

Vaginal Hysterectomy : Present Scenario



Medical Science

KEYWORDS : Vaginal hysterectomy, prolapse, nondescent uterus.

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ABSTRACT

Introduction- In older days, vaginal hysterectomy was limited to only prolapsed uterus but with improved practices nowadays it is gaining popularity in non-descent cases.

Method: Vaginal Hysterectomy was performed in 100 cases. Out of them 50 were of prolapsed uterus and 50 were of non-prolapse uterus.

Result : Mean age of patient is >50 in prolapsed & 40-50 in NDVH cases. Mean parity is 5 in prolapsed cases & 3 in NDVH cases. Commonest indication in NDVH is DUB & size of uterus is 6-8 weeks. Commonest complication is haemorrhage in both types. There is no mortality found in present study.

Conclusion : Vaginal Hysterectomy is recommended as safer procedure in properly selected cases and in hand of surgeons with high expertise.

INTRODUCTION

Hysterectomy : The word is derived from the latin Husteros – Hysteros meaning Uterus.

Thus, hysterectomy literally means removal of uterus through sheath (sheath meaning vagina)-Vaginal hysterectomy.

In older days, vaginal hysterectomy was limited to only prolapsed uterus. But with improved obstetric practices there is reduced incidence and severity of genital prolapse.

Non descent vaginal hysterectomy is the removal of uterus through vagina where there is no descent of the cervix. For some time in history, such a surgical procedure was considered unacceptable. As the awareness of simplicity and benefits involved with the vaginal route, that the vagina is the ideal and most natural route to approach the uterus along with availability of good anaesthesia, light, better suture material, electrosurgical techniques, exploration of the uterus through the vaginal route has become more popular.

Laparoscopically assisted vaginal hysterectomy or total laproscopic hysterectomy although constantly gaining ground is associated with higher costs and longer duration of operation and involves a larger number of specially trained personnel. With increasing concern over the containment of health care cost, there is need for expanding the indications for performing hysterectomies via vaginal non laproscopic method .

MATERIAL AND METHODS

We have studied 100 cases of vaginal hysterectomy done at our hospital.

Selection Criteria of Patients

- All patients of prolapsed uterus were taken.
- In non-descent case if : size is less than 14 weeks uterus is freely mobile to slightly restricted mobility.

Exclusion criteria:

- Patient with positive malignancy.
- Patient with endometriosis
- Patient with cervix that was flushed to vagina
- Patient with large adenaxal masses were not included but with simple ovarian cyst Of Small size were taken.

RESULTS & DISCUSSION

TABLE: 1 Age incidence

Age group (yrs)	Pro-lapse	%	Stockholmss-study by Tegerstedt	Non-descent	%	Dr. Dewan 2004
<40	14	14	4%	16	16	6%
40-50	4	4	6.2%	32	32	37%

>50	32	32	46%	2	2	7%
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TABLE: 2 Parity.

	Pro-lapse	%	Stockholm study by Tegerstedt	ND	%	Dr.Dewan 2004
Nullipara	0	0	2.4%	2	2	
Para-1	4	4	8.8%	2	2	4%
Para-2	2	2	9.8%	10	10	24%
Para-3	10	10	12.2%	14	14	46%
Para-4	14	14	16%	10	10	24%
Para-5 & above	20	20	21%	12	12	

TABLE:3 Operative procedure.

	Prolapse	%	ND	%	Dr.T.C.Pun study(n=94)
Total VH	4	4	36	36	88
Total VH+ARepair	10	10	6	6	--
Total VH+P Repair	2	2	2	2	-
Total VH+SOP(UL/BL)	-	-	2	2	1
Total VH with Salpingectomy	-	-	-	-	1
Total VHwith ovarian cyst removal	-	-	2	2	5
Total NH+AP Repair	34	34	-	-	-

TABLE 4 : Complications.

	Prolapse (%)	ND (%)	Dr.Garry study 2004(%)	TC PUN 1999-2005(%)
Haemorrhage	2	2	2.9	9.5
Bowel injury	0	0	0	-
Ureteric injury	0	0	0	-
Bladder injury	2	0	1.2	3.19
Anaesthetic complication	0	0	0.6	-
Vault haematoma	0	0	1.2	11.7
Pulmonary embolism	0	0	0	-
Vaginal infection	2	0	0	3.19

DISCUSSION :

As Table 1 shows maximum number of patients in prolapsed uterus group were more than 50 years and was comparable to study carried out by Dr.Tegerstedt in korolinska Institite 2004. Whereas in non prolapsed uterus group were between 40-50 years of age group. This shows that with increasing age, laxity of pelvic floor increases and contributes to prolapse.

As Table 2 shows , in present study parity 3 is commonest in ND cases is comparable to study carried out by Dr.Dewan. In prolapsed cases parity 5 & above is commonest and is comparable to the study carried out by Dr.Tegerstedt and this supports the physiology that increase child birth damages the pelvic floor and leads to laxity hence prolapse.

In the present study, prolapse is the indication of VH and in non prolapsed group DUB is the commonest indication as compared to the study carried out in 2004 in which leiomyoma is commonest indication.

In case of prolapsed, size of uterus is atrophic and in patient with non prolapsed uterus, size of 6-8 weeks is most common in present study which is comparable to Dr. Rupali Dewan study carried out in 2004.

As Table 3 shows, in all cases of prolapsed we have done total VH with anterior Repair and Posterior repair according to pathology. In non descent cases we have done two cases of salpingo-oophorectomy due to adnexal pathology and one case of ovarian cyst removal along with total vaginal hysterectomy.

In the present study, 50 patients of non descent uterus were operated, in which, in 56% of cases uterus were removed intact due to normal size of uterus. 6-8 weeks size uterus in same cases required bivalving technique. In Dr. T C Pun study where morcellation was the most commonly used technique.

As Table 4 shows two cases of prolapsed uterus required post operative blood transfusion due to excessive intra operative blood loss as there was excessive congestion of tissue and two patients of ND required BT due slippage of clamp over uterine vessels.

In present study patient were planned for NDVH but were converted to laparotomy in two patient due to cervical fibroid and in two patient due to slippage of uterine vessels clamp causing retraction of vessels.

CONCLUSION

Non descent hysterectomy is constantly gaining grounds because lower cost, less duration as compared to laproscopically assisted vaginal hysterectomy or TLH.

- It is considered as ideal technique as most natural route "vagina" is used to approach uterus and adnexa.
- With increasing expertise previously considered contraindications for performing NDVH are decreasing and making almost all contraindications as relative.
- As in non-descent uterus, anatomy is not altered, various structures are in their normal anatomical position, hence the chances of damage to bladder, ureter are less.
- Previous laparotomies and previous caesarean section can no longer hamper the vaginal route to be used for hysterectomy.

With the help of the present study, we came to the conclusion that use of vaginal route for hysterectomy can be extended from prolapsed uterus to non prolapsed uterus even in uterine size up to 14 weeks. Hence NDVH is highly recommended as safe procedure in properly selected cases and in hands of surgeons with high expertise.

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