RELEVANT ANATOMY
Cervix, transformation zone, squamocolumnar junction, internal cervical os, limits of cervical lesion.

PATIENT POSITION
- Dorsal lithotomy

ANESTHESIA
- Paracervical block—1% lidocaine (Refer to Chapter 13.7 and Figures 13.7.1 and 13.7.2)

EQUIPMENT
- Loop electrode—size dependent on area to excise
- Electrosurgical generator
- Grounding pad
- Nonconductive Graves speculum with integrated smoke tube
- Suction tubing
- 5% acetic acid
- Lugol’s solution
- Long cotton swabs
- Endocervical curette
- Ball electrode
- Monsel’s paste/solution
- Tissue forceps
- Formalin container
- Suture
- Needle driver
- Scissors
- Supplies for paracervical block
Loop Electrosurgical Excision Procedure (LEEP)

**TECHNIQUE**

1. Place grounding pad horizontally over patient’s thigh.
2. Place speculum with suction tubing connected. Cleanse cervix and perform paracervical block.
3. Place acetic acid on the cervix.
4. Excise area of acetowhite lesion. Alternatively, Lugol’s solution may be applied to identify and excise lesion.
5. Set electrosurgical generator at 30 to 40 W on “blend 1.” (Other settings may be used such as 80 W “pure cut.”)
6. Place normal saline on the exocervix to rehydrate the tissue and decrease risk of loop electrode sticking to tissue.
7. Loop is carefully passed simultaneously around and under the transformation zone, thus excising it. The loop should be allowed to glide through the cervix from one side to the other, allowing the cutting current to divide the tissue (Figs. 13.4.1–13.4.3).

8. If the lesion extends into the endocervical canal beyond the reach of the loop, additional tissue may be excised with a smaller-diameter rectangular loop (“high hat”) (Fig. 13.4.4).
9. Remove the specimen in the correct orientation.
10. Place a suture at 12 o’clock on the excised specimen to orient for histopathologic analysis.
11. Achieve hemostasis at the base of the specimen with coagulation using the 5-mm ball electrode and Monsel’s paste/solution.


AFTERCARE

- The patient is instructed to avoid intercourse and place nothing in the vagina, and not immerse herself in water (e.g., take a bath or swim) for 2 to 4 weeks. She is seen in the office at 6 weeks.
- If Monsel’s solution was used, remind the patient that she will have brown, grainy-like discharge for several days.

CPT Code

57522. Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; loop electrode excision

PEARLS

- A blended current mixes cutting and coagulating currents.
- The higher the blend, the more the coagulating current and the greater the thermal damage.
- If the surgeon attempts to pull too quickly through the cervix, the loop will drag, bend, or adhere to the tissue, resulting in a shallower excision than was intended. If the loop moves too slowly, however, excess thermal damage to the specimen will occur. Application of saline onto the excocervix further decreases this risk.
- If hemostasis is difficult to achieve with the ball electrode and Monsel’s paste, sutures may be necessary.
  - Place a suture at 3 o’clock and 9 o’clock. This must be performed at a distal point on the cervix to avoid ureteral compromise and may reduce bleeding by reducing pulse pressure from the cervical artery. Place Gelfoam at the base and tie the suture across the front of the cervix to keep the Gelfoam in place.
- Follow-up in 6 weeks to assess cervical healing, but no action should be taken with respect to dysplasia at this time.
- If colposcopy was satisfactory, an assessment of cervical cytology with or without colposcopy is performed approximately 6 months postoperatively. This should not be performed before 4 months since any specimens obtained at this time are frequently contaminated with debris, metaplastic cells, and leukocytes. If either colposcopy was unsatisfactory or LEEP (Loop Electrosurgical Excision Procedure) was performed for a recurrent CIN II/III lesion, HPV testing is performed at 6 and 12 months postoperatively.