Office Laparoscopy & Pain Mapping

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Dr. Perry: "I'm Dr. Paul Perry, and we're at the Hartford Meeting of the International Pelvic Pain Society. We have with us one of our board members - Dr. David Olive. Dr. Olive is going to discuss with us the concept of office laparoscopy for the diagnosis of chronic pelvic pain and pain mapping. David, do just want to give us a little introduction of what you do, and who you are?"

Dr. Olive: "My name is Dave Olive, I'm the Director of Reproductive Endocrinology and Infertility, and Professor of Obstetrics and Gynecology at Yale University School of Medicine. One of the things that we do within our section is run a fairly large pelvic pain clinic."

Dr. Perry: "Dr. Olive has had a great deal of experience with laparoscopy under conscious sedation, and I'll ask him if would sort of relate where we are with that. There is a great deal of interest among gynecologists, especially those who do pain work, about the effectiveness of office laparoscopy and pain mapping. Would you just share with us your experience? We would appreciate that."

Dr. Olive: "We do have a long experience using office laparoscopy under local anesthesia and conscious sedation. It's the mechanism by which we can help determine what might be hurting the patient, and in fact, if it's a treatable disease by surgery vs. a treatable disease medically. We started out a long time ago, about four or five years ago, looking at the concept of local anesthesia and conscious sedation as a means of doing laparoscopy for a variety of different things. And while it's certainly possible to do a lot of things in the office or in other types of non-traditional settings with laparoscopy, the one thing that's unique to laparoscopy and conscious sedation is the ability to do pain mapping within the pelvis and the abdomen. It gives us an opportunity not simply to palpate the abdomen externally or to do a pelvic examination to try to determine where the pain might be, but actually to have if you would, a hands-on-approach to the pelvic organs, and the inner lining of the abdomen and pelvis in determining exactly what might be hurting, as well as what pathology might seem to exist."

Dr. Perry: "What about the common questions regarding the safety and the cost of office laparoscopy, Dr. Olive? What would you have to say about that?"

Dr. Olive: "We've looked at both of those issues, and there is no question that it's cheaper to do a laparoscopy in an office or other non-traditional settings than it is in a hospital. Your costs as well as your charges will probably be decreased, and that's an advantage both for the physician and for the patient, as well as the payer. In terms of safety, office laparoscopy or at least laparoscopy in non-traditional settings has been around for a long time. There have been probably as many procedures done in non-traditional settings under local anesthesia and conscious sedation, as there have been with general anesthesia. While it's not the norm in the United States - worldwide it's a very, very common phenomena. If you look at the complication profile and rates for procedures done outside of the traditional operating room, you'll find that they are no higher, and in fact frequently are lower than those done within the hospital setting, probably a reflection of the ability to screen appropriately for patients. What we believe is if you can screen properly for your patients, and if you have skill and understanding of the potential complications that can occur - you can take measures to avoid those complications, and it can be an extremely safe procedure."

Dr. Perry: "David, we've done about 150 office laparoscopies at our pelvic pain center and have had only three complications, and those three were just the inability to get into the abdomen. What is your complication rate, and what type of complications have you seen?"

Dr. Olive: "We had about a 92% satisfaction rate among the physicians in terms of getting the information that they want to get from the procedure itself. The patients are satisfied with the procedure 96% of the time. Of those few times where patients or a physician are not satisfied, generally it's from an inability to get the information that we have intended to get at the onset of the procedure. In terms of actual surgical complications - they're very rare. I think again because we screen our patients quite well. We've had one patient in whom we got into the small bowel with office laparoscopy. That was a patient that we knew was high-risk going in; she understood the risks and consented - actually preferred - to attempt it anyway. Getting into the small bowel with a 2 mm instrument is obviously less traumatic than with larger instruments, and I think we probably would have done it anyway had we done the procedure in the operating room. Other than that, our main complications have been shoulder pain in about 3% of the patients following the procedure. We've had one patient who had intractable pain at one of the sites of the trocars that lasted overnight. Other than that, we've had no real complications whatsoever."

Dr. Perry: "We owe a great gratitude to you and your group to give us the numbers. I appreciate the fact that you are following these patients and giving us updates so frequently. But what do you see the role of office laparoscopy under conscious sedation being, let's say, five years from now?"

Dr. Olive: "I think one of the things that we need to learn is what the capabilities of this procedure happen to be. When we started out it was a purely diagnostic procedure. We thought we could look, we could find things, and then if there was something out of the norm - then we could go in the operating room. Very quickly we understood there were some minor surgical procedures that we could do with not much advancement in the instrumentation. Furthermore, we developed the concept of conscious pain mapping, which I think has helped us a great deal in terms of dealing with pelvic pain. I think in reality, the sky's going to be the limit as we develop more and more instrumentation that works easily and works well as a small diameter instrument as we make these inexpensive enough to fit into a doctor's office or to a step-down unit in an ambulatory surgery center. As more people do the procedure, get comfortable with the procedure, and start to apply their brains to the creative aspects of what can be done with this procedure, what we'll find is there are a lot of things that I haven't been clever enough to think of that will eventually become the norm."

Dr. Perry: "Dr. Olive, we thank you and our patients thank you for the work that you've done. We really appreciate your being with us on OBGYN.net - thank you."

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