March '92
Good Housekeeping

"I think it's important to recognize that implantation is not a surgical procedure," says Amy E. Pollack, M.D., M.P.H., medical director of the Association for Voluntary Surgical Contraception in New York City. It's more like a large injection, and so simple that "people with minimal medical skills around the world are doing it, and doing it well."

The only painful part of the procedure is the injection of local anesthetic; Shanon Adams compares it to getting a shot of novocaine at the dentist's. And for a few days afterward, the arm is sore and bruised.

And if a woman on Norplant decides she wants to become pregnant? Says Chenault, "The pregnancy rate returns to normal so quickly that if a patient has the Norplant removed for some other reason, we have to counsel her to use another effective method, or she is likely to become pregnant." ■

Have a hysterectomy one day, come home the next—and with only a few puncture marks? That's the newest boon of an ingenious technique called laparoscopy

Surgery Without Scars

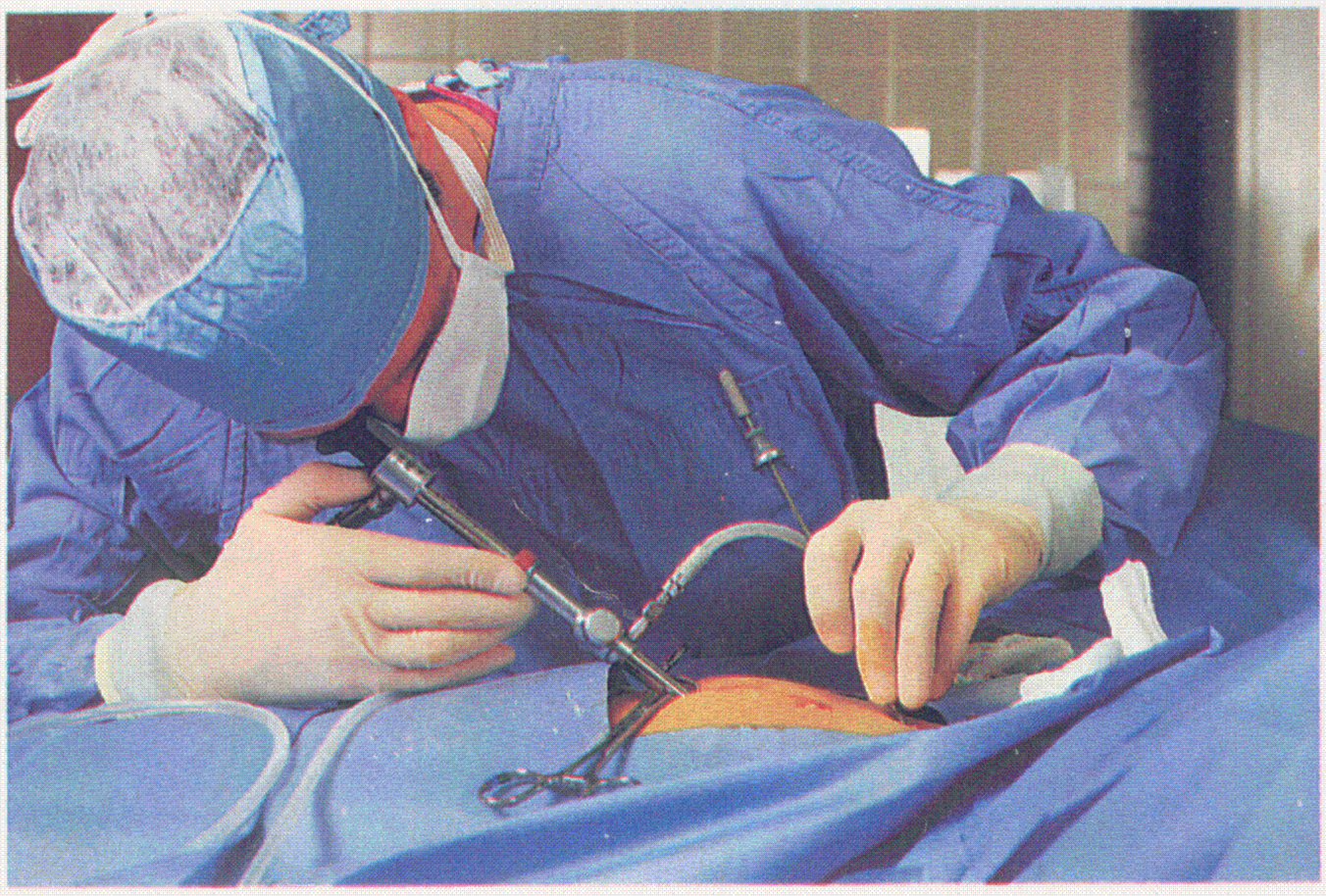
By Kathleen McAuliffe

For most women a hysterectomy has meant major surgery, an ugly six-inch scar across the belly, a lengthy recovery, and a host of fears about the loss of sexuality and reproductive capacity. But now modern medicine is changing all that. With the use of an ingenious instrument called a laparoscope, surgeons are making the procedure less invasive and less disfiguring, limiting hospitalization to a single overnight stay. In some cases, the laparoscope is even enabling doctors to repair–rather than remove–the uterus and to treat endometriosis and other uterine disorders.

