Laparoscopic Assisted Vaginal Hysterectomy Versus Hysterectomy by Vaginal Route in Undescended Uterus

Thesis

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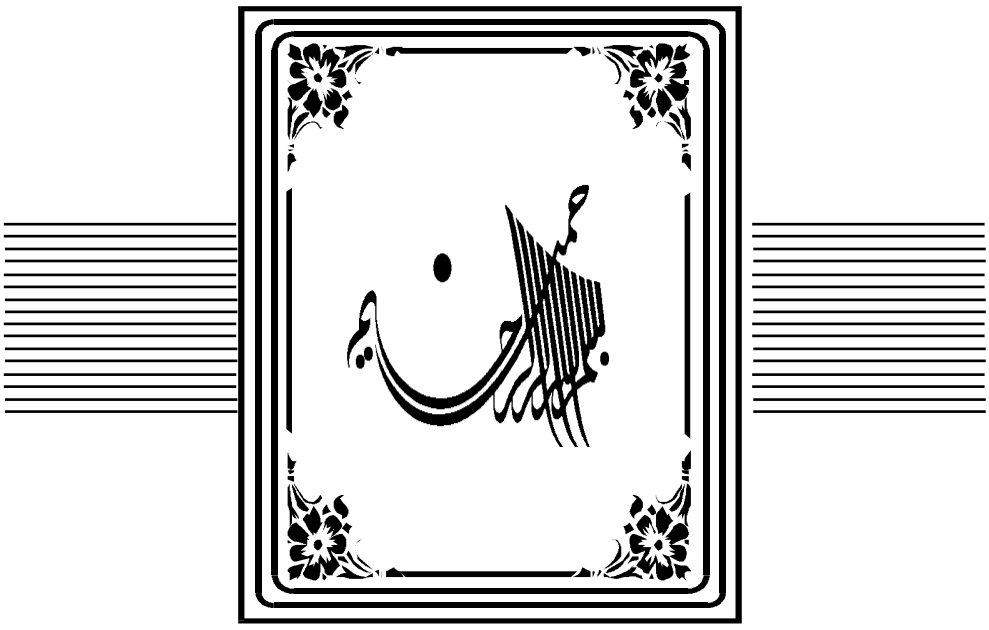

To :

My beloved family

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Abstract

Hysterectomy is the second most common major surgical procedure performed on women after caesarean section. There are various possible approaches to hysterectomy for benign disease of uterus—abdominal hysterectomy (AH), vaginal hysterectomy (VH) and laparoscopic hysterectomy (LH). Laparoscopic approach may be used either to facilitate the ease of vaginal delivery of uterus as in laparoscopy assisted vaginal hysterectomy (LAVH) or it may be carried out completely till final detachment of uterus from pelvic wall i.e., total laparoscopic hysterectomy (TLH).

So, the aim of the present study was to compare the operative parameters including operative time, blood loss and postoperative complications and recovery in patients who underwent laparoscopic assisted vaginal hysterectomy versus vaginal hysterectomy. To achieve this target, the present study included 40 consecutive patients indicated for hysterectomy.

Key words: Laparoscopy - Hysterectomy - . Underwent - uterus

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INTRODUCTION

Hysterectomy is one of the most commonly performed operations in the developed countries .Until the 1990s there were tow techniques for hysterectomy abdominal and vaginal. Observational studies suggest that lower morbidity and quicker recovery in women having vaginal hysterectomy.(Clinch., 1999)

Laparoscopic Assisted Vaginal Hysterectomy (LAVH) is currently accepted as safe and efficient way to manage benign uterine pathology and as an accepted alternative to the standard abdominal Hysterectomy. (Osson H. et al., 1996)

For several decades the abdominal approach has been the most route hysterectomy despite the well–documented benefits of vaginal hysterectomies in terms of lower complications rates, shorter lengths of stay and convalescence, lower hospital discharge, and more favorable quality of life outcomes including reduced mortality. (Kvac SR., 2000)

Subsequent randomized studies have shown that laparoscopic hysterectomy and its derivatives are associated with advantages that are similar to vaginal hysterectomy. However the operating time for laparoscopic hysterectomy; when compared with to vaginal hysterectomy is considerably longer and more expensive procedure without any benefits in terms of postoperative pain or recovery (Richardson et al., 1995). It should be stressed laparoscopically is still associated with complications related to general anesthesia and abdominal entry including the life-threatening major vascular injuries'. **(**Nordestgaad et al., 1995)

There is no doubt that vaginal route is preferable if possible. The main debate is on guidelines for hysterectomy route state that the choice (depends on patient's anatomy and surgeon's experience) and it usually done in women with mobile uteri no larger than 12 week's gestation (280g). (Daral et al., 2001)

Several postulates explaining why abdominal route was the preferred one to do this surgery over the last several decades. The first reason would be the residency training programs which practice the abdominal hysterectomy at the top of the list & other include experience; practice style ;habits and physician preference ; lastly confidence that abdominal route would facilitate dealing with serious pelvic pathology more than other routes . (Sutton C., 1997)

AIM Of THE WORK

To compare operative time; operative complications; blood loss; short term recovery, hospital stay and technical feasibility in patients undergoing laparoscopic assisted vaginal hysterectomy versus vaginal hysterectomy.

