2010 Procedures Adult Criteria

Hysterectomy, Laparoscopically Assisted Vaginal (LAVH), +/- BSO (Custom) - UDOH[1, 2, 3, 4]

Created based on InterQual Subset: Hysterectomy, Laparoscopically Assisted Vaginal (LAVH), +/- BSO
Version: InterQual® 2009

CLIENT:	Name	D.O.B.	ID#	GROUP#
CPT/ICD9:	Code	Facility	Service Date	
PROVIDER:	Name		ID#	Phone#
	Signature		Date	

ICD-9-CM: 65.61, 68.51

INDICATIONS (choose one and see below)

- ☐ 100 Endocervical adenocarcinoma in situ by Bx
- ☐ 200 CIN III
- ☐ 300 Adenomatous endometrial hyperplasia with cellular atypia by Bx/D & C
- ☐ 400 Fibroids in premenopausal woman
- ☐ 500 Fibroids in postmenopausal woman
- ☐ 600 DUB in premenopausal woman
- ☐ 700 Postmenopausal bleeding
- ☐ 800 Uterine prolapse
- ☐ 900 Chronic PID
- ☐ 1000 Endometriosis
- ☐ 1100 Suspected adenomyosis
- ☐ 1200 Chronic abdominal/pelvic pain, unknown etiology
- ☐ Indication Not Listed (Provide clinical justification below)

☐ 100 Endocervical adenocarcinoma in situ by Bx **[One]**[5*RIN, 6]
- ☐ 110 Completed hysterectomy acknowledgement form

☐ 200 CIN III **[All]**[5*RIN, 7]
- ☐ 210 Diagnosed by Bx **[One]**
  - ☐ 211 Colposcopic Bx
  - ☐ 212 Cone Bx
- ☐ 220 Prior conservative surgery **[One]**
  - ☐ 221 Laser conization
  - ☐ 222 LEEP/LLETZ/LOOP

- ☐ 223 Cold knife conization
- ☐ 230 Continued CIN III by ECC/Bx ≥ 8 wks post conservative surgery[8]
- ☐ 240 Completed hysterectomy acknowledgement form

☐ 300 Adenomatous endometrial hyperplasia with cellular atypia by Bx/D & C **[One]**[9]
- ☐ 310 Future childbearing desired **[Both]**
  - ☐ 311 Progestin Rx ≥ 8 wks
  - ☐ 312 Hyperplasia with cellular atypia confirmed by repeat Bx/D & C after Rx
- ☐ 320 No future childbearing desired
- ☐ 330 Postmenopausal woman and BSO planned(10*MDR)
- ☐ 340 Completed hysterectomy acknowledgement form

☐ 400 Fibroids in premenopausal woman **[All]**[11]
- ☐ 410 Diagnosed by US[12]
- ☐ 420 Uterus ≤ 14 wks size by PE[13, 14, 15]
- ☐ 430 Findings **[One]**
  - ☐ 431 Abnormal bleeding **[Both]**[16, 17, 18]
    - ☐ -1 Vagina and cervix normal by PE
    - ☐ -2 Continued abnormal bleeding **[One]**
      - ☐ A) Interferes with ADLs[19]
      - ☐ B) Hct < 27%(0.27) / Hb < 9.0 g/dL(90 g/L) unresponsive to iron Rx > 12 wks[20]
  - ☐ 432 Uterine size doubled by US w/in 1 yr[21]
  - ☐ 433 Ureteral compression by US/IVP
  - ☐ 434 Other associated symptoms **[One]**(22*MDR)
    - ☐ -1 Pelvic/abdominal pain/discomfort w/o other explanation
    - ☐ -2 Urinary frequency/urgency w/o evidence of infection
    - ☐ -3 Dyspareunia[23]
- ☐ 440 PAP smear normal w/in last yr[24]
- ☐ 450 Pregnancy excluded **[One]**[25]
  - ☐ 451 HCG negative[26]
  - ☐ 452 Sterilization by Hx[27]
  - ☐ 453 Patient not sexually active by Hx[28]
- ☐ 460 Completed hysterectomy acknowledgement form

☐ 500 Fibroids in postmenopausal woman **[All]**(29*RIN)
- ☐ 510 BSO planned(10*MDR)
- ☐ 520 Diagnosed by US[12]
- ☐ 530 Uterus ≤ 14 wks size by PE[13, 14]
- ☐ 540 Findings **[One]**

- ☐ 541 Uterine size doubled by US w/in 1 yr[21]
- ☐ 542 Ureteral compression by US/IVP
- ☐ 543 Other associated symptoms **[One]**(22*MDR)
  - ☐ -1 Pelvic/abdominal pain/discomfort w/o other explanation
  - ☐ -2 Urinary frequency/urgency w/o evidence of infection
  - ☐ -3 Dyspareunia[23]
- ☐ 550 PAP smear normal w/in last yr[24]
- ☐ 560 Completed hysterectomy acknowledgement form

