Hysteroscopic Resection of Myomas

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By Paul D. Indman, MD

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Paul Indman, MD: “This is Dr. Paul Indman from the 3rd Mexican Congress of Gynecologic Endoscopy in Puerto Vallarta, and I’m very pleased to have with me Dr. Kees Wamsteker from the Netherlands. Dr. Wamsteker is well known for his system of classifying myomas. Kees, could you please tell us how this classification works?”

Kees Wamsteker, MD: “Yes, thank you very much Paul; it’s my pleasure to do this interview. First of all, I would like to make it clear that the classification of submucous myomas is very important for the hysteroscopic treatment of submucous myomas. I think submucous myomas are much more frequent than people generally think they are because quite often they have complaints and remain unnoticed, and one of the most important things is to find submucous myomas in patients that generally have significant menstrual bleeding, heavy bleeding, and can also have infertility. The hysteroscopic endoscopic treatment is one of the most successful treatments in the whole field of endoscopic surgery but one of the most important things is that you have to find out before doing the surgery which cases are suitable for endo-resection and which are not.”

Paul Indman, MD: “How do you decide which fibroid is suitable to be removed hysteroscopically?”

Kees Wamsteker, MD: “Yes, this is an important point - the submucous myoma can be either completely in the uterine cavity or it can be partially in the uterine wall in the myometrium which is called the intramural extension. If the myoma is completely in the uterine cavity it’s very easy to resect because you can get it completely out but the deeper it goes into the myometrium the more difficult it becomes to remove it and also the higher the risks are for the hysteroscopic resection. This is one of the reasons that classification is very important because you should not just jump into endo surgery without having exactly diagnosed the pathology and knowing that you really can remove this pathology. With the diagnostic hysteroscopy together with ultrasonography you can make out how far the myoma is extended in the myometrium and also the size of the myoma. You can then decide if this particular myoma is suitable for endo-resection and also related to your own experience.”

Paul Indman, MD: “Can you explain your classifications?”

Kees Wamsteker, MD: “Yes, the classification is made up very simply, maybe in the future we will extend this classification more but, basically, the classification is made up of three different classes. We have Type 0 and that is the submucous myoma without any intramural extensions so that’s the pedunculated myomas, which are completely inside the uterine cavity. Then we have Type I myomas, which have some intramural extension, but in any case, less than 50% of the myoma is located intramurally. Then we have Type II myomas which have either 50% or more intramural extension, and the deeper the myoma comes in the myometrium, the larger the vessels are, the higher the risk of intravasation, and the more difficult it is to remove the myoma. This is one of the important things to assess pre-operatively and not to find out during the operation because it may be possible that during the operation you will not be able to remove the myoma completely so the classification of the three different types is part of the pre-operative assessment which I think is absolutely mandatory for the treatment of submucous myomas.”

Paul Indman, MD: “So you wouldn’t be just happy doing a sonogram or a saline enhanced
sonogram, you feel that every patient should have a hysteroscopy before being brought to the operating room?”

**Kees Wamsteker, MD:** “Absolutely, I think specifically with intracavitary or partially intracavitary tumors it is absolutely necessary besides the ultrasonography or a saline infusion sonography to also have a hysteroscopy so you’ll know exactly the intrauterine architecture and you’ll know exactly what you will encounter during the surgery.”

**Paul Indman, MD:** “Very good; thank you very much. That’s Dr. Kees Wamsteker, and I’m Dr. Paul Indman from Puerto Vallarta.”

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