“The mission of the MEFACOOG is to foster continuing improvements in women’s healthcare. The goals of the MEFACOOG are to support continuing Medical Education – Undergraduate, Graduate and Postgraduate, Research Programs, Faculty Development and Development of Educational Networks in women’s healthcare.
Carl Della Badia, DO FACOOG, (Dist.)

MEFACOOG is working hard to come up with new and novel ideas for funding. The new PhRMA code will be out in January and it will be even harder to get grants from the pharmaceutical industry. At our recent Corporate Partnership Council meeting we were educated about the grant process to obtain funding from companies for our various projects and conferences.

We must also continue to work diligently to solicit donations not only from our members but also look to unique sources for grants, such as foundations. At our annual meeting the MEFACOOG board heard an interesting presentation from Dr. Pernoll who ran a very successful campaign with APGO to raise money. He started with his patients and had the foundation named as beneficiary in their estates and also gave cash donations.

We have some very worthwhile projects that we are trying to get funding for. The first is the Visiting Professor Program. This program sends an ACOOG Fellow to each osteopathic medical school to talk about a career in OB/GYN. This has been very successful and was the impetus to start the National Student Society of ACOOG. This program has changed many students’ minds about a career in OB/GYN.

The second project that we need funding for is in AOA approved OB/GYN resident education. We would like to purchase the Challenger program for each OB/GYN resident in our training programs. Please go to the Challenger web site to view this unique educational experience. This will put their educational experience on equal terms with larger programs.

MEFACOOG would appreciate any financial help you can give us!

Carl Della Badia DO, FACOOG (Dist.)
Chair, MEFACOOG Board of Trustees

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Debra Lewis ................................. Graphic Design
Jim Halley ................................. Illustrator
We are pleased to report that the financial review for 2007 reflected an increase in net assets for MEFACOOG. This year, as a percentage of the total, individual contributions increased over programmatically directed corporate contributions. As you can see, the corporate contributions are channeled into programs that benefit education, research and faculty development:

- MEFACOOG/Wyeth Resident Reporter Scholarship Program- educating osteopathic OB/GYN residents at the ACOOG Annual conference and reporting back to their programs and to the profession.
- MEFACOOG/Ortho Women’s Health Visiting Professor Program- educating osteopathic medical students and promoting career choices in obstetrics and gynecology.
- MEFACOOG/Bayer Awards for Excellence in Poster Presentation- encouraging research and rewarding dissemination via poster presentation at the ACOOG Annual conference.
- MEFACOOG/Bayer Research Grant- encouraging research in osteopathic OB/GYN residency and fellowship programs.
- MEFACOOG/Ortho Women’s Health and Urology- Research Grant encouraging research in osteopathic OB/GYN residency and fellowship programs.

The 75th Annual Conference of the ACOOG hosted three ongoing funded lectureships. The 11th annual Barbara Hawkes Memorial Lecture funded by Ortho Women’s Health and Urology was also the College’s first memorial lectureship. This year’s lecture was given by Carl Della Badia, DO. The sixth annual MEFACOOG Distinguished Lecture was presented by Sterling Williams, MD. The third annual MEFACOOG Gail Goldsmith Memorial Lectureship was presented this year by Phillip Brooks, MD. This was the third annual lecture of the ten year endowment made possible by the Friends and Colleagues of Gail Goldsmith and Wyeth.

The MEFACOOG Board approved grants in 2008 for several important initiatives of the College. The ACOOG Historian Committee is producing an educational DVD and CD-ROM bound Historical Volume of ACOOG. It is also overseeing the Faculty Development/APGO Preceptor Workshops. The National Student Society of the ACOOG has met for the first time in St. Louis at the ACOOG Fall Conference. The Osteopathic Manipulative Medicine Guidelines for Osteopathic OB/GYN Residencies in CD-ROM format is in production. These projects would not be possible without the support of you, the donors. Thank you for your continuing support.

