



**LAPAROSCOPIC SUPRACERVICAL HYSTERECTOMY
MCLEOD REGIONAL MEDICAL CENTER, FLORENCE, SOUTH CAROLINA
Broadcast November 29, 2005**

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NARRATOR: McLeod Regional Medical Center partners with Karl Storz Endoscopy to advance medical technology through quality innovation and education.

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LIBBY GODBOLD: I never realized how my quality of life had been compromised.

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ULDINE COX: I just feel real good about feeling better, feeling like my old self.

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LIBBY GODBOLD: It was an experience that, had a known how easy it was, I would have done it a long time before.

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NARRATOR: Over the next hour, witness a minimally invasive high tech surgery which has helped women regain their lives without serious pain and a long recovery. From McLeod Health, located in Florence, South Carolina, Dr. David Chapman will perform a laparoscopic supracervical hysterectomy on a patient suffering from painful fibroids. The surgery requires just three small incisions and it keeps the uterus intact.

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DAVID CHAPMAN MD: The older surgeries, the way I was trained, we took everything out when we did surgery. We took out the cervix, the uterus, the ovaries, the tubes, and the appendix. Everything that was there was a clean sweep. Modern surgery now is minimal surgery. Minimal is better.

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LIBBY GODBOLD: About 24 hours, as I recall, I was okay. Moved slowly for a couple of days, but the incisions healed nicely. I just had no problem.

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NARRATOR: You may email questions to the physicians in the OR by clicking the MDirectAccess button at any time. This program represents McLeod Health's ongoing efforts to bring the latest developments in healthcare to the community.

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CHARLES TATUM MD: Welcome to this live internet broadcast from McLeod Health in Florence, South Carolina, where tonight you're going to witness a laparoscopic supracervical hysterectomy. I'm Charles Tatum, your moderator. This is the first in a series of webcasts we'll bring you in an effort to make patients better decisions and better informed. We emphasize doing the right thing to the right patient for the right reasons at the right time. Here at McLeod Health, we want to encourage a strong collaboration between doctors and their patients. We can start that process right now. At any time during the next hour, you can ask us questions. You can do so by clicking on the MDirectAccess button at the bottom of your screen. During our webcast, you'll hear from two former patients, who will speak about their experiences. Now let's go inside our new, state of the art OR, where Dr. David Chapman is about to begin surgery. Good afternoon, Dr. Chapman.

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DAVID CHAPMAN MD: Dr Tatum, welcome to the operating room.

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CHARLES TATUM MD: Tell me where we are.

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DAVID CHAPMAN MD: Okay. We're just beginning a laparoscopic supracervical hysterectomy. I have already put in the catheter and the transcervical equipment to mobilize the uterus, and we have all three of our operating trocars in. We're going to begin with taking down the ovarian blood supply to the right ovary and tube.

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CHARLES TATUM MD: Maybe, Dr. Chapman, you can explain the instruments you plan to perform the surgery with?

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DAVID CHAPMAN MD: Okay. This instrument that's being introduced now is a harmonic scalpel instrument. This is what I'll use to totally desiccate the vascular tissue and mobilize the ovary out of the way here. We've already localized the patient's ureter and I'm going to isolate the blood supply to the right ovary and totally desiccate this pedicle.

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CHARLES TATUM MD: That's amazing efficiency as you cut through the right

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DAVID CHAPMAN MD: I've gotten away from using clips and staples. There's always a little bleeding, but it's usually pretty well managed with this.

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CHARLES TATUM MD: The ovarian blood supply is divided. As Dr. Chapman proceeds to operate, he's clamping now the right ligament.

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DAVID CHAPMAN MD: I'm using high power here. This is a less vascular plane.

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CHARLES TATUM MD: As you can see, this is a very efficient operation as far as the very little blood loss on the access side of the vascular system. We're down to the round ligament now. This is the portion of the surgery that would normally take much longer. You can perform this same procedure on the opposite side. Can you describe that mass anterior to the uterus, Dr. Chapman?

