Hysterectomy[1]


A hysterectomy[5] is the surgical removal of a woman’s uterus[6]. For many women, a hysterectomy[5] comes as a solution to health problems as diverse as abnormal bleeding to reproductive cancers. First performed in the early 1800s, this procedure has evolved in terms of both technique and popularity. The first successful abdominal hysterectomy[5] was performed by Ellis Burnham[7] in Lowell, Massachusetts, in 1853, although earlier attempts were made in the 1840s. These first hysterectomies were not performed under effective anesthetics—it was not until later in 1853 that a patient of surgeon Gilman Kimball would benefit from the use of chloroform. The hysterectomy[5] of the modern era has become a common and much safer procedure—so common, in fact, that many believe that the hysterectomy[5] is performed too often and in place of other, perhaps healthier, alternatives. In addition to its inherent surgical risks, a hysterectomy[5] also makes it impossible for a woman to have further children.

The uterus[6] is a thick, muscular organ of the female reproductive system. It opens to the roof of the vagina[8] and bears the function of both housing and facilitating the delivery of the fetus[9]. This pear-shaped organ can be described by its wide superior curvature (the fundus), the body, and its inferior end (the cervix[10]). The uterus[6] is about seven centimeters in length, four centimeters wide, and 2.5 centimeters thick in nonpregnant women (the uterus[6] is considerably larger in women who are pregnant). The triangular-shaped lumen of the uterus[6] opens to the vagina[8] with a passageway through the cervix[10] termed the cervical canal. In nonpregnant women, the inner lining of the uterus[6], the endometrium[11], is shed during the monthly menstrual cycle. With pregnancy[12], the embryo implants into the decidualized, or primed endometrium[11].

A hysterectomy[5] is often performed in response to various health problems affecting the female reproductive system. Some of these indications include uterine fibroids, abnormal bleeding, cancer, pelvic support problems, pelvic pain, pelvic inflammatory disease[13], endometriosis[14], endometrial hyperplasia[15], and postpartum hemorrhage. Uterine fibroids, or uterine leiomyomas, are benign growths in the uterine muscle and account for the majority of hysterectomies performed. Fibroids are often the cause of excessive bleeding, pain, and pressure on adjacent organs. Asymptomatic fibroids are usually not removed unless they are excessively enlarged or cause pain or compression to adjacent organs. However, like other major surgeries, a hysterectomy[5] should not be performed in any case unless other medical alternatives have been exhausted.

The hysterectomy[5] procedure can be further classified in terms of which structures are removed. In a subtotal (also known as partial or supracervical) hysterectomy[5], the upper part of the uterus[6] is removed while the cervix[10] is left undisturbed. Alternatively, in a total hysterectomy[5] the cervix[10] is removed along with the uterus[6]. The third classification, the radical hysterectomy[5], involves the removal of the entire uterus[6] along with its supporting structures and paracervical lymph nodes and is typically performed in cases of cancer. A hysterectomy[5] by itself does not involve removal of the ovaries or fallopian tubes[16]. However, when this procedure is performed it is known as a salpingo-oophorectomy[17]. A hysterectomy[5] can also be described by the surgical technique used. These include abdominal, vaginal, laparoscopically assisted vaginal, and total laparoscopic hysterectomies. Which procedure is performed depends both on the reason for surgery and on the results of a pelvic exam[18].

In an abdominal hysterectomy[5], the doctor makes a vertical or horizontal incision about five inches long in the lower abdomen. This procedure affords the physician a good view of the internal organs and is most commonly performed in cases of cancer or large tumors. Abdominal hysterectomies can also be performed for the removal of fibroids and to counter pain and bleeding. This procedure is more susceptible to complications, especially infection, than other modes of hysterectomy[5] and involves both a longer hospital stay (four to five days) and recovery period (six to eight weeks).

In a vaginal hysterectomy[5], the uterus[6] is removed through an incision in the vagina[8]. This procedure allows for a quicker recovery time for the patient (seven to fourteen days) as well as a shorter hospital stay (one to two days). This procedure is appropriate in many cases but depends on the size and mobility of the uterus[6] and well as the training of the physician. The origin of vaginal hysterectomy[5] dates back to AD 120 and some evidence suggests a date as early as fifty years before the birth of Christ. The first verifiable case of a successful partial vaginal hysterectomy[5] occurred in Bologna in 1507.

Similar to a vaginal hysterectomy[5], the surgeon performing a laparoscopically assisted vaginal hysterectomy[5] (LAVH) removes the uterus[6] through the vagina[8]. Before making an incision in the vagina[8], however, a telescope-like device known as a laparoscope is inserted into the abdomen through a small incision. Additional incisions are made to allow for placement of
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