### Financial Review

**Statement of Activities**

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<thead>
<tr>
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### Statement of Financial Position

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<table>
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<td><strong>Total Liabilities and Net Assets</strong></td>
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</tr>
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</table>
Conclusions: Our rate of ICU admissions is similar to other estimates (approx 1/200) of severe maternal morbidity in pregnancy. The major diagnoses are also consistent with the literature.

Objectives: Historically, the most common ICU obstetrical admission diagnoses are severe preeclampsia–eclampsia, HELLP syndrome, obstetric hemorrhage, and infection. Over the past three decades, there has been a significant decrease in maternal mortality, related to improvement in diagnosis and prevention of disorders in pregnancy, without a similar reduction in morbidity.

The purpose of this retrospective study is look at maternal morbidity and mortality in a county hospital setting.

Results: All admissions were grouped according to primary admitting diagnosis. These cases were further delineated based on whether their primary admitting diagnosis was directly “pregnancy related” or “medically related”.

Methods

This is a retrospective review of all ICU admissions involving pregnant or post-partum (within 6 weeks of delivery) patients at Riverside County Regional Medical Center from January 1, 2004 through December 31, 2006.

There were 50 ICU admissions identified by reviewing the ICU log books and searching the coding database. The charts were reviewed by one perinatalogist, one OB/GYN resident, and one medical student.

The patient’s primary diagnosis leading to the ICU admission and any associated/contributing co-morbidities were identified.
• There was one maternal death (or 2% of ICU admissions)
• 3 cases of long term maternal morbidity: dialysis, intraventricular hemorrhage causing persistent neurologic deficit, severe debilitation due to a motor vehicle accident.
• Overall mortality rate was 6% (3 events in 50 ICU admissions).
• The average patient was 27 years old, with a mean gravity 2.8, parity 1.5, and stayed an average of 2.6 days in the critical care unit.
• 82% of all those admitted were postpartum.
• Only 18% were admitted during their pregnancy. Of the 18%, about half were term (gestational age >37 wks) and half were preterm, at the time of their admission to the hospital.
• The majority of the patients were Hispanic; Medi-Cal was the primary payer.
• The majority of patients (82%) had prenatal care.

CONCLUSIONS
• Almost all studies to date have been some type of retrospective chart review.
• This study’s findings are largely consistent with the published data.
• The most common primary diagnoses found in this study were postpartum hemorrhage, severe preeclampsia/HELLP and pulmonary disease.
• Other investigators had found sepsis to be a more prominent admission diagnosis. Perhaps, our findings were not that dissimilar, as many of our patients with respiratory distress were also patients with underlying infection.
• Our maternal mortality and morbidity rate are similar to or even less than those described by Sibai, Demirkiran, Loverno, and Mirghani.
• It does seem evident that preexisting medical conditions are prevalent in this population, as 80% of this population had complicating co-morbidities.
• As a group, the population is younger than the non-obstetrical ICU population. The age, gravity, parity, and other demographics of our population are largely consistent with the published data.

The goal of this study was to determine the primary diagnoses leading to the ICU admission. The most common primary diagnoses were postpartum hemorrhage, severe preeclampsia/HELLP, and pulmonary disease. The morbidity rate was 6%; mortality rate was 2%. These rates are consistent with the findings of other investigators and show a general improvement in rates and show a general improvement and mortality in this population.

REFERENCES

MEFACOOG/BAYER provided a $1,000 prize for this winning poster. We encourage all OB/GYN residents and subspecialty fellows in AOA approved OB/GYN programs to apply. See www.acoog.org for applications and deadlines each year.
The management of twin gestation is an issue of increasing importance in obstetrics. With the increasing number of patients using assisted reproductive technology and the increasing age of primigravids, the number of multiple gestations is increasing as well. Currently, twin pregnancies account for 3% of births in the United States, with 80% of these being dizygotic and 20% monozygotic placentaion. Twin gestations account for 17% of the preterm births and 25% of low birth weight and very low birth weight infants.

Twins are optimally delivered when their risk for neonatal morbidity and fetal mortality is lowest. The recommended time for twin delivery intervention is 38 weeks gestation. The average pregnancy duration is 35.3 weeks. However, 12% are delivered prior to 32 weeks, and greater than 50% are complicated by spontaneous or medically indicated preterm deliveries.