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DAVID CHAPMAN MD: Let me see if I can get the blood controlled a little better. She's having a little oozing from the right round ligament. Let's try to desiccate that. That's good. This is a fibroid tumor that's pedunculated off the top of the uterus. That's going to be removed as part of the specimen when we get down a little further here.

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CHARLES TATUM MD: This is the fibroid tumor Dr. Chapman is describing. This is the blood supply to the ovary, which has already been divided and you can see is totally dry. This is the right round ligament and Dr. Chapman is now down to the broad ligament. The anatomy on this side is totally normal. This amount of blood loss is also normal. He's separating the leaves and, as you can tell, this operation is proceeding very well. The uterine blood supply will come in here and we'll get a little bit of bleeding at that point. He'll be able to isolate that and coagulate.

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DAVID CHAPMAN MD: This is the ascending branch of the uterine artery right here.

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CHARLES TATUM MD: You can see there's a small amount of bleeding there. This instrument has two speeds, high and low. When we take large vessels, we use it under lower power, but as you can tell, this is all completely separated now, almost down to the level of the cervix.

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DAVID CHAPMAN MD: There's a little back bleeding there. We're going to go to the other side now.

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CHARLES TATUM MD: As you can tell, this is a symmetrical operation. This is the left tube and the white tissue here is the ovary. It's mobile. Rectal sigmoid is here. Dr. Chapman will perform the exact same operation on the opposite side now. This is the so-called infundibulopelvic ligament, the ovarian blood supply. As you can tell, this instrument is very efficient, which is really what makes this entire operation possible. This is the uterus. This is the left fallopian tube. There's the ovary. The ovary's been completely separated now. The blood supply is here and it's totally dry. The round ligament. Dr. Chapman is just in the process, under high power. There are very few blood vessels in this tissue and it's very easy to divide, so this is the high power portion of the operation. The

uterus is right here. The bladder sits in front, so as we dissect down, heís moving back toward the ascending branch of the uterine artery on this side. This is the uterosacral ligament. I hope we have something else to talk about in this operation. This looks like itís going very quickly.

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DAVID CHAPMAN MD: The ascending branch of the uterine artery is right here.

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CHARLES TATUM MD: David has taken the top of the broad ligament and heís just getting into the ascending branch of the uterine vessel. Heíll get control of this in just a minute. The cervix is down in this area. Thatís the fibroid we saw anterior. This is the uterosacral ligament, rectum here. As you can see, the greatest thing about this procedure is you have complete visibility. As opposed to a vaginal operation, where youíre unable to see the anatomy, see if the bowel is stuck to the uterus, see the location of the ureter, which we identified clearly on both sides. This is a very small blood vessel. Under the amplification, it looks like a lot of bleeding, but thatís really a very small amount of bleeding so far. Heís just using the harmonic to divide it. As you can tell, this is almost a one-instrument operation for the major portion of the surgery. The uterus is slightly enlarged, say approximately six weeks in size, with a small anterior fibroid, but the posterior portion is relatively clear. Prior to the operation, we had examined the pelvis when Dave placed the ports. We could see there was a little bit of endometriosis in the cul-de-sac, but this oophorectomy and surgery should clear up all of her symptoms. The harmonic scalpel is easily cutting through this tissue. Heís having a little bit of char on there. He wants to be careful not to tear the vessels away as he coagulates these vessels. You can see there are some very large vessels there.

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DAVID CHAPMAN MD: Ím going to start the amputation here, Chuck.

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CHARLES TATUM MD: It looks like this operation is going to be over here pretty quickly, so Íd like to suggest maybe we take a break here, Dave, and go to our first question.

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DAVID CHAPMAN MD: Ím amputating now.

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CHARLES TATUM MD: This is the uterus. Heís cutting now into the corpus. The blood vessels are right here and this is moving very smoothly. Very little blood loss because weíve already isolated the blood supply. Small amount of char, very small. Very little tissue destruction away from where the harmonic is operating. The cervix is here and heís amputating. This is the uterosacral ligament. This is the supportive portion thatís being preserved and that should decrease the risk of prolapse. As you can see, thereís very little bleeding along this tissue, where he had coagulated across. Everything is done under direct vision. Thereís really no risk of injury at this point, as weíre into the corpus of the uterus now, as the amputation is proceeding. This amount of char is normal and this instrument will function fine with that. Now heís going to flip over, I think.

