Mini Review

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Hysterectomy Surgery: Types of Hysterectomy

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Abstract

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 [1]. 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. It is the second most commonly performed gynecological surgical procedure, after cesarean section, in the United States [2]. Nearly 68 percent were performed for conditions such as endometriosis, irregular bleeding, and uterine fibroids. It is expected that the frequency of hysterectomies for non-malignant indications will continue to fall given the development of alternative treatment options. Although there are conservative alternatives, hysterectomy is performed for uterine fibroids, pelvic pain (including endometriosis, adenomyosis), pelvic relaxation (or prolapse), heavy or abnormal menstrual bleeding, and cancer.

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Introduction

Hysterectomy is also a surgical last resort in uncontrollable postpartum obstetrical haemorrhage. Uterine fibroids, although a benign disease, may cause heavy menstrual flow and discomfort to some women. Many alternative treatments are available Pharmaceutical (the use of NSAIDs for the pain or hormones to suppress the menstrual cycle), myomectomy, and often no treatment is necessary. If the fibroids are inside the lining of the uterus, submucosal, and are smaller than 4cm, hysteroscopic removal is an option. A submucosal fibroid larger than 4cm and fibroids located in other parts of the uterus can be removed with a myomectomy where a horizontal incision is made above the pubic bone [3].

Hysterectomy is a major surgical procedure that has risks and benefits. It affects the hormonal balance and overall health of patients. Because of this, hysterectomy is normally recommended as a last resort after pharmaceutical or other surgical options have been exhausted to remedy certain intractable and severe uterine/reproductive system conditions. There may be other reasons for a hysterectomy to be requested. Such conditions and/or indications include, but are not limited [4].

Endometriosis: growth of the uterine lining outside the uterine cavity. This inappropriate tissue growth can lead to pain and bleeding [5].

Adenomyosis

A form of endometriosis, where the uterine lining has grown into and sometimes through the uterine wall musculature [6]. This can thicken the uterine walls and also contribute to pain and bleeding.

Heavy menstrual bleeding: irregular or excessive menstrual bleeding for greater than a week. It can disturb regular quality of life and may be indicative of a more serious condition.

Uterine fibroids

Benign growths on the uterus wall. These muscular noncancerous tumors can grow in single form or in clusters and can cause extreme pain and bleeding.

Uterine prolapse: when the uterus sags down due to weakened or stretched pelvic floor muscles potentially causing the uterus to protrude out of the vagina in more severe cases [7].

Reproductive system cancer prevention

Especially if there is a strong family history of reproductive system cancers (especially breast cancer in conjunction with BRCA1 or BRCA2 mutation), or as part of recovery from such cancers.

Gynecologic cancer

Depending on the type of hysterectomy, can aid in treatment of cancer or precancer of the endometrium, cervix, or uterus. In order to protect against or treat cancer of the ovaries, would need an oophorectomy.

Transgender (Trans) male affirmation: aids in gender dysphoria, prevention of future gynecologic problems, and transition to obtaining new legal gender documentation [8].

Severe developmental disabilities

This treatment is controversial at best. In the United States, specific cases of sterilization due to developmental disabilities have been found by state-level Supreme Courts to violate the patient's constitutional and common-law rights.

Postpartum

To remove either a severe case of placenta praevia (a placenta that has either formed over or inside the birth canal) or placenta percreta (a placenta that has grown into and through the wall of the uterus to attach itself to other organs), as well as a last resort in case of excessive obstetrical haemorrhage.

Chronic pelvic pain

Should try to obtain pain etiology, although may have no known cause.

Hospital stay is 3 to 5 days or more for the abdominal procedure and between 1 and 2 days (but possibly longer) for vaginal or laparoscopically assisted vaginal procedures [9]. After the procedure, the American College of Obstetricians and Gynecologists recommends not inserting anything into the vagina for the first 6 weeks (including inserting tampons or having sex).