☐ 600 DUB in premenopausal woman **[All]**[30, 31]
- ☐ 610 Abnormal bleeding > 3 cycles[16, 17]
- ☐ 620 Vagina and cervix normal by PE
- ☐ 630 Thyroid disease excluded by Hx/PE/testing[32]
- ☐ 640 Pregnancy excluded **[One]**[25]
  - ☐ 641 HCG negative[26]
  - ☐ 642 Sterilization by Hx[27]
  - ☐ 643 Patient not sexually active by Hx[28]
- ☐ 650 PAP smear normal w/in last yr[24]
- ☐ 660 Sonohysterogram/US negative for endometrial lesion[33, 34]
- ☐ 670 Continued bleeding **after** Rx **[One]**[35]
  - ☐ 671 Age < 35 **[Both]**
    - ☐ -1 Progestin/OCP x3 consecutive cycles
    - ☐ -2 Findings **[One]**
      - ☐ A) Interferes with ADLs[19]
      - ☐ B) Hct < 27%(0.27) / Hb < 9.0 g/dL(90 g/L) unresponsive to iron Rx > 12 wks[20]
  - ☐ 672 Age ≥ 35 **[All]**[36]
    - ☐ -1 Endometrium normal w/in last yr **[One]**
      - ☐ A) By endometrial Bx
      - ☐ B) By hysteroscopy with D & C
    - ☐ -2 Progestin/OCP x3 consecutive cycles
    - ☐ -3 Findings **[One]**
      - ☐ A) Interferes with ADLs[19]
      - ☐ B) Hct < 27%(0.27) / Hb < 9.0 g/dL(90 g/L) unresponsive to iron Rx > 12 wks[20]
- ☐ 680 Completed hysterectomy acknowledgement form

☐ 700 Postmenopausal bleeding **[All]**[37]
- ☐ 710 BSO planned(10*MDR)
- ☐ 720 Vagina and cervix normal by PE
- ☐ 730 HRT **[One]**

- ☐ 731 Continued abnormal bleeding after change in/discontinuation of HRT[38]
- ☐ 732 HRT contraindicated/refused[39]

☐ 740 Endometrium normal w/in last 4 to 6 mos **[One]**

- ☐ 741 By hysteroscopy with D & C
- ☐ 742 By endometrial Bx and transvaginal US

☐ 750 PAP smear normal w/in last yr[24]

☐ 760 Completed hysterectomy acknowledgement form

☐ 800 Uterine prolapse **[All]**[40*RIN]

☐ 810 Sx/findings **[One]**

- ☐ 811 Pelvic pressure by Hx
- ☐ 812 Pelvic pain by Hx
- ☐ 813 Stress incontinence by Hx
- ☐ 814 Ulceration with bleeding/spotting by PE
- ☐ 815 Vaginal splinting[41]

☐ 820 Uterine prolapse by PE **[One]**[42]

- ☐ 821 Second degree[43]
- ☐ 822 Third degree[44]

☐ 830 PAP smear normal w/in last yr[24]

☐ 840 Completed hysterectomy acknowledgement form

☐ 900 Chronic PID **[All]**[45, 46]

☐ 910 Pelvic pain ≥ 6 mos

☐ 920 Acute PID ≥ 2 episodes by Hx & PE

☐ 930 Infection documented ≥ 1 episode by positive culture

☐ 940 Adhesions/scarring/hydrosalpinx by laparoscopy[47]

☐ 950 PAP smear normal w/in last yr[24]

☐ 960 HCG negative[26]

☐ 970 No future childbearing desired

☐ 980 Completed hysterectomy acknowledgement form

☐ 1000 Endometriosis **[All]**[48, 49]

☐ 1010 BSO planned[50*MDR]

☐ 1020 Diagnosed by previous laparoscopy[51, 52]

☐ 1030 Continued symptoms **after** Rx **[One]**[53*MDR, 54, 55]

- ☐ 1031 Future childbearing desired **[Both]**
  - ☐ -1 Medical management **[One]**
    - ☐ A) GnRH agonist ≥ 8 wks[56]
    - ☐ B) Depot medroxyprogesterone/OCP ≥ 8 wks

