Literature has revealed in patients with primary LAMN, the appendix is likely to appear abnormal at the time of surgery therefore it is deemed good practice to perform a global assessment at the time of laparoscopy, especially the appendix in a patient with ovarian cysts and in those with pseudomyxoma peritonei. This diagnosis has led to appropriate follow-up with colorectal team and correct management. It is likely that without the previous histology of the appendix a diagnosis of primary ovarian cyst would have made.



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Complex and extra-tubal ectopic pregnancies. Safe surgical techniques for trainees with intermediate laparoscopic skills.

JIM CLARK
ROYAL DEVON AND EXTER NHS TRUST, EXETER, United Kingdom

Abstract

INTRODUCTION

EXTRA-TUBAL ECTOPIC PREGNANCY, CAN PRESENT A SURGICAL CHALLENGE FOR EVEN EXPERIENCED LAPAROSCOPIC SURGEONS. THEY ARE RARE ENOUGH TO BE ENCOUNTERED INFREQUENTLY, SO PRACTICE AND TEACHING IS OFTEN LACKING, BUT THEIR INCIDENCE IS INCREASING AND THEY ACCOUNT FOR CONSIDERABLE MORBIDITY. EVEN SENIOR DOCTORS MAY LACK FAMILIARITY IN DEALING WITH COMPLEX INTERSITIAL, ISTHMIC AND SCAR PREGNANCIES.

METHODS

OVER MANY YEARS LEADING EARLY PREGNANCY SERVICES IN EXETER, I HAVE COLLECTED PHOTOGRAPHIC AND VIDEO FOOTAGE OF MANY COMPLEX SITUATIONS, AND DEVELOPED SURGICAL TECHNIQUES TO SAFELY MANAGE EXTRA-TUBAL PREGNANCIES, SUITABLE FOR JUNIOR STAFF WITH INTERMETDIATE LAPAROSCOPIC SKILLS TO LEARN. THESE ARE PRESENTED PICTORIALLY IN POSTER FORM WITH BACK UP LINKS TO YOU-TUBE VIDEOS THAT CAN BE DOWNLOADED AND EXAMINED.

RESULTS

FEEDBACK FROM THE RCOG ASM IN BENIGN GYNAECOLOGICAL SURGERY IS THAT MY SURGICAL VIDEOS HAVE HELPED TRAINEE AND SENIOR GYNAECOLOGISTS IN DIFFICULT SITUATIONS AND THIS POSTER AND ATTACHED MULTIMEDIA RESOURCE FORM THE RESPONSE TO REPEATED REQUESTS FOR FURTHER ACCESS.

CONCLUSION

THERE IS NO SUBSTITUTE FOR 1 ON 1 MENTORED SURGICAL TEACHING, BUT FOR THOSE WITH INTERMEDIATE LAPAROSCOPIC COMPETENCE, AND SUTURING SKILL, VIDEO FOOTAGE OF TECHNIQUES TO DEAL WITH COMPLEX SITUATIONS CAN PROVIDE HELPFUL GUIDANCE. THIS MAY PROVE VALUABLE IN CHALLENGING SITUATIONS ESPECIALLY WHERE MORE EXPERIENCED HELP IS LESS AVAILABLE.

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A simple in-house simulator-based Laparoscopic Suturing Practice Program (LapSUPP) for trainees in Gynaecology.

Lisa Knight, Katharine Edey, Ben Peyton-Jones, James Clark
Royal Devon & Exeter Hospital, Exeter, United Kingdom

Abstract

Background

Simulation training in the enhancement of surgical skills has been proven to reduce errors and improve manual dexterities and is endorsed by the British Society of Gynaecological Endoscopy (BSGE). Evidence shows similar results in skill improvement when comparing advanced simulator models with simple models facilitated by experienced trainers.

Our aim was to produce a simple, affordable training and assessment program in laparoscopic gynaecology suturing.

Methods

Eight video-based exercises have been developed for obstetric and gynaecology trainees at the Royal Devon & Exeter Hospital, each emphasising a specific skill essential for the development of proper laparoscopic suturing technique. This included assessment of hand-eye coordination; general economy and efficiency of movement; suture handling and knot-tying skills.

Construction of practice aids (e.g. a synthetic vaginal vault made with sponge) were used in a simple box trainer device. Expired sutures and donated laparoscopic graspers were donated from the Gynaecology department. An experienced trainer would supervise the tasks, allocating them a judgement of 'working towards competence' or 'competent' in a formative setting.

Results

All participants showed improvement in their ability to perform the tasks at all levels of prior experience. 100% of participants felt that it was a useful adjunct to clinical training; that if the model was available in their unit they would use it; and that it would be easily reproducible in their own units.

Conclusion

This course set up is inexpensive and effectively creates a non-intimidating environment of learning a complex surgical skill before transferring it into a real-life surgical situation.

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Laparoscopic Gynaecological Oncology Surgery: Does obesity make a difference to outcomes?

Ashleigh Haken, Ken Lim
University Hospital of Wales, Cardiff, United Kingdom

Abstract

Introduction

Obesity in the UK is a growing problem and is classically associated with increasing co-morbidities, longer operative time and more complications. It is increasingly common for gynaecological surgeons to operate laparoscopically which has proven benefits of reducing complications such as wound dehiscence and infection, and shortens recovery time.

Aims

Determine number of laparoscopic hysterectomies performed for cancer in University Hospital of Wales over last 5 years, and analyse complication rates in relation to body mass index (BMI).

Method

Retrospective data analysed on laparoscopic gynaecological oncology surgery from the last 5 years. Data was used to assess operation type in association with BMI and complication rates, conversion to open procedure rates, intra-operative blood loss and length of stay.

Results

The Gynae-Oncology service at the University Hospital of Wales has performed 589 laparoscopic hysterectomies since 2015, and over 80% of these in overweight or obese women. This data demonstrates an increasing trend of overweight and obese patients over the last 5 years, and yet no significant increase in complication rates or length of stay. Our overall complication rate was 5.1%, and conversion to open procedure was required in 2%.

Discussion

Our findings suggest that surgical skill has continued to improve despite the increasing numbers of obese patients. Laparoscopy remains a safe and effective alternative to open hysterectomy in obese patients with endometrial and cervical cancer, and we hope it will continue to replace open surgery as first line in these cases.

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Laparoscopic Repair of a Uterine Niche Causing Mentrual Dysfunction

Patrick Rosser, Tom Aust, Trevor Balling
Wirral university teaching hospitals, Upton, United Kingdom

Abstract

Uterine niche, also known as uterine isthmocele, is a myometrial defect which occurs following caesarean section. The defect fills with endometrium and typically causes postmenstrual bleeding, as well as being a risk factor for caesarean scar ectopic pregnancy. The prevalence is increasing with the increasing number of caesarean section and the increasing awareness of the condition. Whilst the aetiology is known, the precise mechanism and risk factors are not. Several theories, however, have been postulated.

We present a case of successful laparoscopic repair in a 26 year old woman. She had one child born by caesarean section 5 years previously, and she presented with persistent bleeding. An ultrasound scan showed a myometrial defect. At hysteroscopy she was found to have a uterine niche. This was not amenable to hysteroscopic repair, so a levonorgestrel IUS was inserted. However, her symptoms did not improve. The niche was repaired laparoscopically.

At follow up, her symptoms had improved and ultrasound showed that the defect had been successfully repaired.

This case highlights the different management options available for this evolving problem.



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Pelvic Endometriosis: Spectrum of imaging findings

Nardia Poole[1], Rebecca Mallick[2], Faye Cuthbert[1]

[1]Department of Radiology, Brighton and Sussex University Hospitals Trust (BSUH), Brighton, United Kingdom.
[2]Brighton and Sussex University Hospitals Trust (BSUH), Haywards Heath, United Kingdom

Abstract

Introduction

Endometriosis is defined as the presence of functional endometrial tissue out-with the uterine cavity and can generally be subdivided into deep and superficial disease. It can present as a myriad of symptoms ranging from dysmenorrhea, pelvic pain and fatigue to bladder and bowel symptoms and subfertility.

Unfortunately despite being a common condition many women still have to wait, on average 7.5 years, for referral to secondary care and a definitive diagnosis.

Definitive diagnosis is often based on laparoscopic findings, however pre-operative imaging with MRI can be useful for diagnosis and in some cases essential for pre-operative surgical planning.

Aim

The purpose of this educational exhibit is to summarise and illustrate:

1. The principles and role of MRI in the diagnosis and surgical planning of endometriosis
2. The spectrum of MRI findings and differential diagnosis in endometriosis
3. Summarise the 2017 Endometriosis ESUR MRI imaging protocols.
4. Present a pictorial review with learning points of the following:

- Common sites of endometriosis in the female pelvis.
- The pathogenesis, classification, staging of the condition.
- The spectrum of MR imaging features in pelvic endometriosis
- Interesting cases of differential diagnoses mimicking endometriosis.

