Vaginal Hysterectomy

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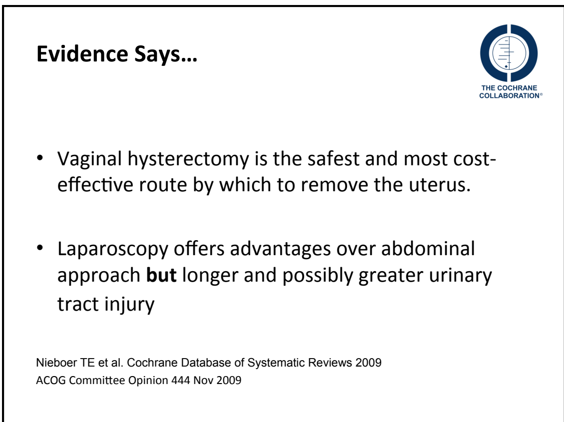

Evidence Says…

- Vaginal hysterectomy is the safest and most cost-effective route by which to remove the uterus.
- Laparoscopy offers advantages over abdominal approach **but** longer and possibly greater urinary tract injury

Nieboer TE et al. Cochrane Database of Systematic Reviews 2009
ACOG Committee Opinion 444 Nov 2009

Comparison of different approaches to hysterectomy

Vaginal Hysterectomy Compared With Abdominal Hysterectomy

- Shorter duration of hospital stay
- Faster return to normal activity
- Fewer febrile episodes or unspecified infections

Vaginal Hysterectomy Compared With Laparoscopic Hysterectomy

- Shorter operating time

Laparoscopic Hysterectomy Compared With Abdominal Hysterectomy

- Faster return to normal activity
- Shorter duration of hospital stay
- Smaller drop in hemoglobin
- Lower intraoperative blood loss
- Fewer wound or abdominal wall infections
- Longer operating time
- Higher rate of lower urinary tract (bladder and ureter) injuries

ACOG Number 444, November 2009

Indications

- Abnormal uterine bleeding.
- Fibroids.
- Utero-vaginal prolapse.
- Adenomyosis.
- Pelvic inflammatory disease.
- Pelvic pain.

Contraindications to VH

- Advanced pelvic malignancy.
- Severe endometriosis.
- Suspicious adnexal mass.

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Complications

- Ureteral injuries (0.2 per 1000 surgeries).
- Bladder injuries (2 % of cases).
- Bowel injuries (0.4 % of cases).
- Postoperative hemorrhages (2 % of cases).
- Infection — Febrile morbidity (15 % of women).
- Urinary retention Higher in VH compared to TAH.

Vaginal hysterectomy: 5 keys to success

- Surgical experience
- Adequate exposure
- Entry into the cul-de-sac
- Uterine mobility (or the ability to create it)
- Good morcellation technique.

Surgical experience

- knowledge of Anatomy
- knowledge of instruments
- Tissue and instrument handling
- Incision and dissections
- Maintenance of visibility
- Electrosurgery
- knot-tying and ligation
- Hemostasis

Adequate exposure

- Good anesthesia.
- Proper lighting.
- A weighted speculum with Deaver retractors.
- Self- retaining retractors.

Vaginal Bookwalter Retractor

Entry into the cul-de-sac

- A sharp and deep incision aids in identification of the appropriate plane
- Sharp dissection to free the bladder from the uterus.
- Use the index finger to palpate the bladder reflection
- Avoid blind entry at all costs.
- Entry into the posterior cul-de sac is often easier.
- The “climb up” technique,
  - If safe entry is not possible, proceed extraperitoneally.

Gaining mobility

- Begin by entering the posterior cul-de-sac.
- Cutting and suture ligating the uterosacral ligaments.
- Take the first bite of the cardinal pedicles bilaterally.
- Once the uterine arteries have been secured, you can split the uterus to gain access to the utero-ovarian pedicles.

Good morcellation technique

- Secure the uterine vessels *before* morcellation begins.
- It is preferable to have entered both cul-de-sacs as well.
- Maintain the orientation of the uterus.
- Bi-valve the cervix in the midline.
- Serial wedges are performed to decompress the uterus.

Vaginal vault Closure and Support

- Vaginal Mucosa closure
- McCall culdoplasty.
- Suturing the cardinal and uterosacral ligaments to the vaginal cuff.
- Sacrospinous fixation.

Thanks