- ☐ C) Danazol ≥ 8 wks
- ☐ -2 Surgical ablation/excision of endometrial tissue[57]
- ☐ 1032 No future childbearing desired **[One]**[58*MDR]
  - ☐ -1 GnRH agonist ≥ 8 wks[56]
  - ☐ -2 Depot medroxyprogesterone/OCP ≥ 8 wks
  - ☐ -3 Danazol ≥ 8 wks
- ☐ 1040 PAP smear normal w/in last yr[24]
- ☐ 1050 Pregnancy excluded **[One]**[25]
  - ☐ 1051 HCG negative[26]
  - ☐ 1052 Sterilization by Hx[27]
  - ☐ 1053 Patient not sexually active by Hx[28]
- ☐ 1060 Completed hysterectomy acknowledgement form

☐ 1100 Suspected adenomyosis **[All]**[59, 60, 61]
- ☐ 1110 Sx/findings **[One]**[62]
  - ☐ 1111 Pelvic pain[63]
  - ☐ 1112 Abnormal bleeding **[Both]**[16, 64]
    - ☐ -1 Vagina and cervix normal by PE
    - ☐ -2 Continued abnormal bleeding **[One]**
      - ☐ A) Interferes with ADLs[19]
      - ☐ B) Hct < 27%(0.27) / Hb < 9.0 g/dL(90 g/L) unresponsive to iron Rx > 12 wks[20]
  - ☐ 1113 Ureteral compression by US/IVP
  - ☐ 1114 Other associated symptoms **[One]**[22*MDR]
    - ☐ -1 Pelvic/abdominal pain/discomfort w/o other explanation
    - ☐ -2 Urinary frequency/urgency w/o evidence of infection
    - ☐ -3 Dyspareunia[23]
- ☐ 1120 MRI/US suggestive of adenomyosis[65]
- ☐ 1130 Continued Sx/findings **after** Rx **[One]**[66]
  - ☐ 1131 NSAIDs ≥ 8 wks
  - ☐ 1132 GnRH agonist ≥ 8 wks[56, 67]
  - ☐ 1133 Depot medroxyprogesterone/OCP ≥ 8 wks
- ☐ 1140 PAP smear normal w/in last yr[24]
- ☐ 1150 Pregnancy excluded **[One]**[25]
  - ☐ 1151 HCG negative[26]
  - ☐ 1152 Sterilization by Hx[27]
  - ☐ 1153 Patient not sexually active by Hx[28]
- ☐ 1160 Completed hysterectomy acknowledgement form

☐ 1200 Chronic abdominal/pelvic pain, unknown etiology **[All]**[68*MDR, 69]

- ☐ 1210 Hx & PE nondiagnostic for etiology of pain
- ☐ 1220 Laboratory testing **[Both]**
  - ☐ 1221 CBC normal
  - ☐ 1222 U/A or urine culture normal
- ☐ 1230 US nondiagnostic for etiology of pain
- ☐ 1240 Testing nondiagnostic for etiology of pain **[One]**
  - ☐ 1241 CT/MRI
  - ☐ 1242 Diagnostic laparoscopy(70, 71)
- ☐ 1250 Continued pain **after** Rx **[One]**(72)
  - ☐ 1251 NSAID ≥ 4 wks
  - ☐ 1252 Depot medroxyprogesterone/OCP ≥ 8 wks
  - ☐ 1253 GnRH agonist ≥ 8 wks(56)
  - ☐ 1254 Abx Rx x1 course
- ☐ 1260 PAP smear normal w/in last yr(24)
- ☐ 1270 Pregnancy excluded **[One]**(25)
  - ☐ 1271 HCG negative(26)
  - ☐ 1272 Sterilization by Hx(27)
  - ☐ 1273 Patient not sexually active by Hx(28)
- ☐ 1280 Send for secondary medical review(73*MDR)
- ☐ 1290 Completed hysterectomy acknowledgement form

Notes

(1)-DEF:
In LAVH, mobilization of the uterus and its upper pedicles is performed laparoscopically; the uterine vessels are not secured by the endoscopic route. A vaginal hysterectomy is then performed.

(2)
Because LAVH offers visualization of the intra-abdominal anatomy through the laparoscope, LAVH may be an alternative to an abdominal approach for hysterectomy in some cases. For example, PID can be treated with LAVH because the tubes and ovaries are seen and treated through the laparoscope.

(3)
Whether to perform prophylactic oophorectomy at the time of hysterectomy done for benign disease is controversial. Removal of the ovaries lessens the chance of the future development of ovarian cancer but increases the risk of osteoporosis and CAD (Parker et al., Obstet Gynecol 2005; 106(2): 219-226).

(4)-POL:
It is a matter of local medical policy whether to require secondary medical review for all hysterectomy requests in women < 30.

(5)-RIN:
For invasive cervical cancer, see the "Hysterectomy, Radical" criteria subset.

