

## OPERATIVE HYSTEROSCOPY

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Operative hysteroscopy is both a new and an old surgical method. The first attempts took place more than one hundred years ago, but it was effectively introduced into gynaecological practice about ten years ago.

In order to do an operative hysteroscopy, one needs a telescope with a surgical sheath, forceps and a liquid medium for the distension of the uterine cavity. As far as laparoscopic surveillance is concerned, whereas five years ago our clinic performed many laparoscopies, it is used at present only in very difficult situations.

Initially, an operative hysteroscope and semirigid forceps were adopted, but with the introduction of the resectoscope (Ø27 F) other instruments are no longer necessary.

The resectoscope of urologic derivation has two channels for the ways in and out of the fluid and a movement for the use of electrodes.

The Hamou electronic pump allows perfect distension of the uterine cavity, with little or no passage of fluid through the tubes. In addition, it is useful to observe the procedures through a TV monitor, and keep a recording for teaching purposes.

There are at present many indications for operative hysteroscopy: resection of intrauterine adhesions, removal of endometrial polyps and submucous myoma, treatment of the septate uterus, endometrial ablation, the lost IUD, and tubal contraception or cannulation.

*Intrauterine adhesions* are fairly common disorders of the endometrium, especially in countries where abortion is legal. Three kinds of adhesions can be identified, depending on when they have formed: endometrial adhesions are more recently-formed and poorly vascularised, and easily dissectable without anesthesia. The other two kinds, muscular and fibrous-connective respectively, require anesthesia, cervical dilatation and sometimes simultaneous laparoscopy to avoid uterine perforation. Our experience with hysteroscopy in 171 patients with adhesions after endoscopic surgical treatment, has given very good results in terms of normal menstruations, conceptions and term pregnancy rate.

*Submucous myoma* are a frequent cause of abnormal uterine bleeding (AUB). Diagnosis with hysteroscopy is very easy; at present we use the resectoscope to slice the surface of the myoma down to the uterine wall. If the myoma is found to be very large, medical treatment with analogues is advisable before surgery, in order to reduce the mass. In cases of intramural myoma, the protruding part is resected, and then, a few weeks later, the procedure is repeated, this time successfully, since the intramural part will have protruded spontaneously into the cavity. In practice, therefore, hysteroscopic resection of submucous intramural myomas can almost completely replace traditional transabdominal surgery.

*Uterine septum* is a malformation disorder of mullerian ducts responsible for many cases of spontaneous abortion. A resectoscope used with fluid dilatation of the uterine cavity allows the septum to be cut back to the level of the utero-tubal orifices. Results after hysteroscopic metroplasty with resectoscope are better than with traditional surgery, with regard to rates of pregnancy, abortion and ectopic pregnancy. In our hospital, hysteroscopic metroplasty has replaced traditional surgery in all cases of uterine septum: the procedure is performed in the day-hospital, there are no subsequent scars on the uterine wall and conception may be attempted after the first follow-up (one month later).

*Endometrial ablation* consists of resecting the endometrium, including the basal layer (more or less 3 mm. in depth) in order to obtain an ipo/amenorrea in the patients: it is principally indicated in cases of AUB resistant to therapy with drugs, or where such

therapy is contra-indicated for problems with metabolism. Another more recent indication for endometrial ablation is endometrial hyperplasia in the perimenopausal age, without cellular atypias. Presurgical assessment must include diagnostic hysteroscopy and an endometrial biopsy, in order to check for malignancies. Many techniques can be used to perform endometrial ablation. We prefer the resectoscope, because of its low cost, the speed of the procedure, and the fact that it permits the histological examination of samples in every patient.

Effective endometrial ablation requires the complete destruction of the endometrium with the preservation of the isthmic area, where there is non-functional endometrium which can recolonize the entire cavity in 1 or 2 months without a real functional response; this type of endometrium prevents the formation of adhesions. Possible complications of the procedure are intra or post-operative bleeding, uterine perforation and intracavitary adhesions; in practice, the incidence of such complications has been extremely low. To sum up, endometrial ablation is a valid alternative to hysterectomy in many cases of AUF in perimenopausal women.

In conclusion, hysteroscopic surgery offers many advantages: short hospitalisation, rapid recovery, low costs, less discomfort for the patients and very often better results than traditional abdominal surgery (<sup>1, 2, 3</sup>).

The authors would like to stress that a good training in diagnostic hysteroscopy and general surgery are essential for anyone wishing to perform operative hysteroscopy.

## REFERENCES

- 1) Hamou J.E., Mencaglia L., Perino A., Gilardi G.: "L'elettroresezione en hysteroscopie et microcolpohysteroscopie operative". In: 'Isteroscopia operativa e laser chirurgia in ginecologia'. Cittadini E., Scarselli G., Mencaglia L., Perino A., Roma, CIC Edizioni Internazionali Publisher, 1988, p. 31.
- 2) Baggish M.S., Barbot J., Valle R.F.: "Diagnostic and operative hysteroscopy". A Text and Atlas, Year Book Medical Publishers, Inc., 1989.
- 3) Siegler A.M., Valle R.F., Lindemann H.J., Mencaglia L.: "Therapeutic Hysteroscopy Indications and Techniques Mosby Company. St. Louis, 1990.

## MICROCARCINOMA OF THE CERVIX: DIAGNOSIS AND TREATMENT

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Over the years microinvasive carcinoma of the cervix has been regarded by pathologists and clinicians under many headings and no unanimously accepted definition exists to date. This lack of uniformity in the classification accounts for the still debated problem of therapeutic approach in the microinvasive lesions.

Since 1960 the FIGO Committee has changed more than once its criteria to define Stage IA carcinoma achieving in 1985 the ultimate definition that adopts the subdivision into Stage IA1 and Stage IA2. However, the validity of such a staging classification does not meet a unanimous consensus since it appears not precise enough to guide the clinician in the treatment of earliest forms of invasive cancer. Conversely, some investigators accept as more or less workable the definition proposed by the Society of Gynecologic Oncologists (SGO). These confounding problems leave some concerning questions unsolved: what constitutes the onset of invasion and determines the metastatic potential; which is the significance of histomorphologic variables and how they can influence the outcome of therapy.