

Research Article

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Vaginal Hysterectomies: 5 Years of Experience in the Department of Gynecology-Obstetrics II, HASSAN II University Hospital of Fez

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Abstract

We made this study to describe through our experience the epidemiological profil, of patients who underwent vaginal hysterectomy and to describe the indications and the complication of such surgery in our department.

Methodology: This is a retrospective study of 60 cases of vaginal hysterectomies collected in the gynecology-obstetrics II department of the Hassan II University Hospital in Fez, during the period from 01/01/16 to 31/12/21.

Results: The mean age of our patients was 50 years (extremes of 33 - 80 years). Most of our patients were multiparous or large multiparous with 58.3% and 20% respectively. 4 patients were nulliparous (6.6%). The reasons for consultation were dominated by abnormal uterine bleeding in 36 patients (60%). The indications in our study was dominated by uterine fibroid (28,3%) and prolapses (23,3%). 37 patients underwent simple hysterectomy with a rate of 61,7% and only 6 of them underwent hysterectomy with adnexectomy with a rate of 10%. we registered 20% of complications (12/60) among which secondary bleeding was frequent in the majority of cases. No cases of intraoperative death or postoperative deaths have been reported.

Conclusion: Out of our experience, we noticed that vaginal hysterectomy is a good treatment of benign gynecologic disease when it is legitimate. To increase it feasibility in our context, a comparative study should be performed between vaginal hysterectomy and the other routes used in our department to show the advantages of vaginal route for hysterectomy which is the most frequent surgery in gynecology.

Keywords: Vaginal; Hysterectomy; Surgery.

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Introduction

In our department of gynecology obstetrics 2 of the Hassan II university hospital of Fez, hysterectomy is the most frequent surgery among gynecological surgery for several indications which might be benign or malignant and most of them are done by abdominal route.

Hysterectomy can be performed abdominally, vaginally, or laparoscopically, with or without robotic assistance [1,2].

Today, when most gynecological operations have endoscopic solutions, the vaginal hysterectomy is gradually losing its leading role in the surgical repertoire, gradually abandoned in many centers, where trainees find the anatomical conditions complicated and develop understandable enthusiasm for endoscopy [3].

The vaginal hysterectomy has major advantages when compared to abdominal or endoscopic procedures [3]. It can be performed with epidural anesthesia, which is very important for elderly women who often belong to high-risk groups. The postoperative mobility is quick, and the need for analgesics is significantly less than in abdominal hysterectomy [3].

The advantages provided by Vaginal Hysterectomy (VH), Laparoscopic-Assisted Vaginal Hysterectomy (LAVH), and Laparoscopic Hysterectomy (LH) over Abdominal Hysterectomy (AH) include less postoperative pain, less need of analgesia, shorter hospital stay, and more rapid recovery and return to daily activities [1,2].

We made this study to describe through our experience the epidemiological profile, of patients who underwent vaginal hysterectomy and to describe the indications and the complication of such surgery in our department

Methodology

This is a retrospective study on 60 cases of vaginal hysterectomies collected in the gynecology-obstetrics II department of the Hassan II University Hospital in Fez, during the period from 01/01/16 to 31/12/21.

Was included in our study all the patients who underwent vaginal hysterectomy without any laparotomic conversion during our study period

Was excluded all the patients who underwent vaginal hysterectomy terminated by laparotomy Data were extracted from patients' folders using epidemiological, clinical, therapeutic data and the post-operative data.

Results

Our study population was 60 patients. The mean age of our patients was 50 years (extremes of 33 - 80 years) with a maximum of vaginal hysterectomy in the 40-50 age group (26 cases or 43%)

32 patients were in genital activity (53%) and 28 were in menopause (46%). The average parity of patients in our series is 4.68 children (range: 0 - 11 children). Most of our patients were multiparous or large multiparous with 58.3% and 20% respectively. 4 patients were nulliparous (6.6%). The reasons for consultation were dominated by abnormal uterine bleeding in 36 patients (60% of cases). The reasons for consultation are in Table 1.

