

METHODS OF HYSTERECTOMY FOR BENIGN AETIOLOGY – TRENDS AND OUTCOMES

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Introduction

Hysterectomy is frequently performed surgical procedure
Selection of the route of hysterectomy for benign causes is influenced by the size and shape of the and uterus; accessibility to the uterus (previous surgery, descent, size) extent of extrauterine disease; the need for concurrent procedures, surgeon training and experience, available hospital technology, devices, and support

Objective

To assess current practice of choosing minimal invasive methods of hysterectomy in a district hospital unit. To evaluate rate of intra-operative and post-operative complications with each method, with reflection on their efficacy towards enhanced recovery

Design

Retrospective analysis of all hysterectomies performed in the unit for benign indications from January2022 to July 2022.

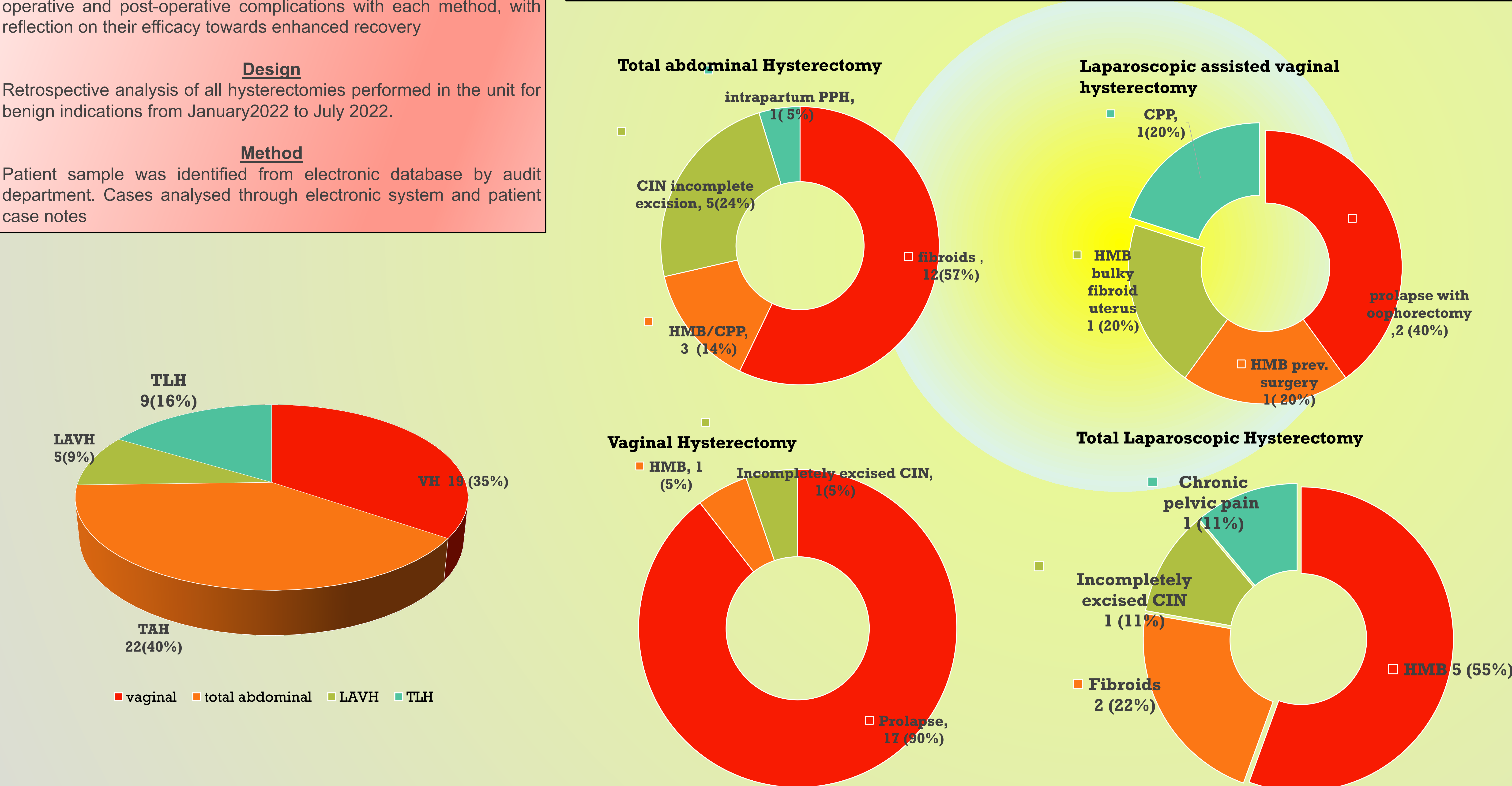
Method

Patient sample was identified from electronic database by audit department. Cases analysed through electronic system and patient case notes

Results

A total of 55 cases identified. There were, vaginal hysterectomies(VH) (19/55)34.5%, total laparoscopic hysterectomy(TLH) – (9/55)16.3%, Laparoscopic assisted vaginal hysterectomy with bilateral salpingo-oophorecotmy(LAVH+BSO)– (5/55)9%, total abdominal hysterectomy with or without bilateral salpingo-oophorecotomy(TAH+/-BSO) 22/55-40%.
TAH+/-BSO was chosen for an indication of fibroid uterus (size ranging of 14-20 weeks) and also for previous repeated LLETZ with no residual ectocervix where VH or TLH are not feasible. LAVH+BSO was opted for patients with refractive heavy menstrual bleeding(HMB) or small size fibroid uterus; with or without associated ovarian pathology. VH was performed mainly for pelvic organ prolapse; other reasons were HMB and incompletely excised CIN.

TLH was performed for HMB, incompletely excised CIN, fibroid uterus and chronic pelvic pain.



