Clinical Pathways Program

Uterine Morcellation, Inpatient, Guideline

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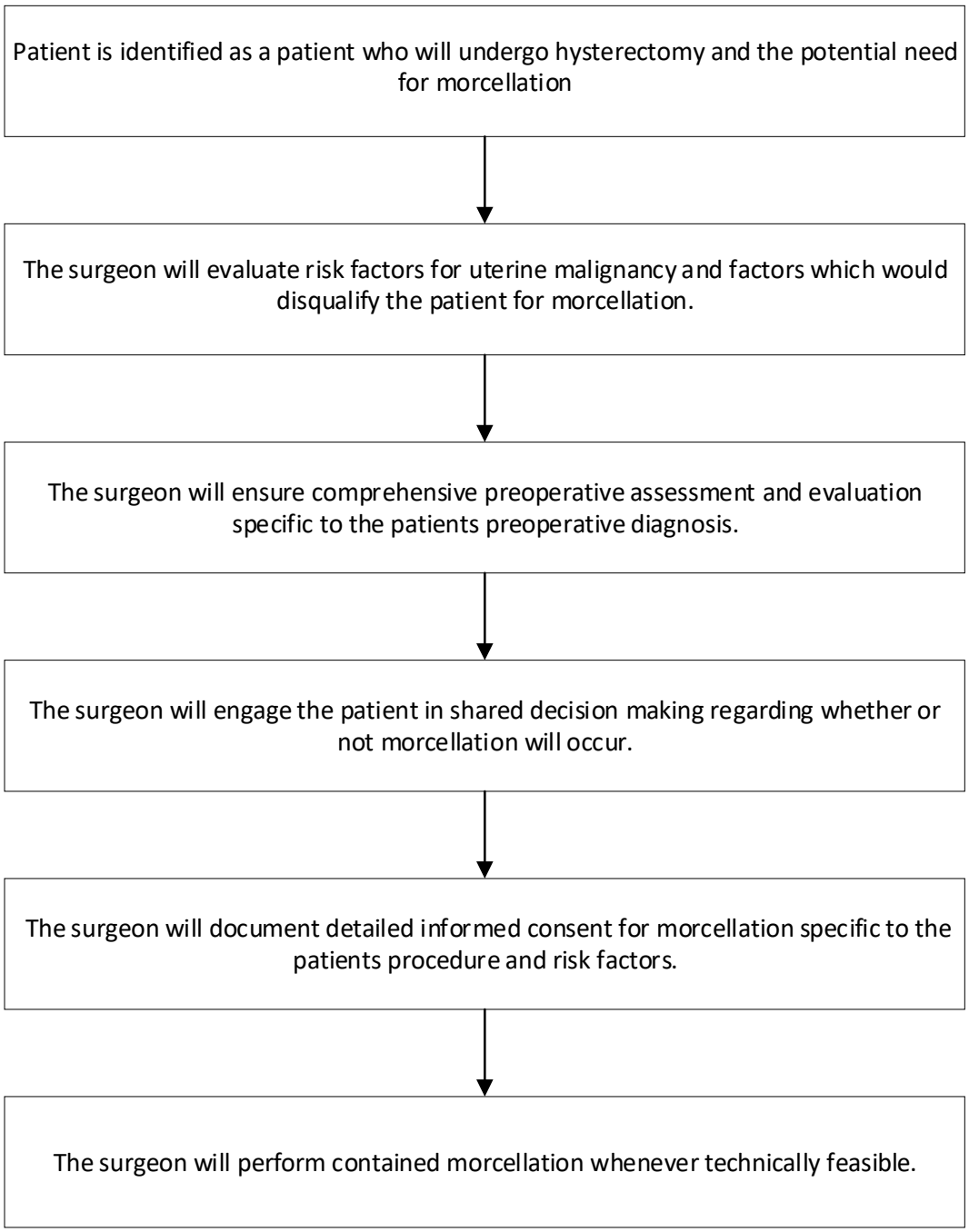
Clinical algorithm:



Clinical guideline summary

CLINICAL GUIDELINE NAME: Uterine Morcellation

PATIENT POPULATION AND DIAGNOSIS:
Women with need for morcellation of any portion of the uterus including women undergoing hysterectomy or myomectomy

APPLICABLE TO: All Spectrum Health Sites

BRIEF DESCRIPTION: This clinical pathway outlines the clinical factors that should be taken into consideration when considering uterine morcellation and the preoperative shared decision making and specific informed consent required for this procedure. The specific requirements for when morcellation should and should not be performed are outlined, as well as procedural considerations for types of hysterectomy and containment of morcellation.