(6)
Most cervical cancers are squamous cell in origin. Adenocarcinomas and adenosquamous cancers represent approximately 15% of cases (Committee on Practice, Obstet Gynecol 2002; 99(5 Pt 1): 855-867).

(7)
The following table illustrates the relationships between the various diagnostic systems:

TRADITIONAL CYTOLOGY & TISSUE PATHOLOGY	BETHESDA CYTOLOGY	RICHART CYTOLOGY & TISSUE PATHOLOGY
HPV	LGSIL	HPV
Mild Dysplasia	LGSIL	CIN I
Moderate Dysplasia	HGSIL	CIN II
Severe Dysplasia	HGSIL	CIN III
Carcinoma In Situ	HGSIL	CIN III

(8)
CIN III is an indication for hysterectomy if conservative surgical therapy fails. When future childbearing is desired, continued conservative surgery may be repeated until the childbearing years end.

(9)
Endometrial hyperplasia can occur with or without atypia (e.g., nuclear enlargement or irregular shape); the atypia may be so severe in some cases that it is difficult to distinguish from well-differentiated adenocarcinoma. Endometrial hyperplasia with atypia is considered premalignant and can progress to invasive disease in up to 29% of cases (Weber et al., Obstet Gynecol 1999; 93(4): 594-598). It can be treated with hysterectomy (e.g., postmenopausal woman, no future childbearing desired) or progestin therapy (e.g., premenopausal woman, future childbearing desired). If progestin therapy is selected, follow-up evaluation at 2 to 3 months is needed to be sure that the hyperplasia has resolved. The majority of these lesions regress with progestin therapy but have a higher rate of relapse when the treatment is stopped than lesions without atypia (ACOG Practice Bulletin. Obstet Gynecol 2005; 106(2): 413-425).

(10)-MDR:
Hysterectomy with removal of both ovaries and fallopian tubes (BSO) should be performed in postmenopausal women because the risk for the development of ovarian cancer is higher than for premenopausal women. BSO is also done for ovarian or tubal disease. Requests for hysterectomy without BSO in these cases require secondary medical review.

(11)
Uterine leiomyomas (fibroids) are the most common indication for hysterectomy and the reason given for 25% to 30% of hysterectomies (Jacobson et al., Obstet Gynecol 2006; 107(6): 1278-1283; Agency for Healthcare Research and Quality, AHRQ Publication No. 01-E051, January 2001). They arise most often in women 30 to 49 years of age and are typically slow growing, multiple, and variable in size (Wallach and Vlahos, Obstet Gynecol 2004; 104(2): 393-406). Alternatives to hysterectomy for fibroids are becoming increasingly available (e.g., hysteroscopic, open, or laparoscopic myomectomy, uterine artery embolization). These alternatives preserve the uterus for future childbearing (ACOG Practice Bulletin No. 16, May 2000).

(12)-POL:
US allows for accurate assessment of the dimensions, number, and location of the fibroid, adnexal evaluation, and documentation of interval growth (Wallach and Vlahos, Obstet Gynecol 2004; 104(2): 393-406; Wegienka et al., Obstet Gynecol 2003; 101(3): 431-437). McKesson consultants feel that preoperative US is appropriate for evaluation of the ovaries or when PE assessment is difficult (e.g., obese patient). It is a matter of local medical policy whether pre-procedure US be performed for the evaluation of fibroids.

(13)
Sizing of the uterus is made by reference to size at a certain time in pregnancy. A 14 weeks uterus, for example, does not imply pregnancy but only uterine enlargement. Uterine size estimated by PE in weeks correlates by US to approximately 1 cm in length for every 1 week (Cantuaria et al., Obstet Gynecol 1998; 92(1): 109-112). A fibroid uterus estimated to be 14 weeks in size, therefore, would be about 14 cm in length by US.

(14)
The surgical approach to a hysterectomy depends on clinical factors including uterine size. A smaller uterus is amenable to a vaginal approach; this route should be taken when possible to decrease recovery time and complications.

(15)

GnRH agonists may be administered to patients with a fibroid uterus of 13 to 18 weeks size to diminish uterine size to enable laparoscopic or vaginal hysterectomy to be performed instead of abdominal hysterectomy (Kovac, Obstet Gynecol 2004; 103(6): 1321-1325). Preoperative treatment with GnRH agonists has been shown to shorten hospital stays, decrease blood loss, and decrease operative time (ACOG Practice Bulletin No. 16, May 2000).

(16)
Abnormal bleeding includes menorrhagia (heavy and prolonged menses) and menometrorrhagia (heavy and prolonged bleeding during and between menses).

(17)
Patients may present with bleeding between periods that is not necessarily heavy or prolonged. Hysterectomy would be unusual for less than heavy bleeding.

