

A CASE SERIES OF NON-DESCENT VAGINAL HYSTERECTOMIES

INTRODUCTION

Hysterectomy is a popular gynecological surgery performed in the world mostly for benign indications such as leiomyoma, adenomyosis, severe dysmenorrhea, and uterine prolapse as well as for malignancies of the uterus, ovary, and cervix. There are various surgical approaches for hysterectomies and surgical approach is the most important factor responsible for perioperative morbidity. Current approaches for hysterectomies include vaginal, abdominal, laparoscopic, and robotic-assisted laparoscopic hysterectomy. But performing a vaginal hysterectomy in a non-descent uterus is a challenging task for a surgeon and it becomes further difficult when it is associated with other comorbidities.

METHODOLOGY

Seven patients with a uterine size not exceeding 14 weeks were recruited. In some cases, traction was applied from the uterine cervix to assess the adhesion of the uterine body to the anterior abdominal wall. An indwelling catheter was used with 20 ml water to inflate the bulb. Vesical reflection was identified, and point scissors or no.11 scalpel was used to enter into the vesica uterine space when needed. POD was entered while using two tissue forceps and dragging the posterior fornix in a vertical manner.

Blunt finger dissections were used where POD was completely obliterated with endometriosis or adhesions. Ligasure or bi-clamp vessel sealers were used to cauterize the uterosacral and transverse cervical ligament, round ligament, ascending branch of the uterine artery, and parametrium. Bilateral salpingectomies were done using right-angled forceps with bi-clamp or ligature electrocautery. Stitches were used only to secure ovarian ligaments and to close the vault.

The average hemoglobin difference and time spent for surgery were 0.62g/dl and 40.7 minutes respectively. The first patient had a previous cesarean section and adenomyotic uterus thus, had difficulties entering POD and vesico cervical space. The second patient had a previous anterior colporrhaphy which made bladder dissection difficult. Here, the point scissor and no.11 scalpel blade were used to reach tissue planes. Another patient was on Warfarin for DVT in the left leg. She had a left ovarian cyst of 7cm x 8cm with normal tumor markers and benign ultrasonic features.

All these patients had total hysterectomy and bilateral salpingectomy. No major incidents (ICU admission, blood transfusion, conversion to open abdominal surgeries or readmission) were reported.

DISCUSSION

The vaginal approach to hysterectomy has been used extensively by gynecological surgeons as it is the least invasive route to perform the surgery. Non-descent vaginal hysterectomy is a better alternative to conventional abdominal hysterectomy and laparoscopic hysterectomy for selected benign gynecological conditions. But NDVH is a difficult surgery to perform in a non-descent uterus. It becomes further complicated when the patient is having previous surgeries (c-section), adnexal masses (ovarian cyst), and pelvic adhesions (endometriosis). There are identified Favourable factors for a non-descent vaginal hysterectomy such as a mobile uterus with normal dimensions, a large pelvis to allow maneuverability, single, large accessible fibroid, previous vaginal births, and multiparity.

In instances where deciding the route of a hysterectomy is doubtful despite the absence of obvious contraindications, it is best to go for a tentative vaginal hysterectomy. Most of the studies have shown a statistically significant decrease in blood loss during surgery, duration of surgery, postoperative pain, time to postoperative mobility, wound infection, febrile morbidity, length of hospital stay, and postoperative blood transfusion in the vaginal group when compared with the abdominal group. ^(4,5)

CONCLUSION

Our results underlined a low rate of complications in the patients who underwent vaginal hysterectomy and none of the surgeries were converted to abdominal hysterectomies. Therefore these cases indicate that non-descent vaginal hysterectomy is a safe and effective surgical treatment for benign gynecological diseases and should be offered whenever possible.

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