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Conference Theme
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All India Congress of Obstetrics & Gynaecology
Inspire, Include, Invent: Improving Women's Health in India

Manual on Shirish Sheth Vaginal Surgery

Series Editors
Ashok Kumar
Madhavi M Gupta
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Editors
Rajendra Saraogi
Suman Sinha
Meenakshi
Nishi Makhija

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Shirish Sheth
Vaginal Surgery

Series Editors

Ashok Kumar
MD PhD
Director–Professor
Department of Obstetrics and Gynecology
Atal Bihari Vajpayee Institute of Medical Sciences
and Dr Ram Manohar Lohia Hospital
New Delhi, India

Madhavi M Gupta
MS
Director–Professor
Department of Obstetrics and Gynecology
Maulana Azad Medical College and Lok Nayak Hospital
New Delhi, India

K Aparna Sharma
MBBS MD
Professor
Department of Obstetrics and Gynecology
All India Institute of Medical Sciences
New Delhi, India

Editors

Rajendra Saraogi
Suman Sinha
Meenakshi
Nishi Makhija



JAYPEE BROTHERS MEDICAL PUBLISHERS
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New Delhi | London

JAYPEE **Jaypee Brothers Medical Publishers (P) Ltd**

Headquarters
EMCA House, 23/23-B
Ansari Road, Daryaganj
New Delhi 110 002, India
Landline: +91-11-23272143, +91-11-23272703
+91-11-23282021, +91-11-23245672
e-mail: jaypee@jaypeebrothers.com

Corporate Office
4838/24, Ansari Road, Daryaganj
New Delhi 110 002, India
Phone: +91-11-43574357
Fax: +91-11-43574314
e-mail: jaypee@jaypeebrothers.com

Overseas Office
JP Medical Ltd.
83, Victoria Street, London
SW1H 0HW (UK)
Phone: +44-20 3170 8910
e-mail: info@jpmedpub.com

EU GPSR Authorised Representative
Logos Europe, 9 rue Nicolas Poussin
17000, La Rochelle, France
Phone: +33 (0) 6 67 93 73 78
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Manual on Shirish Sheth: Vaginal Surgery

First Edition: **2026**

ISBN: 978-93-7545-883-8

Printed in India

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3 CHAPTER

Innovations in Vaginal Surgery

Suman Sinha, Punam Dixit

INTRODUCTION AND OBJECTIVE

The field of vaginal surgery has evolved beyond its traditional boundaries, integrating novel concepts and refined techniques that have significantly broadened its clinical applications. With a growing emphasis on minimally invasive approaches, the vaginal route offers distinct advantages in terms of reduced postoperative morbidity, shorter hospital stays, and greater patient satisfaction, while maintaining surgical precision and therapeutic efficacy.

Recent innovations have revitalized interest in vaginal access for complex gynecological procedures such as vaginal myomectomy, ovarian cystectomy via the vaginal route, cervical cerclage, Vnotes combines traditional vaginal surgery with endoscopic assistance and selective clamping of the uterine arteries. These advancements exemplify the progressive adaptation of conventional principles to meet modern surgical goals, emphasizing organ preservation, reduced invasiveness, and enhanced reproductive outcomes.

This article aims to review the current innovations and technical progress in these areas, outlining their indications, operative nuances, and outcomes. A deeper understanding of these developments is essential to optimize patient selection, improve training in vaginal surgery, and integrate these techniques into contemporary gynecological practice.

VAGINAL MYOMECTOMY: TECHNIQUE AND CASE SELECTION

Myomectomy via the vaginal route, though less commonly performed, represents an excellent option in carefully selected patients. The procedure was first described by Magos et al. in 1994. Appropriate case selection and thorough preoperative evaluation are critical for optimal outcomes. Parous women with easily accessible fibroids are ideal candidates. Imaging and fibroid mapping should be performed to determine the exact location and size. Posterior wall fibroids can be accessed and removed via a posterior colpotomy incision. Prolapsed submucous and small intracervical fibroids can also be removed efficiently. The procedure involves injecting dilute vasopressin to control blood loss, enucleating the myoma, closing dead space with interrupted sutures, and securing hemostasis prior to closing the colpotomy incision.

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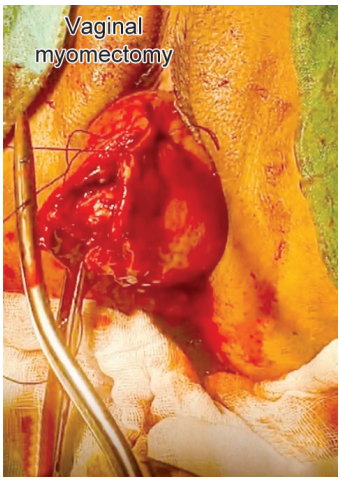


Fig. 1: Removal of post wall fibroids.



Fig. 2: Two fibroids removed (5 × 6) cms.