When determining the optimal time of delivery for twins, it is important to focus on benefits versus risks. In a retrospective study comparing perinatal mortality (PNM) of twins to singletons by Minakami et al. in 1996, the nadir of PNM in twin gestations occurred at 37-38 weeks, and then increased with longer gestation. Kahn et al. quoted 2003 data from the United States National Center for Health Statistics demonstrating the lowest twin PNM at 37-39 weeks. The data indicated that the risk of fetal death in ongoing pregnancy at 39 weeks exceeded the risk of neonatal death.

The timing of twin delivery ideally should attempt to minimize the risks of neonatal morbidity, as well as the risk of fetal mortality by continuing the pregnancy. The primary neonatal morbidity is respiratory distress syndrome. Chasen et al. evaluated the rates of respiratory disorders in twins. There were 126 gravid with twins who underwent elective cesarean section before labor between 36 and 40 weeks. For the infants born at 36-37 weeks, the rate of neonatal respiratory disorders was 13% while the rate for those born at least 38 weeks was only 2%. Other studies have found similar results, which is likely why the ACOG states that it is acceptable to deliver twins at 38 weeks, even for trivial maternal issues.

Once the decision to deliver is made, the optimal route of delivery needs to be decided. The majority of twins (67%) in the United States deliver via cesarean section, despite the fact that there is no compelling evidence to support this practice. The obstetrical literature suggests delivery via cesarean section even though there is only a remote likelihood of “interlocking fetal chins”, quoted as 1:645 (0.15%), the ACOG suggests delivery via cesarean section in these cases because the mortality rate is unacceptably high at 30%-40%. Current obstetrical practice demonstrates that most Obstetricians deliver twins with nonvertex “Twin A” presentation via cesarean section.

Blickstein et al. conducted a retrospective case control analysis and demonstrated that there is a difference in outcome for the delivery of nonvertex “Twin A” presenting twins depending on birth weight and mode of delivery. The study included 13 centers and 613 twin pairs, and was published in a 2000 issue of Obstetrics and Gynecology. They used 5 minute apgars and neonatal mortality as outcome measures in vaginal versus Cesarean for breech first twins.

In the study, infants weighing less than 1500 grams and delivered vaginally had 5-minute apgar scores of less than seven 37% of the time, while those delivered via cesarean section the 5-minute apgar scores were less than seven only 20% of the time. Cesarean section demonstrated a protective effect with regard to peripartum mortality for those twins weighing less than 1500 grams.
the vaginally delivered group the peripartum mortality rate was 45%, while in the cesarean group it was 8%. However, when the infants weighed greater than 1500 grams, the 5-minute apgar scores of less than seven were around 5% in both groups, and the peripartum mortality rate for both groups was similar at 0.3% for the vaginal group, and 0.15% for the cesarean group. Of note, there were no major birth traumas and no cases of fetal entanglements (i.e. locked twins) noted in the vaginal groups.

Most obstetricians willing to attempt a vaginal twin delivery favor vertex/vertex presenting twins, which occur in 40%-50% of cases. However, it is important for the physician to have a plan for the delivery of the second twin if that twin is no longer vertex after delivery of “Twin A”. As many as 10%-20% of second twins change presentation after vaginal delivery of the first. Many obstetricians will abort the attempt of vaginal delivery of Twin “B” following its spontaneous “version” to a non-cephalic presentation, and proceed with cesarean delivery of Twin “B”. The vaginal delivery of Twin “A” followed by cesarean delivery of Twin “B” is referred to as a combined delivery.

Combined delivery occurs at a rate of 2-17% of attempted twin vaginal deliveries, depending on which study or center’s statistics you cite. Wen et al. compared modes of delivery with outcome measures of 5 minute apgars, mechanical ventilation, and seizures. With vaginal or cesarean delivery of both twins the outcome measures were comparable. However, there was a statistically significant difference in all three outcome measures for the second twins involved in combined delivery. The risk for low 5-minute apgar scores and need for mechanical ventilation for these neonates approximately doubled, while their seizure rates increased by a factor of 5-fold. Most centers recommend practitioners to avoid combined deliveries if possible.

