NICE National Institute for Health and Care Excellence

NICE guidance

Vaginal transluminal endoscopic hysterectomy and adnexal surgery for benign gynaecological conditions

Interventional procedures guidance
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www.nice.org.uk/guidance/ipg774

1 Recommendations

1.1 Vaginal transluminal endoscopic hysterectomy and adnexal surgery for benign gynaecological conditions should only be used with special arrangements for clinical governance, consent, and audit or research. Find out what special arrangements mean on the NICE interventional procedures guidance page.

1.2 Clinicians wanting to do vaginal transluminal endoscopic hysterectomy and adnexal surgery for benign gynaecological conditions should:

- Inform the clinical governance leads in their healthcare organisation.

- Ensure that people (and their families and carers as appropriate) understand the procedure's safety and efficacy, and any uncertainties about these.
- Take account of NICE's advice on shared decision making, including NICE's information for the public.
- Audit and review clinical outcomes of everyone having the procedure. The main efficacy and safety outcomes identified in this guidance can be entered into NICE's interventional procedure outcomes audit tool (for use at local discretion).
- Discuss the outcomes of the procedure during their annual appraisal to reflect, learn and improve.

1.3 Healthcare organisations should:

- Ensure systems are in place that support clinicians to collect and report data on outcomes and safety for everyone having this procedure.
- Regularly review data on outcomes and safety for this procedure.

1.4 Patient selection should be done by a multidisciplinary team including clinicians with specific training in patient selection and the procedure.

1.5 This procedure should only be done by an experienced surgeon and theatre team with specific training in this procedure (which may include mentoring) and the ability to convert it to a conventional hysterectomy if needed.

1.6 NICE encourages further research into vaginal transluminal endoscopic hysterectomy and adnexal surgery for benign gynaecological conditions and may update the guidance on publication of further evidence.

Why the committee made these recommendations

Evidence is limited on the safety and efficacy of vaginal transluminal endoscopic hysterectomy and adnexal surgery for benign gynaecological conditions. Although the evidence includes 1 high-quality randomised controlled trial for each of hysterectomy and adnexectomy, the rest of the evidence is lower quality. This is because most of the studies are retrospective (they examine evidence that is already available about the procedure),

and all studies only include short-term outcomes. Given the high number of hysterectomy and adnexal procedures done in the NHS, further evidence is needed to better understand long-term safety and which patients this procedure will work best for.

2 The condition, current treatments and procedure

The condition

2.1 Benign gynaecological conditions refer to non-cancerous conditions affecting the female reproductive systems. These include, but are not limited to, chronic pelvic pain, uterine prolapse, fibroids and abnormal vaginal bleeding. Left untreated, these conditions can lead to severe and prolonged pain, infections, and reduced quality of life.

Current treatments

2.2 The current surgical treatments for this set of conditions includes hysterectomy, adnexectomy and myomectomy. Conventional hysterectomy (removal of the uterus) is done through a cut in the abdomen or through the vagina. There are also laparoscopic approaches.

2.3 An adnexectomy involves removing the ovaries or fallopian tubes. This can be done alongside a hysterectomy or on its own.

2.4 Myomectomies are keyhole or open surgeries which remove fibroids that develop around the womb.

The procedure

2.5 The vaginal transluminal endoscopic hysterectomy procedure is done in a similar way to a conventional vaginal hysterectomy but uses an endoscopic view and laparoscopic instruments. The patient is placed in the lithotomy position. Under general anaesthesia, a circular incision is made in the vagina (around the cervix). Following anterior/posterior

colpotomy and transecting the sacro-uterine ligaments, a keyhole instrument port with transvaginal indication is then inserted to improve access and visibility. The abdominal cavity is accessed through the colpotomy and then insufflated. Laparoscopic instruments are inserted and the surgery is done in a Trendelenburg (head down) position. Then the uterus, fallopian tubes or ovaries are removed vaginally (depending on the procedure type). Then the instrument port is removed, the abdomen is deflated, and the vaginal incision is closed with absorbable sutures.

3 Committee considerations

The evidence

3.1 NICE did a rapid review of the published literature on the efficacy and safety of this procedure. This comprised a comprehensive literature search and detailed review of the evidence from 9 sources, which was discussed by the committee. The evidence included 1 systematic review (of 1 randomised controlled trial and 5 retrospective studies), 1 randomised controlled trial, 2 prospective case series and 5 retrospective cohort studies. It is presented in the summary of key evidence section in the interventional procedures overview. Other relevant literature is in the appendix of the overview.

3.2 The professional experts and the committee considered the key efficacy outcome to be: procedure success.

3.3 The professional experts and the committee considered the key safety outcomes to be: pain, bleeding, infection, organ injury, vaginal prolapse, and dyspareunia.

3.4 There were 48 responses from people who have had this procedure, which were discussed by the committee.

Committee comments

3.5 Clinical experts emphasised the importance of additional research. Concerns were expressed about the generalisability of study results from high-volume centres to smaller practices. To gain a deeper understanding of this procedure's outcomes, the committee encourages further research through well-designed, suitably powered randomised controlled trials, or the use of registry data and audits.

3.6 The committee was informed that contraindications to this procedure include, but are not limited to, some forms of pelvic inflammatory disease, endometriosis and previous surgery or radiotherapy.

3.7 The committee noted that there are multiple methods and ports to do this procedure.

3.8 It is important that further evidence is captured on patient selection and long-term outcomes (particularly vaginal prolapse).

3.9 The committee was informed that this procedure is of particular benefit to people with a high BMI or a history of bowel surgery (for example, colectomy). This is because of improved operative function and view compared with laparoscopic surgeries.

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Endorsing organisation

This guidance has been endorsed by Healthcare Improvement Scotland.

Accreditation