Prior pelvic surgery has been a source of concern when considering a patient for vaginal hysterectomy. Postsurgical scarring and adhesions may produce relative fixation of the uterus or adherence of the urinary or intestinal tract with resultant predisposition to injury. The nature and relative risk of problems associated with some of the commonly encountered prior pelvic operations are discussed. Some methods of transvaginally managing a variety of potentially complicated postsurgical changes are described. When good uterine mobility and other anatomic factors favorable for vaginal hysterectomy are present, significant difficulties related to the prior pelvic surgery are unlikely. A cautious approach is of course warranted.

Prior pelvic surgery has been considered by some gynecologists to be a relative or even an absolute contraindication to vaginal hysterectomy, although several reasonably large reports have indicated the feasibility and safety of vaginal hysterectomy in most of these patients. In 1973 Coulam and Pratt published a report of 621 patients with histories of previous pelvic surgery who underwent vaginal hysterectomy. In no case was there failure to complete the vaginal hysterectomy. In addition, the 621 patients were compared to 942 vaginal hysterectomy patients who had not undergone previous pelvic surgery, and there was no difference in the complication rates.
Several other studies have confirmed these results. Indeed, there are no significant data in the literature that refute the safety and feasibility of vaginal hysterectomy in patients who have previously undergone pelvic surgery. Most of the studies pertaining to this issue, as well as some recent surgical textbooks, state that the decision on the route of hysterectomy should be based on uterine mobility, pelvic architecture, and other such factors as discussed in Chapter 2 and be independent of the history of prior pelvic surgery.

It is difficult to speak in general terms about the effect of prior pelvic surgery on the feasibility of vaginal hysterectomy. The gynecologic surgeon is aware that certain types of previous pelvic surgery are likely to alter the pelvic anatomy significantly. Thus the surgeon must consider certain questions when approaching such a patient.

Do the anatomic changes that may have been caused by the prior surgery predispose the patient to an increased risk of urinary or intestinal tract injury during hysterectomy?

Does the route of the hysterectomy alter this risk?

Are there anatomic alterations that may make the vaginal or the abdominal route preferable?

The gynecologic surgeon must be concerned not only with the particular prior surgery reported by the patient but also with any complications that may have occurred and the findings at the time of surgery, including the nature and extent of any disease process that might have been encountered.

Some previous reports have included distant abdominal surgery, such as cholecystectomy and appendectomy, in their analysis of vaginal hysterectomy after previous pelvic surgery. This type of surgery generally should have little or no bearing on later pelvic surgery. For example, in the report by Coulam and Pratt, 514 of the 866 prior surgeries were appendectomies. Campbell reported vaginal hysterectomy after appendectomy in 339 patients. Neither of these studies reported any significant problems with the vaginal hysterectomy. If a patient is known to have had complicated appendicitis with a ruptured appendix or a periappendiceal abscess, especially if the abscess or bowel adhesions involved the uterus, the gynecologic surgeon would need to be more cautious about choosing the vaginal route for hysterectomy.

The literature reveals that partial or complete adnexectomy, uterine suspension, and cesarean section are the most common prior gynecologic operations performed in patients who subsequently underwent vaginal hysterectomy. Some of the other pelvic operations included laparotomy only, abscess drainage, colporrhaphy, and myomectomy.