Editorial

It Medical Team
https://www.itmedicalteam.pl/

Journal of Universal Surgery
2254-6758

2022
Vol. 10 No. 11: 77

Types of Hysterectomy Surgery and Risk Factors

Dr. Ahfaz Rahman*

Department of Surgery, Tepecik Training and Research Hospital, Pakistan

Corresponding author: Dr. Ahfaz Rahman

ahfaz.rahman@gmail.com

Department of Surgery, Tepecik Training and Research Hospital, Pakistan

Citation: Rahman A (2022) Types of Hysterectomy Surgery and Risk Factors. J Uni Sur, Vol. 10 No. 11: 77.

Abstract

Hysterectomy is one of the most frequently performed surgical procedures in the United States. Selection of the route of hysterectomy for benign causes can be influenced by the size and shape of the vagina and uterus; accessibility to the uterus; extent of extrauterine disease; the need for concurrent procedures; surgeon training and experience; average case volume; available hospital technology, devices, and support; whether the case is emergent or scheduled; and preference of the informed patient. Vaginal and laparoscopic procedures are considered “minimally invasive” surgical approaches because they do not require a large abdominal incision and, thus, typically are associated with shortened hospitalization and postoperative recovery times compared with open abdominal hysterectomy. Minimally invasive approaches to hysterectomy should be performed, whenever feasible, based on their well-documented advantages over abdominal hysterectomy. The vaginal approach is preferred among the minimally invasive approaches. Laparoscopic hysterectomy is a preferable alternative to open abdominal hysterectomy for those patients in whom a vaginal hysterectomy is not indicated or feasible. Hysterectomy is the surgical removal of the uterus. It may also involve removal of the cervix, ovaries (oophorectomy), Fallopian tubes (salpingectomy), and other surrounding structures.

Usually performed by a gynecologist, a hysterectomy may be total (removing the body, fundus, and cervix of the uterus; often called "complete") or partial (removal of the uterine body while leaving the cervix intact; also called "supracervical"). Removal of the uterus renders the patient unable to bear children (as does removal of ovaries and fallopian tubes) and has surgical risks as well as long-term effects, so the surgery is normally recommended only when other treatment options are not available or have failed.

Received: 03-Nov-2022, Manuscript No. IPJUS-22-13218; **Editor assigned:** 07-Nov-2022, Pre-qc No. IPJUS-22-13218 (PQ); **Reviewed:** 21-Nov-2022, QC No. IPJUS-22-13218; **Revised:** 23-Nov-2022, Manuscript No. IPJUS-22-13218 (R); **Published:** 30-Nov-2022, DOI: 10.36648/2254-6758.22.11.77

Introduction

A hysterectomy is the surgical removal of the uterus, and most likely, the cervix. Depending on the reason for the surgery, a hysterectomy may involve removing surrounding organs and tissues, such as the fallopian tubes and ovaries [1]. The uterus is where a baby grows during pregnancy. Its lining is the blood you shed during your menstrual period. You lose the ability to get pregnant and you will not get your period after a hysterectomy.

Three main types of hysterectomy are now used abdominal, vaginal, and laparoscopic. Traditionally, abdominal hysterectomy has been used for gynaecological malignancy when other pelvic disease is present, such as endometriosis or adhesions or if the uterus is enlarged [2]. It remains the “fallback option” if the uterus cannot be removed by another approach. Vaginal hysterectomy was originally used only for prolapse, but it is now also used for menstrual abnormalities when the uterus is of fairly normal size. Vaginal hysterectomy is regarded as less invasive than abdominal hysterectomy [3].

Surgeons can perform hysterectomy through more than a few different methods. Some of the generally performed routes of hysterectomy are vaginal, abdominal, laparoscopic, and robotic-

assisted. Vaginal hysterectomy ranks as one of the least and minimally invasive types of hysterectomies and it have better outcomes and fewer complications compared to other types. It should be regarded as the preferred route of hysterectomy, whenever possible. The advantages of vaginal hysterectomy include less pain, rapid recovery, faster return to work, lower costs, and lower morbidity. It is usually performed for benign hysterectomies [4].

Hysterectomy can be performed in more than a few different ways. Some of the generally performed routes of hysterectomy are vaginal, abdominal, laparoscopic, and robotic-assisted. Vaginal hysterectomy is considered one of the least and a minimally invasive type of hysterectomies and it has better outcomes and fewer complications compared to other types. It should be regarded as the preferred route of hysterectomy, whenever possible.

Risks of Hysterectomy

In 1995, the short-term mortality (within 40 days of surgery) was reported at 0.38 cases per 1000 when performed for benign causes. Risks for surgical complications were presence of fibroids, younger age (vascular pelvis with higher bleeding risk and larger uterus), dysfunctional uterine bleeding and parity [5].

The mortality rate is several times higher when performed in patients who are pregnant, have cancer or other complications. Long-term effect on all case mortality is relatively small. People under the age of 45 years have a significantly increased long-term mortality that is believed to be caused by the hormonal side effects of hysterectomy and prophylactic oophorectomy [6]. This effect is not limited to pre-menopausal people; even people who have already entered menopause were shown to have experienced a decrease in long-term survivability post-oophorectomy.

1. Pain, Scarring
2. Vaginal bleeding or spotting, Constipation
3. Difficulty urinating, Digestive issues
4. Damage to blood vessels, nerves, or surrounding organs
5. Delayed healing, Infections, Hot flashes
6. Vaginal dryness, Changes in libido, Difficulty sleeping, Mood changes, Symptoms of depression or anxiety

Types of Hysterectomy

There are different kinds of hysterectomy

Total hysterectomy: Removing the uterus and cervix, but leaving the ovaries.