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DAVID CHAPMAN MD: Ím going to stay on that side and reposition this a little bit.

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CHARLES TATUM MD: Youíll notice the volume inside the pelvis is altered by the amount of gas. We use carbon dioxide to distend the abdomen and thatís what gives you the separation of the uterus from the bowel and what makes this surgery much safer. Dr. Chapman is just about to the center of the uterus. Theyíve got a little bit of smoke and debris on the end of the scope there and theyíre just cleaning up their instruments now so they can see well. This is the ovary. For a short period of time, this uterus will look very different than it did when we started, as the blood is completely separated and this tissue becomes devitalized from the surgery. I think while they clean the instruments, this would be a good time for Libby Godbold.

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LIBBY GODBOLD: Well, as a typical workaholic ñ shouldnít be, but I am ñ the thought of being out for any period, extended period, is hard for me. I love to go on vacation, but I hate to have to be away from the office, so, you know, it was hard to make a decision to have elective surgery. I had been treated by my gynecologist for, gosh, 24, 25 years, as long as heís been in Florence, and had been diagnosed with fibroids, which are just a bothersome condition. He had talked to me about the fact that they were getting worse and I knew that the problems I was having were getting worse, but I just could not make the decision to have a hysterectomy. So

one time he gave me a little brochure about one procedure and then he gave me another brochure, another time, about the LSH, the laparoscopic supracervical hysterectomy, and he said, Libby, I think this one's just for you because you don't have to miss much work. He knows how I am. So, about a year later, after I put it off for another year, I decided I was going to do that. I scheduled the procedure and, really and truly, I think the most remarkable thing, to me, is that I never realized how my quality of life had been compromised. All along the way, it just gets worse and worse, but you just don't even think about it. Near the end, before I made the decision to have the surgery, I stopped and I thought, Libby, for a couple of days a month, you really have to curtail pretty much your activities, your travel or anything like that, and that's a terrible thing if you can have a procedure quickly and painlessly, pretty much painlessly, so I decided to do it. I schedule it and went to McLeod and I really don't remember many of the details because it was just not a real significant event. I had it done, went home. For a couple of days, I was sore. I had it done on a Thursday. I took Thursday and Friday off, rested for the weekend, and sort of thought that I might come back to work on Monday, against doctor's orders, but then I said why do that, so I stayed out Monday and Tuesday. By Wednesday of the following week, I was ready to come back to work, I felt good, and I have not had the first problem. It was really an experience that, had I known how easy it was, I would have done it a long time before.

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CHARLES TATUM MD: David, we just heard from Libby Godbold and her testimonial. Of course, she represents, I think, an average working patient that this operation is really designed to help. Do you have anything to add about her problems and how her surgery went? It was an excellent tape and discussion. She's very articulate and we appreciate her help.

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We'd like to hear from Uldine now. If we could hear that tape.

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ULDINE COX: I just feel better, mentally and physically, to know that I don't have to worry about it. I do have more energy. I feel more energetic and I feel like traveling. As I stated, as Don said, let's go somewhere, let's plan a trip, I'm ready because I feel like at this stage in our life, we need to, if we so desire, travel not for everyone, but if we enjoy that, why not do it? Whatever a person enjoys, I think they should do it if they're able. We never know when we won't be able to do things. As the saying goes, go while you can and then when you can't, you can think about where you have gone in the past and what you have done in the past. So I just feel like a different person.

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CHARLES TATUM MD: We appreciate hearing from Uldine. Once again, Dr. Chapman is speeding right along with the surgery. As you can see on the screen, the uterus is changed in color from the beginning. It was very pink at the beginning. Now we've separated the uterus at the cervix. Most of this operation has now been performed. Dave, can you tell me how things are going?