To deliver the nonvertex second twin vaginally there are a few important maneuvers to know. The first is internal podalic version. With this approach, the physician will reach for the feet of the infant and gently apply steady traction toward the vagina while the other hand is externally putting pressure on the fetal head to turn the infant. The membranes should remain intact until the infant is delivered to the scapula. It is recommended to deliver the anterior leg first in order to rotate the fetal sacrum anteriorly so the infant will be occiput anterior. With delivery of the head, the Marcieau-Smelie- Veit maneuver or piper forceps can be applied; these techniques help to maintain flexion of the head on the fetal chest, resulting in the smallest cephalic diameter to traverse the pelvic outlet.

Once the first twin is delivered, it is difficult to know how much time should transpire before intervening to affect the delivery of the second twin. Traditional obstetrical practice suggests not waiting more than 30 minutes. Leung et al. conducted a retrospective study which demonstrated a significant relationship between twin-to-twin delivery interval and umbilical artery pH of the second twin. If the interval was 15 minutes or less, the pH was over 7 in all cases. If the interval was 16-30 minutes, 5.9% of the second twins’ pH was less than 7. If the interval was greater than 30 minutes, 27% if the second twin’s pH was less than 7. Once the twin-to-twin delivery interval exceeds 30 minutes, the risk for combined delivery increases by a factor of 5-6 fold. An interval of greater than 60 minutes increases the risk for combined delivery by a factor of 8-fold.

In the event that Twin “B” is noted to be in a non-cephalic presentation following vaginal delivery of Twin “A”, there are essentially three options to affect the delivery of Twin “B”: 1-breech extraction, with or without internal podalic version; 2-external cephalic version with subsequent vaginal delivery of Twin “B” from the cephalic presentation; and 3-combined delivery. Because combined delivery confers significant risk to Twin “B” it is not an optimal option. Robinson et al. evaluated five retrospective studies comparing external cephalic version of the breech-presenting second twin, with breech extraction. All five studies demonstrated that the mean risk for combined delivery when attempting external cephalic version on the second breech-presenting twin was 42%, while the mean risk for combined delivery with breech extraction was 2%.

Schmitz et al. conducted a recent retrospective cohort study to assess neonatal morbidity in twin pregnancies according to the planned mode of delivery. This study was conducted in a French obstetrical center which routinely performs an “active management” of the second twin delivering vaginally. After vaginal delivery of Twin “A”, if Twin “B” is breech, they perform a complete breech extraction. If Twin “B” is transverse, or vertex above zero station, they perform an internal podalic version followed by breech extraction. If Twin “B” is vertex, and at or below zero station, they encourage maternal expulsive efforts to hasten vaginal delivery. The two main tenets in this center’s philosophy are: 1- decrease the twin-to-twin delivery interval and 2- avoid external cephalic version in all cases, in favor of internal podalic version and breech extraction.

They evaluated 758 consecutive sets of twins born after 35 weeks gestation with cephalic presenting Twin “A” fetuses. The primary outcome measures were: cord pH < 7.0; 5-minute apgar score < 3; NICU admission > 4 days; pneumothorax; and fracture. Of the 758 consecutive sets of twins there were 101 (13.3%) planned cesarean sections.

(Continued on Page 8)
MEFACOOG/Wyeth Resident Reporter: Kathleen Fabian, DO
75th Annual Conference of the ACOOG
March 26th, 2008

No two twin deliveries are alike. No two Obstetricians are alike. The delivery and the decisions the Obstetricians make are unique to each situation.

No two Obstetricians are alike. The delivery and the decisions the Obstetricians make are unique to each situation.