	VH (19)	TLH (5)	LAVH (5)	TAH (22)
Intra-operative complication	none	22(1/5) Ureteric injury	none	4.5% (1/22)
Post-op Complication	37%(7/19) Bleeding	22% (2/5) Persistent pain	None	9%(2/22) Sepsis
Return to theatre	15% (2/19)	11% (1/9) Visceral injury	None	none
Day 1 discharge rate	74% (14/19)	55% (5/9)	100% (5/5)	37% (8/22)

Summary

Overall 60% Minimal invasive approach rate
40% TAH (22/55), mainly for fibroid uterus of >14weeks size, or previous bowel surgery x1, CPP scarringx1, peripartum hysterectomyx1

Out of minimal invasive cohort: 33 cases

58% were VH (19/33), 27% TLH (9/33), 15% LAVH (5/33)]
37% of VH (7/19) had post-operative problems – haematoma and bleeding resolved with antibiotics; 2(2/7) cases return to theatre for drainage
LAVH – nil complication rate but number of cases is small
TLH 16% (9/55) – 22% complication rate, number of cases is small

Conclusion

Out of total Hysterectomies, minimal invasive method rate is 60%

TAH was chosen for cases not feasible for minimal invasive such as large fibroid uterus (14 weeks or above), HMB and chronic pelvic pain with previous surgery or risk of scarring, and cases of no ectocervix. Vaginal hysterectomy is obviously difficult in cases with no ectocervix. Total laparoscopic hysterectomy as well is difficult due to problems with poor application of vaginal cuff.
0% return to theatres with TAH, but ‘day1 - safe discharge’ is a agenda to work towards

With LAVH there were no intra-operative, post-operative complications and day1 discharge rate was 100%

Intra-operative complications were nil for VH and is least invasive, but return to theatre of 15%

TLH is best minimal invasive option for patients but limited by the fact that it needs advanced laparoscopic skills.

The study is limited because of out-sourcing number of low-risk hysterectomies to private providers.

These lists often chose to have uncomplicated low risk minimal invasive cases. Hence this is a confounding factor when auditing departmental cases