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DAVID CHAPMAN MD: Okay. We're just trying to get a little bit better view here, mobilizing this uterus. The fibroid tumor is in the way. I've got both uterine arteries, both sides, so I'm just trying to

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CHARLES TATUM MD: This is the uterine artery, right here. What we previously identified, the ureter is right here. The vessels have been coagulated and Dr. Chapman is now cutting across the corpus, just above the cervix. It's just a matter of separating this uterine tissue from the cervix and the lion's share of the procedure will be performed.

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We have a few email questions that we might be able to take. As you can see, this is totally avascular now. Very little blood. There's been no irrigation. There's been no suction. This is the amount of blood and I can tell you this is about a cup of blood, total. Dr. Chapman on this left side is more than 50% amputated. That high pitched sound that you just heard is actually the uterine manipulator as he touches it with the harmonic scalpel. This is going very smoothly.

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We have some questions, Dr. Chapman. I'm going to read the question and try to give an answer, and you can give your take. How long did it take to learn this procedure? You'd best answer that one, Dr. Chapman.

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DAVID CHAPMAN MD: This is my 115th case and I started in 1999. The first one I did took five hours. The equipment is better now. We have better equipment.

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CHARLES TATUM MD: As you can see here, he is really making good progress across here. For me, Dave, it is really just been an extension from the initial laparoscopic surgeries, including LAVH.

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DAVID CHAPMAN MD: I am below that fibroid. Here is the metal transcervical probe.

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CHARLES TATUM MD: The transcervical probe is right here. Dr. Chapman will hit it in a minute and you will hear a high pitched sound. He is just coming across it with the harmonic scalpel. I have to say that most accomplished gynecologic surgeons can become comfortable with this procedure in a relatively short period of time. It is really a mindset. We have some slides that we are going to show. It looks like Dr. Chapman is going to finish this procedure so quickly that I may get him to sit down with me at the completion of this operation and go over some of these points, but it does take time to learn how to use this instrument here, the harmonic scalpel, and as you can see, it is key. This is actually less surgery than a typical hysterectomy because normally you would mobilize the bladder, push the bladder down, and you would separate these ligaments. What we are doing now is we are just amputating across the uterus, so this is going to make the procedure much simpler from a technical standpoint. The ureters are down here. As long as everything is in a normal anatomic position, it is going to be relatively easy to not injure anything. The blood vessels have been coagulated. There is nothing here but uterine muscle that can come across. Dr. Chapman is just moving right along here. We will eventually irrigate and make sure these vascular structures are dry. This amount of fogging is normal and this is just something you have to put up with in a laparoscopic procedure. There is a plume that is developed by this instrument that will cause moisture droplets that will condense on the lens. As you can see, he is pretty well across the top. I would say about 2/3 of the uterus have been separated now. This is a small fibroid. Of course, only 1 in 1,000 of these are malignant. While he is doing this, I think I will ask another one of our questions. How do you decide who is not a good candidate for LSH? The quick answer is most patients with malignancies, you would not want to cut across an endometrial or cervical or uterine malignancy for this procedure, so this is a benign disease operation. It saves the cervix, so that is very important.

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What you just heard was actually a little error message and he is going to have to let this instrument cool down. We have been moving so quickly that the instrument is on the warm side. Patients who are not a good candidate have ovarian, cervical, or endometrial carcinoma. About 2/3 of the hysterectomies in the United States are performed abdominally. For the best of what we can tell, this has been done because this is the procedure that most surgeons feel comfortable with. You can't feel what Dr. Chapman is doing right now. This is all using a video camera and with this instrument you lose this is the vaginal manipulator, so-called Valtchev, that he has used to elevate the uterus. About 90% of hysterectomies performed in this country, according to some, could be done using this procedure, but it is for primarily benign conditions.

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I will read the next question here. A patient states I am scheduled for a hysterectomy in January. I have had three C-sections and a colectomy, so the expectation is that I will have to have a vertical abdominal incision along the old incision line. My physician will be removing my ovaries. Since I am 60 years old, we figure the ovaries are not supplying hormones and will not be missed anymore. Do you agree? The ovaries actually do make a small amount of hormones, even in menopause. This is primarily testosterone. There has been a recent publication that suggests that consideration for ovarian preservation should be made on all patients. Dave, can you tell us where we are now?