There is a large volume of studies concerning the intrapartum management of twins. Most of these are Level-II evidence studies, and the rare Level-I evidence studies that do exist are too small to be statistically significant. The available evidence demonstrates the following: cesarean section does not provide a protective effect over vaginal delivery for twins where Twin “A” is cephalic and has an estimated weight of at least 1500 grams; attempts at vaginal delivery of vertex/vertex presenting twins result in a greater risk for combined twins than vertex/non-vertex presenting twins; external cephalic version for non-vertex presenting second twins results in significantly higher rates of combined delivery than breech extraction, with or without internal podalic version; external cephalic version offers no benefit over breech extraction, with or without internal podalic version, for second twins; combined delivery confers increased morbidity and mortality for Twin “B”; up to 20% of second twins change presentation during or following vaginal delivery of Twin “A”; and, with regard to presentation only, up to 80% of twins could attempt delivery vaginally. Despite the lack of proven efficacy for cesarean section in the delivery of twins, over two-thirds of twin pregnancies are delivered by cesarean section.

In an attempt to provide definitive information with regard to optimal mode of twin delivery, there is an international, multicenter randomized controlled trial comparing planned cesarean section with planned vaginal birth for twin pregnancies. The Twin Birth Study is based out of the University of Toronto, and involves 76 centers from 22 countries and evaluates Twin “A” presenting twins from 32-38 weeks with estimated fetal weights from 1500 to 4000 grams. The primary outcomes include perinatal or neonatal mortality and/or serious neonatal morbidity. The secondary outcomes include death or poor neurodevelopmental outcome of children at two years of age. The study includes a total of 2800 twin pregnancies, with 1400 twin pregnancies in the planned vaginal delivery group, and 1400 in the planned cesarean group. After the first interim analysis of 1,000 twin deliveries, the Data Safety Board has allowed the study to continue.

No two twin deliveries are alike. No two Obstetricians are alike. The delivery and the decisions the Obstetrician make are unique to each situation. Most of the decisions are based on presentation of the twins and the skill and comfort level of the obstetrician. Hopefully, the outcome of the Twin Birth Study will help physicians make better decisions for improved outcomes.

References

The Twin Birth Study Website: http://www.utoronto.ca/min/tbs
Carroll MA, Yomans ER. Vaginal Delivery of Twins. Clinical Obstetrics and Gynecology. 2006; Volume 49, Number 1, 154-166.
Cardiovascular disease is the leading cause of death in the United States for both men and women. There are currently over 70 million Americans who have been diagnosed with the disease. Each year, 1.4 million new cases are diagnosed, with an annual cost to the United States health care system of 393.5 billion dollars.\(^1\)

Risk factors include age (men >45 years old, women >55 years old), family history of premature cardiovascular disease (acute myocardial infarction <55 years old in first degree male relative, and <65 years old in first degree female relative), smoking, hypertension, and high density lipoprotein (HDL) less than 40 mg/dL. The only protective factor is an HDL over 60 mg/dL.\(^2\)

We have become a “super-sized” nation. Metabolic syndrome is defined as HTN, obesity (BMI >30), lipid disorder, and diabetes mellitus/insulin resistance. According to the Adult Treatment Panel III (ATP III), clinical criteria defining metabolic syndrome are as follows:

- High risk: <100 mg/dL
- Moderately high: <130 mg/dL
- Moderate: <130 mg/dL
- Low: <160 mg/dL

An individual falling outside these guidelines should be counseled on therapeutic lifestyle changes including diet and exercise. Stern et al reported improved weight loss results in patients following a low-carbohydrate versus conventional diet.\(^3\)

Additionally, Yancey et al found that a low-carbohydrate diet was superior to a low-fat diet in the treatment of obesity and hyperlipidemia.\(^4\)

Several diet modifications have shown an improvement in lipid profiles. Incorporation of plant stanols and sterol esters into the diet at a dose of 2-3 grams per day can lower LDL cholesterol by 6-15 percent. Omega-3 fatty acids have been approved by the FDA for the treatment of triglyceride levels over 500 mg/dL. Omega-3 fatty acids show a 45 percent reduction in triglycerides, 15 percent for total cholesterol, an increase of 31 percent for LDL, and 13 percent for HDL. Adverse effects of omega-3 fatty acids include eructation, dyspepsia and taste perversion. Finally, the Atkins diet has been proven extremely cardio-protective for individuals who are able to adhere to its guidelines.\(^5\)

The goal for combating cardiovascular disease is to primarily focus on prevention. To do this, we must be vigilant in screening patients for risk factors. Fasting lipid profiles should be started at age 20.

