

INSIGHTS · ISSUE 08 · OCTOBER 18, 2026

Minimally invasive gynecology: the evaluation comes first

Small incisions, a short hospital stay, a faster return to normal life: minimally invasive gynecologic surgery has real advantages. But the approach is only as good as the diagnosis behind it. This issue explains how gynecologic conditions are evaluated, what each minimally invasive approach can and cannot do, when tissue diagnosis matters, and how to plan recovery and travel.

Educational only. Not medical advice. One Stop Cabo Health is a medical concierge — not a hospital. Licensed physicians provide clinical care.

Evaluation before procedure

Gynecologic evaluation starts with your history: your symptoms, your menstrual pattern, past pregnancies and surgeries, the medications you take, and whether you want to become pregnant in the future. The American College of Obstetricians and Gynecologists (ACOG) recommends a physical exam that includes a pelvic exam, and [laboratory tests](#) where they help — for example, a complete blood count (CBC) to check for anemia when bleeding is heavy.

Pelvic ultrasound is central to ACOG's guidance on fibroids, ovarian cysts, and endometriosis. It shows the uterus and ovaries, and ACOG notes that for ovarian cysts it shows the shape, size, and location of the cyst and whether it is solid or filled with fluid. For endometriosis, ACOG describes transvaginal ultrasound as the best imaging test.

[Magnetic resonance imaging \(MRI\)](#) has a narrower role. ACOG notes that MRI is rarely needed to evaluate fibroids, but may be needed to find endometriosis that lies deeper in the pelvis or outside it. The right test depends on the question being asked.

When gynecologic symptoms should not wait for a trip

ACOG advises seeking emergency medical care right away if you are changing pads or tampons every hour for more than 2 hours in a row and you also have chest pain, shortness of breath, or lightheadedness or dizziness. ACOG also notes that a twisted ovary can cause pain that starts suddenly, and that a cyst that bleeds or bursts can cause sudden, severe pain. Symptoms like these need care where you are — not a travel plan.

Common conditions, in general terms

Uterine fibroids

Fibroids are benign (not cancer) growths of the muscle of the uterus. ACOG describes them as the most common type of growth found in the pelvis, most common in women aged 30 to 40. They can cause heavy or painful periods, pressure, and pain — or no symptoms at all. ACOG notes that fibroids that are small, cause no symptoms, or occur near menopause often do not require treatment.

Endometriosis

In endometriosis, tissue like the lining of the uterus grows outside the uterus. ACOG estimates that about 1 in 10 women of reproductive age develop it. The most common symptom is chronic pelvic pain, and ACOG notes that the amount of pain does not always match how extensive the condition is. Surgery (diagnostic laparoscopy) is the only way to confirm it, but ACOG notes that it is not required before starting medical treatment.

Abnormal uterine bleeding

Bleeding between periods, after sex, or after menopause, and periods that last more than 7 days, are among the patterns ACOG considers abnormal. Causes range from ovulation problems, fibroids, and polyps to bleeding disorders and medications — and, ACOG notes, abnormal bleeding can be an early sign of endometrial cancer. That is why the cause is found before a treatment is chosen.

Ovarian cysts

ACOG notes that ovarian cysts are very common, that most are benign, and that many go away on their own. Watchful waiting with repeat ultrasound is often the first step. Surgery may be recommended if a cyst is very large, causes symptoms, or if cancer is suspected.

Minimally invasive approaches, with honest limits

ACOG considers vaginal and laparoscopic procedures minimally invasive because they do not require a large abdominal incision, and they are typically associated with a shorter hospital stay and recovery than open abdominal surgery. **Each approach fits some situations and not others.**

Vaginal surgery

For hysterectomy for benign conditions, ACOG states that the vaginal approach is preferred among the minimally invasive approaches whenever it is feasible. It is not feasible for everyone; the size and shape of the uterus and vagina and the extent of disease all matter.

Laparoscopic surgery

Laparoscopy uses a thin, lighted camera and instruments through small incisions in the abdomen. ACOG describes laparoscopic hysterectomy as a preferable alternative to open surgery when a vaginal hysterectomy is not indicated or feasible. Laparoscopy is also how endometriosis is confirmed and how many ovarian cysts are removed.

Robotic-assisted surgery

Robotic-assisted surgery is a form of laparoscopy in which the surgeon controls the instruments from a console. The U.S. Food and Drug Administration (FDA) notes that the device is not actually a robot, because it cannot operate without direct human control, and that it may not be appropriate in all situations. The FDA encourages patients to discuss the risks and benefits with their physician and to ask about the surgeon's training and experience. It also notes that it has not authorized any of these devices specifically for preventing or treating cancer.

