

Oregon surgery center is pioneer in outpatient hysterectomy

Surgeons perform about 600,000 hysterectomies per year in the US, but less than 1% of these take place in ambulatory surgery centers (ASCs). Richard Rosenfield, MD, is trying to change that.

Before he founded Pearl Surgi-Center in Portland, Oregon, Dr Rosenfield performed outpatient hysterectomies at several local hospitals as an advanced laparoscopic surgeon. He believes that with the right surgeons and the right patients, the time has arrived for ASCs to become the setting of choice for many hysterectomies.

So far, that's been an uphill battle, mainly because relatively few surgeons have the requisite training and because of general uncertainty surrounding the Affordable Care Act (ACA).

"Innovation has not only improved the technology," Dr Rosenfield says, "but we can do [laparoscopic hysterectomies] more efficiently and at lower cost than hospitals." For many procedures, the trend has been a shift from open to laparoscopic or robotic. For hysterectomies, laparoscopic is least expensive when performed in an ASC, he notes, and has been proven safe, even for women with large uteri or large fibroid tumors.

"CMS [Centers for Medicare & Medicaid Services] is pushing for this type of approach to healthcare," he says. "For one thing, ASCs will see more Medicaid patients as the ACA takes effect. Reimbursement, however, has lagged policy changes."

For example, Medicare pays for an ASC-based laparoscopic hysterectomy only if the specimen weighs 250 grams or less—and that payment does not cover the actual cost. Industry representatives such as the Ambulatory Surgery Center Association (ASCA) are lobbying to change that, citing research that demonstrates the procedure is safe for larger organs as well.

Cheaper, safer, yet still rare

Hysterectomy is the second most common surgical procedure performed on a woman, after cesarean section, according to the American Congress of Obstetricians and Gynecologists (ACOG). The most common indications are uterine fibroids, menstrual disorders, uterine prolapse, and endometriosis.

In 2008, according to ACOG, 112,000 hysterectomies, or 18% of the total, were performed in hospital outpatient departments, either laparoscopically or through vaginal access or a combination of the two.

"This is a multibillion-dollar issue," Dr Rosenfield told fellow ASC managers at the annual ASCA conference in May. He cited a study showing that a robotic hysterectomy performed in a hospital costs on average \$8,868, vs \$6,679 for laparoscopic and \$6,651 for open surgery. However, a laparoscopic hysterectomy performed at an ASC costs an average of \$4,000.

Part of the reason, Dr Rosenfield says, is the rising cost of robotic technology and surgical time. Meanwhile, patients face higher co-pays, and providers and insurers seek to reduce costs. The answer, he believes, is moving laparoscopic hysterectomy to ASCs for all appropriate patients. Yet 60% of hysterectomies are still done by the open method, in hospitals.

The Journal of Laparoendoscopic Surgeons in 2011 concluded that minimally invasive hysterectomy was “a safe procedure that may improve patient satisfaction surgically and financially.” Dr Rosenfield adds that the method results in lower infection rates, along with less stress and lower cost. Physicians benefit from greater efficiency; with same-day discharge, there is no need to make hospital rounds because there is no inpatient stay.

“Surgeons are victims of their surroundings,” Dr Rosenfield says. “What makes an ASC the optimum location is that it offers the surgeon the greatest amount of control during this highly specialized procedure.”

Arriving at a hospital operating room for a procedure, surgeons are often faced with variables outside of their control, such as an OR table that is not suitable for the surgeon’s height or, for that matter, laparoscopy. They may not have access to the best endoscope or the best optical quality.

In addition, members of the OR team might be unfamiliar with one another, and the laparoscopy set may not contain the surgeon’s preferred tools.

At Pearl SurgiCenter, Dr Rosenfield performed laparoscopic hysterectomies on 502 patients between October 2005 and April 2010. Of these, 439 were laparoscopic supracervical hysterectomies (LSH), and 63 were total laparoscopic hysterectomies (TLH). An additional 57 candidates were excluded, not for clinical reasons, but for lack of adequate insurance.

The average time in surgery was 88.6 minutes for LSH and 125.5 minutes for TLH. The average time to discharge was 145.5 minutes for LSH and 168.2 minutes for TLH.

Of the 502 cases, there were 21 adverse events (18 requiring hospitalization), or 4.2% of the total. The rate of complications was far below the national average, Dr Rosenfield notes, with no mortalities and no long-term complications.

