A commentary on “Vaginal hysterectomy with anterior and posterior repair for pelvic organ prolapse under local anesthesia: results of a pilot study”

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This prospective cohort study aimed to evaluate the feasibility and safety of performing vaginal hysterectomy (VH) and pelvic floor repair (PFR) under local anesthesia and IV sedation by assessing pain and patient recovery parameters in the early postoperative period. Forty patients with symptomatic uterine prolapse (stage III or IV) who opted to undergo a VH and PFR (uterosacral ligament suspension, anterior and posterior repair) were recruited to the study. The first and second 20 consecutive patients were allocated to the “standard care” group [combined spinal-epidural (CSE) block] and the “study” group (local anesthesia with IV sedation), respectively. The local anesthetic used was 40 ml of 1% lidocaine and 40 ml of 0.5% ropivacaine with adrenaline in a 1:200,000 ratio providing a total of 80 mls of solution. Intensity of postoperative pain, percentage of patients with moderate/severe pain, percentage of patients who used opioids, incidence of nausea/vomiting, level of sedation and patient satisfaction rate were measured during the first 24 h after the surgery.

The median pain intensity was significantly lower in the study group (local anesthesia) at 2 h, 4 h and 8 h. The percentage of

participants needing opioids in the postoperative period for additional pain control was statistically significantly lower for the “local anesthesia” group (35% vs. 95%, $p = 0.002$). Only at 8 h postoperatively were the patients in the “local anesthesia” group presenting with fewer nausea symptoms than those in the “standard care” group. Patients in the “local anesthesia” group had significantly reduced time to first mobilization (min) [median (IQR): 300 (255–495) vs. 870 (750–970)] and reported higher levels of satisfaction [median (IQR): 9 (9–10) vs. 8 (7–9)] regarding their overall surgical experience.

In summary, this study showed that local anesthesia is a viable alternative to regional anesthesia in carefully selected women undergoing VH for pelvic floor reconstruction offering reduced postoperative pain in the first 4–8 h, less opioid use and a high patient satisfaction rate. This is particularly important for geriatric patients or patients with comorbidities having contraindications to general or regional anesthesia and for patients requiring an opioid-free anesthesia-analgesia or an enhanced recovery.

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