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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

post-operation days 20% of patients suffered from weaker peristalsis of intestines which was cured traditionally. Complications arising from laparoscopically assisted vaginal hysterectomy have not been registered.

Conclusions. We believe that this method of surgery should be widely used as soon as hospitals have modern endoscopic equipment and instruments. However, the patient's interests, the surgeon's experience and the concrete operational situation should come first when considering the possibility of applying laparoscopic hysterectomy.

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THE TOTAL LAPAROSCOPIC HYSTERECTOMY – A MODERN ROUTE OF HYSTERECTOMY. IS THERE A BENEFIT?

Objective: Total laparoscopic hysterectomy – a suitable approach to hysterectomy compared to the abdominal way. The aim of this retrospective study is to document the advantage of this technique and to show the complications.

Introduction. Hysterectomy is the most frequent surgery performed on female patients (approximately 70,000 per year in Germany). In more than 90% of the cases, it is indicated for benign disorders. In 1996 about 8% of the operation were done by laparoscopy, in 2002 it was done in about 12% of the cases. Only a very few recent publications focuses on per- and postoperative complications of the total laparoscopic hysterectomy. The advantage of the laparoscopic approach has been mainly associated with a short hospital stay and a quick convalescence. The object of this study was to list the advantage and the complications of the laparoscopic hysterectomy.

Materials and methods. We retrospectively studied more than 200 cases of laparoscopic hysterectomies for benign disorders between January 2003 and May 2005 in the Klinikum Osnabrueck – Germany. The procedures performed with 110mm trocar subumbilical and 25 mm trocars in the area of Mons pubis. Additionaly the manipulator for the uterus (Hohl – Karl Storz) was used.

Results. Due to the total laparoscopic hysterectomy the hospital stay, the operation time, the intraoperative bleeding and rate of complications were reduced compared with the abdominal approach. There were 2 bladder injuries, 1 intestinal injurie, 1 injurie of the ureter and 1 vesico-vaginal fistula. There was 1 deep venous thrombosis. There was no case of blood transfusion.

Conclusion. The total laparoscopic hysterectomy is a real alternative approach for the hysterectomy. Due to this technique the hospital stay was reduced and the complications are as high as in the other techniques.

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OUR EXPERIENCE OF LAPAROSCOPIC, VAGINAL AND LAPAROSCOPIC ASSISTANCE VAGINAL HYSTERECTOMY

Introduction. Hysterectomy is the most common surgery performed by the gynecologist. There are many indications for hysterectomy and uterus can be removed using any of a variety techniques and approaches including abdominal, laparoscopic, vaginal and laparoscopic assistance vaginal. The modern gynecologic surgeon should have an experience to carry out this surgery by different routes.

In contemporary scientific literature there is no clear place for the various type of hysterectomy. The main aim of paper is to describe our experience of hysterectomy performing by less invasive approaches, to formulate the advantages and disadvantages of each route and to determine the indications for each of them.

Material and methods. We investigated 601 patients' histories after laparoscopic, vaginal and laparoscopic assistance vaginal hysterectomy. Retrospective analysis included the time of surgery, complications rate, blood loss volume, postoperative time, conversion rate.

Conclusion. There is no "ideal" route for performing of hysterectomy. There is certain indication for each type of hysterectomy based on advantage and disadvantage of each routes, character of pathology, data of history. The most of hysterectomies could be carried out by vaginal approach.

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