GL5. VAGINAL HYSTERECTOMY IN MODERN GYNAECOLOGY

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Despite the fact that vaginal hysterectomy is acknowledged to be the fastest and least expensive technique available to achieve removal of the uterus and cervix, it is used in only 23 - 25% of the hysterectomies performed. Traditionally, many surgeons have avoided vaginal hysterectomy or used it only in carefully selected patients. Until recently, the procedure was rarely used in patients who have difficult anatomy with limited visibility, including those with narrow vagina without uterine descent, an enlarged uterus, extensive pelvic adhesions, or a history of prior pelvic radiation. Other commonly cited contraindications to the vaginal approach have included nulliparity, obesity, or previous pelvic surgery.

New advances in technology have provided methods to minimize trauma, provide easier access, better methods to achieve haemostasis and have increased utilization of vaginal hysterectomy in patients who previously would have been candidates for abdominal hysterectomy or laparoscopic procedure.

Vaginal hysterectomy offers advantages over

abdominal hysterectomy with regard to operative time, complication rates, recovery, return to daily activities, and overall costs of treatment. In fact, the predominance of the abdominal approach may be based on factors other than clinical considerations, including resident training, use of limited or obsolete guidelines, a presumption rather than a confirmation that pathology exists that contraindicates a vaginal approach, and misconception about the safety and costs of vaginal hysterectomy. A number of studies spanning several years demonstrate that the use of more systematic guidelines for selecting the route of hysterectomy results in a major shift towards the vaginal approach. Evidence also shows that transvaginal hysterectomy is both feasible and optimum for types of patients who have long been considered inappropriate candidates for the vaginal route. New technology facilitates evaluation of patients and determining appropriate candidates for the vaginal approach via assessment of access, uterus size, and extent of pathology.

Surgical removal of ovaries at the same time is also possible with the use of newer instruments and modified surgical approach.

Most patients requiring hysterectomy should be offered the vaginal approach when technically feasible and medically appropriate. If specific additional procedures that can be completed laparoscopically are anticipated before surgery, laparoscopically assisted vaginal hysterectomy may be appropriate in some patients. The benefits of laparoscopically assisted vaginal hysterectomy must be weighed against the potentially increased risk and expense of two distinct operative procedures, laparoscopy and vaginal hysterectomy