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Trading Places: The Future for MIS is in the Outpatient Setting…and the Future is Now!

Announcer:
Welcome to CME on ReachMD! The following activity titled *Trading Places: The Future for MIS is in the Outpatient Setting…and the Future is Now!* is provided in partnership with Omnia Education and supported by an educational grant from Hologic, Inc.

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Here's your host, Dr. Amy Mackey.

Dr. Mackey:
The ability to perform in-office minimally invasive procedures, or MIS, has revolutionized the approach to abnormal uterine bleeding in women, giving them options for fast trauma-free assessment and management of their complaints. However, nearly 150 years after the first hysteroscopic procedure, MIS are still most commonly performed in the hospital setting, increasing the cost of care and causing avoidable delays in management due to the need for multiple appointments. So, why aren't more MIS being performed in the community settings, and what can be done about it?

This is CME on ReachMD, and I'm Dr. Amy Mackey. Today, I'm speaking with Dr. Stephen Cohen, who is on faculty at SUNY Upstate Medical Center and practices at the Women's Wellness Center in Syracuse, New York. Together we'll examine practical strategies to address the current barriers that OB/GYNs face when setting up in-office MIS.

Dr. Cohen, welcome to the program.

Dr. Cohen:
Thank you very much for having me.

Dr. Mackey:
So, Dr. Cohen, can you start by telling us why a community physician who is already performing minimally invasive procedures in the operating room should consider moving some or even all of these procedures to the office setting?

Dr. Cohen:
Absolutely. There's a number of benefits and benefits to everybody, and in fact, taking one step back, to this day it surprises me when I go into the ambulatory OR and see a whole list of, for example, hysteroscopies being done in the ambulatory setting, in the OR, and yet not one cystoscopy being done in that setting because they are all being done in the office. So it does amaze me. And some of the benefits to the patients would be obviously less time—and convenience. The patient is familiar with your staff. They know the building. They know where to park. It's much less intimidating to walk in the office they have been coming to for years. And we use the word procedure. You're not having surgery. You're having a procedure. It's a small point, but I think it makes it sound much less intimidating.

Benefits to the clinician: significantly reduced down time. When you think about what you have to do, somehow you have to get to the ambulatory center. You may drive, you may walk across the street, but it takes time. Your staff has to book these. There are usually multiple calls back and forth to the ambulatory center to make sure there is time. There is usually a pre-op visit required. There is usually

pre-op computer work to do. And when you do it in the office, you can multitask, so you can bring the patient in, say hello, they can set her up, you go back, see a patient, you can put it in your block, wait. You can do multiple things, whereas in the OR, you're fixed there. And there are nice global fees now available to help you from a financial point of view.

And most importantly, or certainly importantly, to the total healthcare system, there is significant cost reduction. As I'm going on the point, you won't need an anesthesiologist, less time for paperwork. We call it paperwork, but we know what we mean, electronic medical record. Less staff is necessary in the room and for admitting. The OR occupation time is markedly reduced so that patients that need an operating room can be done there, and only for necessary procedures, so we can make it much more efficient, for the medical system much more efficient. And even if you're hospital-based, almost all those efficiencies stay the same.

Dr. Mackey:
Okay, great. So, let's say that the community physician has decided to transition MIS to the in-office setting. How would you recommend they proceed, and is there a specific procedure or tips that would make this easier to implement?

Dr. Cohen:
That's a good question, and there certainly are. First thing would be to determine how many procedures that you could move into the office you actually do in the OR, because if you do 2 or 3 or 4 a year, then obviously it's not worth your while to do that, but if you're doing procedures every week and every month, when you start adding these up—and I'll go over what those procedures are—you will know whether it's going to be very valuable to bring those procedures into the office, so it depends what you're doing.

And what procedures should you do or how you should proceed? Well, you should start with the simplest and move on to the more difficult. So, what would be the simplest ambulatory OR procedure to bring into the office? It would be diagnostic hysteroscopy—it's as simple as doing an endometrial biopsy in the office—and then operative hysteroscopy, when you do the hysteroscopy and then do an endometrial sampling, usually with a (inaudible) type device. You could also do hysteroscopic polypectomies, certainly retrieval of lost IUDs. There are peripheral procedures you could do if you are not already doing them, like LEEP and cystoscopy. And probably, the last, most difficult procedures would be the endometrial ablation and the metroplasty, with the metroplasty being the most difficult.

