

Dr. Whitted is dedicated to safe, state-of-the-art, innovative surgeries and healthy lifestyles for women of all ages. In a nurturing environment, the physicians and staff strive to promote a partnership in your healthcare and make every effort to bridge the sterile science of diseases with your emotional, physical, and spiritual needs. Everyone is confronted with difficult healthcare decisions at one time or another. You'll want your physician and staff to have the knowledge, experience, and sensitivity to guide you safely through the decision-making process.

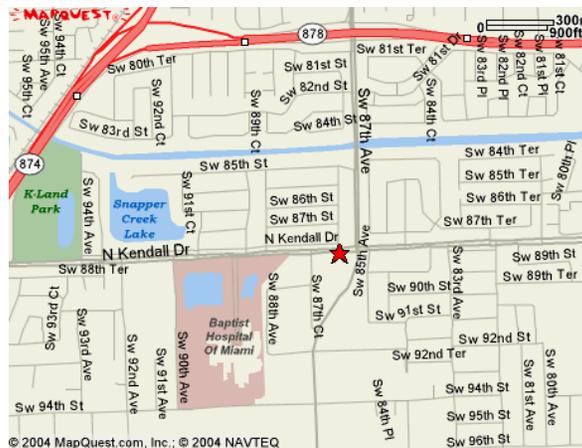
Dr. Whitted provides comprehensive gynecologic office and surgical healthcare. He is certified in laparoscopy and hysteroscopy and is an expert in advanced gynecologic surgery. He has been a national speaker, trainer, and researcher in advanced surgical techniques. In addition, Doctor Whitted is a Certified Menopause Clinician who educates, trains, and has done research in the science of menopause. Finally, he is certified in advanced colposcopy.

Doctor Whitted offers expert education and care in the following areas:

<b>Abnormal Paps (HPV)</b>	<b>Loss of Urine</b>
<b>Abnormal Menstrual Cycles</b>	<b>Menopause</b>
<b>Bladder Prolapse</b>	<b>Ovarian cysts</b>
<b>Chronic Pelvic Pain</b>	<b>Osteoporosis</b>
<b>Endometriosis</b>	<b>Rectocele</b>
<b>Ectopic Pregnancy</b>	<b>Uterine Prolapse</b>
<b>Family Planning</b>	<b>Vaginal Prolapse</b>
<b>Fibroids (Leiomyoma)</b>	<b>Well-Woman visit</b>

\*\*\*Evaluation and Diagnosis of Gynecologic Cancers

If you need surgery, Dr. Whitted usually performs minimally invasive surgery (Vaginal, laparoscopy and hysteroscopy) and has many years experience in these areas.



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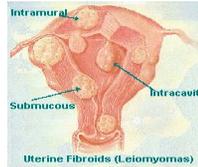
[www.drwhitted.net](http://www.drwhitted.net)



## Raymond Wayne Whitted MD, MPH

*...dedicated to healthy lifestyles and safe, state-of-the-art surgery for women of all ages.*

## UTERINE "FIBROIDS"



Fibroids (leiomyoma) are muscle growths in the Uterus that affect 30%-40% of women. They usually are asymptomatic and can be left alone and rarely are malignant. Fibroids may require treatment for the following reasons:

- Pain (usually cramping and lower pelvic area)
- Bleeding (abnormal)
- Urinary frequency and bladder pressure (usually secondary to size of uterus)
- Rapid growth

Fibroids are classified by location. **Intra-cavitary** ones are in the uterine lining, **intramural** are in the muscle of the uterus, and **serosal** are on the outside of the uterus. **Submucosal fibroids** are partly in the lining and muscle. **Pedunculated** ones are on the outside of the uterus dangling from a stalk.

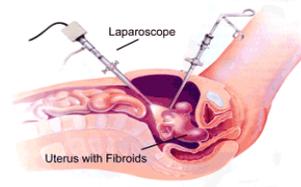
Fibroids are initially diagnosed through pelvic exam and ultrasound. Office hysteroscopy or saline infusion sonography define intracavitary and submucosal ones. Occasionally an MRI is performed to locate each individual fibroid within the uterus. This is especially important in certain types of fibroids if the hysteroscopic or laparoscopic surgery is considered.

