EDITORIAL

Total Abdominal Hysterectomy for Gynaecological diseases.

A hysterectomy (from Greek hystera "womb" and "ektomia" a cutting out of") is the surgical removal of the uterus, usually performed by a gynecologist and most commonly performed gynecological surgical procedure. In 2003, over 600,000 hysterectomies were performed in the United States alone, of which over 90% were performed for benign conditions[1]. Hysterectomy was first performed as a vaginal procedure by Langenbeck in 1813 in Gottingen, Germany when he successfully removed a prolapsed uterus of a 50-year-old woman with an ulcerated cervix[2]. The first abdominal hysterectomy was performed by Charles Clay in Manchester, England in 1843; unfortunately the diagnosis was wrong and the patient died in the immediate post-operative period. The following year, Charles Clay was almost the first to claim a surviving patient, however she died post-operatively and it was not until 1853 that Ellis Burnham from Lowell, Massachusetts achieved the first successful abdominal hysterectomy although again the diagnosis was wrong[3]. At its outset, mortality from hysterectomy was as high as 100% in the best of hands, in large part due to the absence of antisepsis, blood banking, modern general anesthesia, and the attainment of standardized methodologies. The ensuing technical evolution of AH underwent a number of stages[4,5]. Indications of total abdominal hysterectomy are Fibroids, Endometriosis, Infection in the ovaries or tubes Pelvic pain, Endometrial hyperplasia , Abnormal vaginal bleeding and Cancer[6].

Hysterectomy may be performed using an abdominal, vaginal, or laparoscopic approach. The ovaries may or may not be removed at the time of hysterectomy. The choice of surgical approach depends upon clinical circumstances, the surgeon's technical expertise, and patient preference[7]. The types of hysterectomy include: Total hysterectomy, Hysterectomy with salpingo-oophorectomy, Radical hysterectomy, Supracervical hysterectomy, Abdominal hysterectomy, Vaginal hysterectomy, Laparoscope-assisted vaginal hysterectomy/robot-assisted laparoscopic hysterectomy[8]. In benign disease, the possibility of bilateral and unilateral oophorectomy should be thoroughly discussed with the patient. Frequently, in malignant disease, no choice exists but to remove the tubes and ovaries, since they are frequent sites of micrometastases. The predominant point of caution in performing abdominal hysterectomy is to ensure that there is no damage to the bladder, ureters, or rectosigmoid colon[9].

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