Fibroids, Laparoscopy and Fertility: Another Option

By C.R. Zwolinski

Uterine fibroids, non-malignant tumors in and around the uterus consisting of collagen and other soft tissue, can impede fertility. Depending upon the number of fibroids, their type, how quick they grow and their location, they can interfere with conception by changing the shape of the uterine cavity, and impinging on the uterine lining. They can also grow larger during pregnancy; the rising amounts of progesterone triggers fibroid growth. This can cause fetal abnormalities and miscarriage. Certain types of small fibroids, usually outside the uterine cavity may be monitored before fertility treatments take place and a doctor may determine that surgery is not necessary. Most doctors prefer for the majority of fibroids to be removed before attempting fertility treatments.

If small fibroids are discovered, a hysteroscopic myomectomy can be performed. This is a minimally invasive technique which is only useful for the removal of tiny fibroids growing on the surface of the uterine wall. Often, by the time a woman discovers she has fibroids, they are too large to be removed by this technique.

In addition to causing fertility problems, fibroids can cause heavy bleeding, extreme pain, and put pressure on the pelvic organs, including the digestive tract. Surgery is generally recommended to ease the symptoms of fibroids.

SURGERY OPTIONS

For years the standard treatment for fibroids was hysterectomy, or removal of the uterus, which obviously ends any chance of pregnancy. Depending on the type of hysterectomy, various degrees of menopausal symptoms may be experienced by the patient.

Today, open or laparotomic myomectomy, which is major abdominal surgery, is an increasingly common alternative to hysterectomy. Open myomectomy requires a pelvic incision of about four to six inches and a recovery time of about six weeks. Because the uterus is exposed and opened there is a risk of infection. There is also a risk of heavy bleeding from the uterus; many doctors recommend a patient give up to 2 pints of her own blood as a back-up. It is recommended that the patient wait anywhere from three to six months after the operation to attempt to become pregnant. Also, it is possible that during the surgery, the doctor will decide to perform a hysterectomy due to bleeding or the condition of the uterus. A ceasarean section will be the only safe method of childbirth after an open myomectomy.

Today, many doctors perform a variation of an open myomectomy called a "laparoscopic-assisted myomectomy" in which a laparoscope, which is a miniature, fiber-optic telescopic camera, is inserted into the pelvic cavity through a small incision, usually less than ½ an inch wide. The doctor will be able to view the inside of the uterus and the location of the fibroids very clearly, before making abdominal and uterine incisions and performing open-myomectomy. It is important when interviewing a doctor for laparoscopic surgery, to find out if the surgery will be laparoscopic, or laparoscopic-assisted surgery.

If true laparoscopic surgery is performed, miniature surgical tools are lowered into a tiny cut in the pelvis, and all the surgery takes place internally. The uterus never leaves the body. With a skilled and experienced laparoscopic surgeon the risk to the uterus is minimal; bleeding and risk of infection are slight. The benefits of this type of surgery far outweigh the risks. Recovery time is short; generally less than one week for all but the most complicated surgeries. Unfortunately there are very few laparoscopic surgeons the medical profession recommends; the only one recommended in New York, according to this interviewer's queries, was Dr. Tamer Seckin.

Dr. Seckin has over 16 years and over 10,000 hours experience in laparoscopic surgery. He is able to remove not only "normal" fibroids, but can remove very large and awkwardly located fibroids as well.

I interviewed Dr. Seckin at the end of August, 2007.

Interview: "Dr. Seckin, can you tell us why laparoscopy is such a boon to surgeons?"

Dr. Seckin: "Laparoscopy gives us the visualization of the fibroids. Without it, surgeons just have an impression of the size and location. We don't know how challenging the surgery will be unless we can actually visualize precisely where the fibroids are. Are they in or around the outside of the uterus? Are they on the surface, or buried inside? We can find answers to these and other questions during laparoscopy."

I: "If laparoscopic surgery is so progressive and such a good choice, why don't most gynecological surgeons perform it?

