Hysterectomies aren't what they used to be. Find out how the procedure is changing—for the better

The evolution of medicine is as predictable as the autumn leaves falling. Year after year—the impossible becomes possible. The inoperable becomes operable. And the operable becomes less invasive. Such is the case with hysterectomy.

And thankfully so, because the procedure is the second most common surgery performed on women today, according to the National Women's Health Information Center. Used to treat conditions such as uterine fibroids; endometriosis; persistent, heavy or irregular uterine bleeding; uterine prolapse (the uterus protrudes into the vagina); and certain gynecological cancers, hysterectomy may offer the best solution when other treatment options have failed.

But not all hysterectomies are created equal. Today, there are several ways the surgery can be performed in addition to the traditional abdominal hysterectomy. Thanks to surgical and technological advances, lengthy scars and hospital stays are becoming a thing of the past.

Here's a look at the newer options in hysterectomy and for which medical situations they are best suited.

Turning Over a New Leaf

BY RACHEL GRUMMAN AND JILL SCHILDHOUSE

TECHNIQUE: Vaginal hysterectomy

What it is: This procedure involves removing the uterus through a small incision at the top of the vagina. No incisions are made in the abdomen, which shortens healing time and reduces post-surgery pain.

When it's used: Vaginal hysterectomy is usually performed when the uterus is small or when close inspection of other reproductive organs is not necessary, according to the National Women's Health Information Center. Because it is a less invasive alternative to traditional abdominal hysterectomy, most women are able to return to normal activity in one to two weeks.

TECHNIQUE: Laparoscopic hysterectomy

What it is: Tiny, specialized instruments (including a miniature camera) are inserted through small incisions in the navel and abdomen. The uterus is then removed in pieces through the incisions.

When it's used: Opening up the abdomen makes it easier for the surgeon to see the uterus and may be recommended if the patient has a large uterus or large fibroids or tumors. "The new technique allows large uteruses to be taken out with laparoscopic assistance," says Salena D. Zanotti, M.D., a fellow of the American College of Obstetricians and Gynecologists. And because the procedure is less invasive, it offers patients additional benefits as well. "There's significantly less pain because you don't have a large incision, and you should have a speedier recovery," she says.

TECHNIQUE: Robotic-assisted laparoscopic hysterectomy

What it is: As with laparoscopic surgery, small incisions are made in the abdomen to insert miniature surgical instruments. With robotic-assisted surgery, however, the surgeon sits at a computer console to control the high-precision instruments. A computer monitor provides the surgeon with a three-dimensional view of the area being operated on.

When it's used: Some studies—including a recent one in the journal *Minimally Invasive Gynecology*—show that robotic-assisted hysterectomies may have a shorter operation time than nonrobotic laparoscopic surgery and less bleeding than open hysterectomies, but more research is needed. Doctors may suggest this option when doing more challenging procedures like radical hysterectomy, performed in the early stages of cervical cancer.

TECHNIQUE: Laparoscopic-assisted vaginal hysterectomy (LAVH)

What it is: Small incisions are made in the abdomen where tiny instruments are inserted and used to detach the uterus and cervix, which are then removed through the vagina. If the procedure is performed removing only the uterus, leaving the cervix in place, it's called a laparoscopic supracervical hysterectomy (LSH). Because the cervix is left intact, the patient still needs Pap smears to check for cervical cancer.

When it's used: LAVH may be used for a variety of reasons, according to the American College of Obstetricians and Gynecologists. These include when a patient has endometriosis, in which patches of tissue that normally line the uterus grow outside the uterus and become attached to other pelvic organs; fibroids, which are noncancerous growths in the uterus; adhesions, or bands of scar tissue from past surgeries or pelvic infection that can cause pelvic organs to attach to one another; or if the ovaries and fallopian tubes are also being removed.

Although one technique may sound preferable to another, the choice is often dictated by the surgeon, who can recommend the type of hysterectomy that would be most effective to treat a patient's condition.

"Uteri are like fingerprints—no two are ever the same," says Steven R. Goldstein, M.D., an OB/GYN and author of *The Estrogen Alternative* and *Could It Be ... Perimenopause?* "Pick a doctor you have confidence in and let the surgeon explain why the technique is best suited for your case."

FREE BROCHURE

Want to learn more about hysterectomies? Check out the American College of Obstetricians and Gynecologists' patient education pamphlet "Hysterectomy." See the "Special Procedures" section at **acog.org/publications/patient_education**.

1 IN 3 Number of U.S. women who will undergo a hysterectomy by age 60, according to womenshealth.gov.

THEN AND NOW

The times, they are a changin'. Just look at the differences between the open abdominal hysterectomy of the past and the minimally invasive vaginal and laparoscopic hysterectomies available today:

	EXTERNAL INCISION LENGTH	LENGTH OF HOSPITAL STAY	FULL RECOVERY TIME
PAST	5 inches or more (depending on size of the uterus, tumors or fibroids)	Three days	Four to eight weeks
PRESENT	Four incisions about a half-inch each (laparoscopic); or none (vaginal)	One to two days	One to two weeks (vaginal or laparoscopic hysterectomies)