2011 Procedures Adult Criteria

Hysterectomy, Total Laparoscopic (TLH), +/- BSO (Custom) - UDOH[1*RIN, 2, 3, 4, 5]

Created based on InterQual Subset: Hysterectomy, Total Laparoscopic (TLH), +/- BSO
Version: InterQual® 2010

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

ICD-9-CM: 68.4, 68.41, 68.49

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 Endometrial cancer by pathology
- ☐ 900 Suspected ovarian cancer
- ☐ 1000 Suspected tubal cancer
- ☐ 1100 Tubo-ovarian abscess
- ☐ 1200 Chronic PID
- ☐ 1300 Endometriosis
- ☐ 1400 Suspected adenomyosis
- ☐ 1500 Chronic abdominal/pelvic pain, unknown etiology
- ☐ Indication Not Listed (Provide clinical justification below)

☐ 100 Endocervical adenocarcinoma in situ by Bx **[One]**[6*RIN, 7]

- ☐ 110 Completed hysterectomy acknowledgment form

☐ 200 CIN III **[All]**[6*RIN, 8]

- ☐ 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 ≥ 8 wks post conservative surgery[9]
- ☐ 240 Completed hysterectomy acknowledgment form

☐ 300 Adenomatous endometrial hyperplasia with cellular atypia by Bx/D & C **[Both]**[10]
- ☐ 310 Future childbearing **[One]**
  - ☐ 311 Future childbearing desired **[Both]**
    - ☐ -1 Progestin Rx ≥ 8 wks **[One]**
      - ☐ A) ≥8 weeks
      - ☐ B) Contraindicated
    - ☐ -2 Hyperplasia with cellular atypia confirmed by repeat Bx/D & C after Rx
  - ☐ 312 No future childbearing desired
  - ☐ 313 Postmenopausal woman and BSO planned[11*MDR]
- ☐ 320 Completed hysterectomy acknowledgment form

☐ 400 Fibroids in premenopausal woman **[All]**[12]
- ☐ 410 Diagnosed by US[13]
- ☐ 420 Findings **[One]**
  - ☐ 421 Abnormal bleeding **[Both]**[14, 15, 16]
    - ☐ -1 Vagina and cervix normal by PE
    - ☐ -2 Continued abnormal bleeding **[One]**
      - ☐ A) Interferes with ADLs[17]
      - ☐ B) Hct < 27%(0.27) / Hb < 9.0 g/dL(90 g/L) unresponsive to iron Rx > 12 wks[18]
  - ☐ 422 Uterine size doubled by US w/in 1 yr[19]
  - ☐ 423 Ureteral compression by US/IVP
  - ☐ 424 Other associated symptoms **[One]**[20*MDR]
    - ☐ -1 Pelvic/abdominal pain/discomfort w/o other explanation
    - ☐ -2 Urinary frequency/urgency w/o evidence of infection
    - ☐ -3 Dyspareunia[21]
- ☐ 430 PAP smear normal w/in last yr[22]
- ☐ 440 Pregnancy excluded **[One]**[23]
  - ☐ 441 HCG negative[24]
  - ☐ 442 Sterilization by Hx[25]
- ☐ 450 Completed hysterectomy acknowledgment form

☐ 500 Fibroids in postmenopausal woman **[All]**[26*RIN]

- ☐ 510 BSO planned[11*MDR]
- ☐ 520 Diagnosed by US[13]
- ☐ 530 Findings **[One]**
  - ☐ 531 Uterine size doubled by US w/in 1 yr[19]
  - ☐ 532 Ureteral compression by US/IVP
  - ☐ 533 Other associated symptoms **[One]**[20*MDR]
    - ☐ -1 Pelvic/abdominal pain/discomfort w/o other explanation
    - ☐ -2 Urinary frequency/urgency w/o evidence of infection
    - ☐ -3 Dyspareunia[21]
- ☐ 540 PAP smear normal w/in last yr[22]
- ☐ 550 Completed hysterectomy acknowledgment form