Though minimally invasive surgery has come of age in gynecology only in the last three years, the laparoscope has a much longer history. Combining the functions of a telescope and scalpel, it has been employed as a diagnostic tool for decades, and more recently it has revolutionized gallbladder and kidney operations.

Inserted through the wall of the abdomen, the device is basically a long thin tube only a centimeter in diameter with a prism at one end and a light source at the other. Through a series of channels surrounding this optical bundle, a surgeon can manipulate a variety of instruments: lasers and electrical cauterizing devices for cutting, tiny scissors and threads for suturing, and even a minuscule circular saw that grinds up tissue for extraction by suction tubes. In this way the entire uterus can be cut, shredded, and vacuumed through an opening not much larger than a keyhole. Because such surgical feats are laborious and time-consuming, however, the laparoscope, sometimes in conjunction with a separate instrument, is more commonly used to cut the uterus loose from surrounding tissues so that the bulk of the organ can be pulled out through the vagina.

This operation "from above and below" typically takes 60 to 90 minutes–or about 15 to 30 minutes longer than standard abdominal surgery. In the eyes of many women, the cosmetic gains alone justify the extra time on the operating table. The patient emerges from the procedure with a few barely visible puncture marks instead



A laparoscope combines the functions of a telescope and a scalpel; a long, thin tube, it's inserted through the wall of the abdomen.

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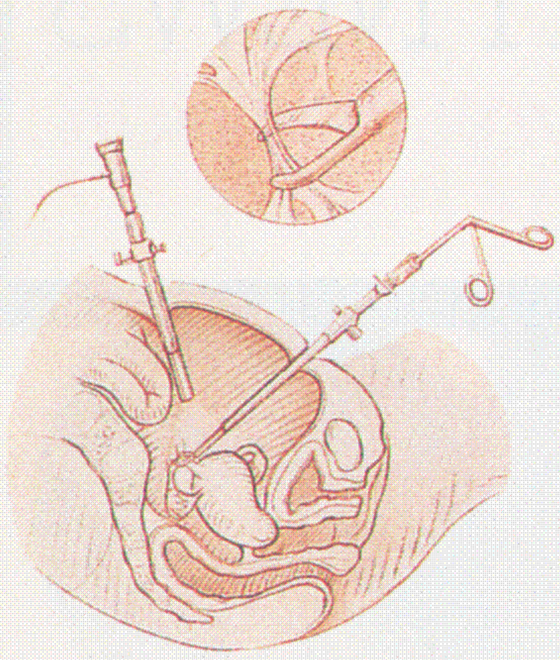

Keyhole surgery: The laparoscope (at left) enables the physician to see what he's doing as he manipulates another streamlined surgical instrument (right and inset detail) to sever the uterus from surrounding tissues.

of the customary scar across the stomach.

