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COMPARATIVE ANALYSIS OF LAPAROSCOPIC AND LAPAROTOMIC METHODS USED IN TOTAL HYSTERECTOMY SURGERY IN WOMEN

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Annotation: A comparative analysis study of patients who underwent laparoscopic and laparotomic total hysterectomy. Research In the private clinics "Med Plaza" and "Med Line" of Khorezm region in 2018 - 2022 a total of 97 patients underwent laparoscopic and laparotomic total hysterectomy operations. Of these, 36 (37.1%) underwent laparoscopic surgery, and 61 (62.9%) underwent laparoscopic surgery. A comparative analysis of 36 patients who underwent laparoscopic surgery and 61 patients who underwent laparotomic surgery was studied. The duration of surgery in 36 patients performed laparoscopically included 60 ± 25 minutes. The average total blood volume was 80 ± 30 ml. Spinal anesthesia was used for all patients in this group. In 61 patients who underwent laparotomic total hysterectomy, the duration of surgery was 45 ± 25 minutes. 12 (19.7%) of the patients in this group had intubation, and 49 (80.3%) had spinal anesthesia. The average amount of total bleeding was 180 ± 40 ml. In our patients who underwent laparoscopic total hysterectomy, the period of ability to work required a long time, while in our patients who underwent laparoscopic total hysterectomy, the opposite result was shown. That is why we recommend using minimally invasive laparoscopic methods in practice.

Key words: total, hysterectomy, laparotomy, laparoscopy, surgery.

Relevance of the problem. The widespread introduction of endoscopic technologies into gynecological practice has significantly changed the methods of treating a number of diseases. The effectiveness of endoscopic methods is high both in restoring reproductive function and performing organoplastic and radical operations. The development of endoscopic surgery allows expanding the scope of surgical interventions in the treatment of gynecological pathologies.

The current state of endovideosurgery allows performing radical operations in the volume of intrafacial supracervical hysterectomy in uterine vaginal extirpations according to Zemma [1,3].

At present, in the leading gynecological clinics of Russia, laparoscopic operations make up more than 80%. The advantage of laparoscopic hysterectomy is low trauma, minimal risk of adhesive disease, absence of pain syndrome and optimal cosmesis[3]. Laparoscopic hysterectomy allows to minimize intraoperative blood loss, shorten the length of hospital stay, rehabilitation period and improve the quality of life of patients compared to open access.

In recent days, high obesity was a contraindication to perform laparoscopic operations with increasing complexity in gynecology. This is not only related to the presence of severe extragenital diseases in patients, the use of carboxyperitoneum, the high risk of putting the patient in the Trendelenburg position, but also to technical difficulties due to abdominal obesity. The extensive development of endoscopic technologies in recent decades has led to a reconsideration of this issue [2,4]. In recent years, laparoscopic hysterectomy has firmly entered daily gynecological practice. Nevertheless, the weight of using this operation in comparison with its traditional laparotomic analogue remains much lower. According to various data, the percentage of laparoscopic hysterectomy compared to general hysterectomy varies greatly in European countries. So in France it is 13.5%; In Great Britain - 36.5%, in the USA - 75%. The reasons for the slow introduction of laparoscopic hysterectomy into clinical practice are the lack of a standardized simple surgical technique available to most operating gynecologists, as well as conflicting literature data on indications and contraindications for this operation, the selection of its reasonable size, performance technique, and clinical expediency [1] .

Hysterectomy is one of the most common gynecological procedures. The development of modern laparoscopic methods has made it the most important tool in modern gynecology for diagnosis and treatment. Accumulated experience and improved laparoscopic instruments allowed gynecologists to expand the indications for laparoscopic procedures, as well as the range of operations [2,3].

Analysis of the conducted literature shows that laparoscopic total hysterectomy tactics is one of the urgent and not yet solved problems of modern gynecology [1]. The optimal method of treatment of this disease is conservative and surgical, and the wide application of treatment with less invasive methods shows the urgency of continuing research in this direction. The development of optimal approaches to the diagnosis and surgical treatment of the mentioned disease determines the need to apply it to gynecology practice.

Purpose: to study a comparative analysis of patients who underwent laparoscopic and laparotomic total hysterectomy.

