

DISCUSSION

Hysterectomy is the most commonly performed major gynecologic procedure around the world. Benign diseases are responsible for more than 70% of the indications for hysterectomy and include menstrual disorders, fibroids, pelvic pain and uterine prolapse.⁽¹⁾

Despite the advantages of the laparoscopic and vaginal routes compared with laparotomy, this remains the most widely used access route for performing hysterectomy worldwide.^(4,5)

In a Cochrane review in 2006, a group of randomized controlled trials were evaluated with respect to the results of supracervical and total hysterectomy.⁽⁶⁾ No difference in urinary incontinence, constipation and sexual function was noted. These studies included in the Cochrane review compared the supracervical hysterectomy and total hysterectomy performed through laparotomy, but have been extrapolated to the laparoscopy.^(15,16,17)

Our study was carried out on one hundred women randomly divided into two equal groups, fifty patients each, recruited from EL-Shatby University Hospital complaining of abnormal uterine bleeding (AUB). All patients were randomly divided into two study groups using the sealed envelope technique: Group A (Laparotomy group): 50 patients had undergone subtotal abdominal hysterectomy. Group B (Laparoscopy group): 50 patients had undergone laparoscopic supracervical hysterectomy (LASH).

Both groups were homogenous as regard the age, parity and indication of hysterectomy. No significant difference was noted between them as regard neither the preoperative TVUS uterine size nor the concomitant pelvic pathology. The preoperative and postoperative Hb and Ht levels were not statistically significantly differ between the both groups.

Intraoperatively; the laparoscopy group had fewer blood loss and suture material with shorter total scar length. Early postoperatively; the laparoscopy group need less analgesia, had less time to get peristalsis, flatus and ambulation with shorter hospital stay than the laparotomy group. Laparoscopy group had also a shorter duration of analgesia with more rapid return to basal activities than in the laparotomy group. The incidences of SSI and scar pain were statistically significantly less in the laparoscopy group than in the laparotomy group.

A Cochrane review done in 2009 about the surgical approach to hysterectomy for benign gynecological disease stated that laparoscopic hysterectomy had less blood loss, shorter hospital stay, quicker recovery and fewer infections than abdominal hysterectomy. These findings were compatible with our findings. Shrestha et al. and Persson et al. reached also the same findings.^(12, 37, 38)

Garry et al. found that the mean duration of abdominal hysterectomy was 50 minutes while laparoscopic hysterectomy mean time was 84 minutes. These figures were compatible with our findings; 60 and 90 minutes respectively.⁽³⁹⁾

Garri et al. and Berner et al. found that the overall patient satisfaction postoperatively was better in laparoscopic hysterectomy than abdominal hysterectomy which matched with our findings. ^(40,41)

Lieng et al. conducted a long term study for follow-up of cases undergone supracervical hysterectomy by either laparoscopic or abdominal approach and concluded that the long term scar pain was significantly less in the laparoscopy group. Our study reached to the same conclusion. ⁽⁴²⁾

Abdelmonem et al. conducted an observational comparison of various types of hysterectomy performed at a university teaching hospital. They concluded that laparoscopic hysterectomy cases had fewest analgesic requirement, earliest recovery and highest satisfaction rates. These data went in parallel with our findings. ⁽⁴³⁾

Huang et al. found that the average time for bowel function recovery was significantly higher in laparoscopic hysterectomy than abdominal hysterectomy. Their finding matched our findings. ⁽⁴⁴⁾

Zhu et al. compare the different characteristics of various routes of hysterectomy and found that there was no statistically significant difference in the operative time of laparoscopic and abdominal hysterectomies. This finding was in contrary with our finding that revealed a significantly longer operative time for laparoscopic hysterectomy. This discordant findings can be explained by the differences in the learning curve and institutional facilities between our study and Zhu study and also the confounding factors like intraoperative complication(s) that warranted longer operative time. ⁽⁴⁵⁾

Leng et al. found that there was no statistically significant difference in the total cost between laparoscopic and abdominal hysterectomy which contradict to our findings of higher cost in the laparoscopy arm. This contradiction can be explained by the inclusion of the sick leave cost in Leng study that was not included in ours. ⁽⁴⁶⁾

Tan et al. stated that the indications for laparoscopic and abdominal hysterectomies were similar. This finding matched our finding. ⁽⁴⁷⁾

Amanda et al. studied the technical aspects of various routes of hysterectomy. One of their findings that the incidence of surgical site infection during the follow up period was significantly lower in laparoscopic hysterectomy patients than laparotomy. Their findings was concomitant with our finding. ⁽⁴⁸⁾

SUMMARY

Hysterectomy is the most commonly performed major gynecologic procedure around the world. Benign diseases are responsible for more than 70% of the indications for hysterectomy. Despite the advantages of the laparoscopic and vaginal routes compared with laparotomy, this remains the most widely used access route for performing hysterectomy worldwide.^(1,4,5)

Our study was carried out on one hundred women randomly divided into two equal groups, fifty patients each, recruited from EL-Shatby University Hospital complaining of abnormal uterine bleeding (AUB). All patients was randomly divided into two study groups using the sealed envelope technique: Group A (Laparotomy group): 50 patients did subtotal abdominal hysterectomy. Group B (Laparoscopy group): 50 patients did laparoscopic supracervical hysterectomy (LASH).

All patients had been subjected to full history taking, general, systemic, and bimanual pelvic examination. Relevant investigations; e.g. CBC, Renal and liver function tests, Blood sugar study and urine analysis had been taken preoperatively. Also Transvaginal ultrasonography done to confirm uterine size, ovarian status, and any concomitant pelvic lesion.

Both groups were homogenous as regard the age, parity and indication of hysterectomy. No significant difference was noted between them as regard neither the preoperative TVUS uterine size nor the concomitant pelvic pathology. The preoperative and postoperative Hb and Ht levels were not significantly different between the both groups.

Intraoperatively; the laparoscopy group had fewer blood loss and suture material with shorter total scar length. Early postoperatively; the laparoscopy group need less analgesia, had less time to get peristalsis, flatus and ambulation with shorter hospital stay than the laparotomy group. Laparoscopy group had also a shorter duration of analgesia with more rapid return to basal activities than in the laparotomy group. The incidences of SSI and scar pain were statistically significantly less in the laparoscopy group than in the laparotomy group.