HISTORY AND DEVELOPMENT

Although significant advances in the technique of hysterectomy did not occur until the nineteenth century, earlier attempts were recorded. Vaginal hysterectomy was performed many centuries before abdominal hysterectomy. Some reference of hysterectomy was made in the fifth century B.C in the time of Hippocrates. Soranus of Ephesus is said to have amputated a gangrenous uterus vaginally in the second century A.D. (Thompson JD., 1997)

Al-Sharavius, an eleventh century Arabic physician taught that the prolapsed uterus that could not be re-inserted, could be surgically removed. (Ewen SP. et al., 1994)

In 1517, An Italian, Jacobo Berengario de Capri reformed a vaginal hysterectomy. In 1560, Andrea della Corce of Spain performed a vaginal hysterectomy. In 1600 Schenck and Grabenberg collected and reported 26 cases of vaginal hysterectomy. (Thompson JD., 1997)

These earliest hysterectomies were vaginal and usually were done for uterine prolapse or uterine inversion vaginal hysterectomies were done sporadically through the seventeenth and eighteenth centuries.(Thompson JD., 1997)

In 1825, Langenbeck made the first attempt to remove the uterus through an abdominal incision. On September 1853, Kimball of Lowell Massachusetts, was the first person to deliberately and successfully perform an abdominal hysterectomy for a correct preoperative diagnosis of uterine leiomyomas. (Thompson JD., 1997)

Mortality from abdominal hysterectomy exceeded 79% in 1880 however, by 1930, the mortality rate had dropped to 3%. (Ewen SP. et al., 1994)

In 1904, D.O. Ott, a Petrogard gynaecologist, described ventroscopy by which he inspected the abdominal cavity of a pregnant woman with the help of head mirror and a speculum introduced into a culdoscopic opening. (Reich H., 1994)

In 1910, H.C. Jacobeus of Stockholm, published discussion of the inspection of the 3 great body cavities. In 1911, Berenheim first used laparoscopy in the United State using a half inch diameter proctoscope and ordinary light for illumination.

Laparoscopy in 1930s, was largely performed by general surgeons and internists for the diagnosis of of hepatic diseases. The first reported operative laparoscopy was in 1933 by Fevers, a general surgeon who performed adhesiolysis. In 1973, Hope from the USA, was the first to describe the use of laparoscope for the diagnosis of extrauterine pregnancy. During this period, other gynaecologists were also performing laparoscopy. (Gordon AG. et al., 1989)

Bosch of Switzerland is credited with doing the first tubal sterilization in 1936. working independently in 1937, an American surgeon, E.T. Anderson suggested coagulation for laparoscopic sterilization. (Hulka JF., 1994)

In Germany the gynaecologist and engineer, Kurt semm introduced new techniques of fibro-optics and careful control of intra-abdominal pressure into instrumentation that was already widely used. Hans Frangenheim, another, German gynaecologist also designed instruments and techniques for gynaecologic laparoscopy that are still in use today. (Reich H., 1994)

In 1960s, the British gynaecologist Partick Steptop adopted the techniques and began performing laparoscopy in the operating room using sterile techniques. In his book "Laparoscopy in Gynaecology, 1967", he described for the first time in the English literature, the complete instrumentation and techniques for gynaecologic laparoscopy and described and illustrated the techniques of laparoscopic sterilization with a two-puncture technique and electrocoagulation with divison, using the Palmer biopsy drill forceps. In 1970 Melvan Cohen wrote the first American textbook on laparoscopy 'Laparoscopy, culdoscopy and gynaecography, technique and atlas. In 1972, Clifford R. Wheeless described outpatient sterilization with local anesthesia allowing rapid recovery and going home in the same day. (Hulka JF. et al., 1994)

The carbon dioxide laser was first to be used extensively and introduced to Europe by Maurice Bruhat and to the USA by James Daniell. Since then, lasers transmitted along flexible fibre-optic cables have increased in popularity and include Nd: YAG, KTP and Argon Lasers. (Gordon AG., 1993)

Suture nanufactures expanded the availability of laparoscopic hemostatic clips and suturing devices. In 1972, H. Courtnay Clarke showed that, hemostasis was feasible with suturing; In 1972 Kurt Semm showed that, it was feasible with endo loop suturing and in 1986, Harry Reich showed that hemostasis was practical by occluding and desiccating (now termed coaptation) of large vessels with bipolar electrosurgery. (Hulka JF. et al., 1994)

In 1989, Reich described the first laparoscopic hysterectomy using bipolar desiccation; later he pioneered the use of staples and finally of sutures for this operation. (Hulka JF. et al., 1994)