We appreciate the comments and insights by Dietl et al regarding our recent study. The authors expressed their concern regarding uterine manipulator use during minimally invasive radical hysterectomy for early-stage cervical cancer as a risk factor for tumor spillage and dissemination. Several previous studies may support their hypothesis. First, uterine manipulator use during minimally invasive radical hysterectomy for early-stage cervical cancer was associated with increased risk of tumor surface disruption (45% vs 13%) and artificial parametrial tumor carryover (65% vs 29%) compared with laparotomy (both, \( P < .05 \)). Second, albeit statistically not significant, there is a trend towards an increased risk of recurrence with the use of a uterine or vaginal manipulator during minimally invasive radical hysterectomy for early-stage cervical cancer: 0% for no manipulator use vs 7–11% for vaginal or uterine manipulator use (\( P = .119 \)).

Although interpretation is limited by the small sample size and methodologic limitations of the data, these studies suggest that direct contact against the tumor in uterine cervix may be associated with iatrogenic tumor spread with manipulation. To avoid such an event, some surgeons advocate a specific surgical technique by concealing the tumor with vaginal cuff closure at the beginning of surgery, followed by a placement of a uterine corpus-holding device inserted through the posterior vaginal fornix. Although this “no-touch technique” may reduce tumor disruption, whether the technique mitigates the risk associated with minimally invasive hysterectomy remains unknown.

Although our findings that compare minimally invasive and open trachelectomy appear reassuring, overall mortality rates were low, significantly limiting the power of our study to detect differences in survival between the groups. Furthermore, we were unable to assess manipulator use or disease recurrence. Further study of the mechanisms underlying the increased risk of death that is associated with minimally invasive radical hysterectomy and techniques to mitigate that risk are ongoing; the use of minimally invasive techniques in the treatment of cervical cancer should be approached with caution.

Koji Matsuo, MD, PhD
Division of Gynecologic Oncology
Department of Obstetrics and Gynecology
University of Southern California, Los Angeles, CA
Alexander Melamed, MD, MPH
Jason D. Wright, MD
Division of Gynecologic Oncology
Department of Obstetrics and Gynecology
Columbia University College of Physicians and Surgeons
New York, NY
jw2459@cumc.columbia.edu

J.D.W. is a consultant for Tesaro and Clovis Oncology and receives research funding from Merck; K.M. has an honorarium, Chugai, textbook editorial, Springer, investigator meeting attendance expense, VBL therapeutics. A.M. reports no conflict of interest.

REFERENCES