

## We should all learn to perform vaginal hysterectomy

The first abdominal hysterectomy was performed by Charles Clay in Manchester, England in 1843 (1). Over the years there have been modifications to the original technique and discovery of other approaches that have made the procedure much safer. To date hysterectomy still remains the commonest gynaecological operation worldwide and it is inevitable that every practising gynaecologist will be required to perform it at some point in their career (2). The common indications for hysterectomy are benign conditions such as uterine fibroids, adenomyosis and abnormal uterine bleeding. It is also performed as part of the management for pelvic organ prolapse and gynaecological malignancies.

There are three approaches to hysterectomy: abdominal, vaginal and laparoscopic (3). Reflecting on the Kenyan practice setting, the abdominal route remains the most preferred method; with vaginal and laparoscopic approaches being offered to a lesser extent. In this issue of the journal, Wameyo and Okutoyi present a coherent review of their work at Kapenguria County Hospital where they perform approximately 40% of hysterectomies vaginally (4). Is this finding reflective of the nationwide practice? What is the most appropriate surgical route for women with benign gynaecological problems in Kenya and the East and Central African region as a whole? I will briefly review some of the evidence in favour of vaginal hysterectomy and hope that these could be translated into our practice setting for quality patient care.

Compared to abdominal and laparoscopic approaches, vaginal hysterectomy has the least risks of bleeding and bowel injury. It also has a rapid recovery time and less postoperative fever (5). Similarly, the authors of a recent Cochrane review, suggest that vaginal hysterectomy should be the surgical route of choice whenever feasible, failure of which the pros and cons for laparoscopic and abdominal approaches should be reviewed in a shared decision making process (6). Vaginal hysterectomy therefore remains the least invasive, safest, most cost-effective and preferred route of hysterectomy for benign gynaecological conditions (7).

A UK-wide descriptive study of 37,298 women conducted over one year (EVALUATE), compared short term patient outcomes to the route of hysterectomy. It also evaluated major complications in 1,380 patients at centres in the UK and South Africa. Overall 1 in 30 women had intraoperative and 1 in 10 had postoperative complications with laparoscopic route

contributing the highest rate. In the abdominal trial arm of the EVALUATE study the laparoscopic route had a higher rate of complications than the abdominal approach, took longer to perform but was less painful with shorter hospital stay and better quality of life at 6 weeks. The results of the vaginal versus laparoscopic trial arm were inconclusive (8). These are very important findings especially in our local setting where laparoscopic surgery is not universally accessible and even where available (mostly private sector) it tends to be more expensive in the short term and not many gynaecologists possess the required skills (5). Taking into consideration the findings of the above studies and the limited availability of laparoscopic surgery, we should encourage vaginal over abdominal hysterectomy in our practice settings. To achieve this, there is need to ensure that all graduating gynaecologists have the necessary competency in the performance of vaginal hysterectomy (5).

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