Open, laparoscopic and robotic myomectomies - comparison of outcomes

To the Editor,

We read the article entitled: "Comparison of perioperative outcomes among robot-assisted, conventional laparoscopic, and abdominal/open myomectomies" by Özbaşlı and Güngör (1) with a great deal of interest.

Myomectomy is the gold standard approach for women desiring fertility preservation. We would like to ask the authors a number of questions. These are:

In your cohort do you have any data regarding the pregnancy rates, spontaneous abortion rates, live birth rates and any comparison between the three groups?

What about the mode of deliveries and possible obstetric complications e.g. uterine rupture in such women?

Is there any experience with single-port approach in the minimal invasive groups? And how do you solve ergonomic issues?

Was there any difference found in conversion rates between laparoscopic and robotic groups? Have you identified any difference in blood loss based on the number of myomas excised in the different groups?

Since 2014, the Food and Drug Administration issued a warning against power morcellation to avoid tumor dissemination in the unexpected scenario of leiomyosarcomas (2). Are the authors using a power morcellator within an endoscopic bag?

As the incidence of unexpected leiomyosarcoma ranges from 1 in 225 to 1 in 580 (2), did you have any occult findings of leiomyosarcoma in your cohort?

Once again, we would like to thank the authors for their well-presented article.

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Author's Response

Dear Editor,

We would like to thank the author of the letter commenting on our article, "Comparison of perioperative outcomes among robot-assisted, conventional laparoscopic, and abdominal/open myomectomies" and the opportunity to respond to their concerns.

The author of the letter asked about the data regarding pregnancy rates, abortion rates and possible obstetric complications. Although pregnancy rates and possible obstetric complications are some of the main concerns in reproductive age patients, in the discussion section of our study, it was stated that some of our limitations were retrospective design and the failure to compare long-term outcomes such as pregnancy rates (1,2). The long-term outcomes such as abortion rates, live birth rates and possible obstetric complications were not compared in our study. As the author pointed out and as it is stated in our study, more prospective, randomized trials with long-term outcomes such as pregnancy rates, possible obstetric complications are needed.

Although single port myomectomy is performed in our clinic, we excluded the cases with laparoscopic or robotic single port myomectomy in this study.

In Iavazzo et al.'s (3) meta-analysis, cases of conversion to open was higher in laparoscopy group than robotic group. But in our study, conversion to laparotomy was not observed either in the robotic myomectomy or laparoscopic myomectomy groups.

Although the number of myomas excised was significantly higher in the open myomectomy group, no significant difference was observed among groups regarding blood loss.

In Taylan et al.'s (4) review, the risk of unanticipated uterine sarcoma in patients undergoing a uterine morcellation was 0.22%. In this review, a retrospective study that included 40,000 patients the prevalence of cancer in women who underwent myomectomy with power morcellation was 0.09%. Although the overall risk of occult malignancy appears to be very low, as the author stated power morcellation should be used with caution especially in older patients. In regards to avoiding tumor dissemination, in most of our cases contained morcellation of myomas using a power morcellator within a tissue morcellation bag (MorSafe®) was performed. As it is stated in our study, pathology results were not significantly different among the groups and no leiomyosarcoma was detected among groups.

We hope this provides some clarification for the author of the letter.

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