Since then, the number of cases has surpassed 750 at Pearl. “The protocol and technique are reproducible and scalable,” Dr Rosenfield says. Surgeons who add the procedure to their ASC practices will be able to take advantage of the expected increase in the insured population under the ACA, especially those who will become eligible for Medicaid.

Yet, he notes, only 1% of ASC cases nationally are gynecologic procedures.

Patient selection

Patricia Krajeck, MBA, BSN, RN, CNOR, is director of Pearl Surgi-Center. Successful ASC-based laparoscopic hysterectomy depends on surgical expertise and careful patient selection, she told OR Manager.

Specific to the specialty is consideration of whether the patient has had previous abdominal or laparoscopic surgery; various pathologies and comorbidities could exclude a patient from the ASC environment. When a patient’s body mass index (BMI) exceeds 34 kg/m², the anesthesiologist must be notified.

As with most other surgical procedures, patients are told to fast for 8 hours and to arrive 1 hour before the surgery.

In the 502 cases Dr Rosenfield tracked, average patient characteristics were as follows:

- age: 43.6 years (range, 19 to 64 years)
- BMI: 29.1 kg/m²
- uterine mass: 110.0 grams (range, < 90 grams to > 2,000 grams).

More than half of the patients, 298, had prior abdominal surgery. Of those, the average number of prior procedures per patient was 1.7.

Dr Rosenfield performs laparoscopic hysterectomies with trocars and high-resolution cameras. He uses five ports and two hands.

“The environment is one variable you can control (to avoid complications), and an ASC is less stressful if you are organized,” he says. However, expertise is important and there are greater risks than with most other ASC procedures. “You’re not likely to hit the vena cava in knee surgery,” Dr Rosenfield told ASCA attendees. “But with a hysterectomy, we’re into the peritoneal [cavity], so we have to face reality.”

Recovery following surgery

The Pearl recovery protocol consists of two phases. The first lasts for not less than 60 minutes, during which time the patient emerges from general anesthesia. Phase 2 begins when the patient meets discharge criteria. These criteria are based on guidelines of the American Society of Perianesthesia Nurses (ASPAN). They include tolerating fluids by mouth; being able to void, stand, and walk; and having nausea under control. Patients are discharged by wheelchair, Krajeck notes.

Patients go home with two prescriptions: Ondansetron for nausea and Norco (hydrocodone and acetaminophen) for pain.

They must have an escort and someone to stay with them for 24 hours. After that they can remove the Band-Aid covering the incision. They are encouraged to drink fluids with high sugar content, to relieve nausea, and to avoid spicy foods and alcohol. They are advised to use a stool softener. They are instructed not to have intercourse or place any object (such as a tampon) in the vagina and to lift nothing heavier than 20 pounds for 14 days.

The day after surgery, they are encouraged to move around to diminish the risk of blood clots, but to avoid strenuous activity, and they are told to take a week off from work. Finally, Krajeck adds, they are warned not to sign any documents or make major decisions during the first 24 hours following surgery because of remaining effects of the anesthesia.

Seeking early adopters

“Is GYN the new spine?” was the title of Dr Rosenfield’s ASCA presentation. With clinical, financial, and legal conditions paving the way for adoption, he and other proponents of laparoscopic hysterectomies are seeing a few remaining obstacles to widespread acceptance among ASC managers.

“The problem is, the typical ObGyn doctor does not have as high a volume of surgery as other specialties,” Dr Rosenfield explains. “Some need to develop expertise.” He conducts training programs in the technique for fellow gynecologists.

A study published in 2009 in the Review of Obstetric Gynecology found similar obstacles to acceptance. “Vaginal and laparoscopic hysterectomies have been clearly associated with decreased blood loss, shorter hospital stays, speedier return to normal activities, and fewer abdominal wall infections,” the researchers state in their report.

“The relatively slow adaptation of laparoscopic hysterectomy may in part be attributed to inadequate exposure and training during residency,” they add. “Relatively low reimbursement rates may also curb provider enthusiasm for additional training and incorporation of the laparoscopic hysterectomy into their surgical armamentarium,” they conclude.

According to Dr Rosenfield, rewards await those who meet the changing environment with new skills and new offerings. His mantra, whether addressing colleagues, Medicare officials, or the public, remains: “Outpatient laparoscopic hysterectomy is safe, feasible, and cost-effective when performed in the setting of a freestanding ambulatory surgical center with same-day discharge home.” ❖

—Paula DeJohn

References

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