Technological advances have benefitted our lives in many ways. As a long-time ob-gyn physician, I can attest that this is true in gynecologic surgery, particularly with regard to minimally invasive laparoscopic hysterectomy. While many individual surgeons, as well as the American College of ObGyn Committee (ACOG), prefer an alternative vaginal surgical approach, I prefer the laparoscopic procedure, for reasons stated below.

**Background**

Hysterectomies are among the most common gynecologic surgeries. As many as 20 percent of women undergo a hysterectomy by the age of 55, for reasons including fibroids, or benign lumps in the uterus; uterine prolapse, a sliding of the uterus from its normal position into the vaginal canal; cancer of the uterus, cervix, or ovaries; endometriosis, in which uterine tissue attaches and grows elsewhere; adenomyosis, a condition similar to endometriosis that affects the muscles of the womb; abnormal vaginal bleeding; and chronic pelvic pain. These conditions may require a hysterectomy to remove the upper part of the uterus; the entire uterus, cervix, and surrounding tissue; and, in some instances, the ovaries.

There are several ways to perform a hysterectomy, and often the reason for the hysterectomy dictates what type of surgery is best. In the past, all hysterectomies required a large abdominal incision and lengthy recovery time. Today, women who have a normal-sized uterus, have no history of abdominal surgeries, and do not have cancer, are good candidates for an alternative: minimally invasive hysterectomy.

“Minimally invasive hysterectomy” is performed in two ways. The first type, done through the vaginal canal without any other abdominal incisions, has been performed for years and has historically been the alternative to large abdominal incisions. The other method is the laparoscopic hysterectomy, which is performed through small incisions in the abdomen using scopes (like telescopes), video monitors, and long instruments. Both of these procedures offer an easier recovery for the patient with fewer complications when compared with the abdominal hysterectomy, although ACOG, in its 2009 Committee Opinion, advocated strongly in favor of vaginal hysterectomies.

**Weighing the choices**

Why do ACOG and some surgeons recommend the vaginal approach over the minimally invasive laparoscopic approach? One reason is that the data used for ACOG’s conclusion predates major advances in laparoscopic hysterectomy that have occurred since 2005. Since that time, extensive data supporting use of laparoscopic hysterectomy demonstrates its success. Another likely reason is the preference and training of the surgeon.
The laparoscopic hysterectomy is generally considered more technical and difficult than the other forms of hysterectomy, and requires additional training.

In practice since the early 80s, I have personally taken part in the transition away from the abdominal approach to hysterectomy. My initial approach was the vaginal hysterectomy, but, like many other surgeons, I now prefer the laparoscopic hysterectomy. My experience is that patient outcomes and satisfaction are improved with the laparoscopic approach, and that patients have more rapid return to normal activities and to work (usually within two weeks), as well as less pain. In fact, I’ve performed hundreds of laparoscopic hysterectomies and have not done a vaginal hysterectomy for more than five years.

The case for laparoscopic hysterectomy
Here, I make my case for laparoscopic hysterectomy as the new “gold standard” for hysterectomy.

No recent data. The main source of information used to create the ACOG Committee Opinion was the latest 2009 Cochrane review of 34 randomized trials of abdominal hysterectomy, laparoscopic hysterectomy, and vaginal hysterectomy, including 4,495 patients. This report highlighted comparisons with abdominal hysterectomy and confirmed the opinion that when a minimally invasive procedure could be performed rather than an abdominal approach, it should be done.

Comparative data: time, cost. The ACOG Committee Opinion focuses on cost effectiveness and efficiencies of the vaginal hysterectomy. Unfortunately, most of the comparisons are to abdominal hysterectomy rather than laparoscopic hysterectomy. To date, there is still a scarcity of data comparing vaginal and laparoscopic hysterectomy. Older studies found that laparoscopic hysterectomies took longer than the vaginal hysterectomy, but as surgeons and teams have mastered these newer, more technical procedures, laparoscopic hysterectomy operating time has shortened. Technological surgical advances, including the use of the barbed suture, newer energy systems, laparoscopic entry techniques, and the focus on doing these procedures in efficient and consistent outpatient facilities have further reduced operating time.

Those factors have also driven down the costs of laparoscopic hysterectomies, one of the issues cited by the ACOG Committee Opinion in 2009. Use of disposable instruments was also cited as a reason for increased cost with laparoscopic hysterectomy. Today, these same devices are now often used with the vaginal approach, which likewise increases cost.

Moreover, same-day discharge or surgery in ambulatory surgery centers is more common with laparoscopic than vaginal hysterectomy, subsequently decreasing cost. At Oakdale ObGyn, our practice performs more than 90 percent of laparoscopic hysterectomy as outpatient surgeries. We are comfortable with that approach and would not be as comfortable with same-day discharge following vaginal hysterectomy.

Training and safety. A strong, consistent trend has been away from vaginal hysterectomy in the last 20 years, with less than 15 percent of hysterectomies now being done vaginally. Most residency training programs are not focusing on training vaginal hysterectomy. In fact, surveys show that most residents are more comfortable with the total laparoscopic hysterectomy or laparoscopic hysterectomy.

Of note: there were no differences in complication rates between vaginal and laparoscopic hysterectomy. However, studies have shown that laparoscopic hysterectomy demonstrated less post-operative pain and shorter hospital stays.

Deciding what’s best for patients. A concluding recommendation from the ACOG 2009 Committee Opinion was that in cases where a vaginal hysterectomy was not feasible, then the laparoscopic hysterectomy was an appropriate alternative to the abdominal hysterectomy. The problem is that there are many limitations that exist with the vaginal approach, which in turn limit the type of cases that can be done vaginally. Visualization and access to the pelvis is limited, especially the upper pelvis, limiting comprehensive treatment of such conditions as endometriosis or other concomitant disease processes. There are very few conditions that preclude the use of the laparoscopic hysterectomy.

Call for more studies. I recommend a reevaluation of all the current data regarding the relative value of these two techniques. A likely outcome from such a study would be that both procedures are safe, cost effective, and produce good outcomes. While some surgeons have strong preferences—and some insurance companies favor one procedure over another—the final decision should be determined by the patient and the surgeon, and informed by scientific evidence.

Conclusion
Women for whom a hysterectomy is recommended should be clear why the hysterectomy is recommended and be educated on alternatives. If a minimally invasive procedure is not being considered they should ask, why not? Questions about the surgeon’s experience with different types of hysterectomy are not inappropriate. If the rationale for recommendations does not seem to be clear, then a second opinion may be appropriately sought.

Jon Nielsen, MD, FACOG, is a fellow of the American College of Obstetrics and Gynecology. He practices with Oakdale Ob-Gyn, a division of Premier Ob-Gyn of Minnesota.