The clinical examination found: 8 cases of endometrial bleed-

ing (13.3%), 2 cases of exocervicitis (3%), 1 case of polyp delivered through the cervix (1.6%) and 14 cases of uterine prolapse (23.3%) among which there were 9 cases of cystocele, 3 cases of rectocele and 2 cases of enteroceles.

Abdominal-pelvic ultrasound was performed for all women in the series. It showed: the presence of uterine fibroids in 17 patients (28.3%); endometrial thickening in 19 patients (31.6%) and 4 cases with an adenomyosis appearance (6.6%).

Hysteroscopy was performed in 26 patients for the etiological diagnosis of bleeding, allowing the diagnosis of uterine myomas, polyps, endometrial atrophy: adenomyosis and endometrial hyperplasia. The cervical smear was performed for all patients in our series. This smear was supplemented by colposcopy +/-cervical biopsy in 16 cases and showing one case of chronic endocervicitis without signs of malignancy, 8 cases of LSIL and 7 cases of HSIL.

Biopsy curettage of the endometrium directed by hysteroscopy, was performed in 24 cases, it objectified: 12 cases of focal polypoid hypertrophy with atypia (3 cases) and without atypia (9 cases); 4 cases of endometrial atrophy and 8 cases of adenomyosis.

For the surgical management of patients in our series we performed vaginal hysterectomies. Surgical procedures are described in Table 2.

Table 1: Distribution by reason for consultation.

Reason for consultation	Effective (N = 60)	Percentage (%)
Abnormal uterine bleeding	36	60
Pelvic gravity	16	26
Pelvic pain	8	13
Leucorrhées	4	6

Table 2: Description of surgical procedures.

	Effective	Percentage (%)
Type of vaginal hysterectomy	60	
Simple	37	61,7
With bilateral adnexectomy	5	8,3
With unilateral adnexectomy	1	1,6
With prolapse treatment	14	23,3
Assisted celio	3	5
Volume reduction gesture	11	18,3
Hemisection of the uterus	6	1
Isolated adhesive lysis	2	3
Association (fragmentation, cervical amputation, myomectomy, adhesiolysis, hemisection)	3	5
Indications for hysterectomies vaginal route	60	
Uterine fibroids	17	28,3
Prolapse	14	23,3
Cervical dysplasia	13	21,7
Abnormal uterine bleeding	7	11,7
Endocavitary polyps	3	5
Endometrial hyperplasia	3	5
Adénomyose	2	3
Diagnostic hysterectomy	1	1,6

Table 3: Distribution by Complications.

	Effective (N = 60)	Percentage (%)
Complications	12	2
Secondary bleeding	6	10
Urinary tract infection	2	3,3
Abscess of the vaginal slice	1	1,6
Simple vaginal infection	1	1,6
Urinary incontinence	1	1,6
Recurrence of cystocele	1	1,6

Discussion

These days, when the use of endoscopy and robotics is rising, many surgeons feel that they should use them to be using the current state of the art, therefore abandoning traditional methods used in the past [3]. The surgical approach of hysterectomy is the most important factor responsible for postoperative morbidity. Many studies have compared the surgical approach and complications according to the type of surgery to determine which method is best for the patient [4].

Despite the advantages of the vaginal hysterectomy, most surgeons hesitate to perform the procedure when faced with a large uterus, previous history of pelvic or salpingo-oophorectomy surgery, pelvic inflammatory disease, severe endometriosis, adnexal mass, or descensus in nonuterine cases [5]. Vaginal hysterectomy looks to be faraway less performed than the other ways of hysterectomy. In a study of the 1685 hysterectomies performed during a study period of 30 months, 131 were done vaginally (13,3%) [6]. In another study made by Schmitt et al among a cohort of 5750 hysterectomies the rate of vaginal hysterectomies was estimated at 35% to 40% [7]. In our study we did not estimate the rate of vaginal hysterectomy among the total hysterectomy performed in our department during the period of this study.

