GI Surgery for The Gynecologist

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Disclosure

- Consultant Medtronic
- Advisory board Trucllear Medtronic
Objectives

• Show dissection of the left sidewall natural adhesions.
• Review incidental appendectomy, Lysis of adhesions.
• Show repair of colostomy, enterotomy.

Lysis of adhesion

• When and why? Do we need to do it?
  – In our way of performing the assigned surgery
  – Patient with chronic pelvic and abdominal pain
    • S. Review for large number of articles including 3 RCT
    • Potentially effective

Lysis of adhesion

• Do it safe
  – Sharp dissection
  – Small bites, mm X mm technique
  – Gentle handling of the tissue
  – A-traumatic instruments

Natural left pelvic side wall adhesion
In our way

In our way/ Pelvic Pain
GI injury

• GI injury basically a hole that needs to be closed
• Know there is a hole
• Where the hole is
• Close it, easy!!
GI injury diagnosis

- Intra operative is a **KEY**
- Post operative
  - Significant morbidity and mortality from

Strategies for prevention and intra-operative diagnosis

- Anatomy!!
- **Safe entry** will drop the risk by > 50%
- **Sharp** dissection with dense adhesion using mm by mm technique, **gentle handling** of the bowel
- **Delineate** the rectum using rectal probe
- **Check:** Bubble test, run the bowl
Strategies for prevention and intra-operative diagnosis

• Small bowel:
  – Run the bowel/inspection

• Large bowel:
  – Inspect/ delineate
  – Bubble test
  – MB/Iodine test

Prevention: Avoid blunt dissection, awareness
Bowel Laceration Repair

- **Less than ½ the circumference**
  - Repair in 2 layer closure with imbricating layer perpendicular to the direction of the bowel, regardless of orientation of the laceration, Consider using delayed absorbable monofilament, delayed absorbable braided suture, barbed suture*

- **Greater than ½ the circumference**
  - General surgery consultation for resection/re-anastomosis
  - Never bad to call for help


Bowel Thermal Injury:

- **Burns**
  - Mark the area immediately!!
  - General surgery consultation
  - Never bad to call for help
Suturing perpendicular to the axis of the bowel

Intra-operative diagnosis

- Antibiotics, Flagyl with full thickness inj
- Rarely will need an ostomy or drain
- Patients do well
Laparoscopic GI surgery in gynecologic oncology

- Ileostomy/colostomy for advance cancer or fistula
  - Safe, effective, improved patient’s outcome.
  - S.S shorter OR time, LOS, less complication
- LAR
  - A. Rather, Cleveland clinic FL, SS02 colorectal session SAGES.
Why include appendectomy?

If treating pelvic pain with **endometriosis**:

- improves dysmenorrhea, non-menstrual pelvic pain, dyspareunia, dyschezia, quality of life.
  
  Roman JD. *JMIG* 2010

- 34.9%appy pathology: endometriosis 13%, peri-appendicitis/serositis in 16%, carcinoid tumor 3%.

  Wie, *Aust N Z Ob Gyn* 2008
Why include appendectomy?

If treating pelvic pain, without endometriosis:

- appendectomy reduces post-op pain.
  - Pandza H, Med Arh 2008
- When appendix appears normal, pathology in 9%, including 3 carcinoids.

Appendectomy

- 1959: Incidental in C Sections.
- 1962: Incidental in ectopic pregnancies.
- 1968: Essential for ovary cancer staging.
- 1977: Suggested prophylaxis in Gyn/Ob procedures. Waters O&G “an elective appendectomy should be performed with abdominal and pelvic surgery whenever the opportunity is presented”
- 1970: Laparoscopic “assisted” therapeutic appy.
- 1991: Laparoscopic incidental appy series of 100 cases. Nezhat, AJOG. “any risk associated with elective appendectomy as reported here is minimal and outweighed by the benefits of eliminating future emergency appendectomy, simplifying future differential diagnosis of pelvic pain and removing unsuspected abnormality found in the appendix.”
National estimated in-hospital appendicitis rate


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<tr>
<td>90-99</td>
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9% rise among all females
257 Incidental Appendectomies During Total Laparoscopic Hysterectomy

Katherine A. O’Hanlan, MD, Deidre T. Fisher, MD, Michael S. O’Holleran, MD

Conclusions: Incidental appendectomy during total laparoscopic hysterectomy is not associated with significant risk and can be routinely offered to patients planning elective gynecologic laparoscopic procedures, as is standard for open procedures.

O’Hanlan & O’Holleran, JSLS, 2007

821 TLH stratified by incidental appendectomy

• No increased complications.
• In cases with appendectomy, similar OT, EBL, LOS.
• Path: 5%. Includes 1% (3) carcinoids. (2 required ileoascending resection for nodes)
• Conclude: Safe - do it!

O’Hanlan et al, JMIG, 2007
Incidental appendectomy
O’Hanlan

• 2016; 1105 TLH with app compared to 821 TLH.
• 10% pathology in normal looking appendix
• No increase in complication

Laparoscopic Appendectomy

• Lift appendix, identify base and “window”.
• Incise through meso-appendix, with 1 cm mesentery, to window.
• Ligate base with Endoloop.
• Incise at 5mm, and deliver using a no-touch technique, using ring forcep on open appy tip through vagina, or 10-11 trochar, or pouch.
• If see enteric material, suction first, then irrigate.
Summary

• Lysis of adhesion only if in your way or the only finding with chronic pelvic pain
• GI injury IO recognition is the key
• Benefits of elective appendectomy in gyn surgery