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Research Article

IMPORTANT CONSEQUENCES OF OPERATIVE GYNECOLOGICAL LAPAROSCOPY IN THE SOUTHERN PUNJAB OF PAKISTAN

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Abstract:

Aim: This subsequent examination analyzed the significant complexities among 4323 usable gynecologic laparoscopies. The general inconvenience rate and every individual class were looked at with those of our past investigation period. The clinical result and rescue methodology were connected with the hour of acknowledgment and the seriousness of starting systems in the individual injury type.

Methods: Records of ladies (n 4323) matured 42.6 12.8 years (mean SD [96% CI 41.2–42.6]) who went through employable gynecologic laparoscopies from May 2019 to April 2020 were looked into in this investigation. Our current research was conducted at Services Hospital, Lahore from May 2019 to April 2020. The confusions were contrasted and those of our past examination in light of 1523 laparoscopies performed between December 1992 and November 1999 for development comparison.

Results: Thirty-four complications occurred in 31 patients requiring fixation techniques, of which 3 had various disadvantages, with an overall confusion rate of 0.73% (32/4320). There were 15 bladder injuries (0.31%), 7 bowel injuries (0.17%), 3 internal death cases (0.07%), 4 vaginal stump hematomas or abscesses (0.08%), 3 ureteral injuries (0.07%), 3 major vessel injuries (0.09%) and 1 trocar hematoma (0.03%). In addition, 125 (2.88%) postoperative blood connections were found without additional employable intercession. The rate of significant complexity decreased contrastingly with that of the previous examination (0.72% [96% CI 0.53%-1.03%] versus 1.58% [95% CI 1.07%-3.38%]; p.005). Overall complexity rates were not quite extraordinary between laparoscopic hysterectomy (LH) and non-LH sampling. Nevertheless, bladder lesions occurred as often as possible during laparoscopic hysterectomy, whereas internal lesions were more normal during non-laparoscopic hysterectomy. In addition, the severity of the first injury, the timing of recognition, and the rescue methodology are related to clinical outcomes.

Conclusion: The fundamental decrease in the significant entanglement rate, in contrast to that of our previous review period, confirms the importance of collecting involvement and using preventive measures to reduce the rate of difficulty. There were no great contrasts between the different categories of injuries during these two review periods. Indications of internal injuries were highly variable and individualized. The collection of careful involvement in the Preventive Movement Guide is useful to essentially decrease the rate of complexity.

Keywords: Important consequences, operative gynecological laparoscopy, southern Punjab of Pakistan.

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INTRODUCTION:

Usable laparoscopy is widely recognized as a useful strategy in the treatment of gynecological wounds. Patients and specialists alike readily recognize these new, minimally invasive methods in the treatment of gynecological diseases [1]. While the rate of inconvenience may decrease as more experience is gained with the laparoscopic technique, the inexorably progressive and intrusive methodology used by gynecologists through laparoscopy further increases the risk of complications [2]. According to a late survey of 1,554,370 patients, the rate of laparoscopic inconvenience generally increases from 0.3% to 12.4% [3]. An early wait for absorption of information with restricted cases may account for the high rate of confusion, up to 10.3% (48 patients out of 457). In a Finnish transnational study, the main confusion rate in general gynecological laparoscopies was 0.5% (134/33 206) for complete strategies and 1.29% (118/9336) for usable laparoscopies. In an American Association Gynecologic Laparoscopy (AAGL) study of enrollment in laparoscopically assisted vaginal hysterectomy (LAVH), the rate of significant entanglement was 6.59% (983 / 14,911) [4]. In Taiwan, Chang Gung Memorial Hospital reported a significant entanglement rate of 1.67% (12/722) in the LAVH group. Our past survey reported 1.57% (24/1507).⁸ As the laparoscopic medical procedure is exceptionally experience-dependent, subsequent investigations in various examination periods deserve to be considered consistently. As part of this review, we have updated our information and compared the results with those of our previous study. Bladder and internal wounds are the main part of the complexity. Bladder injuries are generally elementary in the gynecological field, especially in LAVH. This complexity rate was 2.5% (23/9339) in the Finnish study⁵ and 1.09% (165/14,915) in the AAGL study. It was 0.9% (7/724) in the Chang Gung study⁷ and 0.40% (6/1507) in our previous study [5].

