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TO THE QUESTION ABOUT SELECTION OF RATIONAL SURGICAL ROUTE AT HYSTERECTOMY

Introduction. Hysterectomy is the most often intervention in gynecology up to present day. Varity of clinical situation is demanded individual relation in every case. Selection of surgical route at hysterectomy depends on the criteria for intervention, uterine size, accompanying gynecology and somatic pathology, interventions on organs of abdominal cavity in anamnesis, inflammatory diseases of internal genitals and endometriosis.

Objective of research is substantiation of rationality of surgical route at hysterectomy using laparoscopy, laparotomy and mini-laparotomy with laparoscopic assistance.

Material and methods. During the period from January 2004 to May 2005 in department of surgical gynecology of the D.O.Ott Research Institution of Obstetrics and Gynecology RAMS 55 hysterectomies using laparoscopy (1 group) were performed. Comparing groups comprised 50 patients after laparotomic hysterectomy (2 group) and 50 patients after mini-laparotomy with laparoscopic assistance (3 group) that had been performed in 2003-2005.

Results. Mean age of patients 1, 2 and 3 groups is 48 ± 5,3; 45,6 ± 4,2; 43,6 ± 7,9 years old, respectively. Mean duration of operations is 137 ± 33; 91,3 ± 11,6; 114 ± 11,2 minutes. Mean size of removed uterine is 9,2 ± 2,9; 13,6 ± 4,1 weeks of gestation; 317 ± 12,1 gramm (mean mass). Mean estimated blood loss is 87,3 ± 84,3; 392 ± 57; 71,6 ± 8,1 milliliters. Mean postoperative inpatient stay is 7,8 ± 1,3; 9,2 ± 1,6; 6,1 ± 0,1 days. In first group postoperative complications comprised 3 cases (5,5%): infiltrate in pelvis, hematoma around stump and cystic-vaginal fistula; 9,4% – in 2 group and 5,0% – in 3 group.

Conclusion. Total laparoscopic hysterectomy is performed if there are following criteria for hysterectomy: uterine endometriosis, relapsing endometrial hyperplasia in combination with fibroids or uterine endometriosis, typical localization of fibroids which size is not exceeding 15 weeks of gestation. Mini-laparotomy with laparoscopic assistance is performed if there are atypical fibroids (cervical, over cervical, intraligamental nodules), large fibroids of any localization, rough fibrotic parametrical changes or decrease of uterine ligament. Traditional laparotomy is necessary to use in cases when uterine size is more than 18-20 weeks of gestation, severe fibrotic processes in pelvis, addition of adjacent organs to pathological processes, malignant diseases of internal genitals, necessary to be seriously intervented, contraindications to laparoscopy in consequence of accompanying somatic diseases.

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TOTAL LAPAROSCOPIC HYSTERECTOMY IN THE GROSSLY ENLARGED UTERUS

Introduction: Avoiding laparotomy by performing laparoscopic hysterectomy, of various types, has been shown to be beneficial in a number of ways. Shorter recovery times, shorter length of hospital stay and convalescence period, and earlier return to work than after abdominal hysterectomy are some of the positive factors cited. However, it is often considered that there is a size limitation of 14-16 weeks' gestation to the feasibility of laparoscopic hysterectomy. Whilst a number of studies have shown that the laparoscopic-assisted vaginal hysterectomy (LAVH) successfully manages the large uterus, little has been published regarding a total laparoscopic approach.

Objective. To examine the practice and feasibility of total laparoscopic hysterectomy (TLH) for uteri weighing 500g or more compared to other total laparoscopic hysterectomies performed for the management of benign gynecological diseases.

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