Total Laparoscopic Hysterectomy and Laparoscopic-Assisted Vaginal Hysterectomy

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KEYWORDS

- Laparoscopic hysterectomy • Laparoscopic assisted vaginal hysterectomy
- Minimally invasive surgery • Vaginal surgery • Laparoscopy

KEY POINTS

- When vaginal hysterectomy is not possible, laparoscopic hysterectomy and laparoscopic-assisted vaginal hysterectomy are excellent methods for removal of the uterus.
- Poor descent of the uterus, as with fibroids, or need to evaluate the pelvis, as with endometriosis, are examples of indications for a laparoscopic approach.
- Advanced laparoscopic skills are often required to complete a total laparoscopic hysterectomy. Completion of the hysterectomy vaginally is an option, with the amount of vaginal dissection required dependent on the laparoscopic portion.
- Attention to sound surgical steps, including visualization, traction, and hemostasis, is the key to success. Cystoscopy is recommended at case completion.
- Patients with a successful minimally invasive approach will return to work sooner with decreased pain and a shorter hospital stay when compared with those who undergo abdominal hysterectomy.

HISTORICAL PERSPECTIVE

Hysterectomies have been reported as early as 50 BC by Themison and 120 AD by Soranus, but it was not until 1813 that Conrad Langenbeck performed the first planned vaginal hysterectomy in modern times.[1,2] Charles Clay is credited with performing the first abdominal hysterectomy in Manchester, England in 1839.[1] Thomas Keith started to incorporate aseptic techniques with the procedure and by 1910 had decreased the mortality of vaginal hysterectomy down to 2.5%.[2] Despite improvements in vaginal

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surgery over time, the open abdominal approach to hysterectomies accounted for 75% of the cases for removal of the uterus.[2]

Gynecologists were the pioneers in laparoscopy; as technology advanced, so did the surgical techniques. Harry Reich performed the first laparoscopic hysterectomy in 1989.[1,3] In less than a year, Kovac and colleagues[4] reported the first laparoscopic-assisted vaginal hysterectomy. As more surgeons incorporated laparoscopic techniques into their hysterectomies, a classification system was developed to provide consistency in terminology (**Table 1**).[5] The use of the laparoscope allowed for removal of the uterus in cases whereby it could not be completed solely through the vagina or in cases whereby evaluation of the pelvic structures was necessary.

Table 1
Classification system for laparoscopically directed and assisted total hysterectomy

Type	Description
Type 0	Laparoscopically directed preparation for vaginal hysterectomy
Type I[a]	Dissection up to but not including uterine arteries
Type IA	Ovarian artery pedicles only
Type IB[b]	A + anterior structures
Type IC	A + posterior culdotomy
Type ID[b]	A + anterior structures and posterior culdotomy
Type II[a]	Type I + uterine artery and vein occlusion, unilateral or bilateral
Type IIA	Ovarian artery pedicles plus unilateral or bilateral uterine artery and vein occlusion only
Type IIB[b]	A + anterior structures
Type IIC	A + posterior culdotomy
Type ID[b]	A + anterior structures and posterior culdotomy
Type III[a]	Type II + portion of cardinal-uterosacral ligament complex; unilateral or bilateral, plus
Type IIIA	Uterine and ovarian artery pedicles with unilateral or bilateral portion of the cardinal-uterosacral complex only
Type IIIB[b]	A + anterior structures
Type IIIC	A + posterior culdotomy
Type IIID[b]	A + anterior structures and posterior culdotomy
Type IV[a]	Type III + total cardinal-uterosacral ligament complex; unilateral or bilateral, plus
Type IVA	Uterine and ovarian artery pedicles with unilateral or bilateral detachment of the total cardinal-uterosacral ligament complex only
Type IVB[b]	A + anterior structures
Type IVC	A + posterior culdotomy
Type IVD[b]	A + anterior structures and posterior culdotomy
Type IVE	Laparoscopically directed removal of entire uterus

The system describes the portion of the procedure completed laparoscopically.

[a] A suffix *o* may be added if unilateral or bilateral oophorectomy is performed concomitantly (eg, type IoA).

[b] The B and D subgroups may be further subclassified according to the degree of dissection involving the bladder and whether an anterior culdotomy is created: (1) incision of vesicouterine peritoneum only, (2) dissection of any portion of bladder from cervix, (3) creation of an anterior culdotomy.

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