Hysterectomy, in the literal sense of the word, means merely removal of the uterus. However other organs such as ovaries, fallopian tubes, and the cervix are very frequently removed as part of the surgery.

Types

Radical hysterectomy

Complete removal of the uterus, cervix, upper vagina, and parametrium. Indicated for cancer. Lymph nodes, ovaries, and fallopian tubes are also usually removed in this situation, such as in Wertheim's hysterectomy.

Total hysterectomy: complete removal of the uterus and cervix, with or without oophorectomy.

Subtotal hysterectomy

Removal of the uterus, leaving the cervix in situ.

Subtotal (supracervical) hysterectomy was originally proposed with the expectation that it may improve sexual functioning after hysterectomy, it has been postulated that removing the cervix causes excessive neurologic and anatomic disruption, thus leading to vaginal shortening, vaginal vault prolapse, and vaginal cuff granulations. These theoretical advantages were not confirmed in practice, but other advantages over total hysterectomy emerged [10]. The principal disadvantage is that risk of cervical cancer is not eliminated and women may continue cyclical bleeding (although substantially less than before the surgery). These issues were addressed in a systematic review of total versus supracervical hysterectomy for benign gynecological conditions, which reported the following findings.

There was no difference in the rates of incontinence, constipation, measures of sexual function, or alleviation of pre-surgery symptoms.

Length of surgery and amount of blood lost during surgery were significantly reduced during supracervical hysterectomy compared to total hysterectomy, but there was no difference in post-operative transfusion rates.

Febrile morbidity was less likely and ongoing cyclic vaginal bleeding one year after surgery was more likely after supracervical hysterectomy.

There was no difference in the rates of other complications, recovery from surgery, or readmission rates.

Conclusion

Doctors use UAE to treat various conditions that cause excessive pelvic bleeding, including uterine fibroids. It is a minimally invasive procedure that may be an alternative to more invasive procedures such as surgery. UAE is generally safe and effective, with a low risk of complications. However, the procedure is not for everyone. People considering becoming pregnant in the future may choose to decline this procedure since it may lower their chance of becoming pregnant.

Acknowledgement

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Conflict of Interest

None

References

1 Bahamondes L, Bahamondes MV, Monteiro I (2008) Levonorgestrel-releasing intrauterine system: uses and controversies. Expert Rev Med Devices 5: 437-445.

2 Roopnarinesingh R, Fay L, McKenna P (2003) a 27-year reviews of obstetric hysterectomy. J Obstet Gynaecol 23: 252-254.

3 McPherson K, Metcalfe MA, Herbert A, Maresh M, Casbard A, et al. (2004) severe complications of hysterectomy: the VALUE study. BJOG 111: 688-694.

4 Wingo PA, Huezo CM, Rubin GL, Ory HW, Peterson HB (1985) the mortality risk associated with hysterectomy. Is J Obstet Gynecol 152: 803-808?

5 Shuster LT, Gostout BS, Grossardt BR, Rocca WA (2008) Prophylactic oophorectomy in premenopausal people and long-term health. Menopause International 14: 111-116.

6 Shoupe D, Parker WH, Broder MS, Liu Z, Farquhar C, et al. (2007) Elective oophorectomy for benign gynecological disorders. Menopause 14: 580-585.

7 Burks FN, Santucci RA (2014) Management of iatrogenic ureteral injury. Ther Adv Urol 6: 115-124.

8 Altman D, Yin L, Johansson A, Lundholm C, Grönberg H, et al. (2010) Risk of Renal Cell Carcinoma after Hysterectomy. Archives of Internal Medicine 170: 2011-2016.

9 Zucchetto A, Talamini R, Dal Maso L, Negri E, Polesel J, et al. (2008) Reproductive, menstrual, and other hormone-related factors and risk of renal cell cancer. International Journal of Cancer 123: 2213-2216.

10 Cocks PS (1980) early ectopic pregnancy after vaginal hysterectomy two case reports. BJOG BJOG-INT J OBSTET GY 87: 363-365.