
شبكة المعلومات الجامعية

بسم الله الرحمن الرحيم


# شبكة المعلومـــات الجامعية

# التوثيق الالكتروني والميكروفيلم

شبكة المعلومات الجامعية

# جامعة عين شمس

## التوثيق الالكتروني والميكروفيلم

## ﴿ قـسـم ﴾

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# بعض الوثائق الأصلية تالفة


# بالرسالة صفحات

# لم ترد بالأصـــل

# A COMPARATIVE STUDY OF LAPAROSCOPIC HYSTERECTOMY VERSUS TOTAL ABDOMINAL HYSTERECTOMY



*Thesis*
*submitted to the Faculty of Medicine,*
*University of Alexandria,*
*in partial fulfillment of the requirements*
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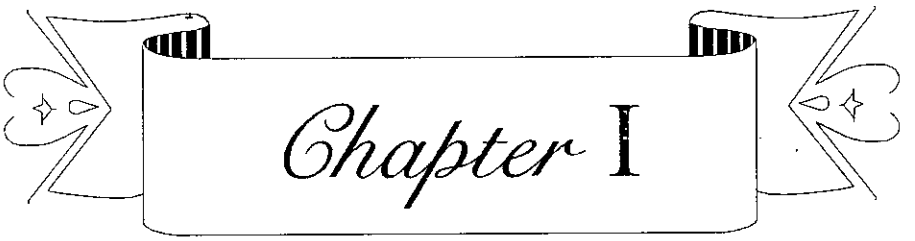


# INTRODUCTION

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## Hysterectomy: A Historical Review

The first abdominal hysterectomy was performed by Charles Clay in Manchester, England in 1843; unfortunately the diagnosis was wrong and the patient died in the immediate postoperative period. The following year, Charles Clay was almost the first to claim a surviving patient, however she died postoperatively and it was not until 1853 that Ellis Burnham from Lowell, Massachusetts achieved the first successful abdominal hysterectomy although again the diagnosis was wrong.[1]

Vaginal hysterectomy dates back to ancient times. The procedure was performed by Soranus of Ephesus 120 years after the birth of Christ, and the many reports of its use in the middle ages were nearly always for the extirpation of an inverted uterus and the patients rarely survived.[2] Heaney (Chicago, 1942) was the first to describe the procedure of the present day vaginal hysterectomy.[3]

The early hysterectomies were fraught with hazards and the patients usually died of hemorrhage, peritonitis, and exhaustion. Early procedures were performed without anesthesia with a mortality of about 70 %, namely due to sepsis from leaving a long ligature to encourage the drainage of pus. Thomas Keith from Scotland realized the danger of this practice and merely cauterized the cervical stump and allowed it to fall internally, thereby bringing the mortality down to about 8 %.[4]

Hysterectomy became safer with the introduction of anesthesia, antibiotics and antisepsis, blood transfusions and intravenous therapy.

In 1929, Richardson[5] introduced the total abdominal hysterectomy to avoid sero-sanguineous discharge from the cervical remnant and the risk of cervical carcinoma developing in the stump. Apart from this innovation, and the transverse incision introduced by Johanns Pfannenstiel in the 1920's[6], there was little advance in hysterectomy techniques until the advent of endoscopic surgery and the performance of the first laparoscopic hysterectomy by Harry Reich in Kingston, Pennsylvania in 1988.[7] The refinement and increasing safety of laparoscopic hysterectomy suggest that it will be used increasingly in the future, although developments in pharmacology and photodynamic therapy and interventional radiology may reduce the traditional indications for the operation.[4]

# Hysterectomy: Rates and Indications

Hysterectomy is the commonest major operation performed by gynecologists and is the definitive cure for many of gynecologic problems. Nonetheless, the annual number of hysterectomies has decreased significantly since the 1980's with the development of surgical and medical alternatives.[8]

The rate of hysterectomy varies among different regions and cultures reflecting differences in health care systems, education, and psychological attitudes toward the procedure.[9] The highest rates of hysterectomy are reported in the United States (36%) with approximately 600,000 hysterectomies performed each year.[10,11] In contrast, the European rates range from 5.8% in France to 15.5% in Italy.[12]

The most common indication for hysterectomy remains uterine leiomyoma (29%), followed by abnormal uterine bleeding (20%), uterine prolapse (15%), and endometriosis (5%). Cancer accounts for roughly 10% of the hysterectomies performed, and endometrial hyperplasia accounts for 5%; the remaining 16% include a variety of conditions, including persistent cervical dysplasia, adenomyosis, infections and peripartum bleeding or abnormal placentation.[13],[14]

**Leiomyomas:** Uterine leiomyomas are the most common pelvic tumors in women; therefore, this condition is responsible for a large number of hysterectomies. Hysterectomy for uterine leiomyomas should be considered only in patients who do not desire future fertility.[15]

**Dysfunctional uterine bleeding:** DUB is the indication for approximately 20% of hysterectomies. In patients older than 35 years of age, endometrial sampling should always be performed prior to hysterectomy, and hysterectomy should be reserved for patients who do not respond to or who cannot tolerate medical therapy.[16]

**Genital prolapse:** Hysterectomy for symptomatic genital prolapse accounts for approximately 15% of hysterectomies performed in the U.S. Unless there is an associated condition requiring an abdominal incision, vaginal hysterectomy is the preferred approach for genital prolapse.[9]

**Endometriosis:** Medical and conservative surgical procedures generally are successful for treatment of endometriosis. Most patients with endometriosis who require hysterectomy have unrelenting pelvic pain or dysmenorrhea.[17]

**Malignant tumors:** Ovarian cancer, stage I endometrial cancer, CIN class III, stage Ia cancer cervix, choriocarcinoma and sarcoma of the uterus; these represent approximately 10% of hysterectomy indications.[13]

# Types of hysterectomy

The following types will be discussed :

- **Vaginal hysterectomy.**
- **Abdominal hysterectomy:**
  1. Subtotal abdominal hysterectomy.
  2. Total abdominal hysterectomy.
  3. Extrafascial hysterectomy: implies removal of the uterus with its outer fascial layer.
  4. Intrafascial hysterectomy: implies that the cervix is cored out, and the outer (endopelvic) fascial layer is left attached to the bladder.
  5. Radical hysterectomy.
  6. Peri-partal hysterectomy:
  - Cesarean hysterectomy: implies removal of the uterus after performing a Cesarean section, e.g. atonic post-partum hemorrhage or placenta accreta.
  - Hysterectomy-en-toto: implies removal of the uterus with a contained dead fetus without opening the uterus. It is indicated in cases of concealed accidental hemorrhage (Couvelaire uterus). Its aim is to decrease the blood loss to a minimum.
- **Laparoscopic hysterectomy.**