Conclusion

Although laparoscopic biopsy and histological correlation is the gold standard for the diagnosis of endometriosis, imaging plays an fundamental role particularly in the staging and the pre-operative planning of deep invasive disease. Radiologists play a key role in the endometriosis MDT and surgeons should be familiar with the imaging findings of endometriosis to aid surgical planning and improve patient care.

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Combination of pre procedure analgesia & cervical and fundal local anaesthetic block technique for endometrial ablation in an outpatient hysteroscopy Service

Gonzalo Mezquita, Ozlem Turan, Fevzi Shakir
Royal Free Hospital, London, United Kingdom

Abstract

Introduction:

Endometrial ablation is a minimally invasive procedure for treatment of menorrhagia which can be performed under local anaesthesia. Combining the traditional cervical block with trans-hysteroscopic fundal block could significantly reduce the women´s perception of pain during the procedure.

Aim:

To investigate the effectiveness of combining cervical block with intramyometrial block of the uterine fundus on women´s perception of pain during Novasure Advanced® endometrial ablation.

Methods:

The cervical block used was 4.4 mls of 3% Citanest with Octapressin. Subsecuently, a hysteroscopy was performed using a 4.2 mm hysteroscope, and an additional 5 mls of local anaesthetic (combination of Lignocaine and Bupivicaine) was placed in the myometrium of the fundal wall through a cooks injection needle. 4 injections of 1.25 mls of local anaesthetic was placed in between each tubal ostia at equal distance apart. The ablation was then performed and pain scores were recorded as visual analogue scores (1-10).

Results:

We present the results over the last year. Endometrial ablation was successfully completed in all women in the outpatient. The mean duration of the ablation procedure was 81.6 s. The mean pain scores during and immediately after the procedure were 3 and 1 respectively. All patients were discharged home after the procedure within 20 minutes.

Conclusions:

Endometrial ablation under local anaesthesia is a safe and feasible procedure that can be performed in an outpatient clinic. The combination of cervical and fundal block in addition to pre-operative oral analgesia could improve pain perception during and after the procedure.

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Intrauterine abscess presenting with severe systemic reactive changes with subtle clinical symptoms: A Case Report

Necmiye Dover[1], Hadi Haerizadeh[1], Balpreet Attilia[2]

[1]Musgrove Park Hospital Taunton and Somerset NHS Foundation Trust, Taunton, United Kingdom.
[2]Musgrove Park Hospital, Taunton, United Kingdom

Abstract

Introduction:

Pelvic abscess is a severe complication of PID, usually located in tubes and ovaries. We are presenting a rare case of a chronic intrauterine abscess likely secondary to a noncommunicating uterine horn in a young lady with general nonspecific symptoms of malaise, weight loss and shortness of breath.

Case summary:

Nulliparous, 21-year-old woman presented with chronic fatigue and unintentional significant weight loss over a 6-month period. Blood tests showed significantly increased CRP levels, iron deficiency anaemia, increased ALP and low albumin levels ,abnormal autoimmune liver function tests and prolonged clotting parameters.

Patient referred to gynaecology by medics with a CT showing a possible endometrial abscess, hydro salpinx, bilateral hydronephrosis, splenomegaly and pelvic-para aortic lymphadenopathy. Examination showed no signs of acute PID but subtle pyrexia. Intravenous antibiotics were started and an emergency laparoscopy showed an enlarged boggy uterus. Pus was drained laparoscopically using a Veres needle inserted into the uterine cavity. The aetiology could be an abscess secondary to undiagnosed congenital uterine malformation with hematometra in a non-communicating uterine horn. The patient is booked for an outpatient MRI scan for confirmation of diagnosis and plan future management i.e. excision of the uterine horn.

Discussion:

Signs and symptoms of Mullerian duct anomalies including a non-functional rudimentary endometrial cavity could be very subtle. Any patient who presented with an intrauterine abscess and no significant risk factors for PID should be assessed regarding congenital uterine malformations.

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Outcomes of extended day case Laparoscopic Hysterectomy (LHi) performed as part of an Enhanced Recovery Pathway (ERP).

Gillian Coyle[1], Gemma Clemente[2], Andrew Kent[3], Piers Johnston[4], Charlotte Goumalatsou[5]

[1]Royal Surrey County Hospital, Guildford, United Kingdom.
[2]Josep Trueta University Hospital, Girona, Spain.
[3]Royal Surrey County Hospital, Guildford, United Kingdom.
[4]Royal SurreyCounty Hospital, Guildford, United Kingdom.
[5]Royal Surrey County Hospital, Guildford, United Kingdom

Abstract

Background

Hysterectomy is a common gynaecological procedure carried out for various conditions including heavy menstrual bleeding and fibroids. LH has always been perceived as taking too long, requiring a high skill set and with little benefit in terms of hospital stay. Previous studies have suggested a higher complication rate compared to the abdominal and vaginal approaches.

We developed an ERP to address these issues, so improving patient care and reducing the clinical and financial burden placed on the service and the patient. The key components are preoperative preparation, the surgical technique (LHi) and anaesthetic, postoperative care and follow up. LHi is carried out using the Harmonic and Valtchev Uterine Manipulator (VUM).

Methods

This prospective study is carried out at the Royal Surrey County Hospital in Guildford from March 2004 to date. Data were anonymised onto an encrypted database. Statistical analysis was carried out using SPSS.

Results

We present the data for over 600 laparoscopic hysterectomies performed in this way. We will discuss the demographics of the cohort including age, BMI, previous treatments and indication for surgery. We will present the intra-operative data to include surgical findings, operation length, additional procedures performed. The intra-operative and short term complication rates will also be discussed.

Conclusion

LHi is a flexible technique with a low complication rate which is simple to learn and teach. As part of an ERP it can allow up to 90% of hysterectomies to be carried out laparoscopically with 90% being discharged within 23 hours, regardless of complexity.

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Is it Safe to perform laparoscopic surgical procedures in women with high BMI?

Luiza Placintescu, Olivia Bottomley, Kyin Yu Maw, Melanie Tipples
St Richard's Hospital,Western Sussex Hospitals NHS Foundation Trust, Chichester, United Kingdom

Abstract

Background:

Obesity is a serious condition worldwide with a general upward trend in adults over the past two decades . In England 26% of adults were obese in 2016, 2.9% being morbidly obese (BMI≥40). UK has the sixth highest rate of obesity worldwide. Gynaecological surgery in women with high BMI is challenging.

Aims:

To assess the complication and re-admission rates within 6 weeks post-laparoscopic surgery on women with high BMI.

Method:

A retrospective study of 38 patients with BMI≥35, who underwent laparoscopic gynaecological procedures under the care of one specific consultant between January 2016 and December 2018. All our bariatric patients had a structured pre-operative MDT assessment.

Results:

Age ranged between 23-83 years with a mean age of 58.6.

BMI range was 35-54 with mean BMI of 43± 9. 50% of them were Class II BMI (35-39.9) and 50% were Class III (BMI≥40).

The most common indication is malignant 50%, followed by benign 39.5% and 10.5% were pre-malignant. The overall complication rate was 13.2%; from which 7.9% were intra-operative and 5.3% were post-operative. One case developed atrial fibrillation during the anaesthesia but recovered. Two cases needed conversion to laparotomy (both of them unsuitable for laparoscopic route due to the size of ovarian mass and difficult access from adhesions). None of the patients required blood transfusion at any stage during or after surgery.

No re-admission rate in our study.

Conclusions:

Our study demonstrated that an optimised pre-op MDT assessment of bariatric patients significantly improves the outcome of laparoscopic surgery.

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Are we removing too many healthy ovaries at the time of hysterectomy?

Joanna Abiola, NATHALIE SMILOVICI
TAMESIDE GENERAL HOSPITAL, GREATER MANCHESTER, United Kingdom

Abstract

The debate between patient autonomy and medical paternalism is, has been and is likely to always be one fuelled with controversy. As clinicians, we are faced with this tension on a daily basis and strive to ensure that we serve patients to the best of our ability. We present data from a 12 month review of hysterectomies in a District General Hospital; highlighting the removal of ovaries at the time of hysterectomy in pre-menopausal women. 60% of patients had ovarian conservation, 27% had bilateral oophorectomy and 14% had unilateral oophorectomy performed at the time of hysterectomy. There was no evidence of suspicious disease in the specimens removed. Evidence states that removal of ovaries at the time of hysterectomy reduces the risk of ovarian cancer in high risk women and also has the potential to reduce the need for further surgery in the future. However, there is also a small yet significant body of evidence that suggests that removal of ovaries may cause a step-wise decline in a womans psychosexual and cognitive function. The Montgomery law challenges us to ensure that we inform patients of the pros and cons of their decisions and plays a significant role in our consent procedure. There is clearly a need for open, honest and documented communication between a pre-menopausal patient and her doctor in relation to the removal or conservation of healthy ovaries.



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Endometrial ablation for menorrhagia-is it only a temporary measure?