(18)
Fibroids, even small ones, are associated with an increased risk of heavy and prolonged bleeding (Wegienka et al., Obstet Gynecol 2003; 101(3): 431-437). It is not necessarily the size of the fibroid that determines the need for treatment, but rather patient symptoms and fibroid location.

(19)
Activities of daily living (ADLs) are frequently divided into those simple activities relating to basic self-care and those that involve more complex interactions with others and the environment (called instrumental activities of daily living or IADLs). This criterion includes both types of activity. Whether a condition is of sufficient severity to interfere with ADLs or IADLs is somewhat subjective. There should be an indication that symptoms impede the patient's ability to effectively work, shop, manage at home, care for family members, or tend to personal hygiene.

(20)
Ferrous sulfate is generally not well tolerated. Other iron preparations (e.g., ferrous gluconate, oral polysaccharide iron complex) are better tolerated and are more likely to ensure compliance with treatment.

(21)-POL:
Growth of a fibroid, especially rapid growth (e.g., doubling within one year's time), may represent malignant transformation (e.g., leiomyosarcoma). Slow-growing fibroids may remain asymptomatic for many years. Uterine size doubling secondary to fibroid growth must be documented by US. Local medical policy may accept PE by the same examiner as a substitute for US.

(22)-MDR:
These are common, troublesome symptoms occurring secondary to uterine enlargement. Before a procedure is performed for discomfort or pain, other potential causes should be considered. In patients with urinary frequency, UTI should be excluded. Because these symptoms are subjective, if there is any question, secondary medical review is required.

(23)-DEF:
Dyspareunia is difficult or painful sexual intercourse.

(24)
The American College of Obstetricians and Gynecologists (ACOG), the American Cancer Society (ACS), the National Cancer Institute, and the American Medical Association (AMA) recommend that all women have annual PAP testing for routine cervical screening within 3 years of the onset of sexual activity and no later than age 21. After the age of 30 and 3 consecutive normal smears, low-risk women (defined as having one lifetime sexual partner who has never had another sexual partner) may have screening performed less frequently at the discretion of the clinician and patient; screening should be performed at least every three years (Noller, Obstet Gynecol 2005; 106(2): 391-397; Smith et al., CA Cancer J Clin 2005; 55(1): 31-44; quiz 55-56; American College of Obstetricians and Gynecologists, Obstet Gynecol 2003; 102(2): 417-427; U.S. Preventive Services Task Force. AHRQ Publication No. 03-515A, January 2003). As part of comprehensive pre-procedure planning, however, a PAP smear should be documented within the last year; a normal PAP smear is essential to exclude cervical disease which, if present, may alter treatment.

(25)
Pregnancy and related complications (e.g., ectopic pregnancy, incomplete abortion, inevitable abortion) must be excluded before performing this procedure.

(26)

Pregnancy testing can be by measurement of either a serum or urine HCG and may be documented in either the PCP's, gynecologist's, or surgeon's records.

(27)

The healthcare provider should document a history of sterilization (i.e., tubal ligation) without a subsequent pregnancy. This criteria does not include sterilization of a partner, nor does it cover alternate birth control methods (e.g., OCP use, IUD insertion).

(28)

Patients have varying definitions of sexual activity (e.g., number of partners, timing of most recent episode, frequency of sexual activity). Unless the provider can confirm on exam that the patient has never had sexual intercourse, whether a patient is sexually active or not is a matter of clinical judgment.

(29)-RIN:

If fibroids are associated with postmenopausal bleeding, see indication 700 within this criteria subset.

(30)

The diagnosis of DUB is made by excluding pregnancy, medication use, systemic conditions, and genital tract pathology as the cause of the bleeding. Blood work and history can exclude coagulopathy, or hematologic or thyroid problems, while PE or US excludes structural problems such as fibroids (Albers et al., Am Fam Physician 2004; 69(8): 1915-1926).

(31)

Premenopausal women report significant improvement in symptoms and greater satisfaction with hysterectomy when compared to continued medical treatment for DUB at 6 months. The degree of improvement is similar, however, in both groups at 2 year follow-up (Kuppermann et al., JAMA 2004; 291(12): 1447-1455).

(32)

Hypothyroidism or hyperthyroidism may cause a variety of menstrual irregularities (i.e., menorrhagia (heavy and prolonged menses), amenorrhea (no menses), or oligomenorrhea (scant menses)). Documentation to exclude a thyroid disorder as a cause of the bleeding may be performed at any time in the work-up of the patient and may be by the patient's PCP, gynecologist, or a specialist.

(33)-DEF:

A sonohysterogram involves catheter insertion into the endometrial cavity and the instillation of saline to distend the uterus during US imaging.

