



## Foreword

# Minimally Invasive Gynecologic Surgery: Improving Outcomes and Recovery While Reducing Discomfort and Cost



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Consulting Editor

This long-awaited issue is the first in *Obstetrics and Gynecology Clinics in North America* to provide an overview of topics pertaining to minimally invasive surgery that apply to gynecologic surgeons. As dual editors, Dr Ted Lee and Dr Nicole Donnellan from the University of Pittsburgh set forth pathways for the reader to diagnose and treat many benign gynecologic disorders. Approaches to chronic pelvic pain, endometriosis, ovarian cysts, myomas, menstrual abnormalities, cervical incompetence, and uterine fibroids are described holistically, that is, more than merely the sum of its parts.

Surgeries described in this issue are to be selected based on their likelihood of improving outcomes due to the complexity of the case or patient factors, with appropriate consideration to costs. Choosing the appropriate patient and counseling about procedural options are essential. For every gynecologic condition described in each article, the authors begin with diagnostic modalities and patient education to assist in the surgical planning. Individualized plans might involve any of the following minimally invasive procedures: hysteroscopy, laparoscopy, robotic surgery, and vaginal surgery. Informed consent should be obtained from patients before surgery with a discussion of the gynecologist's experience, indication(s) for surgery, and potential risks and benefits.

Minimally invasive surgery involves several techniques to operate with less damage to the body than with open abdominal surgery. Anticipated intraoperative and postoperative complications, operative and recovery times, and discomfort with each

procedure should be compared with alternative approaches. In general, minimally invasive gynecologic surgery (MIGS) is associated with less pain, a shorter stay if hospitalization is even necessary, a shorter recovery time, and fewer complications. As described and illustrated in these pages, surgery is performed through one or more small incisions using small tubes, tiny cameras, and surgical instruments. Whether it be laparoscopic, robotic, or hysteroscopic, MIGS provides a magnified, often 3D view of the surgical site, and aids the gynecologist to operate with precision.

The reader's attention is placed throughout these review articles about recovery after minimally invasive surgery. The concluding article deals with enhanced recovery after surgery (ERAS), which refers to multimodal perioperative care pathways or protocols designed to achieve early recovery. In addition to protocols, key factors to a successful ERAS implementation program involve a multidisciplinary team, the organizational will to change practice, and a real-time system for compliance/outcome auditing.

Credentialing and privileging to perform minimally invasive surgery are conducted locally by health care institutions, whereas the American Board of Obstetrics and Gynecology provides certification after completion of either resident training or MIGS fellowship training. Medical specialty organizations, other educational institutions, and the health care industry do not have the authority to credential or privilege but may provide documented training for gynecologists. Some medical specialty organizations, such as the American Association of Gynecologic Laparoscopists, have developed guidelines for credentialing and privileging to use as templates and modified for each individual institution.

Content in this issue should serve as a valuable resource for gynecologic surgeons at any level. Dr Lee and Dr Donnellan gathered a team of experts who provide practical approaches and many technical "pearls" for a contemporary, holistic, and patient-centered focus. The authors share their knowledge about the technology and multitude of treatment options for meaningful decision making shared between the patient and surgeon. I look forward to an update that reflects the expansion of a rapidly growing literature that reports.

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