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DAVID CHAPMAN MD: There is the transcervical probe, right there, the metal probe. This is all cervix here. I have got the uterus grasped and I am trying to complete the amputation here. This is a little bit tricky at this point, but we are almost there.

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CHARLES TATUM MD: Dave, as you have amputated the rest of this uterus, I have got about a 5-minute slideshow to show our audience. If we could cut to the PowerPoint, we could see the slides. Hysterectomy is a major health issue for women, the second most common surgery in reproductive age women, exceeded only by Cesarean

section. 1 in 3 women will have a hysterectomy by their 60th birthday. 2 out of 3 will have an abdominal hysterectomy because that's what their physicians feel most technically proficient. We're not certain why the trend in this country is what it is, but these are the numbers and they have been steady for the last 15 years. Laparoscopic supracervical hysterectomy could be an alternative for the vast majority of abdominal hysterectomies that are performed today. As we discussed, this is not a good technique for any patient that has even the possibility of a malignancy. It takes money to be able to perform this procedure. The instruments are expensive and OR technology investments support the image-guided minimally invasive surgery. These are high tech cameras, high tech monitors, and this is what it takes to be able to perform the procedure safely. It is complex and it does require time.

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Dr. Chapman is getting ready to amputate the final. Can we switch back now to this final step, as Dr. Chapman is dissecting out right here and the uterus is now separated. It's just a matter of removal now. So with only this one instrument, the harmonic scalpel, Dr. Chapman has been able to take the ovarian blood supply and the upper uterine blood supply and he's down to the cervix now. Incredible job, Dr. Chapman. Congratulations. Now it's just a simple task of removing this uterus using the morselator.

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Can we switch back to the PowerPoint for a second? Patient safety and quality, the right thing to do. The majority of hysterectomies can be converted to LSH. It will result in decreased blood loss, shorter operative times, less postoperative pain, and markedly fewer complications. No surgery is without complication. You can compare abdominal hysterectomy with vaginal hysterectomy with LSH. Part of the reason that there's less complications is there's not as much surgery being performed. We haven't dissected the bladder. If we can see that, we have left the connections from the cervix. The ureter runs right down in here. This is the ureter right here. Because we've avoided all that, and of course this is an excellent job that Dr. Chapman has done. The surgery cost to patients for LSH is nearly identical to the cost of an abdominal hysterectomy, but overall the lost days working and other expenses have been measured to be 50% less. Part of the reason is that we've only done the surgery that was necessary. Only the portion of the uterus that was causing a problem has been removed. We have not disturbed the bladder. We have not disturbed the lower uterine segment and the support structures, all of which have to be put back in place in traditional surgery. Quality is the most important of the things that we have to offer here, using high quality monitors and highly trained physicians to be able to perform this surgery. He's ready to be done. I think Dr. Chapman has dinner at 6:00 tonight and he's working right away.

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DAVID CHAPMAN MD: What we're going to do now is, now that we've detached the uterus—see the uterus, ovaries, tubes, and fibroid tumor that have been detached from the cervix. Now we've got to figure out how to get it out of the pelvis through a band-aid incision.

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CHARLES TATUM MD: We're going to do that with a power morselator here. There's a blade that will come out on this instrument here. Dr. Chapman will reach through with this—they're cleaning the scope again.

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DAVID CHAPMAN MD: I'm going to turn the blades on now.

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CHARLES TATUM MD: Dr. Chapman is going to push the blade down. This is all part of the procedure. This is why it takes as long as it does, because obviously the main part of the surgery is already performed. He's going to use a grasper through this device. It has a blade and a circular knife will turn. He has a foot control pedal that will allow this device to basically be removed. Now, this blade is in a position he knows exactly where it is. There's no bowel anywhere near this, so this is very safe. The blood that's coming out is blood that's already in the corpus of the uterus. He's just going to reach in there and grab some tissue he wants to take out and just pull it right through. What you can't see is on the other end, Dr. Chapman will be removing each specimen. This is the reason this is not an appropriate procedure for a malignancy.

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DAVID CHAPMAN MD: That tumor got away down here somewhere.