METHODOLOGY:

Every calm person going through a gynecological strategy in the department of obstetrics and gynecology was selected from the concentrate during this survey period. Our current research was conducted at Services Hospital, Lahore from May 2019 to April 2020. Patient data, counting age, weight, weight list, pregnancy, equality, sign of a medical procedure, some kind of medical procedure, and some kind of inconvenience, were enrolled in our information bank with Access programming. BMI was used to assess the impact of being overweight because it takes into account the woman's weight and height and is a more accurate indicator of the impact that a woman's weight may have on laparoscopic surgery.¹⁰ The definitive clinical course of these complexities and fixation methods was examined from the clinical records in a thoughtful manner. Prior to laparoscopy, patients were required to give informed consent, being aware of the dangers and complexities of laparoscopic techniques and the possibility of switching to laparotomy if the techniques could not be performed by laparoscopy. During the medical procedure, the pneumoperitoneum was inserted using a Veres needle with an intra-abdominal weight of approximately 15 mm Hg. At this time, the patients were placed in the low dorsal lithotomy as well, in the Trendelenburg position at 30 degrees, as recently described. After the introduction of video laparoscopy, patients were given individual laparoscopic methods as needed. In LAVH (also called laparoscopic hysterectomy, type III, AAGL arrangement system), the pedicles of the uterine and ovarian ducts were dried with bipolar Klipspringer forceps (Richard Wolf Instruments, Vernon Hills, IL) and sliced with scissors as indicated by the desired ovarian conservation. The uterine vessels were dried and cut at the cervix.

Table 1:

Injury (no.)	Time of Recognition	Surgery Performed (no.)	Treatment and Outcomes
Bladder (6)	Intraoperative 14 days	LAVH (5) LAVH (1)	Repair at laparoscopy Laparotomy repair
Ureter (4)	Intraoperative, 2, 7 days 3 wks	Oophorectomy (1) LAVH (2) LAVH (1)	Insertion of double J or ureteral catheter Laparotomy repair
Bowel (5)	Intraoperative 1–2 days 10 days	Burch ^a (1) Enterolysis (1), oophorectomy (1), adhesiolysis (1) LUNA (1)	Repair at laparoscopy Laparotomy repair Transphincteric repair failed, laparotomy with colostomy
Ileus (2)	Within 24 hrs 2 days	LAVH ^b (1) Adhesiolysis (1)	Conservative Conservative
Stump or colpotomy wound bleeding (3)	2 days 1 wk	Myomectomy (1) LAVH (2)	Vaginal resuturing Vaginal resuturing Reopened and drained vaginally
Abscess (2)	4 days 1 wk	Salpingectomy (1) LAVH (1)	Secondary laparoscopic drainage Reopened and drained stump vaginally
Vessel injury (1)	Intraoperative	Oophorectomy (1)	Laparotomy repair
Umbilical hernia (1)	1 wk	Oophorectomy (1)	Resuturing

^aThe patient had genuine stress incontinence and vaginal stump prolapse, and underwent laparoscopic Burch colposuspension, enterolysis, and sacropexy.

^bThe patient had uterine prolapse and genuine stress incontinence, and underwent LAVH, modified Halban colpopexy, and Burch colposuspension.

Table 2:

Complication	This Study (N = 1507)			First Study ² (N = 9337)			p	Second Study ¹¹ (N = 843)			p
	No.	Proportion (/1000)	95% CI (/1000)	No.	Proportion (/1000)	95% CI (/1000)		No.	Proportion (/1000)	95% CI (/1000)	
Bladder injury	6	4.0	0.8–7.2	22	2.4	1.4–3.3	0.25	2	2	-0.9–5.7	0.52
Ureteral injury	4	2.7	0.1–5.3	57	6.1	4.5–7.7	0.10	1	1	-1.1–3.5	0.46
Bowel injury	5	3.3	0.4–6.2	15	1.6	0.8–2.4	0.15	4	5	0.1–9.4	0.59
Major vessel injury	1	0.7	-0.6–2.0	3	0.3	0.0–0.7	0.52	2	2	-0.9–5.7	0.27
Hernia	1	0.7	-0.6–2.0	8	0.9	0.3–1.5	0.81				
Others	7	4.6	1.2–8.1	13	1.4	0.6–2.1	0.01	8	9	2.9–16.0	0.16
Vaginal stump bleeding	3	2	-0.3–4.2				—	3	4	-0.5–7.6	0.47
Postoperative ileus	2	1.3	-0.5–3.2								
Pelvic abscess	2	1.3	-0.3–4.2								
Abdominal bleeding							—	5	6	0.7–11.1	—
Totals	24	16	9.6–22.2	118	12.6	10.4–14.9	0.30	16	19	9.8–28.2	0.58

χ^2 test: total complication rate in this study versus the first study, $p=0.30$; this study versus the second study, $p=0.58$ (NS).

