Micro-Laparoscopy for Women with Chronic Pelvic Pain and Pain Mapping

August 25, 2006
By Mark Perloe, MD [1]

OBGYN.net Conference Coverage From American Association of Gynecological Laparoscopists
Atlanta, Georgia, November, 1998

Audio Link  *requires RealPlayer- free download

Dr. Mark Perloe: “I’m here at the 27th annual AAGL meeting with Dr. Larry Demco. Dr. Demco, you probably have more experience than anybody applying micro-laparoscopy for the evaluation of patients with pelvic pain. How did you get involved in this area?”

Dr. Larry Demco: “Actually, it was patient generated. I was seeing patients with pelvic pain and one patient in particular changed the whole focus. She said to me one day, “I have pelvic pain but I also have pimples on my forehead. Dr. Demco, from across the room and behind your desk, can you tell me which pimple hurts and which one doesn’t?” I said, “No, I’d have to touch them.” She said, “Correct, now what are you going to do when you put me to sleep for a laparoscopy? Why are the rules different?” She was my first patient who ever stayed awake and proceeded as a patient to get involved and try to direct the doctor better to the areas that cause pelvic pain.”

Dr. Mark Perloe: “Do you find that pain mapping procedures allow you to find sources of pain that would not be obvious if you had the patient asleep?”

Dr. Larry Demco: “This is correct. With our work with endometriosis, we’ve seen that the patient can direct us to the pain to extend beyond our original lesion up to almost an inch. If we had only treated the lesion, the pain would still remain because the area that was in the normal looking peritoneum was still tender. We’ve also documented that these areas that were normal looking, when we came back three months later, had lesions which were present with endometriosis which were extended all the way to black lesions.”

Dr. Mark Perloe: “Do you find then that the majority of patients, when you identify this area, have micro-laparoscopic possibilities for treatment or does it require in the majority of these patients resorting to a standard laparoscopic approach to manage the lesion or the area of pain?”

Dr. Larry Demco: “We initially thought the patient wouldn’t be able to tolerate treatment under a local. As a result, our initial studies were based upon mapping the patient awake, putting her to sleep, treating the area, coming back six months later to re-map it, and letting the patient evaluate her results whether she was totally pain free or not. We then subsequently combined the operation. We have a series running where patients map the pain, they tell us exactly where it is, and we treat it at the time while they’re awake. They evaluate the results of therapy right there and actually direct me, the physician, exactly where to treat and the results of the therapy.”

Dr. Mark Perloe: “What energy source are you using to treat those areas?”

Dr. Larry Demco: “We’re using the argon beam coagulator, it’s spray paints electricity over a wide area. The reason being is, you have to understand with any other source, you have to touch the painful area for therapy. With the argon beam - you don’t have to touch the tissue, and as a result, you can spray it, destroy or vaporize the tissue, and the patient feels a fair momentary second. Then you can come back and map it immediately.”

Dr. Mark Perloe: “When the micro-laparoscopy equipment first came out a few years ago many
physicians saw this, picked right up on it, and gave it a try. At that point, the equipment had a lot of problems, the vision wasn’t clear, frequently the scopes would fog, and we didn’t have the accessory instruments that we now have. What would you say to those physicians who say, “I’ve tried it and it’s not for me?”

Dr. Larry Demco: “Our techniques and our technology have changed over the last year or two because now we’ve moved up and saw that many of these scopes gave us a picture that we were unfamiliar with. Instruments didn’t move the way we originally thought they would when we’re using larger instruments, and as a result, put us in a very uncomfortable position. We moved back to 3-mm and 4-mm scopes and 3-mm instruments, which have direct correlation. The scopes do make it appear exactly like you would see with a much larger 10-mm scope so you are in a very comfortable position now with a familiarity. Now instruments move the way that you were expecting them to move, and the picture on the monitor is exactly what you would see with a larger scope of 10-mm, for example.”

Dr. Mark Perloe: “When I first got involved in this, I found there was a lot of trial and error in things that I learned in a course. When we’ve talked, there were a lot of tips and pearls that you have that enables someone to perform the procedure in a safer fashion and have more consistent results. How would you advise someone who wants to learn more and adapt this into their practice and train themselves in these new techniques?”

Dr. Larry Demco: “The whole difference in the concept of micro-laparoscopy versus standard laparoscopy with larger instruments is we were taught to keep the scope steady, use our accessory instruments to bring the organ into view, and clear adhesions - and as a result, we affect our operation. In micro-laparoscopy, the smallest of the scopes allows us to keep the organ still or not move the organ, and move the scope in and around it. So in an area underneath, we use very small quantities of gas - 600 cc’s. You may say that’s not enough to perform a regular laparoscopy, but in micro-laparoscopy we know that if you do the Trendelenburg, that 600 cc’s will eventually go underneath the uterus. A space between the ovary and the uterus, which you’d normally say you couldn’t see anything, you could pass the scope by it into the gas bubble below, and as a result with the lower quantities of gas, you eliminate the shoulder tip discomfort. You are able to see just as effectively at one or two centimeters away from the organ that you were previously seven to ten centimeters away from.”

Dr. Mark Perloe: “Any tricks on getting the gas out after the case?”

Dr. Larry Demco: “When you’re using such a small volume of 500-600 cc’s, there’s not really a need. What I always do is unscrew the trocar completely so that it’s completely open and not just opening the valve to try to eliminate as much gas.”

Dr. Mark Perloe: “What do you think is the future of micro-laparoscopy, and what new things do you think will come to for in terms of instruments or applications?”

Dr. Larry Demco: “The future of micro-laparoscopy is to bring the patient into the operating room not as a victim but as a participant to confirm things, to show, to explain, and let the lady see for herself the reasons for her pain, such as letting her see her own endometriosis. It’s very important for these people that have been living with this pain for several years. They want to see what’s causing it, they want to be there and see for themselves the results of therapy, and they want to see it disappear themselves. It’s very important, and this is something that hasn’t been addressed too much. The future is that we can now not only look at micro-laparoscopy in pain mapping in the pelvis but also we’re now mapping within the bladder itself in interstitial cystitis and trying to find areas of lesions that are tender. We’re also looking at the upper abdomen to see pain syndromes there. The patient might give us more insight; a good classical example of this is we are now seeing 15% of patients, when we move the left ovary, will tell us we’re moving the right one. We also mentioned that on the left pelvic side wall underneath the ovary - if we touch this area or it is involved with endometriosis, they have umbilical pain on the right, and it’s reproducible. The new thoughts that the left side of the body doesn’t cause left-sided pain, and the right side of the body only causes right-sided pain is not true. We’re seeing that the patient is sometimes astonished to see something on the left could be causing pain on the right, and she sits there and says, “How would you have
known that without me showing you?”

**Dr. Mark Perloe:** “We all have had patients who come in and repeatedly have standard laparoscopy. The patient may say, “My right ovary is hurting, the problems in my right ovary - take it out.” You go in and find that the pathology that you see is on the opposite side so I think it’s nice to have that explanation now, and we’ll have a better understanding of the causes of pain and potentially improve our results in management.”

**Dr. Larry Demco:** “I think the only person in the room that knows exactly where the pain starts and where it ends is the patient herself. We have to give her the opportunity to express that to herself and to us, her physician, so that the two of us - the patient and the doctor - can put an end to her pain. Neither one of us can do it alone.”

**Dr. Mark Perloe:** “Thank you very much.”

Source URL:

Links: