IJBPAS, September, 2025, 14(9): 4845-4850

ISSN: 2277–4998

International Journal of Biology, Pharmacy and Allied Sciences (IJBPAS)

'A Bridge Between Laboratory and Reader'

www.ijbpas.com

VAGINAL HYSTERECTOMY IN CASES WITH PREVIOUS CESAREAN SECTIONS

SHARMA S[1], SHARMA N[2*] AND SHARMA V[3]

1: Assistant Professor, Department of Rog Nidana Evum Vikriti Vigyana, Faculty of Indian Medical System, SGT University, Gurugram, Haryana

2: Assistant Professor, Department of Prasuti Tantra Evum Stree Roga, Faculty of Indian Medical System, SGT University, Gurugram, Haryana

3: Assistant Professor, Department of Rasa Shastra Evum Bhaishajya Kalpana, Faculty of Indian Medical System, SGT University, Gurugram, Haryana

***Corresponding Author: Dr. Nidhi Sharma: E Mail: drnid31@gmail.com**

Received 10th April 2024; Revised 4th May2024; Accepted 16th Aug. 2024; Available online 1st Sept. 2025

https://doi.org/10.31032/IJBPAS/2025/14.9.8910

ABSTRACT

The vaginal route for hysterectomy in the present times is being pushed to background amidst the glitz and glamour of laparoscopic route, consequently the new generation of gynecologists find their experience limited because of the inadequate training. Over and above that, the vaginal route for hysterectomy in cases with previous scars on the uterus is looked upon with apprehension of not being able to find the correct planes, accidental bladder injury or bleeding. But with a better determination and a little careful approach, the gynecological surgeon can offer the patient all the advantages of the natural orifice surgery.

Keywords: Vaginal Hysterectomy, Cesarean Sections, laparoscopic

INTRODUCTION

Advantages of the vaginal route in cases of previously scarred uterus:

Scarring and adhesion formation are the consequences of practically all the surgeries. In cases of previous LSCS, the adhesions between the bladder and uterine surface, uterus and the parietal surface of anterior abdominal wall and at times the uterus and the bowel or omentum are the ones which are found most commonly **[1]**. These can be

dense, covering the entire uterus, altering the entire pelvic anatomy, but are the well settled and asymptomatic adhesions most of the times. By the vaginal route, one doesn't have to disturb these adhesions, and uterus is removed from underneath these curtains of adhesions, thus eliminating the risk of injury to the viscera while separating these adhesions before reaching the uterus, by the abdominal or laparoscopic route. One just has to dissect the bladder away from the uterine surface or excise the fibrous band from the uterus to the parietal wall. Off course one has to take the help of a laparoscope in a few cases where the approach is difficult by the vaginal route **[2]**.

PREOPERATIVE EVALUATION BEFORE PLANNING THE SURGERY:

History:

Detailed history of why, how and where the cesarean sections were done and complications if any.

Clinical examination:

Per Abdomen:

Nature of the scar, whether uterus is palpable or not

Per speculum:

1) A stretched up posterior wall of the vagina, the cervix that is difficult to visualize and grasp with the vulsellum and the puckering of the anterior abdominal wall on pulling down the cervix (Sheth's sign), **[3]** strongly suggest parietal adhesions or a band.

2) Have to mobility of the uterus.

Per vaginal: Size, mobility and how high the uterus is, along with the evaluation of adnexal pathology if any.

Investigations:

A good sonography for the size, number and localization. A dynamic sonography to look for the signs of suspected adhesions like a pulled up and elongated cervix, not being able to see the full bladder between the fundus of the uterus and anterior abdominal wall and markedly upwardly displaced uterus is of great help.

CONTRAINDICATIONS TO THE VAGINAL ROUTE: [4]

1) Absence of uterine mobility, difficult to visualize and grasp the cervix

2) Positive cervico-fundal Sheth's sign

3) Associated big fibroids, adnexal masses, malignancy

4) Previous complex surgeries of the uterus like rupture

5) Big size uterus (depends upon individual surgeon's experience)

6) Narrow subpubic angle or a narrow fibrosis vagina. In such cases one can take the help of laparoscope or adopt a laparoscopic or abdominal route, though with experience one can deal with some of these cases by the vaginal route.

EXAMINATION UNDER ANAESTHESIA (EUA)

The decision on the final route of surgery should always be taken after EUA as under

relaxation, the descent and mobility tend to change.

Secondly a detailed confirmation of the clinical findings, helps in making a judgement.

Surgical approach

Key steps and precautions

Approaching the lateral window:

After taking the semilunar incision on the cervix, the two lateral corners of the anterior vaginal wall are heldup, a closed scissor or a finger opens up a space medial to the uterocervical border of the incision.

Bladder is dissected up to clear the cervical surface and take the uterosacral ligament **[5]**.

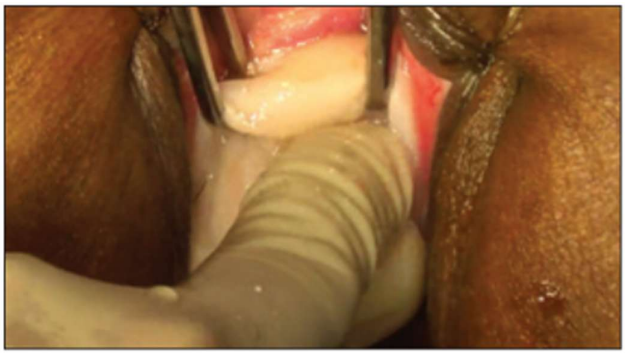

Image 1

Entering the lateral window:

Adhesions of the bladder and the uterus are mainly in the central 3/5 area of the uterocervical surface. Remaining area on the either side, is devoid of any adhesions. This surgical window (Sheth'sspace) just lateral to the uterocervical border and underneath the lateral most border of the overlying bladder, between the two leaves of the broad ligament is a safe space to begin the dissection from **(Image 2)**. The peritoneal fold just over the uterine arteries is held up, incised, and the space widened by opening up the scissor or by finger dissection over the cervicouterine surface to dissect the bladder away. This will lead to the space between the bladder and the uterovesical fold of peritoneum. Similar procedure is carried out on the other side. So now the bladder is adherent only in the centre. A right angle retractor secures the bladder underneath it on the lateral side. Under the guidance of the finger, the central part of the bladder is dissected away, close and flush to the uterus.

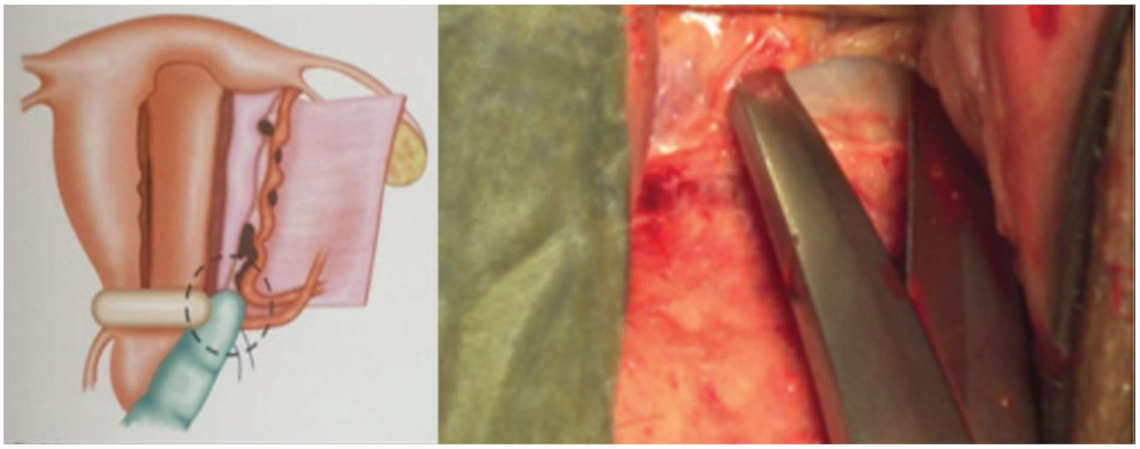

Image 2

Uterine artery

cardinal ligament complex is secured , the uterovesical fold of peritoneum identified and opened, to open up the anterior pouch **(Image 3)** If the UV fold cannot be opened this way then some alternative methods like retrograde opening of the pouch after delivering out the fundus through the posterior pouch or bisecting the cervix causing the thin cervical layer of the fascia to separate from the overlying bladder , thus providing the space to dissect the bladder away and open the anterior pouch .

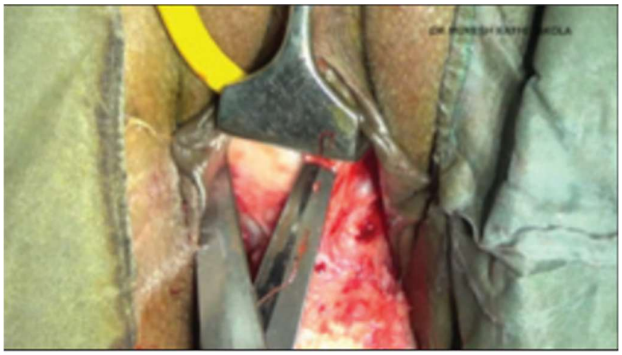

Image 3

From here on the routine steps of the vaginal hysterectomy are taken and the uterus delivered out. Flimsy omental or paraovarian adhesions can be snipped off.

If the thick fibrous band of adhesion is encountered, then if feasible they can be clamped and cut (very often they are avascular) or coagulated and cut. In case the band of adhesion cannot be tackled from below, then one needs to take the help of laparoscope in certain rare circumstances **[6]**.

After securing the pedicles and hemostasis, one must always rule out the accidental injury to the bladder. The reddish tinge or a hemorrhagic urine along with the field of

surgery getting filled with watery fluid, should invariably lead to ruling out accidental cystotomy. Identifying the rent in the bladder is the next step. Filling up the bladder with 100-150 ml of normal saline with methylene blue or giving 20 mg frusemide would help in identifying the location of the rent **[7]**. The anterior and the posterior margins of the rent along with the angles are identified, and depending upon the location, one must ascertain that the ureteric orifice is not close to the suture line. Bladder is then closed in 2 layers with 3-0 delayed absorbable sutures. Omental graft can be placed over the suture line if feasible or the rent is big. Sub-sequently the vault is sutured and the bladder catheter (no 16 or 18) kept 5-20 days depending upon the extent of injury. Non feasibility of the vaginal route for the scarred uterus is a thought barrier. With a proper knowledge of the anatomy and the surgical principles superseded by the zest to do it, the majority of such uteri can be removed by the vaginal route **[8]**.

"It is really difficult to say what is impossible for us "

REFERENCES

[1] American College of Obstetricians and Gynaecologists (ACOG). Vaginal hysterectomy often a better option than abdominal. ACOG Today. Washington DC, USA, American College of Obstetricians and Gynaecologists. 2009, Nov/

[2] Surgical approach to hysterectomy for benign gynecological diseases. Cochrane Database Syst Rev. 2015 Aug 12;(8):CD003677. doi: 10.1002/14651858.CD003677.pub5 . 3) Sheth SS.: Vaginal hysterectomy or abdominal hysterectomy. In: Sheth SS, Sutton C, eds Menorrhagia. Oxford: Isis Medical Media, 1999: pp. 21330

[3] Sheth SS, Hajari AR, Lulla CP, Kshirsagar D.: Sonographic evaluation of uterine volume and its clinical importance. J of Obstet & Gynecol Research. 2017; 43: 185-189.

[4] Sheth SS.: An approach to Vesicouterine Peritoneum through a New Surgical Space. J Gynecol Surg. 1996; 12: 135-140.

[5] G. D. Maiti1*, Ashok Pillai: Non-descent vaginal hysterectomy in women with previous caesarean section scar: our experience: International Journal of Reproduction, Contraception, Obstetrics and Gynecology 2018 Jun;7(6):2404-2409

[6] ShethSS: Vaginal hysterectomy in women with a history of 2 or more cesarean deliveries; Int. journ of

Gynaecology and Obstetrics, 122(2013) 70-74

[7] Ozdemir E, Ozturk U, Celen S, Sucak A, Gunel M, Guney G, *et al*. Urinary complications of gynecologic surgery: iatrogenic urinary tract system injuries in obstetrics and gynecology operations. Clin Exp Obstet Gynecol. 2011;38: 217-20

[8] Mamik M.M. Antosh D. Risk factors for lower urinary tract injury at the time of hysterectomy for benign reasons. IntUrogynecol J Pelvic Floor Dysfunction 2014; 25: 1031-1036