Increasing rates of minimal access hysterectomy: a retrospective cohort study

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Background

With around 60000 cases performed in the UK annually, hysterectomy is a common gynaecological procedure.1 Hysterectomies may be vaginal (VH), abdominal (AH) or laparoscopic (LH). VH still remains Cochrane’s recommended route of hysterectomy over AH and LH in their 2015 update,2 however, the most recent National Institute of Clinical Excellence (NICE) Heavy Menstrual Bleeding guidance (2018)3 is now less prescriptive, stating for the route to be decided after an individual assessment, taking the women’s preferences into account. There has been a global trend to encourage LH over AH due to the well-documented advantages of laparoscopic compared to abdominal approach: decreased blood loss, shorter hospital stay, quicker recovery, reduced complication rates and higher patient satisfaction.4 Despite the UK’s lukewarm national guidance above, recent national data has shown an almost 50% increase in LH from 2011 to 2017 (20.2% to 47.2%),1 with a halving of VH (7.8% to 3.5%) and significant reduction in AH (70.4% to 46.5%) over the same time period.1 These figures however varied from region to region, which may be explained by different factors including training opportunities.1

How is OUR unit (Queen Alexandra Hospital (QAH) doing overall?)

Methods

Objective

To evaluate rates of laparoscopic hysterectomy (LH) both within our unit (BSGE accredited endometriosis centre and cancer centre) and against the National trend.

Methodology

All recorded cases of hysterectomy in 2017 in our unit were reviewed. These were identified using our computerised theatre records. Comparison was made with data from a previous study undertaken in QAH in 2013-2014. Hysterectomies were classified as Abdominal (AH, total or subtotal), laparoscopic (LH) or vaginal (VH). Caesarean hysterectomies were excluded, and a single robotic hysterectomy performed by non gynaecologist was also excluded. Data was recorded and analysed using Excel.

Results

556 patients had a hysterectomy in 2017 after excluding 2 caesarean hysterectomies and 1 robotic by a non-gynaecologist. 255 (45.9%) LH, 183 (32.9%) abdominal (AH), 111 (20.0%) vaginal (VH) and 7 were converted from LH to AH (LHTAH) (1.3%).

Compared to national data, the rate of LH in QAH was similar (45.9% in QAH vs 47.2% nationally); the AH proportion was lower (32.9% in QAH vs 46.5% nationally); the VH rate was almost 5 times higher (20.0% vs 3.5%) and our failed LH converted to AH was lower (1.3% vs 2.8%).

Conclusion

Increased training of gynaecological surgeons and increased use of the laparoscopic route has increased the proportion of hysterectomies performed laparoscopically for benign indications in our unit from 25% in 2013-2014 to 43% in 2017. This increase is in line with the recently reported National trend (47.2% in 2017). Our exclusion criteria differ to those used in the National data reported, which limits our ability to directly compare our rates with regional and National rates. This is a limitation of this study, but does explain our higher VH rate (34%) than National data (3.5%) as we had not excluded hysterectomy for prolapse. The wide range in operating times likely reflects varied complexity of surgery as we have included all benign indications including those cases with, for example, severe endometriosis or large fibroids, will inevitably have longer operating time associated with them.

References


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