(34)

Sonohysterogram or US is performed to exclude a uterine polyp or other endometrial lesion as a cause of the bleeding.

(35)

Hysteroscopic endometrial resection or ablation, in which the whole thickness of the endometrium and some superficial myometrium is removed or destroyed, is performed for DUB as an alternative to hysterectomy (Vilos, Obstet Gynecol Clin North Am 2004; 31(3): 687-704, xi; Zupi et al., Am J Obstet Gynecol 2003; 188(1): 7-12). Over 89% of patients are satisfied with the procedure at follow-up (Perino et al., Fertil Steril 2004; 82(3): 731-734). Pretreatment with GnRH agonists or danazol causes thinning of the endometrium and can improve ablation success and short-term outcomes (Sowter et al., Cochrane Database Syst Rev 2002; (3): CD001124; Donnez et al., Fertil Steril 2001; 75(3): 620-622). Although short-term success rates are high following endometrial ablation, 20% to 30% of women subsequently require hysterectomy or repeated procedures for resolution of continued bleeding (Dutton et al., Obstet Gynecol 2001; 98(1): 35-39).

Non-hysteroscopic (second generation) techniques for ablating the endometrium (e.g., thermal balloon, cryoablation, microwave or electrode ablation) performed with local anesthesia have also been shown to be beneficial for the treatment of menorrhagia and are simpler and quicker to perform than hysteroscopic ablation (Lethaby et al., Cochrane Database Syst Rev 2005; (4): CD001501; Marjoribanks et al., Cochrane Database Syst Rev 2003; (2): CD003855; Pellicano et al., Am J Obstet Gynecol 2002; 187(3): 545-550). There is no significant difference in the need for additional surgery or hysterectomy when comparing hysteroscopic ablation to the second generation, non-hysteroscopic techniques (Lethaby et al., Cochrane Database Syst Rev 2005; (4): CD001501).

(36)

Examination of the endometrium is necessary in women ≥ 35, because there is a greater incidence of malignancy or endometrial hyperplasia in this age group (ACOG Practice Bulletin No. 14, Mar 2000).

(37)

Postmenopausal bleeding should always be investigated, as it could be a sign of endometrial cancer. Postmenopausal bleeding is defined as bleeding after 1 year of amenorrhea in a woman not receiving HRT or, in women taking HRT, unexpected bleeding in patients receiving cyclic HRT or bleeding after 1 year of continuous HRT (Mounsey, Clin Fam Prac 2002; 4(1): 173-192).

(38)

The risk/benefit assessment of HRT for long-term use should be carefully considered for each patient, especially in light of data from large, randomized trials by the Heart and Estrogen/Progestin Replacement Study Follow-Up (HERS II) and the Women's Health Initiative (WHI) randomized controlled trial, which suggest that the overall health risks of HRT (e.g., increased risk of CAD, stroke, breast cancer, venous thromboembolism, PE) exceed the benefits (e.g., lowered risk for colorectal cancer and hip fracture) (Grady et al., JAMA 2002; 288(1): 49-57; Hulley et al., JAMA 2002; 288(1): 58-66; Women's Health Initiative (WHI), JAMA 2002; 288(3): 321-333). Lower dose estrogen may be beneficial and less risky long-term (Lobo et al., Fertil Steril 2001; 76(1): 13-24).

(39)

For patients not currently taking HRT (e.g., refused therapy, contraindicated), an evaluation of the endometrium is still indicated prior to hysterectomy for postmenopausal bleeding.

(40)-RIN:

An anterior or posterior colporrhaphy may be included as part of the hysterectomy if the patient has any degree of cystocele or rectocele, respectively; these procedures do not require separate approval.

(41)-DEF:

With vaginal splinting, the woman must place at least one finger in the vagina to assist a bowel movement.

(42)

Vaginal hysterectomy can be effectively performed for prolapse but the laparoscopy is used to assist in removal of the ovaries and tubes.

(43)-DEF:

Second degree uterine prolapse is downward displacement of the uterus so that the cervix is outside the vaginal orifice.

(44)-DEF:

Third degree uterine prolapse is downward displacement of the uterus so that the entire uterus is outside the vaginal orifice.

(45)-DEF:

Although often synonymous with salpingitis, PID is actually a more general term referring to infections of the upper female genital tract, including endometritis, salpingitis, pelvic peritonitis, and tubo-ovarian abscess.

(46)

The need for hysterectomy with or without salpingo-oophorectomy is often difficult to assess preoperatively.

(47)-DEF:

A hydrosalpinx is watery fluid in the fallopian tube, generally occurring at the end-stage of tubal infection (pyosalpinx).

