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VAGINAL HYSTERECTOMY– ELECTROSURGERY OR SUTURES?

Objective: to compare procedure time, blood loss, postoperative period of vaginal hysterectomy using sutures versus using an electrosurgical bipolar plasma kinetic generator GYRUS.

Materials and methods. During 2005, we perform 64 vaginal hysterectomies, in patients without vaginal vault prolapse at the age from 36 to 64 years with a following pathology: adenomyosis, fibroid, necrosis of fibroid after embolisation, uterine carcinoma (1A). The sizes of a uterus appear to be 6 -14 weeks of gestation. Patients were dividing in two groups: either electrosurgical bipolar vessel sealer (8, Gyrus PlasmaKinetic SuperPulse Generator) or sutures (56, Vicryl) as the hemostasis technique. In the last group sutures were use for the vaginal repair. Technique of the operation is made by the circumcision of the vagina, anterior and posterior colpotomy. Cardinal, uterosacral ligaments, bundles of uterine vessels, round, utero-ovarian ligaments, uterine tubes are cut and ligate in the standard fashion. In the Gyrus bipolar coagulation use the special Wertheim-like clump. Above-mentioned structures sealed and scissored. Then uterus is morcelated. The vagina is restored by vicryl sutures, in both groups performing high McCall's culdoplasty. Procedure time was defined as time from initial mucosal injection to closure of the vaginal cuff. Blood loss estimated by a method of weigh-in, postoperative period is clinically.

Results. Patients from the first group required administration of narcotic analgesics up to 48 hours. In the second group administration NSAID is quite enough. Duration of the hospitalization for the 3-5 days in the first group and 2-3 days the second. Patients were observed is outpatient department within 2 months. Procedure time in the first group was 53.6 min, for the second group – 28 minutes. Mean blood loss was 60 ml in the bipolar sealer arm versus 130 ml for suture arm. 1 (1,8%) patient of the suture arm experienced right leg pain resolved within 14 days without treatment. 3 (5,3%) patients of the first group was poor healing of vaginal wound that has required local outpatient treatment. There are no complications in the electrosurgical bipolar vessel sealer group.

Conclusions. Vaginal hysterectomy can be performed as standard technique in challenging patients with morbid obesity, significantly enlarged uteri, narrow vaginal canals, without vaginal vault prolapse, a uteri carcinoma (1A). Electrosurgical bipolar plasma kinetics coagulation reduce time of operation, blood loss, postoperative period is practically painless. Generator Gyrus cheaper then LigaSure System almost twice, which makes it more preferably for today.

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THE EXPERIENCE OF LAPAROSCOPICALLY ASSISTED VAGINAL HYSTERECTOMY

Introduction. Surgical laparoscopy has been widely adopted in gynecological practice. The first laparoscopic operation was carried out in our center in 1991. Lately different types of laparoscopic hysterectomy have been applied in surgical gynecology. In our clinic we widely use laparoscopically assisted vaginal hysterectomy, which was first performed here in 1996.

Material and methods. Within the period between 2000 and 2004 we did 68 vaginal extirpations of womb, 28 of them laparoscopically assisted. Laparoscopy stage was fulfilled with the apparatus "Karl Storz" (Germany). Recommendations for the surgical treatment were as follows: prolapse of the womb walls, elongation of the cervix of the uterus combined with myoma, adenomyosis, recurrent hyperplasia of endometrium and cysts of ovaries. The average patients' age is 54 years (varying from 38 to 73).The operation consists of two stages – laparoscopic and vaginal. Laparoscopy allows performing the division of commissures, excision and coagulation of the centers of endometriosis, ablation of adnexa of the womb, immobilization of ligaments, dissection and separation of ligaments, immobilization of the womb vessels. All the following stages of the operation are performed traditionally for vaginal hysterectomy.

Results. Compared to the "pure" vaginal hysterectomy the differences are as follows: the usage of laparoscopy reduces traumatisation of tissues, and consequently, blood loss during the operation from 300,0 ml to 100,0 – 150,0 ml; patients endure the combined method of surgery much easier which cuts down their post-operation staying in hospital from 12,3 to 6,2 days. The operation time varied between 85 and 160 minutes depending on the intensity of pathology and the surgeon's skills. The post-operation period is characterized by quicker recovery of patients, for anesthesia non-narcotic analgesics were adequately used. Pre- and intra- operational prevention of infectious complications (Metrogil, Cefasolin) proved to be enough, as a rule. In the first three