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A Simple light-endorsed transvaginal section (LETS) technique facilitates laparoscopically assisted vaginal hysterectomy (LAVH)

E.M. Tsai, H.S. Chen and J.N. Lee

Dept. of Obstetrics and Gynecology, Kaohsiung Medical College, Kaohsiung, Taiwan.

Objective: LAVH is being used for an increasing number of gynecologists. However, problems such as prolonged operating time, limitations of the skills of the surgeons etc. still exist. We describe a simple technique called light-endorsed transvaginal section (LETS) which can facilitate the effectiveness and safty of LAVH.

Method: Fifty women were underwent LETS technique during LAVH with variable indications. The other fifty patients were performed using conventional abdominal hysterectomies(ATH) as control. The clinical characteristics of those women were also studied. When LAVH was scheduled for women, three trocar insertions were applied as usual. After identification of uterus, one simple application of Endo GIA stapler was used on each side for adnexal dissection. The distal endoscope was introduced into the vesico-uterine reflection. By the guidance of endoscopic light, the bladder and uterus could be separated precisely from vaginal approach. Vaginal hysterectomy was then performed easily.

Results: The results revealed the average operating time was much shorter using LETS in LAVH than the traditional LAVH. The clinical outcomes such as complications, blood loss, hospital stay etc. were also discussed in the study group and ATH group.

Conclusion: The most striking advantage of this procedure is reduced operating time in comparison with conventional LAVH. The present technique is feasible and is accomplished easily and safely. As the introduction of LAVH shifted gynecologists' practice from total abdominal hysterectomy currently, the application of LETS will enhance the power of LAVH. Alternatively, it will allow the introduction of LAVH into the gynecological resident training program.

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Comparison of Laparoscopic Hysterectomy Techniques : Review of 1,300 Operations

Lee Y.T., Lee S.H., Shim H.N., Jun J.S.

Dept. of Obstetrics and Gynecology
YoungDong Jeil Hospital, Seoul, Korea

Hysterectomy is the most common operation in gynecology. It used to be performed using abdominal or vaginal approach. Since Reich reported the first laparoscopic hysterectomy in 1989, laparoscopic hysterectomy has become increasingly a therapeutic tool. The purpose of this study is to describe the changes of laparoscopic hysterectomy techniques in our hospital, and to compare surgical outcomes according to techniques.

From June 1994, to June 1998, 1,300 laparoscopic hysterectomies were performed at YoungDong Jeil Hospital. There were changes of laparoscopic hysterectomy techniques in our hospital as follows: Group A (190 cases): Laparoscopic-assisted vaginal hysterectomy (LAVH), Group B (242 cases): Total laparoscopic hysterectomy (TLH) using folded gauze on sponge forceps, Group C (868 cases): TLH with colpotomizer (Coopersurgical, USA). Hysterectomy was performed with monopolar and bipolar coagulation, uterine manipulator (RUMI, coopersurgical, USA). In group C, after pushing the colpotomizer against the uterine cervix, anterior and posterior colpotomy was done. We used the Statview software. The differences of groups were analyzed by one-way ANOVA.

The surgical indications were enlarged uterus (70.4%), pelvic pain & dysmenorrhea (14%), bleeding & menorrhagia (9.1%), CIN or CIS (4.0%), adnexal mass(1.2%), other(1.0%). The pathologies were myoma of uterus (58.3%), adenomyosis (32.8%), CIN or CIS(4.1%), benign ovarian cyst (1.2%), endometrial hyperplasia (0.6%) other (2.9%). According to surgical group, the mean operating time was 149 min, 133 min, 103 min* ($P < 0.01$) respectively. The average uterus weight was 233 gm, 254 gm, 260 gm. The mean postoperative 1 day Hb drop was 1.8 g/dl, 1.7 g/dl, 1.2 g/dl* ($P < 0.05$). The mean hospital stay days was 3.9, 3.8. 3.6 days respectively. Major intraoperative complications were injury to large vessels (1), small bowel injury(1), cystotomies(3). Serious postoperative complications were vaginal cuff bleeding (7), vaginal evisceration (3), ureterovaginal fistula (4), incisional hernia (1), gastroenteritis or ileus (4). Especially 4 ureter injuries were associated with LAVH. Other complications had no significant difference according techniques.

In conclusion, TLH is the superior technique compare with LAVH. It's advantages are shorter operation time, less blood loss and more safe procedure. Additionally, a hysterectomy can be safely performed laparoscopically by the well trained laparoscopic surgeon, resulting in reduced surgical morbidity, blood loss, postoperative discomfort and pain, shortened hospital stay and shorter recovery days.