According to the ATP III guidelines, the goal for triglyceride level is <150 mg/dL. Borderline-high is 150-199 mg/dL, high is 200-499, and very high is defined as <500 mg/dL.\(^7\)

Cardiovascular disease risk is broken into four categories based on the number of risk factors. Low density lipoprotein (LDL) goals are as follows:

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<tr>
<td>Moderate</td>
<td>&lt;130 mg/dL</td>
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<tr>
<td>Low</td>
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In addition to therapeutic lifestyle changes, patients whose LDL is higher than the recommended risk guidelines should be offered pharmacologic treatment. The drug category known as statins...
“Hyperlipidemia”...
(Continued from Page 9)

can reduce LDL cholesterol levels 30-40 percent with proper dosing. All statins come in multiple dosages. The “rule of six” states that for every doubling of a dose of statin, you can expect a 6 percent decrease in LDL cholesterol.6

Bile acid sequestrants lower LDL 15-30 percent, and increase HDL 3-5 percent. Common side effects of the bile acid sequestrants include gastrointestinal upset, constipation, and decreased absorption of other medications.2

Cholesterol absorption inhibitors decrease LDL 18-25 percent, increase HDL by 1-3 percent, and decrease triglycerides by 8-14 percent. Their side effect profile includes back pain, arthralgias, and abdominal pain.2

Nicotinic acid has a significant effect on triglycerides, lowering them by 20-50 percent. LDL is decrease by 5-25 percent, and HDL increases 15-35 percent. Side effects of nicotinic acid include flushing, abdominal pain, hyperglycemia, hyperuricemia, and hepatotoxicity.2

Finally, fibrates decrease LDL by 5-20 percent, increase HDL 10-20 percent, and lower triglycerides 20-50 percent. Dyspepsia, gallstones, myopathy, and elevated creatinine are listed as side effects.2

The table below depicts the direct relationship of LDL cholesterol to coronary heart disease.

It is well acknowledged by our profession that many women view their Obstetrician/Gynecologist as their “primary physician”. Our Osteopathic Philosophy teaches us to treat the whole patient. Remember, the goal for combating cardiovascular disease is to primarily focus on prevention. Do not miss the opportunity to address this important health concern with your patients.

Acknowledgements:
Thank you, Kenneth E. Johnson, DO, for your educational, current and captivating lecture. Dr. Johnson would like to thank Robert Hasty, DO, for generously sharing his powerpoint slides

MEFACOOG/Wyeth Resident Reporter: Jennifer Howell, DO
75th Annual Conference of the ACOOG

REFERENCES
Laparoscopic Supracervical Hysterectomy (LSH) is becoming an increasingly popular procedure. The modern OB/GYN needs to look at the LSH procedure as a serious option for his or her patients. More and more practitioners are using minimally invasive procedures. Patients are going to inquire about these types of procedures and seek out practitioners who are able and willing to perform them. On March 27, 2008, Dr. Steven D. McCarus presented us with an overview of this procedure.

Thirty years ago, it was common practice to remove the ovaries during hysterectomy. Today, we realize that the ovaries play a role in the menopause hormonal milieu. Therefore, we understand that conservation of the ovaries until approximately age 65 benefits long-term survival. The same holds true for the cervix. It is considered normal to remove the cervix during hysterectomy. We must ask: Why are we removing a potentially normal organ? It is thought that the cervix needs to be routinely removed at the time of hysterectomy to decrease the risk of developing cervical cancer. However, appropriate patient counseling and routine annual PAP Smears can also diminish this risk.

When compared with total abdominal hysterectomy (TAH), LSH is a much safer procedure. LSH results in decreased blood loss, decreased injury or risk to the ureter and other pelvic structures, shorter operating time, faster discharge from the hospital, decreased time to return to normal and routine annual PAP Smears must be documented on the patient’s chart. Also, yearly PAP Smears must be documented on the patient’s chart.

