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Change in Surgical Gynecology - Sense and Sense and Nonsense

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The changes in operative gynecology in the last decades are dramatic in terms of changing strategies from ultraradical techniques like exenterations (Brunschwig, Rutledge) to minimally invasive techniques endoscopic or robotic, but also the level of training in terms of anatomical and surgical skills, which are significantly influenced by medico-legal aspects, legal regulations by a European working time law, thus a significant reduction of personal expertise and a changing attitude towards life goals. Predominantly external circumstances have led to an aggravation of surgical training [1].

The economic pressure on clinics and physicians, the conflicts of interest of a financial, personal, academic, and institutional nature initially had stimulating properties, but are now regionally rather paralyzing for constructive further development. Due to complete transparency, there is often more paramedical influence from politics and the media, not least due to patient interest. Together with the increasing digitalization of everyday life and the demands on quality of life, interest in surgical activity and the psycho-physically stressful acquisition of surgical expertise is dwindling.

Gynecological Oncology

The era of ultraradical surgery for all tumor stages, which was characterized by high morbidity and mortality, was followed by the stage-adapted combined surgical and radio-chemotherapeutic strategy with significant reduction of secondary complications for patients. In breast carcinoma, the change from mutilating Rotter-Halsted to breast-conserving surgery under plastic-cosmetic aspects to the abandonment of axillary lymphonodectomy is clear.

The current guideline for the therapy of malignant ovarian tumors describes the surgical balancing act and the high demands on the treating physician. On the one hand, "early" ovarian cancer (FIGO stages I to IIA) should receive comprehensive staging, since the detection of further tumor manifestations may result in upstaging and thus, in addition to the need for complete tumor resection, changes in subsequent systemic therapy. Ultimately, definitive treatment can only be provided by a gynecologic oncologist.

On the other hand, the goal of primary surgery for advanced ovarian cancer is macroscopically complete resection. Overall patient survival is currently being evaluated in the international randomized AGO LION trial (http://clinicaltrials.gov/ct2/show/NCT00712218). Initial results of this trial were presented as a congress paper [3]. Here, no survival benefit was observed for systematic retroperitoneal lymphonodectomy of macroscopically inconspicuous lymph nodes in patients with peritoneal metastatic ovarian cancer and complete intra-abdominal resection. To achieve this strategy, great surgical experience is needed and it is probably not enough for a gynecologist and a surgeon to operate, there should be a specialization in the field of gynecological oncology or special oncologic visceral surgery [7].

The "second-look surgery" that used to be popular in many hospitals, performed after primary surgery and postoperative chemotherapy in the absence of evidence of residual tumor by noninvasive procedures, has not been shown in any study to improve prognosis for resections then performed. Even if the detection or absence of tumor during second-look surgery allows eventual conclusions about prognosis, this has no therapeutic consequence; therefore, there is no indication for second-look surgery [3].

In all oncological surgery, a balance should be maintained between reasonable radicality and the possible complications (as, for example, also in patients with deep infiltrating endometriosis) [8]. Despite high technical standards of surgery, complications are possible. Even the shift to laparoscopic techniques has not led to a decrease in complication rates, e.g., for bowel resections. Ultra-deep anastomoses are particularly at risk.

Pelvic floor surgery

The development of the tension-free polypropylene tape (TVT) by Ulmsten and Petros (1995) resulted in an epoch of explosive development of new surgical techniques for pelvic floor reconstruction, dozens of modifications and modifiers. In this period of euphoria, in which all traditional surgical techniques were thrown overboard, a new era of critical realism has now arrived. After many new, unforeseen, and even unknown complications became known, a restraint set in in many countries, which often had more of a paramedical basis, in that medico-legal disputes with, in part, previously unimaginable compensation sums caused manufacturers to withdraw their products from the market, or politicians believed they had to intervene in a regulatory way by banning products. We know the same, almost hysterical reaction in the lay press from the silicone breast prostheses, the morcellators, the "Robodoc" hip prostheses. The extent to which the press, radio and television are now changing indications can be seen in England, where after several prime-time BBC broadcasts, tension-free tapes are being rejected by patients, although the international professional societies in urology and gynecology have unanimously declared them to be the standard for treating female and male stress incontinence [2]. In addition, the production of many of the materials is abandoned. Nevertheless, in the OECD countries the Eisantzn of still to receive nets is handled quite differently,

With increasing criticism of the approval of new products in the U.S.A. without any prior review using the "equivalence assessment", i.e. for new medical devices only a FDA 510(k) application had to be submitted as a "premarket notification" indicating the comparability of the product with

already approved products. While some countries (France, Germany) refer to their "good experience" and continue to implant alloplastic tapes and meshes, these products are politically "banned" in England, Scotland, Australia, New Zealand, and in others (the Netherlands) they are only approved under considerable conditions with regular audits in certified facilities. Compared to the considerably more complex
Sacropexies, further improvements of the materials have to be awaited. Vaginal mesh surgery is still in its infancy, with new products being tested in multicenter trials, such as degradable estradiol-coated mesh [9]

Hysterectomy

The number of hysterectomies has been declining in Germany for years with an increase in organ-preserving techniques and conservative treatment options. Under (justified) pressure from patients, the automatism of descensus/urinary incontinence-first hysterectomy or pelvic pain-hysterectomy has given way to an individualized approach and has led to a 28.5% reduction in hysterectomies [6]. This is true for both abdominal, and vaginal procedures. The decrease in vaginal hysterectomy is in contrast to the guidelines of all countries after vaginal access has the first preference. In Canada and the US, > 50% of hysterectomies are still abdominal surgeries (in some cases just coded differently). There are no reliable arguments for supracervical amputation, which was already practiced by our surgical grandfathers to reduce the rate of bleeding from the a.uterina and ureteral injuries, and which is propagated again and again today for various mainly paramedical reasons.
The fact is that vaginal hysterectomy is the gentlest uterine technique. This is also described in all international guidelines. In Germany, vaginal hysterectomy has decreased by almost 10,000 cases in favor of endoscopic techniques. This trend is incomprehensible in itself, since the effort, scarring and financing are per se a contradiction to the vaginal method.

Summary

The general conditions and the increasing economic pressure have completely changed the daily operative routine in gynecology:
Changed working hours (due to European working time law), but also increasing part-time positions and other working time models with demographic change in our specialty. Specialization of facilities and change in operative competencies. Significant decrease in absolute case numbers due to stricter indications and conservative treatment strategies. More critical attitude of patients, second opinions. Lack of qualified instructors in the field of operative gynecology. Lack of junior staff and less interest among residents in surgical activities. Massive economic pressure, up to OTA (surgical technical assistant), which further restricts the possibility of training. Specialty society and sub-disciplines must develop concrete training plans and new concepts (phantom courses, computer models, video demonstrations), facilitate and promote interdisciplinary exchange with other institutions to make surgical work in gynecology attractive again. Residency training should be further streamlined to include colleagues aiming for surgical work earlier and to make the few remaining surgical procedures available for training while respecting the required "specialist standard".

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