Definitions:

Uterine tissue: Any portion of a uterus including myometrium, fibroids, adenomyosis, endometrial cavity, or cervix.

Manual Morcellation: Any technique of uterine fragmentation by scissors or scalpel of a large tissue specimen into smaller pieces to facilitate the specimen extraction either through vagina or a mini-laparotomy.

Contained Morcellation: Containment of the morcellation process within a containment bag.

Open Morcellation: Morcellation outside of a containment bag, including extracorporeal vaginal morcellation

OVERSIGHT TEAM LEADER(S): Elizabeth Leary, MD (Div Chief, Gynecology), Robyn Hubbard, MD (Women's Health Dept Chair), Leigh Seamon, DO (Physician, gynecologic oncology)

OWNING EXPERT IMPROVEMENT TEAM (EIT): Gynecology EIT

MANAGING CLINICAL PRACTICE COUNCIL (CPC): Women's Health CPC

OTHER TEAM(S) IMPACTED (FOR EXAMPLE: CPCs, ANESTHESIA, NURSING, RADIOLOGY): Urology, General Surgery, Gynecologic Oncology, Surgical Oncology

IMPLEMENTATION DATE: 8/10/2020

LAST REVISED: 8/10/2020

FOR MORE INFORMATION, CONTACT: Elizabeth Leary

Clinical pathways clinical approach

TREATMENT AND MANAGEMENT:

Risk factors for uterine malignancy - For an individual patient, the surgeon should account for clinical factors and determine which route of hysterectomy will most safely facilitate removal of the uterus and optimize patient outcomes given the clinical situation and patient risk factors. Risk factors for uterine sarcoma include history of prolonged tamoxifen use >5 years, history of pelvic radiation, hereditary cancer syndromes including Lynch Syndrome, Leiomyomatosis and Renal Cell Carcinoma (HLRCC) syndrome, Retinoblastoma syndrome, Li Fraumeni syndrome, and BRCA mutation carrier status, as well as postmenopausal status and increasing age (especially with new uterine mass or enlarged uterus diagnosis).

Morcellation will not be performed in the following circumstances - Suspicion of uterine malignancy, known uterine malignancy or complex atypical endometrial hyperplasia. The adnexa should not be morcellated and should be separated from the uterine fragments for pathologic evaluation.

Preoperative assessment - Patients will receive comprehensive preoperative assessment appropriate to their preoperative diagnosis and risk factors to further risk stratify patients for malignancy. All patients will have current cervical cytology with further evaluation of abnormal histology completed prior to hysterectomy. Patients with abnormal uterine bleeding will have an endometrial evaluation including endometrial biopsy and uterine imaging prior to morcellation. Patients with an enlarged uterus without abnormal uterine bleeding will have current uterine imaging and consideration of endometrial biopsy based on the findings.

Preoperative counseling and informed consent - The surgeon will engage the patient in shared decision making, including informed consent explaining the risks and benefits of each approach to surgery for removal of the uterus or uterine masses. The informed consent will include both the risks and benefits of open or contained morcellation, alternatives to morcellation, and risks of laparotomy compared with minimally invasive approaches. This will occur in any circumstance where the uterus may be morcellated during surgery and this conversation will be documented in the chart including the preoperative history and physical within the hospital electronic medical record. Candidates will receive counseling by the surgeon individualized to the preoperative indication and evaluation of personal risk factors. Prior to morcellation, patients with increased risk of uterine malignancy should be appropriately counseled about their increased risk and morcellation may only be done in a contained fashion.

Technical aspects of morcellation - Morcellation will be contained whenever technically feasible for all laparoscopic/robotic hysterectomy and myomectomy procedures regardless of the route of uterine removal (vagina or minilap). While extracorporeal vaginal morcellation is considered open morcellation, it may be performed in appropriate risk patients to debulk the uterus to allow completion of the vaginal hysterectomy procedure.

References:

American College of Obstetricians and Gynecologists (ACOG). Uterine Morcellation for Presumed Leiomyomas. Committee Opinion No. 770. March 2019

AAGL Special Article: Morcellation during Uterine Tissue Extraction: An Update. J Minim Invasive Gynecol. 2018 May-Jun:25(4):543-550

AAGL Practice Report: Morcellation during uterine tissue extraction. J Minim Invasive Gynecol. 2014: Jul-Aug;21(4):517-30

POLICY Uterine Morcellation, Spectrum Health, Reference # 22739, Version 1, Effective Date 8/10/20