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Our experience with pelviscopic classic intrafascial Semm hysterectomy

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Objective;

To evaluate the efficacy of pelviscopic classic intrafascial Semm hysterectomy (CISH).

Methods;

Review of hospital records of 225 women undergoing pelviscopic CISH between April 1993 and December 1997. All of the hysterectomy procedures were performed in the classic maner with grasping forceps, scissors, ligatures, and sutures. No lasers, or stapling devices were used.

Results;

Indications, associated procedures, surgical outcomes, and complications were analyzed. The most common surgical indication was leiomyomata uteri. No major complications occurred even in patients who had extremely large leiomyomata. The mean uterine weight was 207.49±104.9gm. The average operating time (169.89±56.19min) was consistent with that of other methods. Blood loss(160±182ml) was lower than during conventional abdominal hysterectomy. No procedure was converted to laparotomy.

Conclusions;

Pelviscopic CISH is truly a minimally invasive and organ-preserving surgery, and in our study was associated with significantly low morbidity and no major complications. Pelvic floor support is maintained and the uterus are not in danger. coring out the cervix with the calibrated uterine resection tool(CURT) may prevent the development of cervical cancer. Therefore, we think that CISH may be an acceptable technique for benign uterine disease.

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Experience with 1000 Laparoscopic Hysterectomies.

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Objectives: To evaluate the outcome of 1000 cases of laparoscopic hysterectomies and compare with other techniques and learn lesson from it.

Methods: Retrospective review of the medical records were done for 1000 cases of hysterectomies carried by laparoscope from 1990 to 1997 at the university affiliated teaching hospitals.

Results: Various techniques, either total or subtotal hysterectomies were carried with electrosurgery, laser or mechanical suture tying techniques. Concomitant surgeries done with hysterectomy were repair of pelvic floor defect, retropubic colposuspension, radical hysterectomy with pelvic or para-aortic lymph node dissection and appendectomy. Shortest operation time was 45 minutes for 150 gm uterus with adenomyosis and longest operation time was 270 minutes for leiomyomas with severe pelvic endometriosis. Mean operation time was 87 minutes. Smallest uterus was 75 gm and largest one was 1150 gm. Mean uterine weight was 227 gm. Six cases were converted to laparotomy. Serious intraoperative complications were rectal injury(3), injury on the large vessel(2) and cystotomy(3). Serious postoperative complications were vesico-vaginal fistula(3), uretero-vaginal fistula(1), intra-abdominal hemorrhage(1) and dehiscence of the vaginal cuff(2). Most of the complications were corrected laparoscopically except the first rectal injury, first two vesico-vaginal fistulas and two large vessel injuries.

Conclusions: There were few lessons learned from this review. (1) Operative laparoscopy needs team approach. (2) There is a *learning curve*. (3) As techniques are improved, surgeon might be involved with more serious complication due to participation with lot more advanced operative procedures for the more complicated pelvic pathology. (4) Laparoscopic hysterectomy is a very safe and effective modality of hysterectomy compared to abdominal and vaginal hysterectomy. (5) Laparoscopic hysterectomy can be done with least expensive re-usable instruments and electrosurgery. (6) Most of the complications in laparoscopy can be managed laparoscopically without laparotomy.