Cystoscopy Should Be a Routine Procedure in the Performance of Hysterectomy

I have been involved in the teaching of residents in obstetrics and gynecology since 1976 and fellows in female pelvic medicine and reconstructive surgery since 1995. I truly believe I could teach a monkey to perform a hysterectomy if it were not for the course of the ureter and the attachment of the bladder to the cervix. Gerald Jordan, M.D., current vice president of the American Board of Urology, told me in the early 1980s that there were 3 gynecologic operations: burn the right ureter, burn the left ureter and burn both ureters! And this was prior to the explosion of laparoscopic procedures enabled by various methods of thermal energy.

In 1999, after a couple of reconstructive procedures were frustrated by a lack of flow from a ureteral orifice with a subsequent finding of a nonfunctioning kidney after a hysterectomy some 20 years previous, it became obvious that we did not know the true incidence of urinary tract injury. After a painful process with the Institutional Review Board of Louisiana State University Health Sciences Center and physicians on our staff, we began a study on universal cystoscopy in August 2000, ending in 2008. During the period of the study only 1 injury was missed, which was a vesicovaginal fistula developing several weeks after a “normal” cystoscopy. With a 1.8% ureteral injury rate and another 2.9% bladder injury rate, the study by Visco et al would suggest that it is cost effective to perform this procedure, and this doesn’t even consider the cost of a lawsuit from an injury.

Cystoscopy adds very little operating room time to the procedure. We routinely have all hysterectomy patients in Allen-type stirrups (Allen Medical Systems, Acton, Massachusetts), which make it easy to efficiently perform cystoscopy after the hysterectomy. After our study completion, one staff tried to just frog-leg the patients on a regular operating room table and missed a ureteral injury because of the inability to properly perform cystoscopy with a rigid scope. More important, we document that all our residents are trained in diagnostic cystoscopy on completion of their residency, which helps them obtain cystoscopy privileges. We do not teach them to biopsy any lesions seen, and only our fellows are trained in the placement of ureteral catheters.

Nosti and colleagues have shown in their paper that in spite of training in cystoscopy by 88% of the residents from their area, only 12% actually did universal cystoscopy after hysterectomy, while 68% reported having cystoscopy privileges. A significant limitation of the study was a 35% response rate. I suspect that with a higher response rate, the 12% rate might be a high estimate. When asked, respondents indicated that they performed cystoscopy only if they suspected problems. Why these low rates of cystoscopy in a group that will probably have the highest injury rate because of a lack of experience? Did older physicians in their practice group influence them? Was the low response rate because they were ashamed about their practice pattern? Is this a generational problem in our young physicians we are training?

As expressed by Dr. Brubaker in her editorial on our paper, it is really a safety issue for our patients. In our combined Urology/Gynecology Female Pelvic Medicine and Reconstructive Surgery fellowship program, we are seeing a large number of injuries in these days of “minimally invasive” surgery, and it is much easier to approach these at the time of the initial surgery than later when the patients are not as accepting of complications that could have been corrected earlier. Some of these injuries are also by older physicians adapting to the new minimally invasive surgeries. Most of these complications can be corrected at the time of the initial surgery, such as placing a stent in a damaged ureter or prolonged drainage after incidental cystostomy. Early correction will probably reduce the incidence of lawsuits because of the participation of the surgeon in the repair of the complication.

I believe it is time for the American College of Obstetricians and Gynecologists (ACOG) to change their politically correct ACOG Committee Opinion to suggest that hysterectomy is a high-risk procedure for urinary tract injury, as most physicians performing prolapse surgery already know (or should know) to perform cystoscopy after these operations.
surgeries. Their reluctance to suggest this is certainly because of malpractice lawsuit concerns. The safety of our patients is most important, like using the time out procedures in the operating rooms. Cystoscopy after hysterectomy and any other procedure that can cause ureteral injury, e.g., laparoscopic dissection of an ovary off the pelvic sidewall, should be followed by diagnostic cystoscopy. Failure in the future to do so will result in increasing lawsuits. It is all about patient safety.

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Financial Disclosure: The author has no connection to any companies or products mentioned in this editorial.

Keywords: cystoscopy; hysterectomy; surgical procedures, cystoscopic; urinary tract. (J Reprod Med 2011;56:371–372)