Another common issue to discuss with our patients is the possibility of non-cyclic and cyclic cervical bleeding. These occur at a rate of 7% for non-cyclic bleeding and a rate of 1% for cyclic bleeding (McCarus-2004, 2005). Again, practitioners need to explain this possible outcome to the patient. It should be part of the consent form that recurrent bleeding may occur after the hysterectomy.

Obvious, there are contraindications to LSH. Clearly, the cervix must be removed in cases of cervical or endometrial cancer. Also, it should be removed in cases of invasive endometriosis of the cervix or dysparunia, abnormal Pap smear or cervical dysplasia, cervical myoma, and uterine cervical prolapse.

Prior to surgery, it is important to obtain informed consent from the patient. In the case of LSH, informed consent should include all possible procedures to be performed (LAVH, TAH, etc.). The patient needs to understand that the planned procedure is LSH; however, this can change depending on intraoperative findings. It is also important to include appropriate patient counseling as part of informed consent. This includes counseling about recurrent bleeding, pelvic pain, possible cervical cancer, or cervical prolapse. Also explain that a trachelectomy may be required in the future if any of these problems develop.

There are multiple techniques used to perform LSH as well as a number of different instruments that may be used. In general, three trocars are needed: two 5-mm trocars and one 11-mm trocar. A Harmonic 5-mm ACE is an option but other instruments are available depending on physician preference. A self-righting needle grasper as well as a tissue extractor should be available. Most importantly is the use of a laparoscopic uterine manipulator. This provides excellent movement of the uterus from side-to-side.

During the LSH, the ultimate initial goal is to reach the level of the uterine vessels (Level 1). If you cannot get below this level to see the remaining pelvic structures, you may need to morcellate at this time. Once you are able to see the uterosacral-cardinal ligament junction (Level 2), you should make a reverse cut or “cone” to reduce cervical volume. This decreases the amount of cyclic bleeding which may occur with LSH. While making this cut, you may cut into the cervical-vaginal junction (Level 3). This may be advantageous in...
that the entire endometrial canal would be removed, further diminishing the chance of cyclic bleeding. This hole can easily be repaired with an endostitch. At this time, the morcellator should be introduced. Following morcellation, observe the operative site for any remaining tissue. Also drop the intraabdominal pressure to make sure that the pedicles are hemostatic. Prior to exiting the abdomen, place intercede over the stump to help prevent future development of small bowel obstruction.

Post-operatively, LSH patients do extremely well. They normally only complain of pain at the site of the morcellation trocar. Patients should be admitted to the hospital for 23 hour observation. The Foley catheter may be removed in the recovery room and ambulation should be encouraged. They may be given a regular diet as tolerated and only need oral analgesics to control pain. Recovery is fairly rapid as the patient tends to return to her normal activities in 2-3 days. She may return to work after approximately 7-10 days following surgery. Intercourse may be resumed after 2 weeks. In one study performed by Dr. McCarus at Celebration Health in Orlando, Florida, there were 600 LSH procedures performed between November 1999 and July 2007. There was only one post-operative ileus and one ureteral thermal injury reported. The average hospital stay was 16 hours with return to normal activities within 2-3 days post-operatively. Only nine trachelectomies were performed, only one of which was for cervical cancer. Other studies have shown that LSH is no better for sexual function or pelvic support than TAH. The ACOG Committee Opinion therefore states that LSH should not be promoted as advantageous to sexuality or pelvic support.

In conclusion, LSH is a becoming a very popular option for hysterectomy patients. The goal is to choose the appropriate patient for the procedure as well as appropriate patient counseling. With LSH, we can offer our patients a minimally invasive procedure which is safer and has a faster recovery time than traditional options. As Dr. Radolphe Maheux stated: “It’s not up to the surgeons preserving the cervix to prove that leaving the cervix is a good thing; it’s up to those who remove it to prove that it should be removed.”

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