CERVICAL FIBROIDS: SPECIAL CONSIDERATIONS

Cervical fibroids comprise 0.6–7.7% of all leiomyomas, presenting unique challenges for laparoscopic or open approaches. Vaginal intracapsular myomectomy (CIME) has been evaluated in a case series of 32 patients, indicating feasibility and efficiency. Large anterior cervical fibroids have also been successfully removed vaginally, with various reports supporting the vaginal route in selected cases.

VAGINAL OVARIAN CYSTECTOMY: INDICATIONS AND METHOD

Vaginal ovarian cystectomy is an innovative approach for benign ovarian cysts, ideally in the absence of adhesions or endometriosis. Preoperative assessment should use the International Ovarian Tumor Analysis (IOTA) criteria. The cyst can be exteriorized or aspirated, and after removal, the ovary is returned to the peritoneal cavity, with the incision closed. Clinical studies report shorter operative time, lower postoperative pain, and higher patient satisfaction compared to abdominal or laparoscopic methods. Intraoperative ultrasound enhances surgical safety and accuracy.

Modified Shirodkar Cerclage Technique

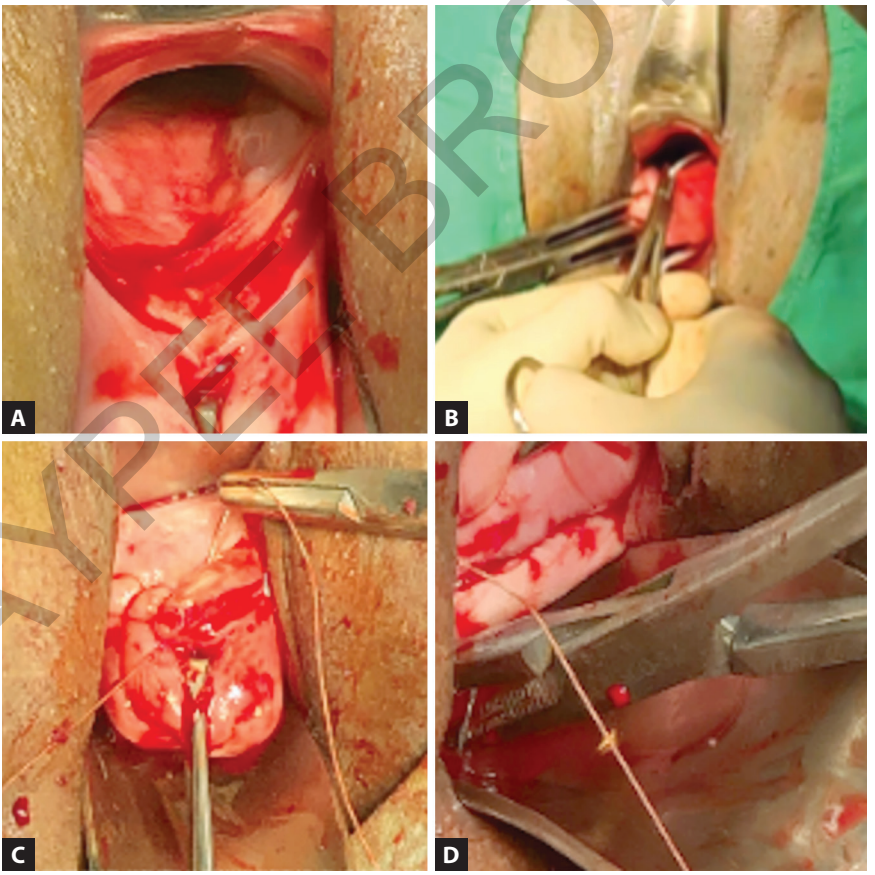
It is one of the most important interventions to prevent premature birth. Compared with the Macdonald's and original Shirodkar's technique, there is less trauma and blood loss. The Shirodkar technique, enables high placement of the suture in the poor anatomical situation of the cervix such as funneling at the internal os, incompetent cervix, deeply lacerated cervix or extremely short cervix.

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Technique

A transverse incision of about 1.5 cm is made through the anterior vaginal mucosa at its junction with the cervix. Similar transverse incision is made at the posterior vaginal mucosa at junction with the cervix.

The bladder is pushed away from the cervix anteriorly after a transverse incision on the vaginal wall and pushed upward to expose the area of the internal os, to enable high placement of the cerclage. A curved round needle 35 mm in length and 1.6 mm in diameter, with Teflon tape/Marceline/Black silk is passed through the anterior para cervical tissue. The same procedure is done at the posterior end and the knot is tied anteriorly. A continuous absorbable ligature closes the incision. Three changes were adopted in the modified Shirodkar technique: (1) To hold and compress the paracervical tissue atraumatic forceps was used. (2) The location of the knot is made at anterior fornix makes it easier to remove. (3) A Silk thread is passed through the cerclage tape assisting in easier removal of the tape by pulling the silk thread.



