Guest Editorial

Total laparoscopic hysterectomy (TLH) is currently accepted as a safe, efficient way to manage benign uterine pathology, and is an acceptable alternative to standard abdominal hysterectomy. The term 'laparoscopic hysterectomy' is used to define various types of hysterectomies with a laparoscopic access to the abdominal cavity. Laparoscopic hysterectomy (LH), defined as the laparoscopic ligation of the major vessels supplying the uterus by electrosurgery desiccation, suture ligature or staples, was first performed in 1988. LH is a safe and feasible technique to manage benign uterine pathology as it offers minimal postoperative discomfort, shorter hospital stay, rapid convalescence, and early return to the activities of daily living. The rationale for TLH is to convert abdominal hysterectomy into a laparoscopic procedure, and thereby reduce trauma and morbidity.

Enlarged uteri often present a problem when choosing the surgical approach, therefore 80-90% of hysterectomies in patients with enlarged uteri are still performed by laparotomy, often with midline incision. Most studies set an upper limit for uterine size, usually 15 to 16 weeks' gestation for performing laparoscopic hysterectomy. Very enlarged uteri allow limited access to uterine vascular pedicles depending on size and location of myomas and may be associated with high-risk complications, such as hemorrhage. Other concerns of laparoscopic management of large uteri are technical difficulties of manipulation, difficulty extracting the uterus, and duration of the procedure. To overcome these limitations, the technique of TLH in cases of enlarged uteri should be modified and adequate training is required.

Given adequate training in laparoscopic surgery and with proper technique, TLH can be performed successfully in most women with very enlarged uteri, with no increase in complication rates and short-term recovery comparable with that in women with moderately enlarged uteri. Therefore, very large uteri should not be considered contraindications for laparoscopic hysterectomy.

We found that the most common reasons reported for not performing a greater proportion of hysterectomies laparoscopically were insufficient training and inadequate equipment.

The problem of needing to perform a laparoscopic hysterectomy in women who have had a previous cesarean section is likely to become increasingly common due to the large percentage of cesarean sections carried out today, which comprises 20% of deliveries in many centers. Surgical adhesions caused by previous cesarean sections can make vaginal hysterectomy a technically difficult procedure. So, abdominal route may be preferred and laparoscopic procedure can give better exposure to these adhesions.

The laparoscopic approach offers a superior view of the anatomy, facilitates meticulous hemostasis, enables the surgeon to perform adhesiolysis effectively, and reduces morbidity associated with large abdominal incisions. Mobilization of the urinary bladder off the cervix is an important step in total laparoscopic hysterectomy and it is always performed before tackling the uterine pedicle. In case of a non-scarred uterus, this procedure of bladder mobilization may not be technically difficult. But in case of a scarred uterus, there can be adhesions not only between the uterus and bladder but also to the anterior abdominal wall which can make this dissection challenging. It is difficult to assess the extent of adhesions based on the number of previous cesarean sections. We use the lateral approach for dissecting the bladder from the cervix and this has been useful for all cases of previous cesarean sections, irrespective of the number.

The acquisition of laparoscopic skills requires formal training, dedication, commitment and constant practice. In our endeavor to shorten the learning curve, we overlook the safety in laparoscopic surgery. The theme of Indian Association of Gynaecological Endoscopists (IAGE) is "Safe Endoscopy", which essentially means to improve the safety of surgical care all over the country by ensuring adherence to proven standards of care in all the laparoscopy centers.

Surgical care has been an essential component of healthcare worldwide. WHO has undertaken a number of global and regional initiatives to address surgical safety. We propose to create such a safety checklist for all endoscopic procedures which can be implemented by everyone. We also look forward to a lot of workshops aiming at our theme of safe endoscopy.

We welcome the Safogians to become members of IAGE, a national organization. We have training programs for gynecologists and surgeons to do laparoscopic surgery with utmost skill, and reduce complications and fear associated with performing surgeries laparoscopically.

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