Gynaecology.co endometriosis centre at King Edward Seventh Hospital

Endometriosis centres have the following criteria at their core:

- Adequate training and workload
- Multidisciplinary working
- Appropriate facilities

Adequate training and workload

There is a training programme for gynaecologists wishing to undertake the management of women with recto-vaginal endometriosis. The development of this training module for gynaecologists was set up by a group led by me in 2008. Thus, evidence of appropriate training is available for newly appointed consultants. This would not apply to established consultants, but they would be able to provide evidence of appropriate exposure and acquisition of skills.

The British Society for Gynaecological Endoscopy (BSGE) guidance determines a minimum throughput of 12 recto-vaginal cases (severe cases involving the area between the vagina and bowel) per consultant per year to be an accredited centre. Most consultants working as part of a centre would also be doing other significant laparoscopic surgery. Thus, best practice for the management of women within the private sector would be as part of an accredited endometriosis centre. Currently this would be very restrictive as many consultants would not have an adequate private referral base for this level of disease. Hence as a minimum, they should work within an NHS accredited centre. This would demonstrate adequate surgical workload to have appropriate competencies. Some consultants do not engage with the BSGE accreditation process and thus they may instead produce other evidence of appropriate throughput.

This level of surgical throughput is a requirement for NHS commissioning (purchasing of care) and the private sector should probably not offer lower quality standards regards consultants with adequate ongoing surgical exposure.

Multidisciplinary working

The make-up of the team are:

- Nurse specialist
- Gynaecologist
- Colorectal surgeon
- Urologist
- Pain management
- Linkage with appropriate radiology and fertility expertise

Nurse specialists are an integral part of the team to ensure patient continuity and understanding and to provide appropriate data follow up and a point of contact outside the doctor visit. This is a mandatory part of being a BSGE accredited centre and has a specific job specification. It is also a recommendation of both NICE and specialist commissioning. The development of this role requires hospital investment and thus the private hospital has to endorse the development of a specialist centre for this to occur. This will only occur where the patient workload justifies such investment in nursing staff.

For more severe disease with significant bowel involvement, it is recommended that a **gynaecologist and colorectal surgeon** should operate together. The colorectal surgeon should be named. Familiarity and consistency of operating with the same colleague results in harmony of motion and better decision making and hence potentially improved outcomes. Often such surgery will reduce the requirements for bowel resection as skills and judgement for shaving becomes greater.

Urology has 2 aspects. The most significant input is endo-urology. Stenting and decision making require significant expertise for the more complex cases. This can result in a staged approach and reduce the requirements for reconstruction with re-implantation. Where re-implantation is required this should be performed by a urologist with specific expertise as the cases will be complex and familiarity will reduce the risk of fistula and stenosis.

Pain management at times is required and where offered in the private sector is ideally carried out by a team used to treating this group of patients.

At times a patient has significant **fertility issues** and it is necessary to have linkage to a fertility expert to help advise on whether treatment of disease for pain should be delayed until after fertility issues have been addressed. An example would be embryo storage before excisional surgery in an older patient with poor ovarian reserve.

As in all areas of surgery, expert **scanning or MRI** by colleagues with knowledge and understanding of the specific condition will yield more information and can help determine the requirements for team surgery and enable better patient planning and counselling.

Appropriate facilities

Over the years the level of technology has advanced to enable better visualisation. The BSGE and the specialist commissioning document for NHS England refers to an advanced theatre set up with modern levels of visualisation. A minimum of an HD camera should be used with 4K technology starting to be introduced. Modern advanced energy sources are required for the more complex cases. The majority of teams feel that integrated theatres with multiple screens improves working for teams and indeed this is supported in the specialist commissioning document. Such advanced theatre environments require significant hospital investment in modern technology and will only be offered where there is sufficient workload to justify expenditure.

Some of these cases are very complex and reported rates of significant complications is up to 10%. Thus, appropriate HDU/ITU facilities are required for the more severe cases and easy access to CT and MRI to enable early identification of a bowel or ureteric complication. Early identification of a problem will reduce the subsequent morbidity and impact on patient recovery.

What we offer at the King Edward VII endometriosis centre

All members of the King Edward VII Endometriosis Team have worked within the endometriosis accredited centre for over 7 years and hence have enormous experience and expertise. The centre consistently receives referrals from other gynaecologists as it runs a tertiary level service. Members of the team run courses for other specialists to observe complex surgery.

The King Edward VII centre is one of the longest running private accredited endometriosis centres. It is unique in offering all the benefits that NHS patients experience from team-work.

Over and above the NHS set up, the team is more refined and offers total consistency in care. Our service offers a service run by leading experts in all aspects. MDT discussion is not charged for and we offer the highest level of care with experience at a level probably not offered by many other teams. In particular we have significant experience of working together which offers further added value. This could be considered a premium service.

King Edward VII Team members

Alfred Cutner and Alastair Windsor
Experienced gynaecologist (who set up and jointly runs the UCH accredited centre) and Colorectal surgeon carry out combined surgery for all joint colorectal cases. This team has performed over 200 joint operations. This is one of the largest series in the UK. This has resulted in a low rectal resection rate and a low complication rate.

Daron Smith and Jeremy Ockrim
A leading expert in endo-urology (Mr Smith) and reconstructive urology (Mr Ockrim). This collaboration entails appropriate ureteric and stent management to preserve renal function and reduce the requirement for reconstruction. In rare cases effective reconstruction is needed to avoid long-term urological sequalae.

Pain management is part of the renowned pain management service at The King Edward VII.

Renata Marucha is the nurse specialist who offers continuity of care and expertise for patient concerns. Her employment and funding and release for CPD is provided by the King Edward VII Hospital. Her role is core to the patient support. This is essential as there are many issues and difficulties for patients with this level of disease severity.

Cost effectiveness

Cost-effectiveness is often measured in terms of completed patient episodes. Where a patient has multiple laparoscopies over several years, the actual cost is greater than a single more expensive individual episode. Inadequate initial surgery may well result in more complex and expensive revision surgery. A more “mature” team with enhanced skill and experience may perform less radical yet more effective surgery and have a reduced complication rate. They may also perform more complete surgery with resolution of the symptoms. They would be better placed to help guide and support patients where further surgery is unlikely to be the best solution to their symptoms. An experienced team would identify and manage complications more effectively and hence reduce the morbidity (and cost) of dealing with such problems.

Working in an experienced multidisciplinary team supported by a hospital that invests in a nurse specialist and advanced technology will result in overall more cost-effective and appropriate care even if an individual episode costs more. There are few units where such expertise of 3 different specialties (gynaecology, colorectal and urology) are made available during the same operation where required. Such team-work reduces morbidity and overall cost.

In all areas of life there will be different levels of cost depending on the level of expertise that a person wishes to purchase even when the stated procedure / case / concern is the same. A premium service requires financial investment of the organisation and time investment of the individuals to develop such specialisation and skill. A “one price fits all” approach is not appropriate where super-specialisation and unique expertise is required: We believe that an initial investment in premium care may well result in a reduced cost overall.

References

There are three documents that provide guidance on accepted best practice for surgical management of women with severe endometriosis within England:

- BSGE guidelines on criteria to be an accredited centre (https://www.bsge.org.uk/requirements-to-be-a-bsge-accredited-centre)

- Nice guidance on the management of Endometriosis (https://www.nice.org.uk/guidance/ng73)

- NHS England specialist commissioning for the treatment of advanced endometriosis (https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2014/04/e10-comp-gynae-endom-0414.pdf)