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Technique for Difficult Laparoscopic Hysterectomy

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Objective: We evaluated the feasibility, safety, conversion rate, and complication rate of difficult laparoscopic hysterectomy using a standardized technique adjusted to particular situations. This was a prospective study carried out at a private endoscopic center.

Methods: From May 2005 to April 2006, 212 women underwent total laparoscopic hysterectomy for uteri weighing more than 280 grams, and in presence of previous caesarean deliveries, adhesions, or endometriosis. A total laparoscopic hysterectomy was performed using some tricks: a) A higher trocar position with a supraumbilical trocar for the optics whenever necessary. A fourth 5-mm ancillary trocar was added in case of massive uteri; b) Use of the 30° laparoscope in case of anterior myomas hindering the vision of the vesico-uterine fold; c) Both surgeons and assistant operating on their own sides; d) Lateral access to the vesico-uterine space in case of thick adhesions from previous C-Sections; e) Lateral retroperitoneal access with ureter dissection in case of endometriosis of the cul-de-sac; f) Use of vessel sealing systems, especially in case of varicosities; g) **Use of a reusable, user-friendly uterine manipulator that allowed a good delineation of the vaginal fornix (Mangeshikar's uterine manipulator, G. Bissinger, Germany);** h) Vaginal morcellation; i) Vaginal cuff closure both vaginally and laparoscopically for apex support.

Results: All the 212 procedures were completed laparoscopically. The mean uterine weight was 610g (mean, 320 to 1250), 45 patients had uteri >900g. The mean duration of the surgery was 145 minutes (range, 110 to 220): the time included adhesion lysis for 98 patients and endometriosis excision in 57. The average drop in hemoglobin concentration was 1.12g±0.86g/100mL (ranging from 0.7g to 2.2g/100mL). The mean postoperative hospital stay was 2.02 days ± 0.61 days. No major complications occurred. Postoperative urinary infections were the most common minor complications. Vaginal cuff bleeding rarely occurred (5%). The Mangeshikar's uterine manipulator allowed an easy completion of the bladder dissection, colpotomy, and vaginal cuff closure.

Conclusions: Laparoscopic total hysterectomy is a safe, effective, minimally invasive approach to hysterectomy even in the presence of considered contraindications, such as very large uteri or previous C-Sections. The length of the procedure positively correlates with adhesion removal and uterine morcellation.