☐ 600 DUB in premenopausal woman **[All]**[27, 28]
- ☐ 610 Abnormal bleeding > 3 cycles[14, 15]
- ☐ 620 Vagina and cervix normal by PE
- ☐ 630 Thyroid disease excluded by Hx/PE/testing[29]
- ☐ 640 Pregnancy excluded **[One]**[23]
  - ☐ 641 HCG negative[24]
  - ☐ 642 Sterilization by Hx[25]
- ☐ 650 PAP smear normal w/in last yr[22]
- ☐ 660 Sonohysterogram/US negative for endometrial lesion[30, 31]
- ☐ 670 Continued bleeding **after** Rx **[One]**[32]
  - ☐ 671 Age < 35 **[Both]**
    - ☐ -1 Progestin/OCP **[One]**
      - ☐ A) x3 consecutive cycles
      - ☐ B) Contraindicated
    - ☐ -2 Findings **[One]**
      - ☐ A) Interferes with ADLs[17]
      - ☐ B) Hct < 27%(0.27) / Hb < 9.0 g/dL(90 g/L) unresponsive to iron Rx > 12 wks[18]
  - ☐ 672 Age ≥ 35 **[All]**[33]
    - ☐ -1 Endometrium normal w/in last yr **[One]**
      - ☐ A) By endometrial Bx
      - ☐ B) By hysteroscopy with D & C
    - ☐ -2 Progestin/OCP **[One]**
      - ☐ A) x3 consecutive cycles
      - ☐ B) Contraindicated
    - ☐ -3 Findings **[One]**
      - ☐ A) Interferes with ADLs[17]
      - ☐ B) Hct < 27%(0.27) / Hb < 9.0 g/dL(90 g/L) unresponsive to iron Rx > 12 wks[18]

- ☐ 680 Completed hysterectomy acknowledgment form

☐ 700 Postmenopausal bleeding **[All]**[34]
- ☐ 710 BSO planned[11*MDR]
- ☐ 720 Vagina and cervix normal by PE
- ☐ 730 HRT **[One]**
  - ☐ 731 Continued abnormal bleeding after change in/discontinuation of HRT[35]
  - ☐ 732 HRT contraindicated/refused[36]
- ☐ 740 Endometrium normal w/in last 4 months **[One]**
  - ☐ 741 By hysteroscopy with D & C
  - ☐ 742 By endometrial Bx and transvaginal US
- ☐ 750 PAP smear normal w/in last yr[22]
- ☐ 760 Completed hysterectomy acknowledgment form

☐ 800 Endometrial cancer by pathology **[Both]**[37, 38]
- ☐ 810 BSO Planned **[One]**
  - ☐ 811 Premenopausal woman and BSO planned[39]
  - ☐ 812 Postmenopausal woman and BSO planned[11*MDR]
- ☐ 820 Completed hysterectomy acknowledgment form

☐ 900 Suspected ovarian cancer **[All]**[40]
- ☐ 910 BSO planned[11*MDR]
- ☐ 920 Diagnosed by **[One]**[41]
  - ☐ 921 US
  - ☐ 922 CT/MRI
  - ☐ 923 Laparoscopy
- ☐ 930 Completed hysterectomy acknowledgment form

☐ 1000 Suspected tubal cancer **[All]**[40]
- ☐ 1010 BSO planned[11*MDR]
- ☐ 1020 Diagnosed by **[One]**[42]
  - ☐ 1021 US
  - ☐ 1022 CT/MRI
  - ☐ 1023 Laparoscopy
- ☐ 1030 Completed hysterectomy acknowledgment form

☐ 1100 Tubo-ovarian abscess **[All]**[43]
- ☐ 1110 BSO planned
- ☐ 1120 Diagnosed by imaging **[One]**

- ☐ 1121 US
- ☐ 1122 CT/MRI

☐ 1130 HCG negative[24]

☐ 1140 Worsening Sx/findings **[Both]**

- ☐ 1141 During IV Abx Rx
- ☐ 1142 Sx/findings **[One]**
  - ☐ -1 Pelvic pain
  - ☐ -2 Abdominal tenderness
  - ☐ -3 Persistent adnexal mass
  - ☐ -4 Temperature > 100.4 F(38.0 C)
  - ☐ -5 WBC ≥ 12,000/cu.mm($12x10^9$/L)

☐ 1150 Completed hysterectomy acknowledgment form

☐ 1200 Chronic PID **[All]**[44, 45]

☐ 1210 Pelvic pain

☐ 1220 Acute PID ≥ 2 episodes by Hx & PE

☐ 1230 Infection documented ≥ 1 episode by positive culture

☐ 1240 Adhesions/scarring/hydrosalpinx by laparoscopy[46]

☐ 1250 PAP smear normal w/in last yr[22]

☐ 1260 HCG negative[24]