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CHARLES TATUM MD: Dr. Chapman is doing what we call fishing. He's going to reach right there, grabbing only the tumor, and just pull it right on through there. As you can see, this procedure is almost done and he's moving along.

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Getting back to our PowerPoint, quality, the right procedure for the right patient at the right time. We think that's the most important aspect of quality. Innovative and precise surgical techniques. As you can see, without this device, you cannot perform this procedure. You'd have no way to remove the uterus. Dr. Chapman is removing the last bits of the uterus here. This is just part of the corpus of the uterus. He'll put it in position. The blade is open, but he's got complete control of this and the blade is controlled with a motorized device that he presses a foot pedal. As you can see, the uterus is just being removed right up through the top here.

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Pre- and post-operative adherence to care guidelines markedly decreases the risk. What that means if you have to choose the right patients for these procedures and you have to follow them up properly. You have to have access for the patient to call you if there are any complications or problems. Respiratory and cardiovascular care are obviously important. Deep venous thrombosis is one of the most devastating complications that a young patient can have involving surgery. It's unpredictable, but at McLeod Health, major efforts have been made to reduce the complications, risks of infection. We've had clinical care teams and implement the national clinical guidelines for prevention of infection. McLeod has been #1 of 268 hospitals studied by Medicare for success in this program, which we think is incredible. The financial costs to the healthcare system: there are 600,000 hysterectomies each year, aggregate cost \$5 billion. As an ex-Navy man, that's about two of our big aircraft carriers and lost work hours are 144 million hours. Obviously if you can go back to work in 2-3 days after this procedure, you'll have much less lost time. McLeod Regional Medical Center realizes the improvement in patient outcome and \$4 million in annual savings with physician-led, physician-driven clinical effectiveness program. This includes \$1,100 reduction per case for hysterectomy services. This is one of the most exciting aspects of what we do. We can't provide top quality care by wasting healthcare dollars. We have to be very careful. What we do, using one instrument to totally remove the uterus, obviously results in a lot of savings. Our costs associated with LSH, if you look at operative times, they're obviously significantly less. We're now approximately 30 minutes into this procedure and we're basically done.

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DAVID CHAPMAN MD: I'll take out the trocar, the big morselator.

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CHARLES TATUM MD: Dr. Chapman is removing the instruments. This device is still in place and he's got just a few little things to do to tidy up this, and what an excellent job you've performed, Dr. Chapman.

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DAVID CHAPMAN MD: Thank you. We can take out her catheter now.

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CHARLES TATUM MD: What Dr. Chapman is referring to is her urinary catheter, which most patients keep for 24-48 hours. The hospital charges to the patient, compared to the cost of care, varies up to tenfold. It's hard to understand this, but McLeod Health is just above the national average of the 4,184 hospitals examined. South Carolina, because of our payer mix, is one of the more expensive areas as far as total hospital costs. As you can see, if you can perform this procedure quickly and efficiently with minimal instruments, we're going to be able to save patients time and money. Total economic costs: there's lower out of pocket expenses. Lost time adds up to financial burden. As any of us who have missed work know, we normally don't get paid on those days off. Currently, LSH saves more than \$250 million annually in this country as a very minor portion of the total hysterectomies. There are more than 125 million workers who report lost time to work because of illness of themselves or their family. Up to 60% of total economic healthcare costs to employers stem from on the job productivity loss. Hysterectomy accounts for 144 million work hours lost to the average 6-week recovery time. This patient will be ready to go back to work next week. Isn't that remarkable? Dave, I think it's time to hear from Libby again, so if we can have that next tape, that would be great.

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LIBBY GODBOLD: I really didn't have that much pain. That was not my problem. One of the girls that I work with here had tremendous pain with her fibroids. I can't say that I had pain, but I had lots of clotting, clotting to the point that I really could not feel comfortable far away from the bathroom for a couple of days a month. Just one

of those experiences where if you're just not comfortable, you tend to cancel appointments. You don't make social engagements. You can't travel. You can't go anywhere with a group and just have certain potty breaks. It's just one of those things that I really was limited every single month as to what I could do, but that too, you just get used to that and you plan your life around those kind of limitations, and then after you do something about them, you say why in the world did I let it go that long?