(48)-DEF:

Endometriosis is defined as the presence of functioning endometrial glands and stroma at a site outside the uterine cavity.

(49)

Hysterectomy is regarded as maximally aggressive treatment for endometriosis associated with intractable pain, an adnexal mass, or failed previous conservative therapy (ACOG Practice Bulletin No. 11, Dec 1999).

(50)-MDR:

Ovarian conservation at the time of hysterectomy for endometriosis is an alternative to hysterectomy with BSO (Martin and O'Conner, Obstet Gynecol Clin North Am 2003; 30(1): 151-162). Performing hysterectomy without BSO, however, often results in a high rate of recurrent symptoms (62% of patients) or the need for additional surgical treatment (31% of cases) (ACOG Practice Bulletin No. 11, Dec 1999). Requests for hysterectomy without BSO in these cases require secondary medical review.

(51)

Confirmation of the diagnosis of endometriosis is necessary to determine appropriate treatment and to assess the progress of the disease.

(52)

Laparoscopy is the procedure of choice for diagnosing endometriosis. Biopsies of suspicious areas should be taken to confirm the diagnosis, as visual diagnosis is often inaccurate (ACOG Practice Bulletin. Obstet Gynecol 2004; 103(3): 589-605). MRI used for the investigation of pelvic pain or pelvic masses is highly accurate in detecting deeply infiltrating endometriomas but is limited in its ability to identify endometriomas of the rectum (Winkel, Obstet Gynecol 2003; 102(2): 397-408).

(53)-MDR:
Because there is little to no evidence surrounding the benefits of medication when compared with surgical outcomes, some surgeons advocate no preoperative medical treatment when surgery is planned for the treatment of endometriosis (Vercellini et al., Obstet Gynecol Clin North Am 2003; 30(1): 163-180). These cases require secondary medical review.

(54)
Symptoms of endometriosis include chronic, recurrent pelvic pain, dysmenorrhea, infertility, and dyspareunia.

(55)
If symptoms do not respond to an OCP or GnRH agonist, then treatment with danazol or a progestin (e.g., depot medroxyprogesterone) is appropriate (Mahutte and Arici, Obstet Gynecol Clin North Am 2003; 30(1): 133-150; Winkel, Obstet Gynecol 2003; 102(2): 397-408).

(56)
The GnRH agonists include leuprolide acetate, nafarelin, and goserelin. These compounds mimic the action of GnRH and, thereby, suppress the hormones produced by the ovary that stimulate endometrial growth.

(57)
Ablation or excision may be performed more than once.

(58)-MDR:
Women with endometriosis and no desire for future childbearing may request a hysterectomy without an initial trial of medical therapy. Requests for hysterectomy in these cases require secondary medical review.

(59)-DEF:
Adenomyosis is the benign invasion and growth of ectopic endometrial tissue within the myometrium (the muscle of the uterus).

(60)
Adenomyosis can be a diffuse condition or may be localized with well-defined borders (an adenomyoma). The cause is unknown but risk factors for the development of adenomyosis include prior uterine surgery (e.g., C section, myomectomy), D & C, and multiple deliveries.

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Hysterectomy is considered the most effective treatment for symptomatic adenomyosis. Adenomyosis is usually diagnosed by pathology after hysterectomy is performed for unresolved symptoms, usually pain or bleeding.

(62)
There are no symptoms that are pathognomonic for adenomyosis and many of the symptoms are associated with other common gynecologic disorders (e.g., fibroids, DUB, endometriosis). Approximately 30% of patients are asymptomatic and the adenomyosis is discovered coincidentally (Bergeron et al., Best Pract Res Clin Obstet Gynaecol 2006; 20(4): 511-521; Peric and Fraser, Best Pract Res Clin Obstet Gynaecol 2006; 20(4): 547-555). The uterus may be enlarged on exam.

(63)
The pain associated with adenomyosis is varied and includes cramping that may begin days or weeks prior to menses, dyspareunia, or dysuria.

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The abnormally located endometrial tissue tends to bleed with menses. Heavy bleeding is associated with increasing depth of myometrial penetration (Peric and Fraser, Best Pract Res Clin Obstet Gynaecol 2006; 20(4): 547-555).

(65)
US in adenomyosis can show uterine enlargement and thickening or asymmetry of the uterine walls; US is the most cost-effective tool for excluding other causes of the patient's symptoms. MRI is a highly accurate, noninvasive technique for imaging the uterus and may be equally sensitive but more specific than US in differentiating adenomyosis from small, multiple fibroids (Rabinovici and Stewart, Best Pract Res Clin Obstet Gynaecol 2006; 20(4): 617-636; Tamai et al., Radiographics 2005; 25(1): 21-40; Imaoka et al.,

Radiographics 2003; 23(6): 1401-1421). Since a diagnosis of adenomyosis can be made by measuring a junctional zone > 12 mm on MRI, MRI is sometimes used to monitor junctional zone thickness in response to hormonal treatment (Rabinovici and Stewart, Best Pract Res Clin Obstet Gynaecol 2006; 20(4): 617-636; Tamai et al., Best Pract Res Clin Obstet Gynaecol 2006; 20(4): 583-602; Tamai et al., Radiographics 2005; 25(1): 21-40).