☐ 1270 Completed hysterectomy acknowledgment form

☐ 1300 Endometriosis **[All]**[47, 48]

☐ 1310 BSO addressed[49]

☐ 1320 Diagnosed by previous laparoscopy[50, 51]

☐ 1330 Continued symptoms **after** Rx **[One]**[52*MDR, 53, 54]

- ☐ 1331 GnRH agonist ≥8 weeks[55]
- ☐ 1332 Depot medroxyprogesterone/OCP ≥ 8 wks
- ☐ 1333 Danazol ≥ 8 wks
- ☐ 1334 Contraindicated

☐ 1340 PAP smear normal w/in last yr[22]

☐ 1350 Pregnancy excluded **[One]**[23]

- ☐ 1351 HCG negative[24]
- ☐ 1352 Sterilization by Hx[25]

☐ 1360 Completed hysterectomy acknowledgment form

☐ 1400 Suspected adenomyosis **[All]**[56, 57, 58]

☐ 1410 Sx/findings **[One]**[59]

- ☐ 1411 Pelvic pain[60]

- ☐ 1412 Abnormal bleeding **[Both]**(14, 61)
  - ☐ -1 Vagina and cervix normal by PE
  - ☐ -2 Continued abnormal bleeding **[One]**
    - ☐ A) Interferes with ADLs(17)
    - ☐ B) Hct < 27%(0.27) / Hb < 9.0 g/dL(90 g/L) unresponsive to iron Rx > 12 wks(18)
- ☐ 1413 Ureteral compression by US/IVP
- ☐ 1414 Other associated symptoms **[One]**(20*MDR)
  - ☐ -1 Pelvic/abdominal pain/discomfort w/o other explanation
  - ☐ -2 Urinary frequency/urgency w/o evidence of infection
  - ☐ -3 Dyspareunia(21)

☐ 1420 MRI/US suggestive of adenomyosis(62)

☐ 1430 Continued Sx/findings **after** Rx **[One]**(63)

- ☐ 1431 NSAIDs **[One]**
  - ☐ -1 ≥x8 weeks
  - ☐ -2 Contraindicated
- ☐ 1432 GnRH agonist **[One]**(55, 64)
  - ☐ -1 ≥8 weeks
  - ☐ -2 Contraindicated
- ☐ 1433 Depot medroxyprogesterone/OCP **[One]**
  - ☐ -1 ≥8 weeks
  - ☐ -2 Contraindicated

☐ 1440 PAP smear normal w/in last yr(22)

☐ 1450 Pregnancy excluded **[One]**(23)

- ☐ 1451 HCG negative(24)
- ☐ 1452 Sterilization by Hx(25)

☐ 1460 Completed hysterectomy acknowledgment form

☐ 1500 Chronic abdominal/pelvic pain, unknown etiology **[All]**(65*MDR, 66)

- ☐ 1510 Hx & PE nondiagnostic for etiology of pain
- ☐ 1520 Laboratory testing **[Both]**
  - ☐ 1521 CBC normal
  - ☐ 1522 U/A or urine culture normal
- ☐ 1530 US nondiagnostic for etiology of pain
- ☐ 1540 Testing nondiagnostic for etiology of pain **[One]**
  - ☐ 1541 CT/MRI
  - ☐ 1542 Diagnostic laparoscopy(67, 68)
- ☐ 1550 Continued pain **after** Rx **[One]**(69)
  - ☐ 1551 NSAID **[One]**
    - ☐ -1 ≥4 weeks

- ☐ -2 Contraindicated
- ☐ 1552 Depot medroxyprogesterone/OCP **[One]**
  - ☐ -1 ≥ 8 wks
  - ☐ -2 Contraindicated
- ☐ 1553 GnRH agonist **[One]**(55)
  - ☐ -1 ≥ 8 wks
  - ☐ -2 Contraindicated
- ☐ 1554 Abx Rx x1 course

☐ 1560 PAP smear normal w/in last yr(22)

☐ 1570 Pregnancy excluded **[One]**(23)

- ☐ 1571 HCG negative(24)
- ☐ 1572 Sterilization by Hx(25)

☐ 1580 Send for secondary medical review(70*MDR)

☐ 1590 Completed hysterectomy acknowledgment form

Notes

(1)-RIN:

These criteria address total hysterectomy performed using laparoscopy. For total hysterectomy using an abdominal incision, see the "Hysterectomy, Abdominal, +/- BSO" subset. For subtotal or supracervical hysterectomy, see the "Hysterectomy, Open/Laparoscopic Supracervical (LSH), +/- BSO" subset.