Hysteroscopic surgery

Hysteroscopy passes a thin scope through the vagina and cervix to see and treat the inside of the uterus, with no abdominal incision. ACOG notes it can remove fibroids that protrude into the uterine cavity and that an overnight stay is usually not needed – but it cannot remove fibroids deep in the wall of the uterus.

Open abdominal surgery remains an important option for some patients. ACOG lists the factors that shape the choice: the size and shape of the uterus and vagina, access to the uterus, disease outside the uterus, other procedures needed at the same time, the surgeon's training and experience, the resources available, and the informed patient's preference.

When tissue diagnosis matters

Sometimes the diagnosis depends on a tissue sample examined under a microscope. For abnormal bleeding, ACOG lists endometrial biopsy – a sample of the lining of the uterus – among the tests that may be needed, depending on your symptoms and age.

Tissue matters during surgery too. To remove a large fibroid or uterus through small incisions, surgeons sometimes cut tissue into pieces, a step called morcellation. The FDA estimates that a hidden uterine sarcoma, a type of cancer, may be present in about 1 in 225 to 1 in 580 women having surgery for fibroids, and that there is no reliable way to tell before surgery. The FDA recommends against laparoscopic power morcellation in women with suspected or confirmed cancer and in women over 50 having surgery for fibroids, and recommends it only for appropriately selected women and only with a tissue containment system.

For ovarian cysts, ACOG notes that if cancer is suspected, it is important to remove the cyst intact, and that open surgery is sometimes the only way to do that. These are questions to ask before the date is set, not after.

Non-surgical options come into the conversation too

Surgery is not the only path. Depending on the condition, ACOG describes watchful waiting, hormonal and non-hormonal medications, a hormonal intrauterine device (IUD), and procedures that do not remove the uterus, such as uterine artery embolization for fibroids. Medications can reduce heavy bleeding and pain, though ACOG notes they may not stop fibroids from growing and that endometriosis pain often returns after medication stops. Which option fits — and whether surgery is needed at all — is a decision for you and your physicians after evaluation.

Recovery and travel planning

A shorter hospital stay is not the same as being ready to fly. The Centers for Disease Control and Prevention (CDC) lists recent surgery, and the use of estrogen-containing birth control or hormone replacement therapy, among the factors that raise the risk of blood clots during travel. Your surgeon should set the timing of your flight home based on your own risk.

The CDC recommends seeing your own health care provider or a travel medicine clinician at least 4–6 weeks before a medical trip. [A pre-surgical evaluation](#) before the procedure date checks that you are [ready for anesthesia and recovery](#), and [a written plan](#) should cover follow-up visits, activity limits, and the return home.

If you are in Canada and waiting for a gynecologist

In the Fraser Institute's Waiting Your Turn 2025 survey of physicians, the national median wait for gynecology from referral by a family doctor to treatment was 40.6 weeks: 25.0 weeks to see a gynecologist, and 15.6 weeks from that consultation to treatment.

Bring your referral letter, ultrasound and other imaging reports, and any biopsy results you already have. A specialist review can tell you whether more testing is needed, and the written plan should go back to your family physician.

If you are in the United States with a recommendation in hand

You may already have a diagnosis and a recommended procedure. Before scheduling it far from home, it is reasonable to ask: Which approach is planned, and why? Is a tissue diagnosis needed first? Will tissue be morcellated, and if so, how will it be contained? Share your imaging, biopsy and pathology reports, and operative notes from any prior surgery, so the review starts from what is already known.

A procedure date is not a diagnosis

A plan that starts with a booked procedure answers a question before it has been fully asked. A gynecologic plan worth traveling for starts with history, examination, and the right imaging — and a tissue diagnosis when it matters — then decides whether watchful waiting, medication, a procedure that keeps the uterus, or surgery fits.

Records for the doctors at home

The CDC recommends bringing copies of your medical records and getting copies of all your records before you return home — translated into English if needed — and arranging follow-up care before you travel. For gynecologic surgery, a useful packet includes the imaging reports, any biopsy and the final pathology report, the operative report (approach used, and whether tissue was morcellated and contained), the discharge instructions, the medication list, and the follow-up plan.

Where a medical concierge fits

One Stop Cabo Health is a medical concierge, not a hospital. Licensed physicians make every clinical decision. Our role is ownership of the sequence: one dedicated concierge who coordinates the gynecologic evaluation, imaging and laboratory tests, pre-surgical evaluation, a procedure only if it is indicated, the pathology report, and the records that travel home with you — at top-level private hospital facilities in Los Cabos, on one itinerary, with one point of contact.

Diagnosis first, in gynecology too

This series began with one idea: a clear diagnosis comes before a treatment plan. Issue 01 made that case, and Issue 02 explained why pre-surgical evaluation exists. In gynecology, where symptoms overlap and some answers only come from tissue, the idea matters as much as anywhere.