Figs. 3A to D: (A) Bladder mobilized; (B) Marceline tape being passed; (C) Closure of ant Colpotomy; (D) Closure of Posterior colpotomy.

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STEPS OF MODIFIED SHIRODKAR CERVICAL CERCLAGE TECHNIQUE

vNOTES

Vaginal Natural Orifice Trans luminal Endoscopic Surgery, is an advanced surgical approach that combines traditional vaginal surgery with Endoscopic tools, resulting in better cosmetic outcomes, less pain and faster recovery times.

Technique

A circular paracervical incision is given followed by dissection of the posterior vaginal pouch down to the peritoneum which is opened. The dissection allows the exposure of the uterosacral ligaments which are cut and ligated to be later attached to the vaginal vault for prevention of vault prolapse. Then the vesicouterine space is dissected till the peritoneum and the vesicouterine pouch is opened (Anterior colpotomy). The Alexis retractor is inserted in the ant pouch opening. Then the posterior part is placed. It helps to place the platform. Patient is then placed in 20° Trendelenburg and the cavity is infiltrated with 8 mm gas. Peritoneal exploration is done under vision. First the left uterine pedicle is coagulated , followed by left utero ovarian pedicle and section of the mesosalpinx. Then right uterine pedicle is coagulated followed by coagulation and cutting of right infundibulopelvic ligament and then left infundibulopelvic ligament is coagulated and cut. The uterus is then removed through the opening. The Alexis retractor and platform is removed. The vault is closed in a running suture with Vicry no1. The utero sacral ligament is reattached to the vault. The patient is discharged after 24–48 hours when she is stable and has passed urine and there is no complications.

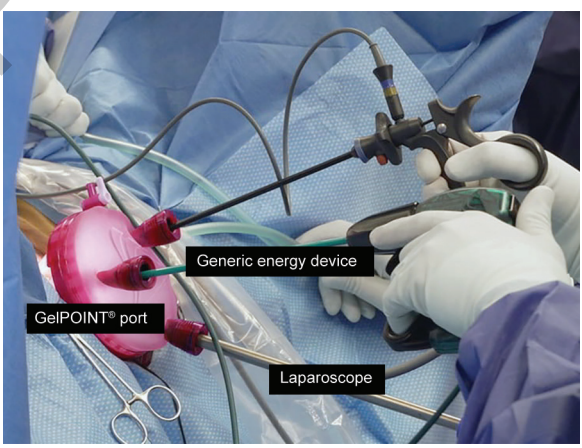


Fig. 4: Vaginal natural orifice transluminal hysterectomy.

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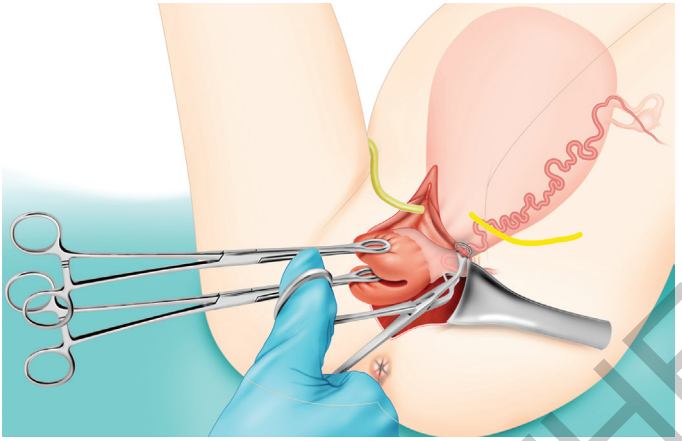


Fig. 5: Transvaginal clamping of bilateral uterine arteries.

Transvaginal Uterine Artery Clamp

A temporary intervention to stop bleeding in postpartum hemorrhage. Most of the maternal death in PPH are due to delay in management. Uterine arteries are the major contributor of blood supply to the uterus and methods to occlude these arteries can reduce perfusion effectively. In low resource setting it is a very useful device. Methods like uterine balloon tamponade do not give immediate response when every passing minute is crucial for the patient. So for quick action bilateral occlusion of uterine arteries using Trans vaginal uterine artery cervical occlusion clamp (TVUAC) is a promising device to prevent maternal morbidity and mortality in women who delivers vaginally.

KEY POINTS

- Both vaginal myomectomy and cystectomy are safe and effective with proper case selection and surgical expertise.
- These techniques yield substantial benefits, including minimally invasive access and optimized reproductive outcomes.
- Continued research and training will further enhance their adoption and standardization.
- The modified Shirodkar's technique, enables high placement of the suture in the poor anatomical situation of the cervix and thus prevents premature birth.
- Transvaginal uterine artery cervical occlusion clamp is a promising devise to control PPH in low resource settings.
- Vnotes is minimal invasive gynecological surgery done through vaginal route. Endoscopic instruments and laparoscope are inserted vaginally and surgical procedures like hysterectomy, adnexectomy can be performed under vision., offers benefits like less pain and fast recovery.

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