Iqra Luqman, Rekha Pillai
University Hospitals of Leicester, Leicester, United Kingdom

Abstract

Objective:

Review of evidence to find the incidence of hysterectomy following endometrial ablation for menorrhagia and if as clinicians we should be selling this more to our patients.

Background:

Menorrhagia can be a seriously debilitating illness for women and it can have huge impacts on the psychological, physical and sexual heath of young women. Endometrial ablation is offered as one of the surgical options for treatment of menorrhagia even in the presence of fibroids of less than 3 cm (NICE guidance).

Methodology:

Electronic database were searched from 1974-2018. Literature search was performed and analysed. Inclusion criteria of studies was only long term case series which showed outcome of patients who underwent endometrial ablation for menorrhagia.

Results:

Eight studies (n=2507) were identified and the results tabulated of which seven of them were retrospective observational study and one study was prospective. The age of the patients ranged from 29 to 59 years. Follow up for these patients was from 10 to 25 years. 15.7% of the patients went on to have hysterectomy as their symptoms didn't settle with endometrial ablation alone, compared with the 84% who avoided hysterectomy.

Conclusion:

Endometrial ablation is an effective surgical technique for patients with menorrhagia. It allows for increased patient satisfaction with shorter operating times and reduced morbidity as compared to hysterectomy. However, this effective technique cannot be used for patients with cancer, large fibroids, or women who wish to preserve their fertility.

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Urological complication at Laparoscopic salpingectomy

GIllian Coyle, Lesley Roberts, Andrew Kent
Royal Surrey County Hospital, Guildford, United Kingdom

Abstract

Background

Laparoscopic salpingectomy is a method of sterilisation utilised when hormonal methods of contraception are not tolerated (RCOG 2016. We present a case where a presumed vascular injury during laparoscopic salpingectomy transpired to be an abnormally sited pelvic kidney, and the management thereof. The incidence of ectopic kidney is 1:3000 and can be associated with other Mullarian duct abnormalities such as arcuate or didelphic uterus (Heinonen 2018)

Case- 49yr woman who had failed trials of oral and intrauterine contraceptives. She was counselled and consented in keeping with the RCOG consent advice for laparoscop[ic sterilisation and attended for daycase laparoscopic bilateral salpingectomy. Middlesborough entry and 360 degree laparoscopy was performed uneventfully. Bilateral salpingectomy was performed. On completion of the procedure a bluish mass was noted at the pelvic brim on the right pelvic side wall. At the time of identification the patient had a hypotentsive episode and was appropriately resuscitated. Consideration of a vascular injury was made and the general surgeons and vascular surgeons were called. Following further assessment a laparotomy was performed to assess and treat the possible haematoma. On further exploration the mass was found to be an ectopic kidney. The patient recovered well post operatively and follow up CTIVU revealed a pelvic kidney with a duplex outlet.

Conclusion

Management of intra-operative complications is complex. Analysis of causation is important and one should always be aware of potential aberrant anatomy. It often involves a multidisciplinary approach and this case highlights the effects of human factors.

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Laparoscopic colposuspension (LC) - the way forward after vaginal mesh

Charlotte Goumalatsou, Gillian Coyle, Andrew Kent
Royal Surrey County Hospital, Guildford, United Kingdom

Abstract

Background:

Before TVT, colposuspension was the operation of choice for stress urinary incontinence (SUI), cystocoele and prolapse (Burch 1961). Due to the current pause in vaginal mesh use, colposuspension is again to the fore. LC offers an alternative to open colposuspension and TVT with similar outcomes and trends towards a shorter stay, quicker recovery and fewer complications (Dean 2017). The perceived downside is that operating time is longer.

We have been offering this procedure routinely in Guildford since 2006. We carry out LC using 4 ports and a transperitoneal approach, delivered as part of an ERP. Two sutures are placed bilaterally and the small peritoneal defects closed (Kent 2009, 2014). The catheter is removed before discharge.

Aims:

To assess the subjective cure rate of SUI. Secondary outcomes include peri- and postoperative complications (blood loss, bladder injury, failure of TWOC, infection); length of stay; requirement for re-operation; and patient satisfaction.

Methods:

This was a retrospective study with a telephone interview to assess patient satisfaction and long-term subjective cure. Data were anonymised onto an encrypted database. Statistical analysis was carried out using SPSS. NRES South East Coast advised that this study did not require submission for formal ethics review.

Results:

We present outcomes including demographic data, complications, cure of SUI, further surgery and patient satisfaction.

Conclusions:

LC is a safe and effective alternative to OC and vaginal mesh. Our modified procedure with simple dissection and robust suturing techniques allows a reduced operating time with all the benefits of the laparoscopic approach.

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Trainee feedback on the need for the development of a laparoscopic simulation training curriculum in the Oxford Deanery

Somia Khalid[1], Alexandros Grammatis[2], Emily Carter[3], Kirana Arambage[1]

[1]Oxford University Hospitals, Oxford, United Kingdom.
[2]Stoke Mandeville Hospital, Aylesbury, United Kingdom.
[3]Milton Keynes University Hospital, Milton Keynes, United Kingdom

Abstract

Introduction

Changes to junior doctors working patterns and loss of the 'firm' structure in many deaneries has led to trainees reporting difficulty acquiring sufficient gynaecological surgical skills to operate independently at consultant level. Laparoscopic simulation training was introduced to the RCOG training matrix in 2016 and there is a mandatory curriculum requirement for ST1-2 trainees.

Aim

Evaluate the need for a laparoscopic simulation curriculum as a mandatory component of training at ST3-5 level.

Methods

We gained feedback from ST3-5 trainees who attended a laparoscopic simulation course including video-based lectures, case-based workshops, simulated laparoscopic tasks, virtual reality and hysteroscopic simulation aimed at ST3-5 curriculum requirements.

Results

Objective structured self-assessments forms were used pre- and post- course. Feedback received about the course itself was overwhelmingly positive. Post-course all trainees (100%) felt more confident with salpingectomy and cystectomy.

When asked about their laparoscopy training prior to the course, 25% of trainees felt 'dissatisfied". 67% had less than 5 hours experience using a box trainer and over 80% had never used a virtual reality simulator. 84% of trainees felt that simulation training should be a prerequisite and part of the curriculum.

Conclusion

Our ST3-5 trainees strongly support the development of a laparoscopic simulation curriculum to aid both completion of the RCOG training matrix and lifelong skills. Our focus now is on developing this curriculum to supplement independent learning in combination with a simulator.

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The ill defined endometrium in postmenopausal bleeding : an hysteroscopic evaluation

Mohamad Abdelwehab, Latika Narang
St Helier hospital, London, United Kingdom

Abstract

Objective :

To evaluate the need for further investigation (outpatient hysteroscopy) in women with postmenopausal bleeding showing an ill defined endometrium on transvaginal ultrasound (TVS)

Methods :

Retrospective analysis of the hysteroscopic findings in women with postmenopausal bleeding and an ill defined endometrium in St Helier Hospital from January 2017 - December 2018. A 2.7mm rigid hysterosope was used. Data concerning women's symptoms and transvaginal ultrasound findings were collected.

Results :

A total of three hundred and eighty four women were referred for outpatient hysteroscopy from the rapid access clinic following a transvaginal ultrasound investigating postmenopausal bleeding.

Thirty nine (10% of referrals) of these showed an ill defined endometrium on TVS. Thirty (76.9%) exhibited an atrophic endometrium on OPH and were discharged. Two (5.1%) patients had unsuccessful procedures due to cervical stenosis and were referred to MDT. Seven (17.9%) patients showed uterine pathology in the form of five polyps and two submucosal fibroids. All were resected in the outpatient setting with subsequent benign histology except one case of Grade 3 endometrial cancer found within a resected polyp.

Conclusion :

An ill defined endometrium on TVS is mostly due to endometrial atrophy however it can also be due to abnormal uterine structures.

The incidence of an endometrial malignancy is reduced compared to an ultrasound finding of thickened endometrium but cannot be excluded.

The use of OPH in these cases is warranted until studies with larger numbers are performed.

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Hysteroscopic training simulators – a qualitive evaluation and comparison of different modalities

Chris Skelly, David Morgan
Antrim Area Hospital, Antrim, United Kingdom

Abstract

Introduction

Outpatient Hysteroscopy is evolving, with many devices and techniques available for treatment of intrauterine pathology. In the outpatient setting, where patients are fully alert, competence can be gained through simulation prior to patient contact.

Design

We sought to assess 3 hysteroscopic training modalities during a 36 delegate Hysteroscopy Practical Workshop; Prodelphus Hysteroscopy and Resectoscopy Simulator, 'Limbs and Things' Hysteroscopic trainer, Smith and Nephew Truclear SIM.Delegates rotated through stations on morcellation, fluid management systems, mini-resectoscope, vaginoscopy and hysteroscopic instruments.

Results

Truclear SIM provides realistic imaging, with graphics representing pathology, from polyp to multiple fibroids. The program assesses competence, providing a score. There is no tactile feedback, and no septum resection option. 84% of delegates rated it 'excellent', 8% 'very good ', 8% 'good'.