Diagnosis first: why a clear plan beats “wait and see”

Before the operating room: why pre-surgical evaluation exists

Gynecologic surgery we coordinate

MRI in Los Cabos

Share your reports — and your questions.

Start a confidential case

Pre-surgical evaluation

contact@onestopcabohealth.com · Same-day typical reply

Frequently asked questions

What makes gynecologic surgery “minimally invasive”?

The American College of Obstetricians and Gynecologists (ACOG) considers vaginal and laparoscopic procedures minimally invasive because they do not require a large abdominal incision. Robotic-assisted surgery is a form of laparoscopy, and hysteroscopy works through the vagina and cervix. These approaches are typically associated with a shorter hospital stay and recovery than open abdominal surgery.

Is robotic-assisted surgery better than standard laparoscopy?

Not automatically. The U.S. Food and Drug Administration (FDA) describes robotic-assisted devices as tools the surgeon controls directly and notes they may not be appropriate in all situations. The FDA encourages patients to discuss risks and benefits of all options and to ask about the surgeon’s training and experience with the device.

What is power morcellation, and why does it matter?

Power morcellation cuts tissue into pieces so it can be removed through small incisions. The U.S. Food and Drug Administration (FDA) estimates a hidden uterine sarcoma may be present in about 1 in 225 to 1 in 580 women having fibroid surgery, and recommends morcellation only for appropriately selected women and only with a tissue containment system.

Do fibroids always need surgery?

No. The American College of Obstetricians and Gynecologists (ACOG) notes that fibroids that are small, cause no symptoms, or occur near menopause often do not require treatment. When treatment is needed, options include medications, procedures that keep the uterus, and surgery, chosen based on symptoms, size, location, and your plans for pregnancy.

How do I start a gynecology case with One Stop Cabo Health?

Email contact@onestopcabohealth.com or start a confidential case on the contact page with a description of your symptoms and any ultrasound, magnetic resonance imaging (MRI), biopsy, or pathology reports. One concierge typically replies the same day. Licensed physicians review your case and decide which evaluation fits, and a written plan follows.

SOURCES

1. American College of Obstetricians and Gynecologists (ACOG). Choosing the Route of Hysterectomy for Benign Disease. Committee Opinion No. 701 (June 2017). <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/06/choosing-the-route-of-hysterectomy-for-benign-disease>
2. American College of Obstetricians and Gynecologists (ACOG). Uterine Fibroids (FAQ074; last reviewed December 2025). <https://www.acog.org/womens-health/faqs/uterine-fibroids>
3. American College of Obstetricians and Gynecologists (ACOG). Endometriosis (FAQ013; last updated August 2026). <https://www.acog.org/womens-health/faqs/endometriosis>
4. American College of Obstetricians and Gynecologists (ACOG). Abnormal Uterine Bleeding (FAQ095; last reviewed August 2025). <https://www.acog.org/womens-health/faqs/abnormal-uterine-bleeding>
5. American College of Obstetricians and Gynecologists (ACOG). Ovarian Cysts (FAQ075; last reviewed July 2025). <https://www.acog.org/womens-health/faqs/ovarian-cysts>

6. U.S. Food and Drug Administration (FDA). Power Morcellation During Gynecologic Laparoscopic Surgeries. <https://www.fda.gov/medical-devices/surgery-devices/laparoscopic-power-morcellators>
7. U.S. Food and Drug Administration (FDA). Computer-Assisted Surgical Systems. <https://www.fda.gov/medical-devices/surgery-devices/computer-assisted-surgical-systems>
8. Centers for Disease Control and Prevention (CDC), Travelers' Health. Blood Clots During Travel. <https://wwwnc.cdc.gov/travel/page/dvt>
9. Centers for Disease Control and Prevention (CDC), Travelers' Health. Medical Tourism: Travel to Another Country for Medical Care. <https://wwwnc.cdc.gov/travel/page/medical-tourism>
10. Moir M, Esmail N. Waiting Your Turn: Wait Times for Health Care in Canada, 2025 Report. Fraser Institute (December 9, 2025), Tables 2-4. <https://www.fraserinstitute.org/studies/waiting-your-turn-wait-times-for-health-care-in-canada-2025>

Ready to start with the evaluation?

Tell us about your symptoms and share any ultrasound, imaging, biopsy, or pathology reports you already have. One dedicated concierge replies, usually the same day.

Start a confidential case · Pre-surgical evaluation in Los Cabos

MRI in Los Cabos

contact@onestopcabohealth.com

Plaza Koral Center, Km 24.5, Los Cabos, B.C.S.

Read online · <https://www.onestopcabohealth.com/insights/minimally-invasive-gynecology>