This study versus the first study: not significant in bladder ($p=0.25$), bowel ($p=0.15$), and ureteral injuries ($p=0.10$); significant in others ($p=0.01$).

This study versus the second study: not significant in bladder injuries ($p=0.52$), bowel injuries ($p=0.59$), ureteral injuries ($p=0.46$), and others ($p=0.16$).

RESULTS:

During the course of the survey, 4,719 women who underwent gynecological laparoscopy were recruited for this study. Of these, 405 patients were excluded from the study due to persistent pelvic agony or infertility. The mean age of these patients was 41.6-12.7 years (96% CI 42.2-41.9). The mean BMI was 23.8-5.2 (96% CI 23.6-24.5). Patients using more than one method were classified by the main system. The main methods for these 4309 laparoscopies were summarized in Table 1. Laparoscopic methods included LAVH in 2174 cases (51.6%), global or fractional oophorectomy or salpingectomy (SO) in 1436 cases (33.3%), medical intervention for ectopic pregnancy in 317 cases (8.4%), electrocautery for endometriosis or pelvic adhesiolysis in 154 cases (3.7%), myomectomy in 82 cases (2.9%), ovarian piercing in 41 cases (1.0%), uterine or vaginal suspension in 35 cases (0.9%), HLMR in 31 cases

(0.7%), 16 uterosacral nerve ablation by laparoscopy in 22 cases (0.6%), tuboplasty in 22 cases (0.6%), and organizing medical procedure (LAVH and BPLND) in 6 cases (0.12%). 36 injuries in 32 cases occurred and required rescue systems during our review period. They represented a significant difficulty rate of 0.72% (31/4307). Of these, 3 cases with multiple injuries were: (1) LAVH with hematoma of the bladder and vaginal stump; (2) SO with bladder and ileal hole; and (3) LAVH with bladder also, vaginal stump wound. The complexities were characterized in 7 classifications. Clinical indications of wound types, wound areas, recognition season, introduction strategy, treatment techniques and outcome were recorded (Table 2). The BMIs of patients with and without complications were not essentially extraordinary, with a mean of 24.8 4.5 (96% CI 23.7 - 26.6) compared to 23.8 5.2 (96% CI 23.9 - 24.1) individually (p.307).

Table 3:

Main Procedure	Number	%
LAVH	737	48.9
Oophorectomy and/or salpingectomy	326	21.6
Ovarian cystectomy	143	9.5
LUNA	56	3.7
Burch colposuspension	55	3.7
Myomectomy	47	3.1
Adhesiolysis	44	2.9
Ablation of pelvic endometriosis	32	2.1
Tubal ligation	19	1.3
Uterine suspension ¹⁰	15	1.0
Fimbrioplasty	12	0.8
Other	21	1.4

LAVH = laparoscopic-assisted vaginal hysterectomy; LUNA = laparoscopic uterosacral nerve ablation.

DISCUSSION:

Regardless of innovation and experience, laparoscopic confusions remain an important reason for critical morbidity [6]. The multidimensional nature of surgical procedures furthermore potentiates the higher risk of complications. This is a follow-up survey with two stages of examination between the years 2000 to 2006 and the years 1993 to 1999 [7]. The decrease in the inclination of general complexities over the different periods shows that the laparoscopic medical procedure is exceptionally insightful and subordinate. The collection of meticulous experiences and guides for preventive measures have also reduced the rate of inconvenience [8]. Urinary bladder injury was the most widely recognized discomfort in a significant part of the writing, as in our arrangement. This occurred all the more often in the LH group because of the proximity of the bladder to the cervix and the incessant history of cesarean sections [9]. Fortunately, all but one of our patients with bladder injury was seen during a medical procedure and fixed vaginally, laparoscopically or by laparotomy without incident. Early recognition by a rapid fixation method makes it possible to overcome subsequent sequelae [10].

CONCLUSION:

Overall entanglement rates, but not individual classifications, essentially declined in this survey period compared with the previous survey period. He further states that the laparoscopic medical procedure is exceptionally experience-dependent. Bladder injuries occurred more generally in the chronic lymphocytic leukemia (LH) patient groups, whereas bowel injuries occurred more generally in the non-LH patient groups. Signs of bowel injury were exceptionally factorized and individualized. The severity of a single injury and the timing of recognition, combined with satisfactory rescue strategies, can influence clinical outcome. Early recognition of injuries, ideally during medical intervention, and early awareness of postoperative signs during the period of perception, followed by prompt treatment, are essential to decrease the disastrous consequences henceforth.33 With careful experience and preventive movement guides, the rate of entanglement can be reduced in an essential way.

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