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CHARLES TATUM MD: Libby is one of the most impressive patients I've heard speak about hysterectomy. She speaks to issues that I think we frequently don't always address. I think that sometimes we try to perform a surgery that we're comfortable with, as opposed to what works best for her. It's an excellent example of how we're bending our procedures to the patients. Uldine has another thought for us and we'd like to hear from her, if we could.

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ULDINE COX: Any little ache or pain sends of this idea, has it reoccurred or anything. I was real nervous and, as I stated, I was in a lot of pain. I had pelvic pain and lower quadrant right side pain a lot, which, you know, they did a bunch of tests, this and that, and could not find anything. Then I would always keep my yearly checkups with Dr. Chapman. When I went and he did the ultrasound, he found the mass on the right ovary, so after doing tests and everything, he had put me on an antibiotic, hoping it would shrink the mass. It did not and it did not relieve the pain. He said, with your past history and all this going on, I think we would be wise to do a procedure and check it out. I said that's good, you know. Once he did the procedure, he stated that he found a lot of scar tissue also on the right lower side, along with the mass, and that was what was giving me a lot of pain. After he removed all that, I've not had any.

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CHARLES TATUM MD: We certainly appreciate Uldine and Libby sharing their experiences with us. As you can see, Dr. Chapman has made very simple this procedure. You may wonder what does all of this take and how long does it take? Well, there's a trocar here and there's a trocar here and then there's a scope trocar, so right now we have 3 punctures. Everything is dry. This is the uterine vessels here and here. This is the cervix, amputated. The bladder is right here. This is the area that the bladder expands when it gets full. Dr. Chapman is removing the probe. The urinary catheter is out and he's going to coagulate a little bit of the tissue right here. We're basically done. She'll end up with 3 little band-aids from where these devices came into the abdomen.

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We've got a few more questions here, Dave. The patient says I'm 28 years old with endometriosis and have tried various treatments without success. I have only one child and would like to have one more. After this, I'm considering hysterectomy, now that it can be done laparoscopically. Do you think I'm too young for this and what are the potential complications of the procedure for me? Well, you know

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DAVID CHAPMAN MD: She wants to have another baby and then look at a hysterectomy?

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CHARLES TATUM MD: I think that she's so impressed at how quickly and simply this case was performed that she's ready to have her surgery now. This is from Kristen. Kristen, you really need to sit down and talk to your physician to find out when it's the right time for a hysterectomy. It's very difficult. This is an irreversible procedure. This can't be put back once it's removed. In a young person who is considering children, this is probably something that I'm not going to be able to help you out with tonight.

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The next question is how much is the average blood loss for a laparoscopic supracervical hysterectomy versus and exploratory surgery with a large incision? How long does the exploratory laparoscopy take? This is basically a comparison question.

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DAVID CHAPMAN MD: The blood loss in this case is probably 5-10 cc.

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CHARLES TATUM MD: As you can see, there are just small traces of blood with irrigation. The blood loss with abdominal hysterectomy is greater. That's true with every study. You bleed from both the incision and from where the uterus has been removed. With most laparoscopic supracervical hysterectomies, there's a relatively small amount of blood loss and the operative time is usually less. You have to compare apples to apples, though,

so a 20-week size fibroid uterus is going to bleed more. As you can see, Dr. Chapman's incisions are three small band-aid cuts. The band-aids will come off the day after tomorrow.

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Here's a good question: why leave the cervix? Is there a future cancer risk? As you can see here, Dr. Chapman is placing some Intercede up into the abdomen to cover over the cervix. Cervical cancer, as we understand it today, is a sexually transmitted disease that comes from HPV virus. Some of these patients in a stable sexual relationship are not exposed to this virus and they're really not at risk. The next generation of children will be receiving a vaccine which will prevent cervical dysplasia and we can't wait to get it here. Dr. Chapman is positioning a methyl cellulose device that will decrease the risk of infection and decrease the risk of adhesion formation. He's just going to cover this stump and he's just putting it in position. He'll wet it and spread it out here in just a moment, but as you can see, this is perfectly dry. It's very comfortable at this point to end the procedure. This is not necessary and most surgeons don't necessarily perform that.

