

Laparoscopic Supracervical Hysterectomy for Benign Gynecologic Conditions

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ABSTRACT

Recent results from metaanalyses and observational studies have suggested that total abdominal hysterectomy (TAH) is superior to laparoscopic supracervical hysterectomy (LSH) for the treatment of benign gynecologic conditions. However, because LSH is associated with fewer intraoperative complications, shorter operative time, and preserves patient anatomy and sexual function in comparison with TAH, clinicians should reconsider the benefits of LSH.

Key Words: Cervical dysplasia, Laparoscopic supracervical hysterectomy, Gynecologic surgery.

INTRODUCTION

Laparoscopic supracervical hysterectomy (LSH) has continued to represent a favorable alternative to total abdominal hysterectomy (TAH) for the treatment of benign gynecologic conditions, particularly due to the reduced complication rates, shorter surgery/hospital stay, and prompt resumption of patient daily living activities.¹⁻⁷ Nevertheless, studies continue to suggest that LSH should not be used as a treatment for benign gynecological conditions, particularly cervical dysplasia.⁸⁻¹⁴ The purpose of this commentary is to address the primary objections against LSH and further illustrate the benefits inherent in this procedure.

Initially, the primary impetus for removal of the cervix at the time of hysterectomy in patients with benign conditions was to prevent cervical cancer.⁹ However, the incidence of cancer in the cervical stump is extremely low and primarily preventable due to latent disease progression, pap smear technology, and HPV screening.^{8,15-18} Therefore, removing this organ solely for the purpose of preventing cervical cancer appears counterintuitive, especially considering that both at-risk patients and the general nonhysterectomized population receive the same recommended screening guidelines.^{9,19-21}

Since LSH involves the removal of the uterine section ostensibly related to the specific condition, the operation fixes many gynecologic problems while it conserves the patient's anatomy and sexual function by retaining the cervix and its mucous-secreting glands.^{8,15,19,20,22} Furthermore, the cervix is not typically associated with pelvic pain or bleeding, and thus patients can thereby avoid the common complaints of vaginal dryness and dyspareunia.²

Studies have further indicated that removal of the normal cervix can cause untoward bladder and bowel consequences, including prolapse and urinary incontinence.^{8,20,22,23} Additionally, prior research has reported that LSH outcomes coincide with favorable rates of prolapse and vaginal cuff dehiscence (VCD).^{22,23} In particular, Hur et al²² examined the prevalence of VCD in a large

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hysterectomy study, indicating that the condition has a significantly following TAH compared with LSH.

Randomized controlled trials and metaanalyses have documented that LSH is associated with a higher incidence of cervical stump complications (eg, cyclical bleeding and urinary incontinence).^{12,13,24} However, the cyclical bleeding with LSH is often slight and can be tolerated if the patient receives adequate preoperative counseling.²⁵ In terms of stress urinary incontinence, TAH appears to be associated with more favorable outcomes compared with LSH, whereas there were no reported lower urinary tract symptom (LUTS) differences between the 2 procedures.^{12,13} We contend that because vaginal suspension alters the bladder neck angle and reduces postoperative incontinence, when performing LSH, consideration for suspending both the vagina and the cervical stump may significantly mitigate stress urinary incontinence.^{23,26,27}

While there were no reported differences between TAH and LSH regarding the incidence of LUTS, urinary tract infections, incomplete bladder emptying and voiding complications increased after TAH at 1-year follow-up but decreased in the LSH patients.¹³ In an earlier surgical study, Gimbel et al¹² also reported a much higher incidence of serious adverse events and perioperative blood loss in patients treated with TAH compared with those treated with LSH. Furthermore, the TAH group exhibited more bladder/ureteral injuries, underwent longer operative times.

Patients who present with recurrent cervical dysplasia should consider having their cervix removed if a total hysterectomy is warranted. However, when a patient initially presents with cervical dysplasia, LSH may be preferable to hysterectomy particularly given the reportedly lower complication rates, reduced surgical time, and earlier recovery.¹⁻⁷ The combination of improved prevention programs, patient adherence to annual screening recommendations, and an informed community appreciation of the virus's vaccination distribution may further render this issue inconsequential.¹⁷

We suspect that the controversy surrounding the removal of the cervix is partially attributed to both insufficient LSH outcome studies and because many gynecologic surgeons are not formerly trained or experienced with this treatment option.⁵ While we recognize that both the American College of Obstetrics and Gynecology and a recent Cochrane analysis clearly state that TAH is more beneficial than LSH in treating benign gynecologic conditions,^{24,28} clinicians should strongly consider the several encouraging LSH findings and emerging studies that continue to

substantiate the efficacy of LSH for treating many common benign gynecologic conditions.^{1,5,24,29}

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