



CENTER FOR WOMEN'S CARE AND REPRODUCTIVE SURGERY

Gynecologic Endoscopic Surgery

Texas Woman Picks Atlanta Surgeon for Hysterectomy

after what used to be considered major abdominal surgery.

Cheryl Rossi of El Paso, Texas, interviewed seven surgeons in four cities before deciding to have her hysterectomy performed by Tom Lyons, M.D., of the Center for Women's Care & Reproductive Surgery in Atlanta. Before flying to Georgia recently, the 46-year-old nurse anesthetist, Director of Obstetrical Anesthesia at Sierra Medical Center in El Paso, understood the medical system very well from the perspectives of both caregiver and patient.

In fact, only in June, 1994, she finished six months of grueling chemotherapy and thirty days of radiation therapy for a particularly virulent form of breast cancer. The treatments put her cancer into remission, but in the process caused her reproductive organs to atrophy. It was recommended that she have her uterus and ovaries removed.

As a very active runner, Ms. Rossi didn't want any potential complications associated with traditional abdominal hysterectomy--such as a long recuperative time of six to eight weeks after surgery. Nor was she interested in the possibility of vaginal adhesions or pelvic pain associated with a vaginal hysterectomy. She had heard of supracervical laparoscopic hysterectomy, which is performed through tiny incisions on the abdomen with a laparoscope, and has a recuperative time of less than ten days. But she searched in vain in her own city to find a surgeon skilled in the procedure.

"El Paso is still into frontier medicine," laughed Rossi the day before the procedure was performed at the Advanced Surgery Center of Georgia north of Atlanta. "No one in my city could do it, and as a medical professional, I know how to network." Her search took her to Dallas and San Francisco, which she strongly considered because she could have stayed with family while recuperating.

Friends in the medical profession recommended Dr. Tom Lyons, originator of the procedure, as the best.

And she also conferred with an R.N. who'd had the procedure performed by Dr. Lyons. "Being a nurse, I respect another one's opinion. Nurses are in the trenches and they know what's going on; and they know how much a doctor cares about his patients."

According to Rossi, Dr. Lyons was the only physician she spoke with who gave her the option of removing her cervix or not. "There is no known link between breast cancer and cervical cancer, and with all the functions that the cervix performs, such as support of the bladder, sexual feeling and vaginal lubrication, I decided that it was important to keep it in place. I was surprised that no other doctors brought it up as an option. This underscores the fact that women MUST be extremely well-educated or they'll get something they may not have bargained for." She emphasized that she learned during cancer treatments that many health changes aren't revealed until after they happen, often to the patient's unpleasant surprise.

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Not only did she like the fact that Dr. Lyons gave her power and choices, she also liked the speed with which he would perform the procedure--in 45 minutes to one hour--because the less time one spends under anesthesia, the better. And since the surgery was performed in an outpatient surgery operating room instead of a hospital, the chances of her catching a disease from hospital germs were virtually non-existent.

"In El Paso it was their way or the highway," said Rossi. "Dr. Lyons asked me about my ultimate goal and gave me a way to achieve it." She had decided to take estrogen and he told her she could go on it immediately for its positive effects--decreased osteoporosis and decreased risk of cardiovascular problems associated with menopause.

Her outpatient surgery was performed on Monday and she stayed at the Advanced Surgery Center of Georgia as a 23 hour patient. Wednesday morning, two days after the procedure, she flew back to Texas unassisted. Feeling fine, she resumed work on the Monday only two weeks

The most common reason for a woman in her reproductive years to see the gynecologist is because of abnormal vaginal bleeding. Most often, this problem is caused by one of two abnormalities, either altered hormonal function or a "mechanical disorder". By a mechanical disorder, we mean some problem such as a fibroid or a polyp in the lining of the uterus, which could cause the bleeding to occur. Hormonal Irregularities can be caused by a myriad of problems but regulation medically is usually successful.

After the diagnosis has been made, by sampling the uterine lining and looking into the uterine cavity with a telescope (hysteroscopy), the patient can choose a number of potential therapies depending upon the diagnosis. If there is no overgrowth of the lining (hyperplasia) and no evidence of large fibroids in the uterus causing the bleeding, then one method of treatment may be endometrial ablation. Of course medical treatment should first be tried but if these efforts fail to correct the problem and if pain is not a significant part of the patients symptoms then ablation can be performed.

Endometrial ablation is a simple procedure in which the uterine lining (endometrium, not to be confused with endometriosis) is removed either with the laser or electrosurgery while looking through the hysteroscope. The procedure can be performed under local anesthesia if the patient wishes or general anesthesia is available if so desired. The recovery is very rapid and most patients are able to leave the surgery facility in a few hours and are able to return to normal activity by the following day. There is frequently a vaginal discharge for several days but significant problems with recovery such as pain, infection, or bleeding are rare. Today, because endometrial ablation seems to be a very safe procedure, the procedure is beginning to be performed in the physicians' office with new types of devices made especially for this purpose. Cryotherapy (freezing) has now been used in this area to successfully ablate the uterine lining.

It's important to realize that these procedures are not guaranteed to produce amenorrhea (cessation of menses). Most studies including our own have shown that the rate of absolute stoppage is 50%, while another 25% have very little bleeding, and 90% of the individuals are pleased with the result. Failures of the procedure have been ascribed to adenomyosis in most cases and patients with significant pain should be counseled against ablation.

Endometrial ablation gives today's women another alternative to hysterectomy when abnormal bleeding occurs and is persistent despite other treatments. This is a minimally invasive option, which spares the patients anatomy, allowing acceptable results and rapid recovery. If you have questions about abnormal bleeding, endometrial ablation, or other solutions call the Endometriosis Care Center or the Center for Women's Care & Reproductive Surgery.

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