'Limbs and Things' provides a training system for diagnostic hysteroscopic technique, permitting insertion of hysteroscopic instruments. Set-up is simple. Its use can be long lasting when only used for diagnosis and examination. 16% delegates rated it 'excellent', 36% 'very good', 48% 'good'.

Prodelphus provides an artificial uterus with capacity for biological implants.It requires 'no touch' vaginoscopic technique - a vital skill in outpatient hysteroscopy; and realistic pathologies – polyp, septum, myoma, also admitting biological tissue. It responds accordingly to fluid pressure changes and set pressures, making it a valuable resource for resection training and is reuseable. 94% of delegates rated it 'excellent', 6% 'very good'.

Conclusion

A combination of simulation systems is optimal to learn the full range of outpatient operative procedures.

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50 cases of Hysterectomy after first and second generation endometrial ablation

Chris Skelly, Emma Sheehan, Keith Johnston
Antrim Area Hospital, Antrim, United Kingdom

Abstract

Background

Heavy Menstrual Bleeding is the most common reason for gynaecological consultation in the UK, having a major impact on quality of life in women of reproductive age.When endometrial ablation fails, hysterectomy is often offered as the definitive intervention.

Methods

A retrospective audit was performed for 50 women who underwent hysterectomy between January 2012 and December 2018, subsequent to a previous transcervical resection of endometrium (TCRE), Novasure or Thermablate ablation procedure in the Northern Health and Social care trust. Casenotes were reviewed and data analysed using Microsoft excel.

Results

Mean age at hysterectomy was 46

100% underwent a pre-operative pelvic ultrasound scan

64% of patients had been treated with Thermablate; 24% Novasure; 12% TCRE

TCREs were performed when there were concerns over caesarean scar thickness or with 3 or more previous caesarean sections, or due to previous failed second generation ablation

58% had a trial of Mirena IUS prior to ablation

Most common symptoms prior to hysterectomy were irregular bleeding and pelvic pain

Mean ablation to hysterectomy interval - 17 months

Mean specimen weight at hysterectomy - 152g

Abnormal pathology confirmed in 76% of hysterectomy specimens (adenomyosis 62%, fibroids 17%, fibroids and adenomyosis 21%).

Conclusions

Endometrial ablation remains a viable option for the treatment of menorrhagia, however it will fail in the minority of cases. Review of specimens suggests an association between failed ablation and presence of pathology, most notably adenomyosis. The identification of pre-procedure pathology may be useful in counselling patients regarding risk of ablation failure.

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Audit comparing the effectiveness and safety of laparoscopic excision of deep rectovaginal endometriosis at the Endometriosis CaRe Oxford Endometriosis Centre, compared to the standards published by the BSGE multicentre prospective cohort study

Ahmad El-Zibdeh, Ilyas Arshad, Kirana Arambage
Oxford University Hospitals, Oxford, United Kingdom

Abstract

Objective:

To prospectively audit the effectiveness of rectovaginal endometriosis excision by analysing the change in endometrial pain scores for patients' preoperatively and postoperatively. Also, to audit the incidence of urological complications in excision of deep rectovaginal endometriosis

Setting:

Endometriosis CaRe Oxford Endometriosis Centre, Oxford University Hospitals NHS Foundation Trust

Participants:

349 patients underwent planned excision of deep rectovaginal endometriosis.

Intervention:

Laparoscopic excision of rectovaginal endometriosis with pararectal space dissection. Patients were given validated questionnaires to assess their preoperative and postoperative pain, with supplementary questions regarding their quality of life. Moreover, to collect detailed data regarding the extent of endometriosis and procedures involved, surgeons performing laparoscopic excision of endometriosis completed a detailed questionnaire over the surgical findings and intervention.

Outcomes:

This is an audit of patients' pain scores preoperatively and postoperatively at 6, 12 and 24 months based on standardized questionnaire designed by BSGE. Perioperative urological complications and ureteric injury were audited against the results of BSGE study.

Results:

Preoperative menstrual pain had a median score of 9, this reduced to 5, six months postsurgery. The cumulative incidence of urinary tract injury (Bladder injury: 0; Ureteric injury: 2; Urinary tract fistula: 0 Urinary leak:1) was 0.86 % (3/348) the reported urinary tract injury in the BSGE database was 1.0%.

Conclusion:

Menstrual pain was decreased by 5 at 6 months and maintained at 12 and 24 months. This is in keeping with the benchmark published by the BSGE cohort study. Our incidence of urinary tract injury was within that set by the BSGE.

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10 year Trends in Endometrial Hyperplasia

Chris Skelly, Johanna Breen, Keith Johnston
Antrim Area Hospital, Antrim, United Kingdom

Abstract

Introduction

Atypical Hyperplasia carries a nearly 30% risk of developing endometrial cancer over 20 years. We wished to study any trends in endometrial hyperplasia over the past 10 years within one healthcare trust in Northern Ireland.

Methods

Patients with a histological diagnosis of endometrial hyperplasia with or without atypia, were identified from the histopathology database for the years 2008, 2013 and 2018. Information was gathered from patient casenotes and data analysed in Microsoft Excel.

Results

Endometrial Hyperplasia incidence:

2008 29 cases 23% atypical 77% without atypia

2013 34 cases 24% atypical 76% without atypia

2018 39 cases 21 % atypical 79% without atypia

Mean BMI for each year studied:

2008 34

2012 37

2018 38

Age range 36 – 79 years

94% of cases of Hyperplasia with atypia were hysterectomised. The remainder were managed conservatively with Mirena IUS or oral progestogens and surveillance due to unsuitability for surgery.

Hyperplasia without atypia was managed conservatively with progestogens and surveillance in 76% of cases. The main indication for hysterectomy in this group was persistent troublesome bleeding in the absence of progressive histology.

Concomitant endometrial carcinoma rate was 18% overall

The 2018 cohort of patients were managed according to 2016 RCOG guidance in terms of recommended follow-up, in 84% cases.

Conclusions

There was a mild increase in incidence of hyperplasia. The rate of atypical vs without atypia appears to have remained largely unchanged. Overall local clinicians appear to be adhering to RCOG guidance for best practice in management and surveillance of hyperplasia patients.

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Laparoscopic Management of an Inguinal Ovary Presenting as a Hernia

Patrick Rosser, David Rowlands, Maria Callaghan
Wirral University Teaching Hospital, Upton, United Kingdom

Abstract

Inguinal ovaries are a rare occurrence and can be associated with uterine malformations. Ovarian descent is usually arrested at the level of the uterus, but in rare cases the gubernaculum fails to adhere to the uterus. The ovary then can descend into the inguinal canal. The presentation usually mimics an indirect hernia and is rarely discovered preoperatively.

We present the case of a 16 year old who presented with an intermittent left groin lump since the age of 11. Menarche was age 13, she has had normal development and she suffers from asthma. She was admitted for an elective open indirect inguinal hernia repair. At operation, the presumed hernia was found to be an ovary and rudimentary fallopian tube. There was no defect found at the deep ring. Laparoscopy was under taken and a uterine anomaly was found, the left side was rudimentary with the round ligament extending into the inguinal canal. The right side was normal, with a normal ovary and tube. The ovary and tube were conserved, brought intraperitoneally, and separated from the rudimentary uterus. The abdominal wall defect was closed to prevent hernias. Follow up ultrasound did not demonstrate renal tract abnormalities.

This case highlights this rarity of this condition, the appropriate use of the MDT approach, and the use of laparoscopy in the diagnosis and management.



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When first and second generation ablation fails – a review of 100 cases of endometrial ablation

Chris Skelly, Susan Wilson, Kathy Niblock
Craigavon Area Hospital, Craigavon, United Kingdom

Abstract

Background

Heavy Menstrual Bleeding is the most common reason for gynaecological consultation in the UK. Endometrial ablation is often offered as a less invasive alternative to hysterectomy.

Methods

A retrospective audit was performed on 100 women who underwent transcervical resection of endometrium (TCRE) or Novasure between June 2015 and March 2016 in a District General Hospital in Northern Ireland. Women undergoing subsequent hysterectomy after ablation were identified.All charts were reviewed and data analysed using Microsoft excel.

Results

Mean age was 44

40% presented with heavy menstrual bleeding as the exclusive symptom; 21% with regular bleeding and pelvic pain.

100% underwent a pre-operative pelvic ultrasound scan

60% of patients were treated with Novasure; 29% TCRE alone; 6% Transcervical resection of fibroid (TCRF) & endometrium; 3% TCRF; 3% TCRP (polyp) & Endometrium.

40% had a trial of Mirena IUS prior to ablation

Hysterectomy rate was 12%; 8% Novasure 4% Transcervical resection

Most common complaints prior to hysterectomy were irregular bleeding and pelvic pain

Mean ablation to hysterectomy interval was 14 months

Abnormal pathology was confirmed in 84% of women undergoing hysterectomy (adenomyosis 59%, fibroids 15%, fibroids and adenomyosis 26%).