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Although rarely done, uterine artery embolization (UAE), an emerging treatment for patients with fibroids, may be an alternative to hysterectomy for a woman with adenomyosis who wishes to preserve future childbearing (Rabinovici and Stewart, Best Pract Res Clin Obstet Gynaecol 2006; 20(4): 617-636; Tamai et al., Radiographics 2005; 25(1): 21-40).

(67)

GnRH agonists have been shown to not only control symptoms but decrease the depth of the junctional zone on MRI in patients with adenomyosis (Rabinovici and Stewart, Best Pract Res Clin Obstet Gynaecol 2006; 20(4): 617-636).

(68)-MDR:

This is a procedure or indication that requires secondary medical review. These criteria have been developed to provide reviewers with a basis for proactively gathering and documenting patient specific clinical information that will facilitate secondary medical review.

(69)

These criteria address chronic pain of unknown etiology, not abdominal or pelvic pain of acute onset. Chronic pelvic pain refers to pain that lasts 6 months or longer (Williams et al., Obstet Gynecol 2004; 103(4): 686-691; Obstet Gynecol 2004; 103(3): 589-605). Some of the gynecologic causes of chronic pelvic pain include endometriosis, chronic PID, and fibroids. Other diagnoses that need to be excluded may be related to the digestive system (e.g., irritable bowel), the urinary tract (e.g., interstitial cystitis urethritis), or pain in the muscles and nerves around the pelvis (e.g., fibromyalgia).

(70)

Laparoscopy has controversial utility in the evaluation of chronic pelvic pain. Pathologic findings are frequently detected secondary to improved laparoscopic technology but their significance and association with the pain is debated (Scialli et al., eds., Chronic Pelvic Pain, 2000, p23). Conscious laparoscopic mapping, defined as identifying lesions that correlate with some or all of the patient's pain while undergoing laparoscopy under local anesthesia, may eliminate unnecessary surgery or identify lesions amenable to medical therapy (ACOG Practice Bulletin. Obstet Gynecol 2004; 103(3): 589-605). Many cases of pelvic pain not caused by infection or pregnancy are due to endometriosis. Endometriosis is suspected by pain generally beginning midcycle and increasing through menstruation. PE is usually normal except for tenderness; rarely, large areas of endometriosis may be palpable (Vercellini et al., Obstet Gynecol Clin North Am 2003; 30(1): 163-180).

(71)

Adhesions found at laparoscopy should be lysed and excluded as a cause of the patient's symptoms. Several clinical trials demonstrate that women with dense adhesions showed decreased pain after adhesiolysis (Keltz et al., JSLS 2006; 10(4): 443-446; ACOG Practice Bulletin. Obstet Gynecol 2004; 103(3): 589-605). One well-designed study showed pain relief after laparoscopy; there was no significant difference, however, between patients undergoing adhesiolysis and those who had diagnostic laparoscopy without lysis of adhesions (Swank et al., Lancet 2003; 361(9365): 1247-1251).

(72)

Conservative or less invasive interventions should be tried prior to recommending hysterectomy for the treatment of chronic pelvic pain. Medications such as progesterone and GnRH agonists have shown benefit in decreasing pain, as has a multidisciplinary approach to pain management (Stones et al., Cochrane Database Syst Rev 2005; (2): CD000387). Presacral neurectomy and uterine nerve ablation are techniques that disrupt the nerves that carry pain stimuli to the pelvis. Although several studies have shown significant improvement in pain scores after treatment, the evidence to support these techniques in the treatment of pelvic pain is limited and therefore, these procedures cannot be recommended (National Institute for Health and Clinical Excellence (NHS), Interventional procedure overview of laparoscopic uterine nerve ablation (LUNA) for chronic pelvic pain. February 2007, 26; Proctor et al., Cochrane Database Syst Rev 2005; (4): CD001896; Johnson et al., BJOG 2004; 111(9): 950-959).

(73)-MDR:

The evaluation of chronic pain can be extensive and finding a cause of the pain may remain elusive. Because this process of elimination does not ensure that hysterectomy will resolve the pain and pain can persist even after hysterectomy, requests for hysterectomy for chronic pelvic pain require secondary medical review.