IS–73  Vaginal Hysterectomy: Learning Experience from Sapporo, Japan

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Background: Various reconstructive surgical techniques aiming at restoration of anatomy closely to normal has been tried in recent years. We were performing PFR and vaginal hysterectomy in conventional Shaw’s method prior to 1993. A new surgical technique which is popular in Japan, was introduced in T.U. Teaching Hospital by Dr. T. Yamaguchi, JICA Consultant to Nepal from 1993 – 1996. Objectives: To study pelvic floor repair and vaginal hysterectomy performed in a different way as learned from Sapporo, Japan. Methods: Retrospective study was done from April 1993 to March 2000 at TU Teaching Hospital. Results: Annual gynecological admission for uterovaginal prolapse was in average 122.5%. Yearly operative treatment for uterovaginal prolapse, in average accounted 36.5%. Out of total 364 pelvic floor repair with vaginal hysterectomy done during this period, 162 cases (44.5%) were accomplished by this new surgical technique introduced by Dr. T. Yamaguchi, which is popular in Sapporo, Japan. This new method consisted of (i) Circular incision around the cervix just below the bladder demarcation, (ii) Anterior reflection of bladder above the level of uterosacral pouch, (iii) Therapy separating the anterior vaginal mucosa from the underlying rectovaginal fascia, (iv) Opening the pouch of Douglas, (v) Cutting of the Mackenrodt ligament, (vi) Hence, skeletonising and ligating the cut ends of uterosacral and Mackenrodt ligaments and closure of the pelvic peritoneum. This is followed by anterior colpocurexy and posterior colpoperineorrhaphy. Conclusions: Although utero-vaginal prolapse is a common gynecological problem among Nepalese women, significantly subtracting quality of life, due to composite etiological factors, operative intervention in surgical correction of this disorder is available only to small number of women. To conclude, this method was found to be appreciably good as it showed much lesser immediate and long term complications compared to the conventional Shaw’s method. This method is slowly regaining popularity not only because it is simple but also the chances of slipping of uterine vessel and post-operative haemorrhage is considerably very low, almost negligible.

IS–74  Technical Minutiae of Non Descent Vaginal Hysterectomy

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Vaginal surgery is a discipline by itself. Reported figures state that 70%of hysterectomies and in a few centers as many as 85%are done abdominally whereas only 30%are done vaginally. The need for the hour is minimally invasive surgery where early discharge from the hospital early resumption of work avoidance of disfiguring scar on the abdomen and the cost effectiveness of the procedure are as important as the cure of the disease. Vaginal hysterectomy fulfills these criteria to absolute satisfaction. Of the close to 9,000 hysterectomies done by us 74%have been vaginal hysterectomies. The major technical barriers to the minds of most of the surgeons not only at the initial level of training but even after considerable experience are at three steps of the surgery. 1. Reaching and opening of the vesico uterine fold of the peritoneum. 2. Clamping, cutting and ligating the uterosacral and Mackenrodt when the descent is poor and the space is inadequate. 3. When, either the uterus is enlarged or occasionally there is no mobility in spite of securing the cardinal ligaments. Each of these steps will be discussed in detail. The opening of the anterior pouch is facilitated by a modification of the standard incision on the vagina which the author takes higher at the level where the bladder meets the cervix. This is followed by sharp dissection. An elliptical incision is made at the junction of the vaginal wall and epithelial surface of the cervix. This is a useful variation in a clamp or clamping technique. Failure of uterus to descend after both the cul de sacs are open and uterosacral and Mackenrodt ligament complex has been ligated does sometime occur. A large size of the uterus is usually known to the operator and there are other infrequent causes. We use myometomy, hemissection and removal of myomas that suit the situation overall whenever there is difficulty experienced in mobility of the uterus. If hemissection is resorted to it eases the situation in a very large number.

IS–75  Continuous Sonographic Monitoring during Hysteroscopic Myomectomy in Deeply Invaded Submucous Myomas

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Objective: We investigated the serial change of myometrial thickness before, during and after hysteroscopic myomectomy, in order to clarify the safety of this surgical procedure. Methods: Sixteen women having a submucous myoma with the myometrial thickness between the myoma and the serosa no more than 1 cm were enrolled in this prospective study. We used two resectoscopes, outer diameters of 7 mm and 9 mm, respectively, to accomplish a one-step hysteroscopic myomectomy. The myometrial thickness between the outer edge of the myoma and the inner edge of the serosa, as well as that of the opposite uterine wall were measured before, during, and after hysteroscopic myomectomy. Results: The myometrial thickness between the myoma and the serosa increased gradually and significantly from 6.7 mm (interquartile range 6.1 – 7.8) before, 8.9 mm (7.6 – 12.7) during, to 16.1 mm (13 – 20.9) after hysteroscopic myomectomy (P < 0.001). The thickness of the opposite uterine wall increased from 10.1 mm (7.5 – 11.9) before, 11.4 mm (10 – 13.8) during, to 18.8 mm (16 – 23.7) after surgery, too (P < 0.001). Conclusions: The one-step hysteroscopic myomectomy is a safe and effective surgical procedure in removing submucous myomas with deep intramural invasion.