(2)-DEF:

In total laparoscopic hysterectomy (TLH), mobilization of the uterus and its upper pedicles is performed laparoscopically; the uterine vessels are then secured by the endoscopic route. The fundus is then divided and removed piecemeal through the abdominal wall incisions or through the cul-de-sac (via a culdotomy incision).

(3)

Robotic gynecologic surgery is fast becoming popular but there are currently no good quality studies demonstrating positive long-term outcomes or improved quality of life; further trials need to be done before this becomes a favored surgical technique (Lambaudie et al., Surg Endosc 2008; 22(12): 2743-2747; Visco and Advincula, Obstet Gynecol 2008; 112(6): 1369-1384; Falcone and Walters, Obstet Gynecol 2008; 111(3): 753-767).

(4)

Whether to perform prophylactic oophorectomy at the time of hysterectomy done for benign disease is controversial; there are no good quality studies to support conservation or prophylactic removal of the ovaries (Orozco et al., Cochrane Database Syst Rev 2008; (3): CD005638). 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., Clin Obstet Gynecol 2007; 50(2): 354-361; Parker et al., Obstet Gynecol 2005; 106(2): 219-226).

(5)-POL:

It is a matter of local medical policy whether to require secondary medical review for all hysterectomy requests in women < 30.

(6)-RIN:

For invasive cervical cancer, see the "Hysterectomy, Radical" criteria subset.

(7)

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. Reaffirmed, 2006).

(8)

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

(9)

CIN III is an indication for hysterectomy if conservative surgical therapy fails. Retesting is done approximately 2 months after the attempt at conservative treatment, as the cervix needs time to heal and continued inflammation can give abnormal biopsy results. When future childbearing is desired, continued conservative surgery may be repeated until the childbearing years end.

(10)

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. 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).

(11)-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.

(12)

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). 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, UAE, MRI-guided focused US therapy). These alternatives preserve the uterus for future childbearing (ACOG, Obstet Gynecol 2008; 112(2 Pt 1): 387-400).

(13)-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 pre-procedure 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.

(14)

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

(15)

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

(16)

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.

(17)

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.

(18)

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.

(19)-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.

(20)-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.

(21)-DEF:

Dyspareunia is difficult or painful sexual intercourse.

(22)

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.

(23)

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

(24)

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.

(25)

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).

(26)-RIN:

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

(27)

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).

(28)
Premenopausal women report significant improvement in menstrual bleeding and greater satisfaction with hysterectomy when compared to oral medication for DUB at 4 months and again at 2 year follow-up (Marjoribanks et al., Cochrane Database Syst Rev 2006; (2): CD003855; Kuppermann et al., JAMA 2004; 291(12): 1447-1455). The degree of improvement is similar, however, in both groups at 5 year follow-up (Marjoribanks et al., Cochrane Database Syst Rev 2006; (2): CD003855).

(29)
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.

(30)-DEF:
A sonohysterogram involves catheter insertion into the endometrial cavity and the instillation of saline to distend the uterus during US imaging.

(31)
Sonohysterogram or US is performed to exclude a uterine polyp or other endometrial lesion as a cause of the bleeding.

(32)
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 (Obstet Gynecol 2007; 109(5): 1233-1248; Zupi et al., Am J Obstet Gynecol 2003; 188(1): 7-12). Approximately 89% of patients are satisfied with or benefited from the procedure at follow-up (Dickersin et al., Obstet Gynecol 2007; 110(6): 1279-1289; 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). Although short-term success rates are high following endometrial ablation, approximately 18% of women subsequently require hysterectomy for resolution of continued bleeding; most of the repeat operative procedures are performed within the first 2 years after the initial surgery (Marjoribanks et al., Cochrane Database Syst Rev 2006; (2): CD003855). Up to 31% of patients require reoperation when followed for 4 years (Dickersin et al., Obstet Gynecol 2007; 110(6): 1279-1289).
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 (Obstet Gynecol 2007; 109(5): 1233-1248; Lethaby et al., Cochrane Database Syst Rev 2005; (4): CD001501).
The levonorgestrel-releasing intrauterine system has been shown to be as effective as ablation in reducing menstrual blood flow, and women report high satisfaction scores for both interventions. The intrauterine system is more cost-effective than either ablation or hysterectomy, however, for treating DUB (Busfield et al., BJOG 2006; 113(3): 257-263; Lethaby et al., Cochrane Database Syst Rev 2005; (4): CD002126; Hurskainen et al., JAMA 2004; 291(12): 1456-1463).