You also have to evaluate your office space. If you're already working in a tiny room and there is no place to see patients to do things, then your office may not accommodate this, but in most offices, even a medium-sized exam room can be turned into a part-time procedure room as well. You want to transition slowly from the outpatient surgery center into the office, so again, you proceed in the simplest procedures, the ones you're most comfortable doing, and you bring those into the office. How do you use the equipment or how do you find equipment would be the next question that you might ask. "Wow, look at all that equipment in the operating room. I can't afford all that fancy equipment and the TV and the monitor and all the stuff that they have, the pump." You don't need hardly any of that, and I'm going to explain that to you as we go on in the next few minutes. But you don't need a hysteroscopic pump. You don't need a TV stack like we used to need in the old days. You don't need a printer necessarily because everything is digital, so that works really well. It's so much simpler than it was even a decade ago.

Dr. Mackey:
So, Dr. Cohen, I understand you've operated in an in-office setting for a number of years now. Would you say that it's easier to make the transition now compared to what it was, say, 5 years ago, and why?

Dr. Cohen:
It's not anywhere near the same, so it's much, much easier. The equipment, as you would expect, has become portable, multifunctional, less expensive, and very convenient. Everything has got a screen that basically walks you through everything you need to do. There is almost nothing to assemble, and you can just proceed. It's almost like you're doing a pelvic exam or a Pap smear. The equipment is incredibly safe, very efficient as it's evolved over the last few years. Even endometrial ablation, which was the most difficult procedure we do, is now much safer and so quick to do in the office. It takes just a few minutes of your time. You can almost fit it right in—once you're experienced—fit it right into your regular schedule. Hysteroscopes are smaller. There is better lighting. There is better field of view. There is better depth of field. And complications are extremely rare.

Dr. Mackey:
If you are just tuning in, this is CME on ReachMD. I'm Dr. Amy Mackey, and I have the pleasure of speaking with Dr. Stephen Cohen on the topic of in-office minimally invasive surgery.

Earlier you spoke a bit about the advantages of performing MIS in the offices and minimal equipment needed to get started, and I'd love to take a deeper dive into this last point. Is there a specific training for nurses and staff that need to be considered when clinicians set up an in-office MIS?

Dr. Cohen:

It's minimal training. Your nurses, your LPNs, the people that are going to assist you, they need to have in-services on the equipment that you're using, particularly how to set it up and how to sterilize, what you're going to do in your office to sterilize some of this equipment. Much of it has now become disposable. The sterilization process and the setup is not as necessary as it was. So you have to evaluate each piece of equipment and what type of sterilization it needs, how to handle it and how to make sure, so there is some training for these people, but not the extensive training that would have been required a decade ago. And one way to help your staff is, if you're doing it in the day surgery OR, bring them there. Let them watch a case or 2 that you're going to bring to the office so they can actually see the routine occurring, and that makes it much clearer to them when they actually watch and take notes and see how it happens.

Safety training, again, everybody has safety training in the office, whether you're doing procedures or not. Most of the safety issues with these procedures are allergies, not anything else. Rarely do you have an operative safety concern that you have to be involved with, but somebody, certainly, you might need a CPR cart, but no more than you would need it for any other, for example, injections or vaccinations or things like that.

As far as equipment, you need a hysteroscope. We'll talk about that in a moment. But you don't need pumps and all those other things they have in the OR. You need an IV bag, IV tubing, and maybe a blood administration cuff to squeeze the bag.

As far as pain management, in my experience over my last 40 years, it's the worry about, "How am I going to control this patient's pain? I bring her to the OR. They give her meds. She starts to wake up during the case. She's moving all over the table. Even MAC is not enough." Well, that's the problem with MAC. What MAC does is sometimes not reduce the amount of pain, but it makes them impossible to talk to. You have no more communication with the patient. Often times I find that a poor MAC is the worst thing of all. I'd rather have no anesthesia than a poor MAC. So in the office I never use IV drugs. I will occasionally use oral drugs, and I'll get to that also in a minute. So that means you don't have to have special training, advanced training. You don't take a course at the hospitals or offices that you usually require. You don't need an anesthetist. No IV drugs have I ever used and never had a problem.

