# Why The Traditional Abdominal Hysterectomy Is Obsolete

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A lot has changed in the treatment of uterine disorders in the past few years, and it is important for women to educate themselves on all their options. A bit of surgical history is important for background.

Laparoscopic techniques have dramatically changed the surgical options for patients undergoing gallbladder removal. Until the early 1990s, people put up with sometimes debilitating gallbladder attacks while trying to put off gallbladder surgery, since this used to involve a large incision across the upper abdomen, and a horribly painful recovery lasting four to six weeks. Laparoscopy changed all that, converting this operation into one that can be done with a few tiny Band-Aid incisions, allowing the patient to typically return home in less than 24 hours and resume most normal activities in less than a week.

While gynecologists were the first to operate through these tiny telescopes, they have been slow – when compared to general surgeons – to adopt this minimally invasive approach to procedures within their surgical specialty, such as hysterectomy. It is now considered the "standard of care" to remove gallbladders laparoscopically. Only in rare and unusually difficult circumstances do surgeons resort to the old-fashioned open technique.

The first laparoscopic hysterectomy was performed in 1989 – more than 20 years ago. Sadly, though, very few gynecologists today are capable of doing this procedure (known as a TLH) in order to avoid making a large C-section size incision. In fact, an embarrassing 60%-65% of all hysterectomies in the United States are still performed through large abdominal incisions. This operation is referred to as a total abdominal hysterectomy or TAH. It requires a hospital stay of two to three days, and a difficult, painful recovery of six to eight weeks. It also leaves an unsightly scar in the lower abdomen, and can occasionally result in infections, hernias, or other wound-healing problems.

The most minimally invasive route in removing a uterus is the total vaginal hysterectomy or TVH, which involves no incisions at all. However, very few gynecologists are trained in this technique, and even fewer are able to do this as an outpatient surgery. For many patients, a TVH

may not be technically possible, for example: if the patient has had previous surgeries such as C-sections; if the uterus is very enlarged (e.g., because of fibroids); if the patient has endometriosis that also needs to be removed; or if problems with the ovaries require that they be removed at the same time. For these patients, the TLH is recommended.

Both the TVH and TLH offer women numerous advantages over the traditional TAH, including no unsightly incisions, minimal tissue damage, and a much faster, far less painful recovery. The procedures are typically performed as outpatient surgeries requiring a one- or two-night hospital stay. However, there are a few gynecological surgery facilities in the country – including the Georgia Advanced Surgery Center for Women – that perform these as well as all other major gynecological procedures in a *true* outpatient setting, with patients safely returning home the very same day of surgery.

The two main issues that have required keeping hysterectomy patients in the hospital are nausea (mostly related to anesthesia) and control of pain. Research has shown that addressing pain and nausea preemptively (before the surgery starts) results in dramatically less symptoms afterwards.

Our unique outpatient surgical protocol prevents nausea with a special combination of transdermal (through the skin), oral, and intravenous medications that are given before and at the beginning of the surgery. To minimize postoperative pain, the ligaments connecting the uterus and cervix to the body are numbed with an anesthetic before they are divided to begin detaching the uterus. This dental-type numbing block prevents the otherwise difficult-to-control pain experienced when the anesthesia wears off and awareness returns. It is well known that it is difficult to play "catch-up" once pain is established, whereas pain is infinitely more controllable if the sensory nerve pathways are blocked *before* the stimulus of the surgical incision occurs. In addition, a special pain medicine is also given before the patient wakes up. The combination of the numbing block and this medication also virtually eliminates the requirements for using narcotics (such as Morphine or Fentanyl) during the procedure itself, which further helps to prevent nausea. Many patients have told me at their follow up visit that they only used their prescription pain medicine for a day or two.

With these special techniques, our hysterectomy patients can drive within two to three days, and safely resume most activities within a week! The main restriction afterwards is what is known as "pelvic rest," meaning nothing placed in the birth canal for four to five weeks. However, bathing, swimming, riding in a car, climbing stairs, light housework (always to be done by the husband!), carrying groceries, or going out to a movie or restaurant can be resumed as soon as the patient feels up to it.

In my almost 20 years of performing minimally invasive hysterectomies, the top two comments I hear from patients afterwards are "It's the best thing I've ever done," followed closely by "If I knew how easy this would be and how much better I would feel, I would have done it years ago."

Now that truly outpatient hysterectomy is a reality, I see more and more patients choosing a definitive cure of their symptoms with this special technique. If anyone says that your hysterectomy can't be done without a traditional incision, don't let them cut you open without consulting a gynecological surgeon who specializes in laparoscopy and other minimally invasive surgical techniques.

***Hugo D. Ribot, Jr., M.D. is an Emory-trained, Board Certified Ob/Gyn specializing in advanced laparoscopy. He is the founder and medical director of the Georgia Advanced Surgery Center for Women, Georgia's first and only fully accredited surgical facility for performing all major and minor gynecological procedures in a true outpatient setting. Dr. Ribot also is the managing partner of Cartersville Ob/Gyn Associates, where he has practiced since 1990 and introduced numerous innovations in women's healthcare and advanced gynecological surgery.***