Material and methods

In 2018-2022, a total of 97 patients were subjected to total hysterectomy by laparoscopic and laparotomy methods in private clinics "Med Plaza" and "Med Line" of Khorezm region. Of these, 36 (37.1%) underwent laparoscopic surgery, and 61 (62.9%) underwent laparoscopic surgery. The average age of these patients ranged from 37 to 74 years. These included 17 patients aged 37-45, 41 aged 46-55, and 39 aged over 56. During the treatment of such patients, it is important to check them early, to prevent complications of bleeding, uterine myoma, complete prolapse of the uterus, atypical changes in the tissue of the cervix, atypical hypertrophy of the endometrium, and oncological risk factors. Of these patients, 44 (45.4%) had bleeding, 21 (21.6%) had atypical changes in the cervical tissue, and the remaining 32 (33%) had various other complications.

We analyzed patients in two groups. 61 (62.9%) patients of the comparison group treated in 2018-2020 were studied retrospectively, diagnostic measures and treatment process were conducted and analyzed in 36 (37.1%) patients of the main group. Minimally invasive laparoscopic hysterectomy was performed due

to the low weight, late presentation of patients to the clinic, the size of the uterine fibroids, and the size of the uterus. Because in these patients it was not possible to take out the extirpated uterus. That is why hysterectomy was performed in the traditional (laparatomic) way in most of the patients who came to us late.

The late arrival of these patients with various complications, such as changes in the anatomy of the topographic location of the uterus, also had an impact on the treatment results. All patients, in addition to general clinical examination methods, underwent ultrasound examination of abdominal organs, ECG and cervical colposcopy when they came to the clinic.

Results and discussion. The early and long-term results of treatment after extravasation surgery in patients depended on the general condition of the patients before the operation, the activity of the organs of the cardiovascular and respiratory systems, the methods of transporting the patients, the time and volume of the operative treatments.

A comparative analysis of 36 patients who underwent laparoscopic surgery and 61 patients who underwent laparotomic surgery was studied. The duration of surgery in 36 patients performed laparoscopically included 60 ± 25 minutes. Spinal anesthesia was used in all patients. The average total blood volume was 80 ± 30 ml. Infusion (crystalloid, colloid, protein preparations up to 4000 ml) was given to our patients, and hemotransfusion was performed in 2 patients. All patients were prescribed antibacterial therapy for 2-3 days. In order to prevent complications of thromboembolism, low-molecular anticoagulant drugs were prescribed 2±5 days depending on age and weight. Nonsteroidal anti-inflammatory drugs were injected for pain relief for 2 to 3 days. The average hospital stay of patients was 3 to 5 days. Despite the high risk of gas embolism in hysterectomy performed in this way, complications of gas and thromboembolism were not observed in our group of patients. But this method also has its own disadvantages, including the longer duration of the procedure, the higher risk of gas embolism, and the need for a highly skilled laparoscopist and an assistant.

Thus, in patients of this group, quick standing, recovery, and early and rapid healing of the injury were reduced by (4-5) days faster than in the traditional method.

In 61 patients who underwent laparotomic total hysterectomy, the duration of surgery was 45 ± 25 minutes. 12 (19.7%) of the patients in this group had intubation, and 49 (80.3%) had spinal anesthesia. The average amount of total bleeding was 180 ± 40 ml. Infusion (crystalloid, colloid, protein preparations up to 5000±1000 ml) was given to our patients in this group, and hemotransfusion was performed in 18 patients. Because these patients, in most cases, came to us in post-hemorrhagic cases, having lost a lot of blood. Patients were prescribed antibacterial therapy for 5-7 days. In order to prevent complications of thromboembolism, low-molecular anticoagulant drugs were prescribed 2±5 times a day depending on age and body weight. For analgesia, non-steroidal anti-inflammatory drugs were injected for pain from 3 to 5 days. The average hospital stay of patients was 4 to 8 days. During hysterectomy performed in this way, fever and purulent septic conditions were observed in 2 (1.2%) patients. No thromboembolic complications were observed in this group of patients either.

Thus, patients in this group had a little delay in getting up quickly, a longer recovery period, a longer duration of recovery (up to 10 days) due to the size of the operative wound, and required more time than the minimally invasive method.

According to our analysis, no severe complications were observed in our patients who underwent laparoscopic and laparotomic total hysterectomy. Both groups of patients had good and satisfactory results.

Conclusion: In our patients who underwent laparoscopic total hysterectomy, the period of ability to work required more time, while in our patients who underwent laparoscopic total hysterectomy, the opposite result was shown. That is why we recommend using minimally invasive laparoscopic methods in practice.

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