No adenomyosis was diagnosed on pre-operative ultrasound imaging.

Conclusions

Hysterectomy rate is inkeeping with other post ablation studies. Adenomyosis is not easily diagnosed on pre-operative imaging, but is the main histological finding on failed ablation hysterectomy specimens. Arguably, women presenting with heavy menstrual bleeding and cyclical pelvic pain, who have previously failed medical therapy, could be offered hysterectomy over ablation.

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Laparoscopic Trachelectomy following Subtotal Hysterectomy: The Lanarkshire Method

Laura Beatty, Jennifer Bisland, Mohammad Allam
University Hospital Wishaw, Glasgow, United Kingdom

Abstract

Introduction

Subtotal hysterectomy is regarded as a safe and effective management of benign uterine conditions. Of these however, 24.3% report symptoms related to the cervical stump necessitating further surgery. Within NHS Lanarkshire we have innovated a new technique for laparoscopic trachelectomy following subtotal hysterectomy. The advantages of the laparoscopic approach include possible adhesiolysis and providing adequate postoperative vault support.

Methods

A retrospective case note review of laparoscopic trachelectomy was performed. In our unit, 8 laparoscopic trachelectomies were performed between November 2016 and November 2018. Patient demographics, primary surgery, indication for trachelectomy, interim period between procedures, intra operative and post operative complications, and post operative recovery were analysed. The Lanarkshire method of laparoscopic trachelectomy will also be discussed in detail.

Results

Laparoscopic trachelectomy was performed on a range of women aged 29-52 years. Indication for trachelectomy owed to bleeding in 50% of cases and abnormal smears in 50%. On average, trachelectomy was performed 7.6 years following primary surgery. Intra operatively there was a single bladder injury sustained laparoscopically (8.3%). Hospital stay post trachelectomy was 2 days. At follow up all women were satisfied with the results of laparoscopic surgery with nil ongoing issues.

Conclusions

Laparoscopic trachelectomy displays reduced complications intra operatively, quick post operative recovery and excellent patient outcomes at post operative follow up. Our study demonstrates that the Lanarkshire method for laparoscopic trachelectomy is both a safe and effective alternative to vaginal trachelectomy and where feasible should be offered to appropriate patients.

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Mobile Health App & Technology- A Proposed Mobile App for Innovative Surgical Treatment of Fibroid With Usability Testing

Samina Elahi
University College London, London, United Kingdom

Abstract

Background

Fibroids are the most frequently seen tumours of female reproductive system. A cross sectional study in Europe of 1756 women with fibroid-related symptoms found myomas in 12 to 24 percent. (Marshall; Obstet Gynecol 1997). They are non-cancerous growths also called myoma or leiomyoma. A mobile App would be a knowledge hub not only for the provider but also for consumer. This will bring a new level of convenience and efficiency to delivering quality care but also great clinical resource for healthcare professionals.

Methodology and design

Important features of a safe and effective mobile app in gynaecology would be described with models of proposed App in fibroids surgical treatment. Usability testing would be described using Proof of concept study for the validity of proposed App.

Conclusion.

Mobile health technology has revolutionized the health care system. It has improved practice, efficiency and knowledge. However, there are concerns about the accuracy and unregulated status of mobile health Apps. The appropriate usability testing with recommendations would improve the safety and validity of the Apps.

Reference:

1: Marshall LM et al: Variation in the incidence of uterine leiomyoma among premenopausal women by age and race. Obstet Gynecol. 1997 Dec;90(6):967-73.

2: Noel VA et al: Use of mobile and computer devices to support recovery in people with serious mental illness: Survey study. JMIR Ment Health. 2019 Feb 20;6(2).

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Surgical management of deep infiltrating endometriosis within an emerging endometriosis centre. Short term outcomes

Mihai Gherghe, Konstantinos Papadakis, Karina Datsun, Robert Hawthorn
Queen Elizabeth University Hospital, Glasgow, United Kingdom

Abstract

Introduction

Deep infiltrating endometriosis is a significant health burden to women of reproductive age. Surgical excision is known to improve quality of life however surgery is associated with significant morbidity.

The emerging endometriosis centre within Greater Glasgow and Clyde (GG&C) is aligning with national standards; the data for 28 patients are compared to BSGE reported outcomes from 51 endometriosis centres (5162 women).

Methods

Data is collected retrospectively of 28 premenopausal women having surgery for pelvic infiltrating endometriosis. The referral criteria are: previous failed conservative or surgical management, complete or partial occlusion of Pouch of Douglas (POD), bowel or bladder infiltrationtration.

We recorded surgical outcomes, intraoperative complications and quality of life assessments (QoL) prior to surgery.

Results

Average age was 37.1 (+/-5.3) with 50% of patients having had previous endometriosis surgery, the rest were newly diagnosed.

At surgery, the POD was completely obliterated in 8/28 patients (28%). Rectovaginal nodular endometriosis was found in 17/28 patients (60%). Pararectal dissection and ureterolysis were performed in all patients. There were no conversions to laparotomy and bowel shavings was required in 2 patients.

The pre-surgery QoL questionnaires were available for 22 of 28 patients. The overall QoL was 63 +/- 27.1 compared with 55 from BSGE data. 13% of patients stated they were unable to perform daily activities and 11/22 having “some problems”.

Conclusion

Further follow up is planned in 6, 12 and 24 months following surgery, however our short term surgical outcomes and QoL assessments are comparable with national statistical findings.

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Audit reviewing general anaesthetic rates for hysteroscopy in a large teaching hospital

Nikki Webb, Mark Davey
UniversityHospital Southampton NHS trust, Southampton, United Kingdom

Abstract

Background:

Outpatient hysteroscopy should be conducted outside of the formal operating theatre setting. (RCOG 2011)

There are clinical and economic benefits associated with this type of service. (RCOG 2011)

Objective:

The aim of this audit was to review the number of women having a hysteroscopy procedure under general anaesthetic and to see if any could have had the procedure in an outpatient ambulatory gynaecology clinic (OAGC)

Method:

This was a retrospective audit of 116 women who had hysteroscopy listed as a procedure under general anaesthetic over a 3 month period. Notes were reviewed and data in relation to type of procedure, attempt at outpatient hysteroscopy and the reason documented for not attempting hysteroscopy in OAGC. The data was reviewed to see if there were recurrent themes and areas of development.

Results:

32% of women of women who had a GA hysteroscopy had an attempt at outpatient hysteroscopy. 50% could have reasonably had an attempt at an outpatient hysteroscopy. 62% did not have a documented reason why they had a hysteroscopy under general anaesthetic.

Conclusion:

The audit has highlighted that despite capital investment in equipment and staff, the service has been somewhat underutilised and there is still a significant amount of women having a hysteroscopy under GA that could have an attempt at an outpatient hysteroscopy. This audit has been presented at the care group audit meeting to highlight the issues and a nurse is near completion of outpatient hysteroscopy training. This should show a decrease in GA hysteroscopy when reaudited.

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This house sings: Ain't no uterus big enough - Trainees debate.

Lauren Standing, Elinor Carlisle, Georgios Goumalatsos
Basingstoke & North Hampshire Hospital, Basingstoke, United Kingdom

Abstract

Background

Recent data shows that only 20% of hysterectomies for benign disease in the UK are performed laparoscopically, with fibroids being the main indication for laparotomy1. This seems unlikely to change due to the controversy over morcellation and laparoscopic limitations. Despite hysterectomy being the most frequently performed major gynaecological surgical procedure, the current training programme does not require competence in any approach to hysterectomy before CCT.

Aims

To debate the decision-making process regarding management of large fibroid uteri, optimisation of pre-operative assessment, surgical approach, intra-operative challenges and how to overcome them. We argue on how these decisions impact training.

Conclusion

We draw on literature review as well as our DGH experience from laparoscopic hysterectomies for large fibroid uteri (over 16 week size) and present techniques to overcome the common challenges; the use of MRI to aid in planning and risk stratification, pre-operative uterine artery embolization, surgical decisions such as port placement, energy types and we debate the need for stenting vs ureterolysis. The debate becomes heated when it comes to specimen extraction techniques.

We believe that with reduced working hours, trainees will benefit from increasing numbers of laparoscopic hysterectomies by using them to gain experience to minimal access surgery. Laparoscopic hysterectomies for large uteri will enhance this exposure further.

References

Patterns of Benign Gynaecology Care in English NHS Hospital Trusts 2015/16. RCOG.



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A Freedom of Information Act (2000) survey and analysis of English NHS Trusts' adoption of the BSGE 2018 statement on Outpatient Hysteroscopy and the RCOG Patient Information Leaflet.

Katharine Tylko

Macmillan CancerVOICES, Bath, United Kingdom.
Cochrane Gynae Cancer Collaboration, Bath, United Kingdom

Abstract

Since 2014 the BSGE has included hysteroscopy in its Patient & Public Involvement (PPI). In 2018 BSGE members worked with RCOG PPI to produce a Montgomery-compliant patient leaflet for OP hysteroscopy.

