

CORRESPONDENCE

Technique for adnexal removal in vaginal hysterectomy

To the Editors:

The technique described by Smale and associates (AM. J. OBSTET. GYNECOL. 131:122, 1978) for adnexal removal at the time of vaginal hysterectomy, disturbs me greatly in the sense that it would, in my opinion, appear to defy principles of safe surgical technique.

First, a free tie is placed over tissues proximal to the clamp, placed for hemostasis on the infundibulopelvic ligament, "opening the clamp slightly, and then finishing the tie . . ." I would be most concerned, without having transfixed the suture, that a blood vessel might retract as I was "finishing the tie." Therefore, in my opinion, the first suture placed should be of transfixion type and not a free tie.

Second, after the free tie has been placed, "all the vessels in the infundibulopelvic ligament are incorporated in a subsequent transfixion suture." In Fig. 1 this latter suture is shown to be placed lateral to the free tie. Again, I would be concerned that in the placement of the transfixion suture the needle might pass through a blood vessel and that one might develop a hematoma lateral to the suture. Therefore, in order to prevent development of a hematoma, it has always been my opinion that safe surgical technique requires the "free tie" to be placed lateral to the "transfixion suture" in this surgical adnexal extirpation.

Should my opinions prove wrong I shall be glad to be shown and accept the errors of my surgical technique; but if Smale and associates agree with my opinions it would, again in my opinion, be most important that they so publicize before too many gynecologists adopt the technique reported in the above-captioned article and potentially place their patients in jeopardy.

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Reply to Dr. Fribourg

To the Editors:

The authors thank Dr. Fribourg for his perception of an error in our illustration. It is our practice and our teaching to place the transfixion suture between the clamp and the free tie whenever possible for the reasons Dr. Fribourg stated.

However, he seems to misunderstand when the tie is placed and the reasons for its placement. It is placed prior to the excision of the adnexa; therefore, no vessels can retract, and it serves only to ensure complete incorporation of all pertinent tissues in the clamp. After the clamp is again securely locked, then, and only then, are the adnexal tissues excised.

Because of possible confusion illustrated by Dr. Fribourg's letter, I shall enumerate the steps for salpingo-oophorectomy as practiced by about 10 gynecologists in our community. An informal poll of them showed no significant hematomas, etc., arising.

1. When possible the fimbrial end of the tube is reflexed and incorporated into the tie encompassing the uterine end.

2. A strong (Heaney) clamp is placed carefully over the tissues of the broad ligament including the ovarian suspensory and infundibulopelvic ligaments. An initial small clamping and transfixion suturing may be necessary when the clamp will not easily transport across all the tissues to be clamped. This small clamping will include the round ligament and a portion of the mesosalpinx.

3. A free tie is placed and the clamp is opened slightly to allow the tissues to gather into the tie and the clamp.

4. Next the adnexa are excised 2 to 3 mm away from the clamp.

5. The transfixion suture is placed finally. Usually and preferably it is placed between the clamp and the free tie.

We thank Dr. Fribourg for giving us the opportunity to be a bit more specific about our surgical technique.

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Anesthesia in laparoscopic surgery

To the Editors:

The recent article by Caceres and Kim¹ provides an interesting alternative to the routine anesthesia for patients undergoing laparoscopic surgery. Unfortunately, it contains two inaccuracies which require correction. ASA classification refers to physical status as defined by the American Society of Anesthesiologists²