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If you and your Doctor decide surgery is your best choice for the management of your fibroids you will need to understand the 3 approaches to non-hysterectomy surgical fibroid management.

These are Hysteroscopy, Laparoscopy, and/or Laparotomy (abdominal incision) approaches..

## Laparoscopic Myomectomy



Laparoscopic Myomectomy is chosen based on feasibility. It is performed like abdominal myomectomy only through minimal incisions on the abdomen. It is most feasible when there are no more than 3 fibroids, the largest one measuring no more than 10cm, and none in the extremely anterior or posterior position. Finally, special surgical skill is required to perform laparoscopic myomectomy.

When laparoscopic myomectomy is chosen a “telescope” is placed through the “belly button” after an incision is made. 3 other small incisions are made based on the locations of the “fibroids”. These are usually in the right and left lower quadrants and in the suprapubic area.

Once the trocars are placed, instruments are inserted through the trocars and the operation is performed. An injection of diluted pitressin (a hemostatic agent) is made in the capsule of the fibroid. Once blanching is seen an incision is made through the capsule identifying the fibroid. It is then shelled out of its “bed”. The defect in the uterus is then closed with sutures. The fibroid is then brought out through one of the trocar sites by morcellating (cutting into pieces) it. The tissue is sent for pathologic evaluation.

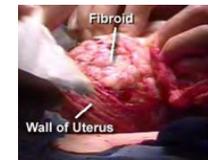
The risks associated with any myomectomy are bleeding, infection, injury to abdominal organs, possible need for cesarean section, possible hysterectomy, fibroid recurrence (30%), endometriosis, adenomyosis,

Laparoscopic myomectomy is usually an outpatient surgery and has minimal postoperative recovery associated with it.

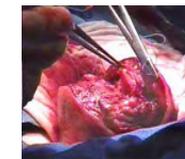
## Abdominal Myomectomy



Fibroid Location



Capsule incision



Fibroid Removal



Incision closure

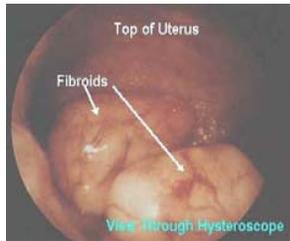
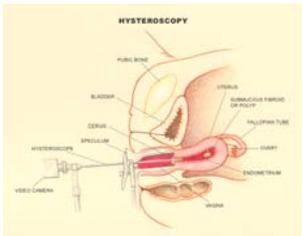
Abdominal Myomectomy is chosen when the minimally invasive approaches are not feasible. This method requires a large incision on the abdomen. The incision can be a “bikini” cut or may need to be a vertical one (from pubic bone to “belly button”) depending on the sizes and locations of the fibroids.

Abdominal myomectomy can have significant blood loss because the uterus is a very vascular organ. To minimize this we utilize a tourniquet to reduce the vascular supply. In addition we inject the fibroid with a diluted solution of Pitressin (a vasoconstrictive agent).

The risks associated with abdominal myomectomy include bleeding, infection, injury to abdominal organs, possible need for cesarean section, possible hysterectomy, fibroid recurrence (30%), endometriosis, adenomyosis.

Abdominal myomectomy usually requires a 1 or 2 day hospital stay and requires 3-6 weeks recovery.

## Hysteroscopic Myomectomy



During Hysteroscopy a telescope is inserted inside the uterus through the vagina. No incisions are used. Distending fluid medium allows for visualization of the intra-uterine abnormalities. Instruments are inserted through the hysteroscope so that specific abnormalities can be removed. Common gynecologic problems that can be addressed with the hysteroscope include:

- Removal of Fibroids and Polyps
- Endometrial Sampling
- Endometrial Ablation (destruction of the endometrial lining)
- Adhesiolysis
- Septolysis
- Fallopian tube cannulization
- Removal of an IUD (intra-uterine contraceptive device)

The risks associated with hysteroscopy include bleeding, infection, perforation, injuring abdominal organs, fluid overload, inability to complete the procedure, failure to correct the symptoms, and air emboli.

Hysteroscopy is usually an outpatient surgery and has minimal postoperative recovery associated with it.