(33)
Examination of the endometrium is necessary in women ≥ 35; there is a greater incidence of malignancy or endometrial hyperplasia in this age group (ACOG Practice Bulletin No. 14, Mar 2000).

(34)
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.

(35)
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.

(36)
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.

(37)
Endometrial cancer occurs primarily in postmenopausal women > 60 years old. The risk of development of endometrial cancer is increased by high levels of estrogen (e.g., early menarche, late menopause, tamoxifen treatment, obesity). In premenopausal women, the diagnosis is difficult to establish and often delayed because symptoms are often confused with DUB (Sorosky, Obstet Gynecol 2008; 111(2 Pt 1): 436-447; ACOG Committee on Practice Bulletins, Obstet Gynecol 2005; 106(2): 413-425).

(38)
TLH is safe and effective in treating early stage endometrial cancer. Disease-free and overall survival rates are comparable to treatment by abdominal hysterectomy with para-aortic lymphadenectomy (Malzoni et al., Gynecol Oncol 2009; 112(1): 126-133).

(39)-POL:
Up to 10% of women with endometrial cancer have synchronous ovarian malignancy and, therefore, hysterectomy with BSO is warranted (Sorosky, Obstet Gynecol 2008; 111(2 Pt 1): 436-447). Ovarian conservation at the time of hysterectomy for endometrial cancer in premenopausal women remains controversial and is a matter of local medical policy.

(40)
Hysterectomy and BSO may be an intraoperative conversion from a diagnostic laparoscopy.

(41)
Ovarian cancer is most commonly detected by US. CT or MRI performed for another reason may have demonstrated the cancer.

(42)
Tubal cancer is most commonly detected by US. CT or MRI performed for another reason may have demonstrated the cancer.

(43)
Generally, patients with a tubo-ovarian abscess have significant PID. The amount of tissue that must be removed is determined by the extent of the PID, the abscess itself, and the surrounding inflammatory tissue. Sudden severe pain, increasing fever, or signs of peritoneal irritation (direct and referred rebound tenderness) in a patient with suspected PID are suggestive of a ruptured tubo-ovarian abscess.

(44)-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.

(45)
The need for hysterectomy with or without salpingo-oophorectomy is often difficult to assess preoperatively.

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

(47)-DEF:
Endometriosis is defined as the presence of functioning endometrial glands and stroma at a site outside the uterine cavity.

(48)
Hysterectomy is regarded as maximally aggressive treatment for endometriosis associated with intractable pain, an adnexal mass, or failed previous conservative therapy.

(49)
Ovarian conservation at the time of hysterectomy for endometriosis is an alternative to hysterectomy with BSO (Shakiba et al., Obstet Gynecol 2008; 111(6): 1285-1292; 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 or the need for additional surgical treatment. BSO is preferred but some patients opt for ovarian conservation.

(50)
Confirmation of the diagnosis of endometriosis is necessary to determine appropriate treatment and to assess the progress of the disease.

(51)
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 (Mounsey et al., Am Fam Physician 2006; 74(4): 594-600; 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).

(52)-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.

(53)
Symptoms of endometriosis include chronic, recurrent pelvic pain, dysmenorrhea, infertility, and dyspareunia.

(54)
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).

(55)
The GnRH agonists include leuprolide, nafarelin, and goserelin. These compounds mimic the action of GnRH and, thereby, suppress the hormones produced by the ovary that stimulate endometrial growth.

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

(57)
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 (Panganamamula et al., Obstet Gynecol 2004; 104(5 Pt 1): 1034-1038).

(58)
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.

(59)
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.

(60)
The pain associated with adenomyosis is varied and includes cramping that may begin days or weeks prior to menses, dyspareunia, or dysuria.

(61)
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).

(62)
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 multiple, small fibroids (Rabinovici and Stewart, Best Pract Res Clin Obstet Gynaecol 2006; 20(4): 617-636; Tamai et al., Radiographics 2005; 25(1): 21-40). 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).

(63)

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).

(64)

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).

(65)-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.

(66)

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. Reaffirmed, 2006). 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).

(67)

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. 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).

(68)

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).

(69)

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).

(70)-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.