Dr. S: "It requires great skill; it involves rapid movements of stitching, bleeding control, and precision dexterity. It is quite difficult positioning the camera; like a video game you have to score once and move on. Also, there are very few surgeons who teach the technique."

I: "I see. That's why it requires years of experience. Why did you choose to specialize in laparoscopic techniques?"

Dr. S. "The benefits to the patient are immense. Recovery time is quicker—some of my patients return to work in less than a week; there is less risk of infection; a lot less pain; and also aesthetic value because there is such a small incision. The scar left behind is usually tiny, between a ¼ and ½ an inch. The surgeon is enabled to work on a micro-anatomical level. Also, importantly the surgeon can control bleeding even in tiny capillaries, something that macro-surgery cannot even attempt. I can reach into 'corners' of the pelvis which I could otherwise never see. Once you do this kind of surgery, you don't want to do other techniques."

I: "How close-up is your view of a capillary?"

Dr. S.: "I see a 1 millimeter capillary enlarged to 3 centimeters on the video screen the laparoscope is connected to. In laparoscopic surgery the surgeon sees everything between 4 and 30 times magnified, in full-color."

I: "Do you use lasers?"

Dr. S.: "Not really. I do use electrical bi-polar energy. It is like cutting with a very fine scissors. We also use miniature surgical tools."

I: "Can you treat other diseases with this surgery?"

Dr. S.: "Yes. Endometriosis, the evil twin of fibroids, can be treated with this type of surgery. Fibroids are the product of the uterine muscle—endometriosis is the product of the uterine lining. It too causes infertility, bleeding and pain."

I: "I have heard that an open-myomectomy can turn into a hysterectomy. Is this possible with laparoscopy?"

Dr. S.: "I have never had a single case of this happening. Generally speaking, this event would be directly proportionate to a surgeon's skill and experience."

I: "Obviously, this is why only a very experienced laparoscopic surgeon should be chosen by the patient. Why are many doctors today so willing to perform hysterectomies, surely a radical procedure, for the treatment of fibroids to begin with?"

Dr. S.: "That is what they are taught. Medical schools train gynecological surgeons to perform hysterectomies, D and Cs, and C-sections."

I: "Are there new techniques you have perfected which make laparoscopic surgery an even more effective and safe procedure?"

Dr. S.: "Yes, one in particular being a type of tourniquet I developed which ties off the tissue right at the point of the removal, virtually eliminating bleeding. A version of this technique is done in open myomectomy; to my knowledge I am the only surgeon doing this during laparoscopic surgery. I especially apply it when fibroids are close to the arteries. The removal of a fibroid can potentially cause serious blood loss. My technique enables me to remove very large fibroids that many surgeons won't attempt even during open myomectomy; when surgeons are performing open myomectomies, and see what they are dealing with inter-operatively, they convert the surgery to hysterectomy."

I: "Are there any other special techniques?"

Dr. S.: "Yes. I am able to remove very large fibroids because after removing the fibroid, I place it in a special collection bag, and remove it through the birth canal. Other surgeons either pulverize them in the womb, which is very dangerous, or they remove them from the surgical incision. I use the body's anatomy, which is a gentler and safer technique."

"I also perform what is essentially plastic surgery of the uterus. I may, when removing fibroids, repair any scar tissue or endometriosis. With these techniques, I make the womb a more hospitable place for a fetus, and a healthier organ overall."

I: "Do you recommend that women have fibroids removed before trying to get conceive?"

Dr. S.: "Although they have to be evaluated with respect to position and type, I usually recommend that even tiny fibroids be removed. Anything that competes with the uterine cavity should be eliminated. If fertility isn't an issue, and some small fibroids are present with symptoms, ablation of the cavity through heat, freezing, or radio frequency should be attempted. This way the uterus is saved."

I: "Thank you for sharing your knowledge. If readers have further questions about laparoscopy, where may they reach you?"

Dr. S.: "You're welcome. I have offices in Manhattan and Brooklyn. 872 Fifth Avenue, in Manhattan, 212-988-1444 and in Brooklyn at 8524 10th Avenue, 718-833-1020. In addition to asking questions, patients can see actual video footage of the internal organs as I perform laparoscopy."

