## ****Non-Descent Vaginal Hysterectomy (NDVH) – Protocol Sheet****

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**Adapted from:** FOGSI, AAGL, SOGC, ACOG, and RCOG Guidelines  
**Version:** 1.0

### **Purpose & Scope**

* To establish a structured, evidence-based, and standardized protocol for performing NDVH.
* To ensure patient safety and improve surgical outcomes by aligning practice with international recommendations (FOGSI, SOGC, AAGL, ACOG, RCOG).
* To serve as a reference for surgeons, trainees, and operating room personnel involved in hysterectomy procedures.

## Indications (FOGSI and International Consensus)

* Symptomatic uterine fibroids (preferably ≤14–16 weeks in size)
* Abnormal uterine bleeding not responding to medical management
* Adenomyosis and small benign ovarian cysts (if accessible vaginally)
* Benign endometrial conditions following adequate evaluation
* NDVH should be prioritized as the **preferred route** for benign uterine disease whenever feasible.

**Exclusion Criteria**

* Clinical or radiological suspicion of malignancy (requires oncologic laparotomy)
* Extensive endometriosis or severe pelvic adhesions restricting uterine mobility
* Very large uterus (>16–18 weeks; considered a relative contraindication)
* Adnexal pathology necessitating laparotomy
* **As per FOGSI Guidelines:** The surgical route should be individualized; however, unnecessary abdominal hysterectomy must be avoided.

**Preoperative Workup**

* **Clinical evaluation:** Assess uterine size, mobility, descent, and adnexal status.
* **Imaging:** Transvaginal sonography (TVS); add CT/MRI if pelvic distortion or adnexal pathology is suspected.
* **Endometrial assessment:** Sampling recommended for abnormal uterine bleeding in women ≥40 years or with risk factors for malignancy.
* **Routine investigations:** Baseline hematology and biochemistry, anaesthetic fitness assessment, and blood cross-matching when indicated.

**Informed Consent**

**Counselling should include:**

* Comparative risks and benefits of **vaginal**, **abdominal**, and **laparoscopic** approaches.
* Possibility of **intraoperative conversion** if adequate access or safety cannot be ensured.
* Potential complications: **hemorrhage**, **bladder/ureteric/bowel injury**, **infection**, or **vault-related problems**.
* Advantages of the vaginal route include shorter hospital stay, faster recovery, less postoperative pain, and lower overall cost.

### **Operative Protocol (Stepwise)**

1. **Position:** Extended lithotomy; bladder catheterization; antiseptic preparation and draping.Perform a final bimanual examination to confirm feasibility of the vaginal route.
2. **Vaginal incision:** Circumferential, anterior, or posterior colpotomy depending on accessibility.
3. **Entry:** Open **posterior pouch** first, followed by the **anterior pouch**.
4. **Sequential clamping and ligation:**
   * Uterosacral ligaments
   * Cardinal ligaments
   * Uterine vessels
   * Utero-ovarian or infundibulopelvic ligaments (as required)
5. **Debulking techniques** (endorsed by FOGSI) for large or non-mobile uterus:
   * **Bisection of uterus**
   * **Myomectomy (fibroid enucleation)**
   * **Morcellation** (coring or wedge resection)
6. **Vault closure:** Secure closure with apical support by fixing the uterosacral ligaments (e.g., McCall’s or modified uterosacral suspension) to minimize vault prolapse, following AAGL and FOGSI recommendations.

## ****Conversion Criteria****

Conversion from vaginal to abdominal or laparoscopic route should be considered **for patient safety**, not as a procedural failure.  
**Indications include:**

* Uncontrolled intraoperative bleeding
* Inaccessible or pathologically altered adnexa
* Dense adhesions or distorted anatomy preventing safe dissection
* Intraoperative suspicion of malignancy

***Conversion ensures patient safety and reflects sound surgical judgment rather than failure****.*

## ****Postoperative Care****

* **Mobilization:** Encourage early ambulation. Apply elastic stockings and pharmacologic prophylaxis (when indicated) to reduce thromboembolic risk.
* **Catheter & pack removal:** Within 24 hours post-surgery.
* **Analgesia**: Multimodal pain control (Paracetamol + NSAID ± short opioid) for 3 days.
* **Antibiotic Prophylaxis**: Administer **Cefazolin 1–2 g IV** within **30–60 minutes before incision.**Continue antibiotics for **up to 5 days** only if there is **intraoperative contamination, prolonged surgery, or other infection risk factors.**
* **Discharge**: After 48–72 hrs if stable.
* **Follow-up**: At **2 weeks** (wound and recovery review) and **6 weeks** (final evaluation and return to normal activities).

## ****Documentation & Audit**** (as per FOGSI recommendations)

* Clearly document **indication** and **rationale for route selection**.
* Record **intraoperative findings**, **surgical steps**, **estimated blood loss**, and any **complications**.
* If conversion occurs, specify **indication and timing**.
* Maintain regular **audit parameters:**
  + Complication rates
  + Conversion rates
  + Average hospital stay
  + Re-admission and re-intervention rates

Continuous audit, feedback, and hands-on training are essential for maintaining surgical quality and improving outcomes.

**References**

1. FOGSI Focus: Vaginal Surgeries (Federation of Obstetric and Gynaecological Societies of India, 2015)
2. FOGSI Guidelines: Hysterectomy and Reporting Standards
3. SOGC (Society of Obstetricians and Gynaecologists of Canada) Clinical Practice Guideline No. 377: Hysterectomy for Benign Gynaecologic Indications
4. ACOG (American College of Obstetricians and Gynecologists) Committee Opinion: Choosing the Route of Hysterectomy for Benign Disease
5. AAGL (American Association of Gynecologic Laparoscopists) Position Statements and Teaching Modules on Vaginal Hysterectomy
6. RCOG (Royal College of Obstetricians and Gynaecologists) – Relevant recommendations on route of hysterectomy