Smaller surgical wounds also translate into a faster recovery and less postoperative pain and discomfort. Hospitalization is usually reduced from four days to less than two, and most women can return to work in a week as opposed to the standard month required for recuperation from abdominal surgery. The price tag is roughly the same–about $7,000 including hospital care, equipment, and doctors' fees. But when lost wages are figured into the equation, a laparoscope-assisted hysterectomy represents a substantial savings in money. Says Dr. Joseph Feste, clinical associate professor of gynecology at the University of Texas Health Science Center in Houston, "The technology has changed a major operation into a minor one."

According to conservative estimates, anywhere from 20 to 70 percent of the 300,000 hysterectomies performed annually by abdominal incision could be done with the assistance of the laparoscope. But the gynecologist who pioneered the procedure, Dr. Harry Reich of Nesbitt Memorial Hospital in Kingston, Pa., believes that as many as 90 percent of hysterectomies will eventually be done laparoscopically as surgeons gain confidence in the technique. In addition, the tool is increasingly being used to repair damage to the ovaries and Fallopian tubes from endometriosis (a painful disease in which tissue of the uterine lining occurs outside the uterus) and to remove benign ovarian cysts, scar tissue blocking the Fallopian tubes, and small fibroid growths.

As many as 90 percent of hysterectomies may eventually be done by laparoscopy.

Still, laparoscopy is evolving rapidly, permitting specialists to tackle increasingly difficult cases. At Montclair Community Hospital in New Jersey, for example, gynecologist Herbert Goldfarb has used drug therapy in conjunction with the laparoscope to obliterate grapefruit-sized fibroid growths while leaving the rest of the uterus intact. For three months prior to surgery, his patients are given Lupron, an estrogen-blocking agent that helps shrink the fibroid to the diameter of an orange. With the aid of the laparoscope, Goldfarb then snakes the tip of a laser into each fibroid, zapping the shriveled mass in as many as 75 different places. In less than 15 minutes, the entire blood supply to the fibroid is sealed off, ensuring its continued shrinkage.

At the American Gynecological Laparoscopy meeting in Las Vegas last November, Goldfarb reported the results of a follow-up study of the first 75 cases. Up to a year after treatment, none of the women had experienced any regrowth of fibroids or reported any return of symptoms.

While the procedure has the virtue of preserving the uterus, it is not recommended for women who still want to bear children. "Until more clinical studies are completed," cautions Goldfarb, "we can't rule out the possibility that the laser may damage the uterus, which would limit a woman's ability to become pregnant."

Still, the laparoscope is widely viewed as a safe and increasingly attractive alternative to conventional abdominal surgery for appropriate candidates. "In experienced hands," says Dr. Richard Soderstrom, director of gynecological endoscopy at Swedish Hospital in Seattle, "it's a very precise tool that promises to be a major boon to gynecology." ■

ILLUSTRATION: BONNIE HOFKIN

YOU SHOULD KNOW...

With the technology still in its infancy, women eager for more information about the latest therapeutic options may need to shop around to find a knowledgeable physician. At present, fewer than 1,000 of the nation's 30,000 gynecologists are trained to perform laparoscope-assisted hysterectomies and related procedures. Whenever treatment is sought, the patients should always check to make sure the surgeon has completed a training program in laparoscopy–usually a two-day course, followed by a period in which the surgeon's method is supervised by an expert. Most hospitals insist on such qualifications before a surgeon is permitted to operate, but a few don't. "If the hospital doesn't have a credentialing program, go somewhere else," advises Dr. Richard Soderstrom, director of gynecological endoscopy at Swedish Hospital in Seattle. "This is not a see-one, do-one, teach-one procedure. It takes considerable learning to use the laparoscope adeptly."

Prospective patients should also get a second opinion when a physician recommends a laparoscope procedure that will take longer than three hours. Because the risk of severe complications under anesthesia increases exponentially over time, the swifter scalpel of the surgeon may be a wiser option in such cases. Says Dr. August Schwenk, ob-gyn at Bellevue Hospital in Schenectady, N.Y., "It doesn't make sense to expose someone to life-threatening risks from prolonged anesthesia to spare them a scar."

If you would like more information on laparoscopy, please contact Dr. Jordan Phillips, chairman of the American Association of Gynecologic Laparoscopists, 13021 Florence Avenue, Santa Fe Springs, Calif. 90670; Tel: 310-946-8774.