The Campaign Against Painful Hysteroscopy via www.whatdotheyknow.com has shared with the BSGE Freedom of Information Act surveys, including audits of NHS Hysteroscopy - Pain control and Patient choice.

Recent NHS OPH pain-score audits typically show 25% patients reporting severe pain (VAS ≥ 7/10).

These statistics prompted the BSGE, followed by RCOG, to publish this statement in December 2018:

"Diagnostic hysteroscopy is a commonly performed investigation; it is safe and of short duration. Most women are able to have the procedure in an outpatient setting, with or without local anaesthesia, and find it convenient and acceptable. However, it is important that women are offered, from the outset, the choice of having the procedure performed as a day case procedure under general or regional anaesthetic. Some centres are also able to offer a conscious sedation service in a safe and monitored environment. It is important that the procedure is stopped if a woman finds the outpatient experience too painful for it to be continued. This may be at the request of the patient or nursing staff in attendance, or at the discretion of the clinician performing the investigation."

The presentation will analyse CAPH's recent FOIA survey of 1) where and whether the BSGE statement and, 2) the RCOG OP hysteroscopy Patient Information Leaflet are being adopted by NHS Trusts in England.

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Increasing rates of minimal access hysterectomy: a retrospective cohort study

JUNEIDA KHODABOCUS, JANET BERRY, DENIS TSEPOV
Queen Alexandra Hospital, Portsmouth, United Kingdom

Abstract

Objective:

To evaluate rates of laparoscopic hysterectomy (LH) both within our unit (BSGE accredited endometriosis centre and cancer centre) and against the National trend.

Methodology:

Review of all hysterectomies in 2017. Cases identified using computerised theatre records, and analysed using Excel. Caesarean hysterectomies, and any performed by non-gynaecologists, were excluded.

Results:

We identified 556 hysterectomies in 2017; 256 (46%) LH, 190 (34%) abdominal (AH) and 111 (20%) vaginal (VH). 6 patients were converted from LH to AH (2.3%).

After excluding oncology cases (n=228, to make our data comparable with our unit's previous study) there were 328 undertaken for benign indications. 145 (44%) LH, 72 (22%) AH and 111 (34%) VH. Benign LH increased from 25% to 44% over four years, with corresponding reductions in AH (30% to 22%), and VH (43% to 34%).

LH had shorter mean operating times (159 minutes, median 150, IQ range 124-182) than AH (165 minutes, median 152, IQ range 134 – 196) as found in our previous study.

Conclusion:

The overall number of hysterectomies in our unit has remained stable over 4 years with LH increasing from 25% to 44%. This is comparable with the recently reported National trend (47.2% in 2017). Our exclusion criteria differed to those used in the National data, limiting our ability to directly compare our rates with regional and National, but does explain our higher than National VH rate (34% compared to 3.5%).

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Use of Extracorporeal C-Incision Tissue Extraction (ExCITE) technique –FIBROID Total laparoscopic hysterectomy- Case report

Shumaila Tabassum, Krishna Smitha Murala
Yeovil District Hospital, Yeovil, United Kingdom

Abstract

ExCITE has been in practice in USA since 2014 as an alternative to traditional intracorporeal tissue extraction using power morcellation during minimally invasive gynaecological procedures like myomectomy and hysterectomy. A relatively newer technique in UK, not many cases have been reported so far. We present a case of ExCITE technique for removal of specimen in a district hospital of UK.

A 71 year old lady suffering from low-backache was referred to fast track clinic with a calcified mass on X-ray of her pelvis. A subsequent ultrasound scan showed a 58mm uterine fibroid in addition to a 5 cm simple right ovarian cyst. Her CA-125 level was 8. A total laparoscopic hysterectomy with bilateral salpingo-oophorectomy was planned in view of her symptoms. She had a narrow vaginal introitus excluding the option of retrieving the specimen vaginally. Intraoperatively an ExCITE technique was adopted and the incision at the umblicus was extended to 2.5cm. The specimen was placed in an endoscopic specimen retrieval bag. Using a no.10 blade scalpel, a reverse C-incision was created, similar to peeling an apple while trying to keep the skin of the fruit intact. As a result a long strip of tissue was created which was extracted through the umblical incision.

ExCITE is a tremendous technologic advancement that enables the clinicians to continue to offer minimally invasive surgical options to patients. It is an undoubtedly safe and standardised approach that ensures tissue extraction without the need for power morcellation and avoids intraperitoneal spillage by specimen containment.



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Did laparoscopic intervention for subfertile patients with endometriosis improve assisted fertility outcomes for NHS patients in South Wales between 2008-2017?

Meera Ramcharn, Arianna D'Angelo
University Hospital of Wales, Cardiff, United Kingdom

Abstract

Background

Endometriosis is the 5th commonest reason for assisted reproduction in the UK. There is evidence that surgical intervention for mild endometriosis improves the fecundity rate. There is a lack of evidence to support surgical interventions for severe endometriosis.

Method

A retrospective analysis of a contemporaneous database for a South Wales assisted fertility unit was performed. Patients between 2008-2017 who were coded for endometriosis and received IVF/ICSI/IUI were included. Exclusion criteria included a negative diagnostic laparoscopy, incomplete treatments and possible confounding factors. Relevant information was extracted using digitised notes.

Results

Of the 5217 assisted fertility cases, 10% of these cases had endometriosis documented as the major factor. Of those, 41% were excluded due to confounding factors. Complete data was available for 190 patients. Of these, 79% of cases had operative intervention. Surgery offered no advantage in patients receiving a positive pregnancy test (39% vs 38%). However a higher proportion of patients who received surgery had one or more live births (29% vs 18%).

Conclusion

These results suggest operative intervention for endometriosis is advantageous when measured in terms of live birth rate, for the South Wales population. Further work is required to elucidate the factors behind this, as is consistent with current research.

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OVARIAN CRYOPRESERVATION AND TRANSPLANTATION

Paul Hardiman, Fevzi Shakir, Gonzalo Mezquita
Royal Free Hospital, London, United Kingdom

Abstract

Introduction:

Freezing human ovarian tissue has taken place since 1999 and is well established in Europe, the US and Japan but the UK has lagged behind and patients have to go abroad and pay to receive this treatment to be given the chance to restore their fertility after chemo/radiotherapy for cancer.

Aim:

To present the steps and processes involved in ovarian cryopreservation and ovarian transplantation to improve awareness.

We present the first UK service to be fully funded by the NHS, which enables specialists in cancer/blood disorders to refer patients ahead of their cancer treatments for ovarian tissue freezing and later implantation to restore their fertility and/or prevent early menopause.

Methods:

The treatment involves the patient undergoing Laparoscopic ovarian tissue retrieval or oophorectomy which can then be processed, frozen and stored at -196 degrees centigrade, until the tissue is transplanted back to the patient when she has completed treatment. We demonstrate the processes involved.

Results:

We present the results internationally and what we can expect in the UK.

Discussion:

Patients who are cured by their chemo/radiotherapy can have the cryopreserved ovary tissue recovered, thawed and surgically placed onto the remaining ovary or into the lining of the abdominal cavity (which we demonstrate in this presentation). Worldwide there have been around a hundred successful births as a result of this treatment and several other women have benefited from restoration of their menstrual cycle after tissue implantation, which we hope to replicate in the UK.

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A case of bilateral endometriomas in stage four endometriosis and its susequent management.

Stephanie Boyle
Royal Albert Edward Infirmary, Wigan, United Kingdom

Abstract

A patient with stage four endometriosis with bilateral 10cm ovarian endometriomas presented with acute abdominal pain, distention and sepsis. Evidence of cyst rupture seen on CT scan and this was drained under ultrasound guidance. This culture revealed E.coli. Sepsis not improved therefore taken to theatre for a laparotomy, subtotal hysterectomy bilateral salping-oopherectomy, cystoscopy and ureteric stenting. Transferred to ITU post operatively and de-escalated to the gynaecology ward. Four days later, she began showing signs of worsening sepsis. CT demonstrated marked intra-abdominal ascites and bilateral pleural effusions with a white cell count of 37. Multi-diciplinary discussion with the general surgeons took place and the decision was made to return to theatre for laparotomy and washout. 3000mls of blood and turbid fluid drained from abdomen as well as blood clots and exudate. Returned to ITU post laparotomy then stepped down to ward same evening. Began with worsening shortness of breath and climbing white cell count. Clinical deterioration but drainage of pleural effusion not thought to be beneficial. Considered reescalation to ITU and started on antifungal medication and regular frusemide. CT revealed no new intra-abdominal collection. Treated as hospital acquired pneumonia and improved on intravenous antibiotics. Continued to improve clinically and was discharged five days later. Interesting points for discussion on the surgical challenges of operating on infected endomeriomas in a patient with significant surgical history and pre-existing endometriosis. The growth of E.coli in the peritoneal fluid and the reaccumulation of pelvic collection requiring a second laparotomy and surgical drainage.

