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How I Do It: Day Case Vaginal Hysterectomy and Vaginal Repair Surgery

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Patient Selection

- All women who need surgical treatment of prolapse
- No exceptions
- All surgeons working to the same protocol

Anaesthetic Techniques

- **General or Spinal Anaesthesia**
- General Anaesthesia
    - Induction and maintenance with target controlled propofol and alfentanil infusions.
    - Spontaneous ventilation with Laryngeal Mask Airway
- Spinal Anaesthesia
    - 3mls 2% hyperbaric prilocaine
- All Cases
    - Always give 1 litre crystalloid as this reduces PONV and dizziness: usually do not need more than this.
    - IV Dexamethasone 6.6mg and ondansetron 4mg iv for hysterectomies
    - Anti-emetic medication is not routinely required for vaginal repair surgery
    - Subcutaneous fragmin 5000u at end of procedure if >60 minutes

Surgical Technique

- Lithotomy position.
- Infiltration with 0.25% Bupivacaine and 1:200000 adrenaline. 20mls per compartment.
- If hysterectomy, then I use finger switch diathermy to make incisions.
- I ensure meticulous haemostasis.
- Mostly 3 pedicle hysterectomy
- If uterine size more than 12 weeks pregnancy size, then I will bisect the uterus after taking the uterine pedicle to make it easier to place a clamp around the cornual pedicles.
- No pack and no catheter as routine.

Peri-operative Analgesia

- Pre-medication with oral Ibuprofen Retard 1600mg and Paracetamol 1g.
- Intra-operative iv fentanyl 25mcg prn.
- Post-operative iv fentanyl prn, then oramorph and regular paracetamol.

Take Home Medication

- Paracetamol 500 mg/ codeine 30mg po qds, laxido 1 sachet bd, plus ibuprofen 400 mg po qds

Anticipated Day Case Rates

- > 80%