



CENTER FOR WOMEN'S CARE AND REPRODUCTIVE SURGERY

Gynecologic Endoscopic Surgery

Supracervical Laparoscopic Hysterectomy

A Dramatic Alternative to Abdominal Hysterectomy

Sherry Figueredo, despite experiencing debilitating pain and heavy bleeding from fibroids and endometriosis each month during her period, had avoided having a hysterectomy for several years because of the nightmare of a six to eight week recuperation and concern over the potential for sexual problems post-operatively. The mother of three at the time was manager of national accounts for Delta Air Lines' Meeting Network, and had to be "on" at all times during trade shows and group presentations to customers.

"I envisioned being unable to carry on--with no one to help me, since the kids are grown and out of the house," she said. "Despite having to deal with the pain using occasional medication, heating pads and hot baths, for years I could not bring myself to schedule this debilitating operation."

Like many women, Ms. Figueredo was unaware that there are alternatives to total abdominal hysterectomy. "No previous gynecologists or surgeons had suggested laparoscopic surgery, even though this was a long-term problem. All they talked about was surgery performed the old way, with scalpels," she said.

New Procedure Aids Resumption of Sexual Activity, Documented by 30-Year Finnish Study

As the originator of a new laser procedure which leaves the woman's cervix intact, called supracervical laparoscopic hysterectomy, I feel that less is more in surgery. The cervix is a supportive structure to the female anatomy, something of a 'keystone,' so I feel that there are many more positives to this approach than even the laparoscopically assisted vaginal hysterectomy. The woman experiences significantly less discomfort and an even quicker recovery--she's leaving outpatient surgery after 18 hours. She can resume normal activity within two days and sexual intercourse within two weeks, compared to a six to eight week resumption with abdominal hysterectomy.

Within the first week after surgery Sherry Figueredo walked a mile. She was back at work two weeks to the day after the surgery was performed, and back at the athletic club doing Nautilus, Stairmaster and playing tennis within a month.

My philosophy is to perform the procedure only when absolutely necessary, and to make it as minimally invasive as possible. A study conducted in Finland by Pentti Kilkku, M.D., and other physicians between 1950 and 1980 determined that the reduction in orgasm and problems with sexual function after total abdominal hysterectomy as compared to supracervical hysterectomy appears to result from the greater radicality of the former.

*1140 Hammond Drive, Bldg. F-6230
Atlanta, GA 30328
770-352-0037 or
Toll free 888-545-0400*

With total abdominal hysterectomy, the vagina and cervix are damaged more than in supracervical hysterectomy, and scar tissue often forms in the vagina. It is probable that these physical changes and subconscious psychological reactions due to total removal of the uterus explain why supracervical hysterectomy yields more satisfactory sexual response than total abdominal hysterectomy. In the study, preoperatively 76% of the patients were orgasmic, and six months after surgery 78% were orgasmic.

As another patient Venita Dobbs said, "If I didn't know that my uterus had been removed, I wouldn't know the difference. It's like a modern day miracle to me."

Hysterectomy, surgical removal of the uterus, is one of the most commonly performed procedures in the United States--some say too common. Each year, some 650,000 women nationwide undergo hysterectomy for abnormal uterine bleeding, fibroids (benign uterine tumors), chronic pelvic inflammatory disease, endometriosis and uterine or ovarian cancer. Abdominal hysterectomy typically requires women to spend four to six days in the hospital and and four to six weeks recuperating at home. Supracervical laparoscopic hysterectomy is performed as an outpatient surgery, which means most patients can go home the same day. Until about four years ago, 75 per cent of all hysterectomies were performed through an incision in the abdomen. In the remaining cases, the uterus was removed through an incision in the vagina, a procedure that also carried a two-to-three day hospital stay and four-week recovery.

Both procedures have drawbacks, according to gynecologic surgeons. The abdominal approach requires a four-to-six inch incision and results in considerable postoperative pain, a lengthy recuperation and a visible scar. Vaginal hysterectomy is not possible if the patient's ovaries must be removed, if the patient has had previous pelvic surgery or if the surgeon must treat related disorders near the uterus.

The new procedure was developed in response to the problems we saw surgeons experience while learning laparoscopically assisted vaginal hysterectomy. I looked for a procedure that would cause less trauma to the patient, and adapted supracervical hysterectomy to the laparoscopic approach. With the pelvic floor still intact, support mechanisms are in place as a further deterrent to urinary stress incontinence later on.

The surgery takes place under general anesthesia, so the patient is unconscious throughout the procedure. Using a trocar (a narrow, tube-like instrument), the surgeon gains access to the abdomen through the navel. A laparoscope (tiny telescope) connected to a camera is inserted through the trocar, allowing the surgeon to view a magnified image of the patient's internal organs on a video monitor. This enables the surgeon to perform the hysterectomy as well as to diagnose and treat related conditions at the same time. The laparoscope allows the surgeon to see small areas of endometriosis (a painful disease in which tissue of the uterine lining occurs outside the uterus) as well as check the gallbladder and liver for possible disease.

Two or three additional trocars are inserted to accomodate special instruments, including lasers and other minimally invasive devices which detach the uterus. After the uterus is detached, it is removed through the navel. Tubes and ovaries can also be removed with the laser, if necessary. Because the laser cauterizes during the surgery, blood loss is generally 50 cubic centimeters or less. Even a patient with a large uterus may be a good candidate for the procedure.

Laparoscopy was pioneered by gynecologists in the early 1960s, and has been widely used in a range of procedures, including tubal ligation, the removal of ovaries and fibroids and the treatment of tubal pregnancies. Laparoscopy is also used for gallbladder removal, appendectomy, hernia repair and lung and bowel surgery. In one of the newest applications, also developed by our group, it is being used to repair the bladder to treat urinary stress incontinence.

Supracervical laparoscopic hysterectomy requires more skill than abdominal hysterectomy because you're operating through a camera. Technically, it is a more difficult procedure.

Patients should choose a surgeon who is experienced in working with lasers and laparoscopy, and should be presented all of the available medical options for relief of their pain and/or bleeding, in addition to surgical alternatives.