I use a good paracervical block. It's easy to do, and I use 6 CC or less for that paracervical block, not 20. And the tip here is you have to leave it time. It's a nerve block, not a local block, so you've got to give it 5 or 10 minutes. While you're doing that, you can go off and see another patient.

For ablations and metroplasties, they are the only procedures that I use—medication for. I use Ativan 1 mg, Lortab 5/325, 1 to 2 tabs, and Toradol 10 mg, all orally, all 1 hour before the procedure. If I'm doing an ablation, I add Cytotec 200 mg orally the night before.

And that's the way it works, and the patients are very comfortable. You can explain to them what you're doing. You can tell them the procedure is almost over, because most of these procedures take a minute to 3, and the patients like that communication direct with you.

Dr. Mackey:
So, Dr. Cohen, how do you recover your patients after an MIS procedure, and what instructions do you give them to go home?

Dr. Cohen:
It's a very good question. In the office, we don't have a separate recovery room like an operating room does, so what we do is our procedure room—we recover the patient in the procedure room. with the exception of centrally of ablations, those patients, once I'm done, get up, sit up, and get dressed and go home. And remember, they haven't had any oral or IV meds, so they can drive themselves to the office and then drive themselves to the next stop.

As far as the ablation procedures, since I give them oral drugs before they come in, they need someone to drive them and then someone to drive them home, and I do recover them right in the room where I've done the procedure. Most of those patients I keep, oh, somewhere between 15 to usually 30 minutes in the office with no special preparation. They don't have IVs, so we just watch them and make sure that there isn't bleeding, there isn't excessive pain, that they are doing okay. Most of them have no trouble with the amount of drug that we give them and do well.

When they go home, I tell them to be on the lookout for things that we would normally do, the same advice they would get if they came out of the operating room. Look for evidence of fevers, severe pain, heavy bleeding, those types of things that we tell—the exact advice we give them coming out of ambulatory surgery, and should they have that, they should call us and let us know, and we'll see them and evaluate. So it's pretty much the same. Again, without IV drugs and without any drugs for most of these procedures, the patients come in, have the procedure, get up and leave the office without any problems.

Dr. Mackey:
Okay. So, is there new equipment available that an in-office MIS clinician can consider?

Dr. Cohen:
There's definitely new equipment. There is a whole list of new equipment, but I'll tell you about the ones that have the most impact. there are 2 companies making basically disposable hysteroscopes with a permanent handle that has a little TV screen about the size of your Smartphone. So what you have is a self-contained unit. You have the little TV right at the end of the scope. You have a disposable shaft.

The other 2 things that are available are very similar. One is called Resectr. Another is called MyoSure MANUAL. Many of you have used MyoSure in the OR. This is a MANUAL. And there's a suction built in. There's a little bag built in. You place it in the uterus. This is for polyps, for example. You see that polyp. Instead of having to go to the operating room, you just open the package, you put it through the operative channel of your hysteroscope and the patient has to go nowhere. They're done. It's over. So these instruments—and there are others, but these are the impact instruments— I think allow you to do these procedures very easily in the office setting.

Dr. Mackey:
Great. And before we wrap up, Dr. Cohen, any parting words to share with our ReachMD audience?

Dr. Cohen:
Yes, the parting words I'd share, if the last time you looked at this was 5 years ago or 10 years ago and said, "I just cannot do this in my office, I can't control the pain, I can't afford an anesthesiologist, I don't want to give IV drugs, I don't have the room," You need to take another look. You need to look now, because it's a whole different world for office procedures.

Dr. Mackey:
Well, this discussion has been very helpful in identifying simple steps community OB/GYNs can take to move minimally invasive procedures from the OR to the offices.

I'd like to thank my guest, Dr. Stephen Cohen, for sharing his valuable insights. Dr. Cohen, it was great speaking with you today.

Dr. Cohen:
Thank you very much. I enjoyed speaking to your audience. Thanks for inviting me.

Announcer:
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