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If there are any other web questions, we're going to have some time at the end of this operation to answer any questions that you have, so we'd be more than happy to do that. This is a patient-altering procedure in that quality of life is significantly improved after having this type of procedure performed. Patients like Libby, who hemorrhaged and couldn't leave her house, what an incredible change from a relatively simple operation done through three small incisions. Her quality of life is dramatically improved. How many patients live in fear that they're going to flood their clothes from menstrual blood, embarrassed in front of their children and coworkers. It's a socially debilitating issue.

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DAVID CHAPMAN MD: Okay, she's got a band-aid on there and ready to go home.

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CHARLES TATUM MD: Dr. Chapman, I think as the moderator, I have to say I'm totally impressed here at how well this procedure has gone. I'm glad that you'll be available now to take over the moderator spot for the remaining 10 minutes of this broadcast. Are you going to have to close these incisions now, Dr. Chapman? Dr. Chapman is removing his scope. This is the final step. As I said, this has gone very well. Value is innovation, quality, safety, and lowest cost. McLeod Center has certainly invested in the technology and training for our surgeons. McLeod Health has been the cornerstone of care for over 50 years, devoted to medical excellence one life at a time.

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Dave has 3 incisions. 2 of the incisions are 12 mm, which is approximately $\frac{1}{2}$ inch. He's closing that now, as you can see through the camera shot. He's elevating the deep fascial layers using a retractor, so he can get down. This will prevent a herniation from forming, which is a potential complication of this procedure. This should prevent that as a possibility. This will heal quickly. They often have some bruising, but this is a structurally strong incision from the time the patient leaves the operating room. He's just going to palpate there and feel.

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We'll see here if we have a few more questions. One of the questions was how old is your patient, Dr. Chapman?

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DAVID CHAPMAN MD: 50.

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CHARLES TATUM MD: David, do you have any comments at the completion of this procedure?

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DAVID CHAPMAN MD: I thought it was an interesting question about leaving the cervix. When I was trained and when you were trained, we took out everything. We took out the cervix, the uterus, the ovaries, the tubes, the appendix, and anything that got in the way, but that's old fashioned surgery. Now, modern surgery takes out only what needs to be removed. To take out the cervix for no good reason doesn't make modern surgical sense. The cervix adds a certain amount of blood supply and support to the pelvis and to the lower vagina. If the patient does not have risk factors for cervical cancer or prolapse or cervical Pap smear problems, then she can have the cervix left intact. What makes the patient recover from the operation so fast is that she does not have a vaginal incision. Not having a vaginal incision means that she won't have all the pain that requires a morphine pump and overnight stay in the hospital and all the morbidity with that.

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CHARLES TATUM MD: I agree with you, Dr. Chapman. I think traditions in medicine and surgery remain. I think there's no reason to perform any procedure or remove any tissue that's not necessary. You definitely will decrease the blood loss and the complications if you do less surgery. It's just common sense. Dr. Chapman, I appreciate you inviting me to help moderate. I'd like to thank you for joining us here at McLeod Health Hospital, Florence, South Carolina, for a look at a laparoscopic supracervical hysterectomy. What makes this surgery so important is how our patients end up feeling afterwards. It is so important to have the medical innovation and technology we've shown you today so that we may help so many people, but equally important is that we've touched lives in a way that technology never will. With that, here's a final thought from Libby Godbold. For Dr. David Chapman and myself, good night.

00:52:30.000

LIBBY GODBOLD: I look back and I think why in this world did you put it off so long, but you don't really know until after you feel better how bad you did feel. My energy level is better. I feel better. You know, I don't have to plan my life around 2 days of the month. That is such a liberating feeling, I just can't tell you.

00:53:01.000

NARRATOR: This has been a presentation of a laparoscopic supracervical hysterectomy at McLeod Health in Florence, South Carolina. To obtain more information or to make an appointment or make a referral, please click the button on your screen.