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Hysterectomy trends for benign conditions across West Midlands

Aarti Lakhiani[1], Gourab Misra[2]

[1]The Shrewsbury and Telford Hospital NHS Trust, Birmingham, United Kingdom.
[2]Royal Stoke University Hospital, Birmingham, United Kingdom

Abstract

Hysterectomy is the most common gynaecological operation performed, not only for malignant disease but also for many benign conditions such as fibroids, endometrial hyperplasia, uterine prolapse, dysfunctional uterine bleeding, and cervical intraepithelial neoplasia. There are multiple approaches to hysterectomy for benign disease: abdominal hysterectomy (AH), vaginal hysterectomy (VH), laparoscopic assisted vaginal hysterectomy (LAVH) and total laparoscopic hysterectomy (TLH). LAVH and TLH offers a means of converting an otherwise abdominal approach into a vaginal procedure which has the added benefit of shorter hospital stay, recovery time and return to work. Despite the added advantages, the uptake of laparoscopic hysterectomies continues to be low in the United Kingdom. This study looks to compare the practices of hysterectomies for benign conditions across the major hospitals in the West Midlands over the last two years with the aim of improving the training and uptake of laparoscopic hysterectomies.



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Day Case Robotic Assisted Laparoscopic Hysterectomy: Retrospective Analysis of Safety, Complications and Cost Analysis

Jennifer Mei Wye Hoh[1], Fong Lien Kwong[2], Tony Chalhoub[1]

[1]Newcastle upon Tyne Hospitals NHS Foundation Trust, Newcastle, United Kingdom.
[2]North Cumbria University Hospitals NHS Foundation Trust, Carlisle, United Kingdom

Abstract

Aims

Retrospective analysis of complications and outcomes of robotic hysterectomy performed using the Da Vinci System. Furthermore, we looked at cost analysis and the success of the gynaecology robotic programme.

Methods

259 cases of robotic assisted hysterectomy were performed between December 2014 to March 2019 based on alternate Wednesday operating day. Case notes of patients were retrospectively analysed and complications and outcomes were documented. Costing of procedures was based on 2 arms utilisation and the cost was documented on a proforma for each case.

Results

The weight of patients ranges between 50kg to 160kg. Mean operative time was 102 minutes for the first 10 cases and 23-60 minutes for the subsequent cases. Total EBL averaged between 30 -50 mls. There were zero conversion, and 1 patient needed blood transfusion (3 weeks post surgery presenting with vaginal bleeding). There were 2 cases of vault discomfort, 1 case of post-op urinary retention requiring 10 days indwelling catheter and 1 case of full thickness rectal injury in a patient with AFS Stage 2 endometriosis which was repaired robotically. None of the patients had vault dehiscence following surgery. Most patients went home the same day.

Conclusion

Robotic hysterectomy is as safe as standard laparoscopic hysterectomy. We have demonstrated through our audit the efficiency of robotic hysterectomy and the low complication rates as well as the cost of 2 arms robotic hysterectomy which could be comparable to standard laparoscopic hysterectomy.

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Total laparoscopic hysterectomy and bilateral salpingoopherectomy in the presence of CSF Shunts – a case report

Brendan Gallagher, Rebecca Mallick
Princess Royal Hospital, Haywards Heath, United Kingdom

Abstract

A 29 year old patient underwent a total laparoscopic hysterectomy and bilateral salpingoopherectomy to treat menorrhagia and dysmenorrhoea. She had three previous caesarean sections and known benign intracranial hypertension with an LP shunt in situ. There was also a previous shunt still in situ. The procedure was uncomplicated and both shunts were visualised and not disturbed. She was discharged the day after the procedure.

She represented 13 days post operatively complaining of fever, headache, and abdominal pain with a clear vaginal loss. WBC was 19 and CRP 200 with all other results normal. Speculum examination did not reveal any fluid draining vaginally. Initially a CT abdo/pelvis and urogram was requested to rule out a bladder injury. A large fluid collection of 18 x8x19 was found in the peritoneum. It was noted that it contained some gas locules and encased the LP shunts. Appearances were suggestive of an infected seroma/haematoma/CSF pseudocyst and it as arranged for this to be drained under USS.

Before this was performed she started losing a large volume of clear fluid vaginally. A small amount was drawn off under USS and the collection was significantly smaller. The fluid was confirmed to be CSF and was started on empirical antibiotics and referred to the neurosurgery team. The LP shunt was externalised. Two weeks later she developed mennigism which was treated with antibiotics. Since then the old shunt has been replaced and she had slowly improved with antibiotics. She was an inpatient for 6 weeks.



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Rare presentation of deep infiltrating endometriosis in patient canal of Nuck cyst

Mihai Gherghe, Inna Sokolova
Crosshouse University Hospital, Glasgow, United Kingdom

Abstract

Introduction:

Canal of Nuck cyst is a rare gynaecological finding in girls and women with only a few cases reported in the literature and even fewer cases have associated endometriosis.

There is a strong association with renal abnormalities in 40% of patients and skeletal abnormalities in up to 25% patients.

Methods:

A 34 year old woman was referred to gynaecology outpatient clinic with long standing right iliac fossa pain and fertility concerns. She had an early miscarriage 6 months prior and opted for surgical management. Outstanding in her medical history was excision of a right inguinal Canal of Nuck cyst as a child with no complications. No other imaging was organised at the time of this surgery.

Results:

A transvaginal ultrasound scan showed an apparent normal uterus and ovaries. Inpatient hysteroscopy revealed a single (Right) ostia and possible obliterated Left ostia secondary to surgical evacuation of uterus.

At diagnostic laparoscopy uterus was unicornuate with Left rudimentary horn and normal looking and patent Right Fallopian tube. Deep infiltrating endometriosis was seen involving utero-sacral ligaments with superficial and nodular endometriosis involving both pelvic sidewalls, surgically excised.

Further imaging of renal tract was organised.

Conclusion:

Anomalies of genital tract, including those of the procesus vaginalis (responsible for formation of cyst of canal of Nuck) should be regarded in the context of possible associated genital and renal tract abnormalities. Fertility concerns and pelvic pain early in reproductive life may be suggestive of deep infiltrating endometriosis in this group of patients.

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Pre-operative risk prediction for bowel resection amongst patients undergoing bowel surgery for severe rectovaginal endometriosis.

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Abstract

Study Objective:

To assess the association and accuracy of British Society of Gynaecological Endoscopy (BSGE) pain scores to predict bowel resection during surgery for rectovaginal endometriosis.

Study Design:

Retrospective observational cohort study of consecutive patients undergoing bowel surgery for severe endometriosis at University College London Hospital. Data was collected from the BSGE online database excluding those patients not requiring bowel surgery. Univariate analyses were performed using Mann-Whitney U tests to assess relationship associations between bowel resection and pre-operative pain scores including:dysmenorrhoea; dyspareunia; and dyschezia during or outside periods.

Main Results:

We included 100 consecutive women recruited between January 2016

and May 2018. Nine women (9%) underwent bowel resection during this period, 91 underwent a rectal shave. Cyclical dyschezia was the only pre-operative pain score associated with bowel resection ($p = 0.002$). A cut off score > 7/10 cyclical dyschezia, 9/55 (16%) required a bowel resection, and 0/45 patients with a pain score ≤ seven required a bowel resection. With a cyclical dyschezia score > seven, the probability of requiring a bowel resection is 10.9%.

Conclusions:

Cyclical dyschezia is the only pain score to be positively associated with bowel resection during surgery for severe endometriosis with bowel involvement. A cut off score above seven was highly sensitive but not specific for bowel resection. Cyclical dyschezia ≤ seven performs well as a rule-out test for those proceeding with surgery for severe endometriosis. This aids counselling, consent, and theatre scheduling. A multivariate analysis with additional pre-operative markers is required for greater accuracy.

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MANAGEMENT OF MASSIVE CORPUS LUTEAL BLEEDS; Is Surgery Always the Answer?

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Abstract

Haemoperitoneum due to a bleeding corpus luteum is rare. It can, however, present as a Gynaecological emergency needing urgent attention.

We present a case series of women presenting to the Acute Gynaecology Unit with a bleeding corpus luteum. We discuss in detail the presenting history and suggest a step wise approach to diagnosis and management options including conservative and surgical management.

There is no standard management reported and management can be conservative or surgical. Expectant management can be first line if the patient is hemodynamically. In case of haemodynamic instability of requiring blood transfusion, surgery becomes necessary. Laparoscopy should represent the first line approach.

The above 40yr old patient presented with acute onset lower abdo pain following coitus. She had a large volume haemoperitoneum with a negative pregnancy test. She was initially managed conservatively but due to pain, a laparoscopy was carried out and 2L were drained.

There is currently no guideline or consensus on managing these patients and we propose that we should move towards one, firstly to work on an evidence base, but also to decide – do we always need to take them for surgery?

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Severe sepsis following endometrial ablation; Clinical dilemmas in management

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Abstract

Introduction:

Endometrial ablation is an efficient method of treating heavy menstrual bleeding in women. There is a risk of postoperative endometritis which can usually be managed conservatively with antibiotics. We are presenting a case of sepsis post ablation which required urgent hysterectomy with a focus on challenges in management of these cases.