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A Patient's Story

After an eminent, highly recommended fertility specialist and a well-known fertility clinic both ignored what were clearly problematic fibroids, (I had symptoms, and repeated examinations showed that I had several uterine fibroids) an acupuncturist recommended I seek another opinion. She referred me to a doctor who told me I needed a laparotomic (open) myomectomy right away and urged me to book the surgery. I was terrified--wanted a second opinion. I called Rabbi Jacobowitz from A TIME who told me I should strive to have laparoscopic surgery only. He recommended I see Dr. Adrian Vidali from ABC Fertility Centers since he had vast experience with fibroids. Dr. Vidali concurred with Rabbi Jacobowitz's belief that that an open myomectomy was not my only option.

Dr.Vidali said that the fibroids had to be removed, but he recommended that I contact Dr. Tamer Seckin who could remove my fibroids laparoscopically. Dr. Vidali told me most doctors are unable to do this surgery laparoscopically—it is too difficult but he said that Dr. Seckin had over ten years' experience performing this surgery and that people came from around the world to see him.

For a variety of reasons, I decided to consult one other surgeon. She only performed open myomectomies-- she explained the procedure to me. She said she would pull my uterus out of my pelvic area, lay it on my abdomen, cut it open and remove the fibroids. She told me bleeding was very common. She also told me there was a 50-50 chance that the surgery would scar me so badly that fertility would be impossible, but that without the surgery, there was no chance I would ever have a child. I began to read everything I could find about fibroids and surgery and was more confused than ever.

My husband was very unhappy with this surgery option, as was I, but we felt we had to move forward and agreed to the surgery. In the meantime I did even more research. I found out that it was not unheard of for surgeons to begin a myomectomy and end up doing a hysterectomy because of bleeding and other complications. A miracle clearly happened. After weeks of scheduling post-surgical care (I would not be able to cook, clean, work or walk for at least 4-6 weeks with an open myomectomy) we met with Dr. Seckin. Our meeting took place the day before my open myomectomy was scheduled! It appeared that I had 4 or 5 fibroids, one of them quite large. Dr. Seckin explained that he would better know the number and exact locations when he viewed them during surgery. After the examination, Dr. Seckin sat with my husband and me in his Manhattan office and showed us DVDs of laparoscopic surgery being performed. No, these DVDs are not for the faint-hearted. But within a few minutes, we were convinced-this was the right choice for us. The fact that I would be most likely able to go back to work within a week after surgery and would walk unassisted almost right away, in addition to the lesser risk to the uterus, were factors in our decision.

It was a beautiful Thursday in June. The day of surgery arrived. When I spoke with Dr. Seckin pre-surgery, my confidence soared. He is a perfectionist and totally dedicated to his work and I found that very reassuring. I was confident he was the messenger Hashem had sent to help me. After surgery I felt almost no pain from the incisions. Though most patients can go home the same day, I had 11 fibroids removed, one the size of a baseball! It was recommended that I stay overnight. The hospital staff I questioned believed that an open myomectomy would have surely turned into a hysterectomy—they were all excited about the surgery I had and were all interested in discussing it with me.

The next morning I was able to walk by myself, albeit slowly. I recalled a friend who recently underwent open surgery—it seems I felt like she did at six weeks! I went home in time for Shabbos; friends, neighbors and my husband prepared the seudahs for us, and many sent dinner the following week. I was able to walk, and even work an hour or two a day after four days. Aside from some minor digestive upsets the first couple of days, and some bladder difficulties because of the post-surgical catheter, there was little surgery-related discomfort.

Doctor Seckin examined me that week, and again, a couple of weeks later. I had some minor post-surgical adhesions removed by hysteroscopy by my new fertility specialist, also recommended by Rabbi Jacobowitz and A TIME (and by hasgacha pratis, recommended by Dr. Seckin too) and am now in the process of receiving fertility treatments.

Thank You,
A Time