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Expert Opinion: Broken Play Laparoscopy – What to do when there's no findings?

Greg J. Marchand

Marchand Institute for Minimally Invasive Surgery, 10238 E. Hampton, Ste 212, Mesa, AZ 85209, USA¹

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ABSTRACT

A short review of the uncomfortable scenario of a negative laparoscopy when expecting endometriosis, adhesive disease or other pathology. The article reviews different commonly used but rarely documented strategies for ameliorating pelvic pain in the absence of clear pathology.

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Contents

Broken play laparoscopy - what to do when there's no findings?	124
“Almost” incidental appendectomy	125
“Desperation” ovarian cystectomy	125
Intra-abdominal local anesthetics	125
Gentle hydrodistention	125
Close up and declare victory	125
Funding	125
Disclosure of interests	125
IRB approval	125
Data declaration	125
Details of ethics approval	125
References	125

Broken play laparoscopy - what to do when there's no findings?

Any surgeon who has done enough laparoscopy has been in this unfortunate circumstance. In the office it seemed like the patient had all the classic signs of endometriosis. She had a family history of endometriosis, the pain was worse during intercourse, worse during her period, there might have even been a little hemorrhagic cyst that looked “oh-so-close” to an endometrioma on ultrasound. But you got the scope in and her abdomen is cleaner than a self-

reported surgical complication list. Other than just waking up the patient and explaining the pain must not be from gynecologic causes, what do you do? In football we have a scenario very much like this - we call it a “Broken Play.” Basically the quarterback gets the ball and whatever was supposed to happen that play, be it a handoff or pass suddenly cannot happen. It could be because of unexpected coverage, or it may be the running back tripped or the receiver ran the wrong route. Whatever the reason, the quarterback ends up with the ball in a collapsing pocket, wondering if there's any way he can make something good happen out of the horrible turn of events that have unfolded for him. I've heard many ideas about what to do in this scenario, so I'll cover a few of them in detail.

¹ www.marchandinstitute.org.

“Almost” incidental appendectomy

We all know that the appendix is going to look a little injected. Does that mean it deserves to go? Do you even have privileges to remove it at this hospital (or surgery center?) The nurse thinks that there's a general surgeon a few operating rooms over, or in the cafeteria, or living just “5 min away.” Generally, suspicion of acute appendicitis is considered an emergency that does not require advanced consent. While I agree the temptation may be strong, experts recommend not to perform the incidental appendectomy unless you really feel there are compelling signs of inflammation [1]. Proactively, however, I do recommend discussing the appendectomy with all patients who have primarily right sided pelvic pain before surgery, although I can't say I always remember to do it. It really should be something to think about consenting the patient for whenever you are going in for right sided pelvic pain without a clear cause. I recommend going so far as to asking the patient ahead of time “if I don't find anything, would you want your appendix removed?”

“Desperation” ovarian cystectomy

As gynecologic surgeons we are sometimes put in a real dilemma as to whether or not to remove a normal appearing ovary that really seems like the cause of the pain [2]. If you're like me, it really takes a high threshold to remove an otherwise normal appearing ovary, just because it is assumed to be the unproven cause of the patient's pain. Cystectomy, on the other hand, backed by clinical suspicion, can appear as a seemingly free move in the uncomfortable case of a laparoscopy devoid of findings. We can always find a small follicle that could be the cause of the pain, right? With less than a third of ovarian tissue being required to maintain hormonal support, one could also ask the question of why you would not try to fix the patient's pain with a generous ovarian cystectomy? After all, you are already in her abdomen! The answer, of course, lies with our hippocratic responsibility, and the possible damage to the women's future fertility, as well as the unlikely, but possible loss of the ovary.

Intra-abdominal local anesthetics

Although supported by a paucity of data, the intra-abdominal use of marcaine or other local numbing agents, whether sprayed at the target area of pain, or simply injected into the abdominal cavity, can be considered in the absence of other treatable causes of pelvic pain [3]. The logic, at least, makes sense. The possibility of interrupting a theoretical abhorrent neurologic pathway that was eternally fixed on reporting horrific non-existent pain may seem tempting and without risk, but some pitfalls must be understood. Just as we are able to perform dialysis using the physiology of the abdomen, fluid in the abdominal cavity can quickly become intravascular. High doses of these medications can cause Local Anesthetic System Toxicity, (LAST Syndrome) so you will need to know your patient's weight off hand for safe, effective usage. With the exception of this caveat, there is little harm in using small doses of local anesthetic in the abdomen.

Gentle hydrodistention

The jury is still out as to whether an old fashioned gentle hydrodistention of the bladder is a good way to diagnose and treat interstitial cystitis. There is no doubt, however, that quite a few patients will give a very impressive display of bladder petechial lesions after being stretched to about the 300cc mark. Whether all those patients have pain from IC is another story. With the high correlation between interstitial cystitis and endometriosis, it certainly makes sense to continue your quest to find the cause of your patient's pain in

the bladder after coming up empty handed in the pelvis [4]. This almost risk-free exploration makes an attractive go-to for any pelvis who's pain could be explained by a condition in the bladder.

Close up and declare victory

Is there anything wrong with just desufflating the abdomen and hoping that the sheer act of having insufflated it will help with your patient's pain? While probably just wishful thinking on our parts as surgeons, there is some data behind the placebo effect of laparoscopy even in the absence of discovered pathology.⁶ I have heard many of my colleagues tell family members in the waiting room that if you just tell her “they fixed everything,” when they wake up - they will feel a ton better. I'm honestly not sure whether this is the power of positive thinking or straight-forward dishonesty. Nonetheless, a placebo effect can never be completely discounted, and there probably isn't much use in telling a patient that she definitely will not feel better after her surgery [5].

In conclusion, I hope you, me, and all our colleagues never find ourselves operating with no explanation for a patient's pelvic pain, or in a “Broken Play Laparoscopy” as I have described it. I would encourage those of you that do find yourself in this situation to consider your next moves based on your training, intuition, and what little evidence you find available. I can only hope that I may have helped with a little insight into this difficult scenario.

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