Outpatient Laparoscopic Radical Hysterectomy

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Background
Laparoscopic radical hysterectomy was first described more than twenty years ago and nowadays, more than 1200 procedures had been reported in the literature [1-2]; conversely, outpatient laparoscopic procedures in general gynecology have become increasingly popular due to its wide acceptance by patients and doctors in general [3], there is limited literature regarding outpatient laparoscopic surgery in gynecologic oncology [4-6].

Objectives
The goal of our study is to report on the first series of ambulatory laparoscopic radical hysterectomies in patients with early-stage cervical cancer and suggest some criteria for proper implementation.

Methods
We performed a retrospective review of all patients who underwent an outpatient laparoscopic radical hysterectomy at the Instituto de Cancerosología - Las Americas in Medellín, Colombia, between January and September 2013. Inclusion criteria were: age less than 60 years old, informed consent, residence of less than 1-hour distance from medical center, available caregiver at home during initial 48 hours, ECOG 0 and ASA 1, BMI <30.

Results
A total of eight patients were included and all had stage IB1. The median age was 38 years (31-53) and the median body mass index was 24.4 (19.1-30). Histology was adenocarcinoma in 6 patients (75%) and squamous cell carcinoma in 2 patients (25%). No lymph node mapping was performed. The median operative time was 138 mins (120–160) and the median estimated blood loss was 40 ml (30-150). No intraoperative or postoperative transfusions were given. There were no intraoperative or postoperative complications. All patients underwent a transverse abdominis plane block and 5 patients (62.5%) reported 0/10, two patients (25%) reported 1/10 and one patient (12.5%) reported 2/10 in the pain evaluation scale at discharge. All patients were able to void spontaneously and tolerate oral intake before discharge. There were no readmissions postoperatively either to our hospital or to their local hospitals. The median nodal count was 14 (8–30). All patients had negative margins and no parametrial involvement. One patient (12.5%) had positive lymph node. The median follow up was 2 months (0.3-7). Three patients (37.5%) underwent adjuvant chemoradiation.

Conclusion
Outpatient laparoscopic radical hysterectomy is feasible and can be performed safely in a developing country in well-selected patients.

Suggested Safety Criteria for Outpatient Laparoscopic Radical Hysterectomy (OPRAH)

Preoperative: Signed informed consent, residences less than 1 hour away, to have a careraker at home, ECOG 0, ASA 1, less < 60 years old, BMI < 30.

Operative: Surgery completed before 14:00, surgical time less than 3 hours, estimated blood loss under 200 ml, hypogastric nerve displayed and preserved at least one side, availability of Transversus Abdominal Plane Blockade (TAP Block).

Postoperative: To tolerate oral intake at 4 hours, spontaneous voiding at 4 hours, visual pain scale score < 3 and desire to go home.

TAP BLOCKADE
The transverse abdominis plane (TAP) block is a peripheral nerve block designed to anesthetize the nerves supplying the anterior abdominal wall (T6 to L1). It was first described in 2001 by Ralli as a traditional block technique using the lumbar triangle of Petit [7].

Local anesthetic is then injected between the internal oblique and transverse abdominis muscle just deep the fascial plane between them.

The introduction of ultrasound has allowed providers to identify the appropriate tissue plane and perform this block with greater accuracy under direct visualization [8].

References

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