Most of our patients were multiparous or large multiparous with 58.3% and 20% respectively while 4 patients were nulliparous (6.6%). Vaginal hysterectomy is not performed only in multiparous. It can be performed in nulliparous as it's the case in some studies [7,8]. Dhainaut. C et al. [8] reported in their study that 75% of vaginal hysterectomy can be performed in the women with no parity when the vaginal route seems legitimated. Certain patient characteristics have historically been perceived by gynecologic surgeons as potential contraindications to vaginal hysterectomy. These include a uterus greater than 12 weeks in size (>280 g), no vaginal parity, history of laparotomy (particularly a cesarean delivery), and obesity. However, the literature has included studies that support the use of vaginal hysterectomy in patients with these characteristics [7]. For some authors [1], vaginal accessibility should be assessed before indicating vaginal hysterectomy. That is determined by assessing 3 key components: the angle of the pubic arch, the shape of the vagina, and the uterine descent. A pubic arch that is wide, or more than 90 degrees, allows for easier access to the uterus and placement of instruments, facilitating the vaginal approach. However, with a small 1-2 cm posterior midline episiotomy, vaginal accessibility may be obtained even when the pubic arch is less than 90 degrees [9-11]. The shape of the vagina, especially the breadth of the vaginal apex, is best assessed during vaginal examination. A vaginal apex 3 cm wide facilitates a vaginal approach, as it provides ample space for anterior and pos-

terior entry, and improves lateral visualization of the vasculature [9,10]. Vaginal hysterectomy is recommended by some authors to be performed for benign pathology. All our patients were operated by vaginal route for benign pathologies. The indications in our study was dominated by uterine fibroid and prolapses. Most of the time hysterectomy is performed for uterine fibroid. Buambu BSF and al [12] reported in their series that uterine fibroid and prolapse where the principal indications for hysterectomy with the respective rates of 63,9% and 17,5%. The same notice was made by Bahat and al. [5] in their study where prolapse was the most common indication of vaginal hysterectomy in 61% of cases followed by uterine fibroid in 22% of cases.

In our study, 37 patients underwent simple hysterectomy with a rate of 61,7% and only 6 of them underwent hysterectomy with adnexectomy with a rate of 10%. Adnexectomy during vaginal hysterectomy appear to be less frequent due probably to technical issues. Many surgeons are reluctant to attempt bilateral adnexectomy during vaginal hysterectomy because of concerns about decreased surgical access and visibility [10]. According to Sheth S and al [13], ovaries are visible and accessible during vaginal surgery, and it is generally safe to perform bilateral adnexectomy at the time of vaginal hysterectomy. The same authors [13] reported in their study that prophylactic oophorectomy was possible at VH in 1510 of 1572 cases (96% of cases). In another study, Bahat Y and al reported 43% of prophylactic adnexectomy during vaginal hysterectomies. In the vast majority of cases prophylactic oophorectomy will be performed successfully regardless of the route of hysterectomy [10]. In our study, we registered 20% of complications (12/60) among which secondary bleeding was frequent in the majority of cases. It is reported with evidence that in general, vaginal hysterectomy is associated with better outcomes and fewer complications [10].

A Cochrane review of 34 randomized trials of abdominal hysterectomy, laparoscopic hysterectomy, and vaginal hysterectomy, including 4,495 patients, concluded that vaginal hysterectomy has the best outcomes of these three routes [10].

Conclusion

Out of our experience, we noticed that vaginal hysterectomy is a good treatment of benign gynecologic disease when it is legitimate. To increase it feasibility in our context, a comparative study should be performed between vaginal hysterectomy and the other routes used in our department to show the advantages of vaginal route for hysterectomy which is the most frequent surgery in gynecology.

Declarations

Competing interests: There is no competing interests between the authors.

Authors'contributions: All the authors participated to the management of the patient, the writing and approved the final version of the manuscript.

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