Supracervical hysterectomy: Removing just the upper part of the uterus while leaving the cervix.

Total hysterectomy with bilateral salpingo-oophorectomy: Removing the uterus, cervix, fallopian tubes (salpingectomy) and ovaries (oophorectomy). If you haven't experienced menopause, removing the ovaries will start menopausal symptoms [7].

Radical hysterectomy with bilateral salpingo-oophorectomy: The removal of the uterus, cervix, fallopian tubes, ovaries, the upper portion of the vagina and some surrounding tissue and lymph nodes. This type of hysterectomy is performed when cancer is involved.

Results

An abdominal hysterectomy usually requires a hospital stay of one to two days, but it could be longer. You'll need to use sanitary pads for vaginal bleeding and discharge. It's normal to have bloody vaginal drainage for several days to weeks after a hysterectomy [8]. However, let your surgeon know if you have bleeding that's as heavy as a menstrual period or bleeding that's persistent.

1. Get plenty of rest.
2. Don’t lift anything heavy for a full six weeks after the operation.
3. Stay active after your surgery, but avoid strenuous physical activity for the first six weeks.
4. Wait six weeks to resume sexual activity.

Discussion

The strength of the present study lies in its prospective approach and on the large number of unselected cases. It is not biased by such problems as the use of hospital records only, the influence of special units or experienced surgeons or the analysis of a specific approach for hysterectomy or selected patient population. In this study, the operation-related details in three approaches for hysterectomy currently used for benign diseases are reported. The previous reference study [9], concentrated only on the vaginal and abdominal approaches. The present survey describes the surgical details and the complications that an average gynaecologist can face in all three hysterectomy techniques performed today. It also serves as a nationwide quality assessment. In the same year (1996) a total of 10 972 hysterectomies was performed in Finland [10]. This value also includes malignant cases which usually comprise some 10% of all and this is why it is believed that data have been collected on all the hysterectomies performed for benign indications in that year. Our data suggest that vaginal hysterectomy is preferable to abdominal hysterectomy, provided that it can be done safely. Claims that laparoscopic hysterectomy can allow identification of pelvic disease that might otherwise lead to complications during vaginal hysterectomy and that the meticulous haemostasis achievable during laparoscopic hysterectomy might reduce pelvic haematomas or vaginal cuff infections have not been borne out in this review. However, a laparoscopic approach may be appropriate if an oophorectomy is needed. Whether the increased detection of unexpected disease at laparoscopic hysterectomy subsequent clinical outcomes remains uncertain.

Conclusion

Significantly speedier return to normal activities and other improved secondary outcomes (shorter duration of hospital stay and fewer unspecified infections or febrile episodes)

suggest that vaginal hysterectomy is preferable to abdominal hysterectomy where possible. Where vaginal hysterectomy is not possible, laparoscopic hysterectomy is preferable to abdominal hysterectomy, although it brings a higher chance of bladder or ureter injury.

Our conclusions are limited by the strength of the evidence: for many outcomes, including many important long term outcomes, data were notably absent. Our review found no important disadvantages of vaginal hysterectomy compared with any other surgical approach, thus it remains an excellent option. Avoiding abdominal hysterectomy accelerates recovery, diminishes postoperative pain, and avoids abdominal wall infections and general postoperative febrile illness. Laparoscopic hysterectomy may help to avoid a laparotomy, but urinary tract injury is a genuine concern. Research is needed to ascertain longer term outcomes and to evaluate the newer approaches to hysterectomy, such as total laparoscopic hysterectomy.

Acknowledgement

None

Conflict of Interest

None

References

1 Karadag MA, Cecen K, Demir A, Bagcioglu M, Kocaaslan, et al. (2015) Gastrointestinal complications of laparoscopic/robot-assisted urologic surgery and a review of the literature. J Clin Med Res 7 (4): 203-10.

2 Dean Meara, Ramsay Robert, Heriot Alexander, Mackay John, Hiscock Richard Lynch, et al. (2017) Warmed, humidified CO2 insufflation benefits intraoperative core temperature during laparoscopic surgery: A meta-analysis. Asian J Endosc Surg 10 (2): 128-136.

3 Ma Y, Yang Z, Qin H, Wang Y (2011) A meta-analysis of laparoscopy compared with open colorectal resection for colorectal cancer. Medical Oncology 28 (4): 925-33.

4 Semm K (1983) Endoscopic appendectomy. Endoscopy 15 (2): 59-64.

5 Mond HG, Sloman JG, Edwards RH (1982) the first pacemaker. PACE 5: 278-282.

6 Furman S, Szarka G, Layvand D (2005) Reconstruction of Hyman's second pacemaker. PACE 28: 446-453.

7 Joseph AW, D'Souza G (2012) Epidemiology of human papillomavirus-related head and neck cancer. Otolaryngol Clin North Am 45: 739-764.

8 Perez-Ordoñez B, Beauchemin M, Jordan RC (2006) Molecular biology of squamous cell carcinoma of the head and neck. J Clin Pathol 59: 445-453.

9 Paz IB, Cook N, Odom-Maryon T, Xie Y, Wilczynski SP, et al. (1997) Human papillomavirus (HPV) in head and neck cancer. An association of HPV 16 with squamous cell carcinoma of Waldeyer's tonsillar ring. Cancer 79: 595-604.

10 Hobbs CG, Sterne JA, Bailey M, Heyderman RS, Birchall MA, et al. (2006) Human papillomavirus and head and neck cancer: a systematic review and meta-analysis. Clinical Otolaryngology 31: 259-266.