Case Summary:

49 year old lady underwent a Novasure procedure following a long history of heavy menstrual bleeding irresponsive to hormonal treatment. She was admitted a week later with sepsis and a CT of abdomen and pelvis showed a possible uterine perforation. An emergency laparoscopy showed no evidence of uterine perforation or a pelvic collection and healthy small and large bowel loops with were seen. Patient was continued on extended spectrum intravenous antibiotics. However, she developed persistent hypoxia. Further CT showed evidence of moderate ARDS and a lower abdominal wall abscess. She responded well to antibiotics and was discharged with a planned follow up in one week. She presented 10 days later with increased abdominal pain, feeling unwell and pain in left lower extremity and was found to have an extensive bilateral external iliac DVT. An IVC filter was inserted and a total laparoscopic hysterectomy bilateral salpingo-oophorectomy, adhesiolysis and drainage of pelvic abscess was performed next day.

Discussion:

Management of women with severe endometritis after endometrial ablation can be challenging. In cases refractory to conservative treatment with antibiotics, early surgical intervention with hysterectomy should be considered to treat life threatening sepsis and disastrous complications.

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Retrospective analysis of trends and outcomes of Total laparoscopic hysterectomy at a UK District general hospital over a 6 year period.

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Abstract

Background

Total laparoscopic hysterectomy (TLH) is associated with less intra-operative blood loss, less postoperative pain, shorter hospital stay and earlier return to normal activity. However, major data for safety has been obtained from tertiary care centers.

Objective

To evaluate the implementation of minimal invasive option at a UK District General hospital and assess surgical outcomes.

Materials and methods

Retrospective data analysis of 120 cases of TLH between Jan 2011 and Dec 2017 including indications, age of patient, hospital stay as inpatient, readmission rates and complications were analysed

Results

Age of patients ranged from 29-88yrswith average being 55yrs. Indications for procedure included Atypical hyperplasia(18 cases), Hyperplasia with or without atypia, Grade 1/2 Endometrial Carcinoma(53 cases), uterine fibroids not responding to medical management(46 cases) , HMB with failed ablation(12 cases) , borderline ovarian tumor(3 cases), early micro invasive cervical cancer(2 cases), UV prolapse (2 cases),persistent PMB (9 cases), chronic pelvic pain(9 cases), grade 3-4 endometriosis(2 cases).Duration of hospital stay ranged from 2- 19 days with average of 3.47. Readmissions and complications were noted in 5 cases which included pelvic collection, chest infection, transverse colon perforation leading to colostomy, vaginal vault gaping needing re-suturing under GA.

Conclusions

Laparoscopic hysterectomy performed at this UK District General hospital seems safe and feasible with outcomes for patients that can replicate the results from larger tertiary centres.

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Outcomes of ambulatory Hysteroscopic Mechanical Morcellation in a multi-ethnic population

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Abstract

Background:

Postmenopausal bleeding is a common problem and endometrial polyps are a common finding in this population. Traditionally women have been offered hysteroscopy polypectomy under general anaesthesia using blind technique, scissors or resectoscope. With the introduction of mechanical morcellation devices, procedures are being offered in ambulatory setting with reduced risk of anaesthesia and removal of pathology under direct vision.

Objective:

Study the outcomes of Myosure removal of intracavitary lesions in women presenting with postmenopausal bleeding.

Method:

Case notes review of women treated in the ambulatory gynaecology clinic using Myosure morcellation device from 2014-2017. Proforma were filled in prospectively and data analysed for age, BMI, pathology, morcellation time, VAS scores and histology. All women had undergone previous outpatient hysteroscopy to confirm presence of intracavitary lesion.

Results:

605 women underwent procedure from 2014-2017. 61% (n=369) were postmenopausal; mean age 61.5 yr; mean BMI 32 and 59% of postmenopausal women were of Asian ethnicity (n=76). Pipelle biopsy before Myosure showed atrophic changes in 28.46% (n=105) with only 4.5% having complex hyperplasia with/without atypia and cancer (n=17). However, histology of the intracavitary lesion showed 64% (n=236) benign polyps; 2.7% endometrial cancer (n=10), 21.5% complex hyperplasia with or without atypic (n=80). There was significant difference between the endometrial and intracavitary lesion histology (p=<0.01). Mean morcellation time was 70 sec, mean fluid deficit 128 +/-71 mL; VAS 2.97+/- 2.3 and only one procedure was abandoned.

Conclusion:

Ambulatory hysteroscopic morcellation is well tolerated by postmenopausal women and helps to remove pathology under direct vision.

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Successful Laparoscopic Assisted Surgical Evacuation of a Caesarean Section Scar Ectopic Pregnancy Following Failed Methotrexate Treatment

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Abstract

We report on a case of a 25 year old gravida 2 para 1, who at 7+1 weeks gestation, presented to a tertiary referral centre emergency department with abdominal pain. The patient was found to have a live 7+1 weeks gestation pregnancy occupying 24x18x20mm at the site of previous caesarean section scar. Her BHCG was 24,093 IU/L. The patient was initially administered a single dose of systemic methotrexate, which failed to resolve the pregnancy. Following this, the patient underwent a laparoscopic assisted suction curettage of the caesarean section scar ectopic and laparoscopic adhesiolysis. The surgery was successful, with a resolution of the pregnancy, conservation of the uterus and the patient's fertility preserved. The patient was followed up with serial bHCG until negative. The case demonstrates that laparoscopic assisted suction curettage can be used successfully in haemodynamically stable women with caesarean scar ectopic pregnancies.



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Evaluating the burden of increasing hysteroscopies: a full review of the secondary care service

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Abstract

Objective:

To confirm whether an apparent increase in theatre cases of hysteroscopy is true, and aim to identify underlying reasons.

Methodology:

Hysteroscopies for October 2017/18 were identified using computerised theatre and ambulatory clinic outcome records. October 2017/18 workloads were compared, and the service evaluated over 1/11/17 – 31/10/18. Clinic letters were used to obtain clinical information. Data was analysed using Excel.

Results:

The proportion of allocated gynaecology theatre time for hysteroscopies increased from 8.8% to 25.6% between October 2017/18. Hysteroscopy was indicated for postmenopausal bleeding in 41/83 (49%) and menorrhagia in 24/83 (29%). 39/83 (47%) had a documented offer of outpatient hysteroscopy. For 28/83 (34%) it was a repeat procedure. Reasons for theatre were as follows: patient choice (25%), ambulatory not tolerated (19%), cervical stenosis (7%), deemed 'unsuitable' (15%) and no reason identified (34%).

Ambulatory gynaecology hysteroscopies were stable at 128 and 129 in October 2017/18 respectively. In one year, there were 2362 consultations from 2486 appointments (124/2486, 5% DNA). These separated to 810/2362 (34%) benign ambulatory and 1552/2362 (66%) postmenopausal bleeding clinics.

Attempted hysteroscopy varied from 835/1552 (53.8%) in postmenopausal, to 666/810 (82.2%) in ambulatory, with success rates of 85.4% and 92.5% respectively. Overall 421/2362 (18%) outpatient hysteroscopy consultations required theatre admission (334/1552, 21.5% from postmenopausal and 87/810, 10.7% benign ambulatory).

Conclusion:

We confirmed a clinically significant increase in theatre hysteroscopy, which impacts upon elective waiting times, and increases costs. We need to improve offering patients the choice of ambulatory setting, and reduce the number of repeat procedures required.

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Outcomes of Ambulatory Endometrial Ablation procedure: experience from a recently set service

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Abstract

Background:

Endometrial ablation is a recommended procedure for heavy menstrual bleeding (HMB) (NICE). Multiple device have been used over the years in both ambulatory and under GA setting. We offer both under GA and ambulatory options to our women and present the results.

Objective:

Study outcomes of Novasure Endometrial Ablation within ambulatory gynaecology service and assess feasibility.

Methods:

Case notes review of women attending Ambulatory service for Novasure ablation from 2015-2017. All women had pre-procedure analgesics and offered Entonox during procedure if required. Age, BMI, Ablation time, second look Hysteroscopy and VAS score were recorded.

Results:

48 women underwent the procedure for HMB, mean age 45.37 +/-3.86 yr; mean BMI 31.6+/-6.85; one was nulliparous; 82% were White British. During the procedure, 80% required cervical dilatation to no 7-8, 39/48 had Novasure cycle completed and 95% showed cavity was ablated on second look hysteroscopy. Mean VAS was 7+/-3 and the worse pain was felt during the treatment of ablation itself. 25% (n=10) had varying degree of dizziness and pain post procedure requiring observation.

Conclusion:

Novasure endometrial ablation is a reasonably tolerated ambulatory procedure if the woman is counselled and prepared. Understandably, the ablation itself causes pain and heat generation which is felt by the woman. It is a good option for those who are at high risk under general anaesthesia.

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