

**A Comparative study between
surgical treatment of uterine fibroid by
classical laparotomy and laparoscopic
myomectomy**

Thesis Submitted for the Partial Fulfillment of the Master
Degree of Gynecology and Obstetrics

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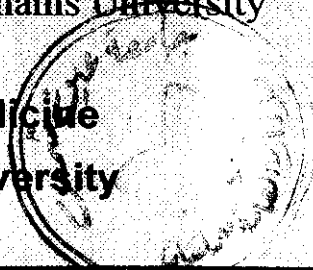
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بسم الله الرحمن الرحيم

قالوا سبحانك لا علم لنا إلا ما علمتنا

إنك أنت العزيز الحكيم

صدق الله العظيم

سورة البقرة، الآية ٣٢

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List of Tables

Page

Table (1):	Comparison between the 2 groups as regard age.	70
Table (2):	Comparison between the 2 groups as regard the operative time in minutes	70
Table (3):	Comparison between the 2 groups as regard the time of hospital stay after the operation in days	71
Table (4):	Comparison between the 2 groups as regard the blood loss during the operation in milliliters.	71
Table (5):	Comparison between the 2 groups as regards the parity.	72
Table (6):	Comparison between the 2 groups as regard the site of the tumour	73
Table (7):	Comparison between the 2 groups as regard the main complaint	73
Table (8):	Comparison between the 2 groups as regard the number of myoma	74
Table (9):	The comparison between the 2 groups as regard the size of myoma in cm	74

List of Figures

Page

Fig. (1): The comparison between myomectomy by laparoscopy and by laparotomy as regard the time of operation (75)

Fig. (2): The comparison between myomectomy by laparoscopy and by laparotomy as regard the hospital stay after operation (75)

Fig. (3): The comparison between myomectomy by laparoscopy and by laparotomy as regard the blood loss during operation (76)

List of contents

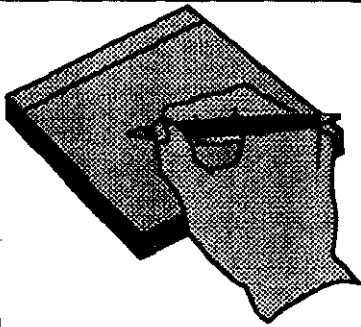
	<i>Page</i>
Introduction and aim of the work	1
Review of literature	4
• Laparoscopy	4
• History	4
• Uterine Manipulators	9
• Indications and contraindications	11
• Complications	13
• Advantages	24
• Disadvantages of open surgery	25
• Uterine fibromyoma	26
• Pathology	29
• Histogenesis	31
• Mechanism if infertility	33
• Rate of growth and secondary changes	39
• Diagnosis and differential diagnosis	46
• Treatment	49
• Myomectomy	52
• Laparoscopic myomectomy	58
Patients and Methods	62
Results	66
Discussion	77
Summary and Conclusion	85
References	87
Arabic Summary	

Abstract

Thirty-three patients included in this study. They had uterine fibromyomas, and the line of treatment was myomectomy. Twelve percent of the whole patients were complaining of menorrhagia, eight were complaining of infertility, one patient was complaining of pain, menorrhagia and infertility and only two patients had myomas and discovered accidentally.

After full clinical examination and full investigations, they were divided into two groups; the first group (number of patients = 20), myomectomy was conducted via the classic laparotomy while the second group (number of patients = 13), myomectomy was conducted via laparoscopy. The patients were divided into two groups according to certain criteria as: size, number, and site of the tumor, age and parity of the patient.

The study suggests that the laparoscopic myomectomy has many advantages over the laparotomy with good selection of patients for the laparoscopic approach.



*Introduction and
Aim of the Work*

INTRODUCTION

Just when uterine fibroids were first recognized and described, we do not know, but it is clear that their association with the human race dates back to the earliest antiquity.

Myomas are sometimes discovered in the process of evaluating infertile female. Their presence should not be considered immediately as a cause of infertility. Myomas may impair fertility if they occlude the endocervical canal, sufficiently distort the ischemic portions of oviducts, or to impair proper implantation (*Bonney, 1974*).

As regard the development which happened in the management of uterine fibroids, *Bonney* had published more than one paper on the uterine fibroids and myomectomy in 1918, 1925 and 1946. He advised "Bonney's myomectomy clamp" to control bleeding during the operation (*Bonney, 1974*).

As regard the medical treatment for fibromyoma, in uterus, the gonadotropin releasing hormone (GnRH) antagonists have proven very useful for limiting the growth or to cause a decrease in the tumor size.

Examples of the clinical situation GnRH antagonists may be useful including control of bleeding from uterine fibromyoma (except the polypoid submucous, which may actually be worsened). The

shrinkage of size of the tumor sufficient to allow laparoscopically assisted vaginal hysterectomy and in certain cases for myomectomy. However, some authors have noted that the use of GnRH antagonists for more than 3 months make myomectomy more difficult. Unfortunately, in all circumstances, GnRH antagonists may be used only temporarily, because they create an artificial menopause (*Alvin and Martin, 1994*).

Laparoscopy is one of the most gynecologic operative procedures performed today and is being done with increasing frequency and safety (*Gordon and Magos 1989*).

The value of microsurgical techniques in reducing post operative adhesion is universally agreed upon (*Eddy et al., 1980*). The indications for gynecological laparoscopy have been greatly extended from its initial use as a diagnostic aid procedure. Operations which in the past required open laparotomy to be successfully performed can now be done laparoscopically (*Bruhat et al., 1989*).

Laparoscopic myomectomy is now performed by various techniques with minimal perioperative complications.

Small and single uterine fibromyomas were managed more easily than multiple and larger tumors (*Nezhat et al., 1991*).

AIM OF THE WORK:

This study aims at comparison between the myomectomy done through classical laparotomy and that done by laparoscopic approach in rather similar cases from different points of view technically.

