

Hysterectomy- “A Boon or Bane”

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ABSTRACT:

Objective: Hysterectomy has become one of the commonest surgery, even the general surgeons are doing the surgery by the patient's wish without surgical indication. The retrospective study was carried out in patients, who had come with complaints after hysterectomy and required admissions. Study also included referred cases of post hysterectomy. Their indications, complications, and follow up period were noted. Analysis done.

Material and Methods: 75 patients study with history of hysterectomy were studied and analysed.

Results: 60% of patients were operated for benign conditions which could have been treated conservatively. 20% patients had post hysterectomy ovarian tumours followed by infection, urinary symptoms, psychological disturbances and carcinoma of vault /stump accounting for 12 % each.

Conclusion: Hysterectomy surgery is not the ultimate treatment for most of conditions.

Keywords: Hysterectomy, Benign conditions

INTRODUCTION

This study was carried out to evaluate whether hysterectomy was really necessary for most of patients. As rural patients think that they have completed their families and even for minor complaints and benign conditions they are willing to undergo hysterectomy instead of adopting family planning measures. Although in some cases it is essential and beneficial, as in early stages of carcinoma cervix and ovarian tumours causing pressure symptoms. But in other cases where other palliative treatment and conservative line of treatment is beneficial, surgery may end in some complication and may have adverse effects and psychological disturbances. No surgery is 100% safe, and even with best of hands, complications are known. Hysterectomy is one of the most common major operations for women in industrialized countries¹. About 1 in 3 women in the United States undergo hysterectomy before the age of 60 years². By 60 yrs 30% undergo hysterectomy, 85% of these are performed for benign diseases & 15% for carcinoma of Cervix³. Mortality rates after hysterectomy are 1-2 per 1000⁴. Morbidity is seen in 25-40% of women⁵. Rates for procedures were estimated as 5.6 per 1000 women in 1997⁶. Repeated controlled studies indicate that hysterectomy can result in psychiatric condition such as depression and anxiety.

AIMS AND OBJECTIVE

To study the post operative complications of the patients who had undergone hysterectomy and also to analyse the indications and necessity of the surgery.

MATERIALS AND METHODS

Retrospective study in Department of Obstetrics and Gynaecology, R.D.Gardi Medical College Ujjain, from June 2014 – Dec 2014.

DATA COLLECTION

Age, income, locality distribution and routes of hysterectomy, was collected and the complications were noted and analysis done.

OBSERVATIONS AND RESULTS

Results are tabulated in following tables where n = no. of cases recruited

Table 1: Socio Demographic Data

| Characteristics of subjects | n=75 | Percentage |
|-------------------------------------|-------|------------|
| Age (yrs) | <40 | 18 |
| | 41-60 | 48 |
| | >60 | 09 |
| Socioeconomic status (income/annum) | <5000 | 60 |
| | >5000 | 15 |
| Address | Urban | 18 |
| | Rural | 57 |

64% were between 41-60yrs of age, 24% below 40yrs of age, 12% above 60yrs of age. 80% were of low socio-economic status and 76% rural.

Table 2: Interval between hysterectomy and complication

| Duration of follow-up | n = 75 | Percentage |
|-----------------------|--------|------------|
| < 3 months | 12 | 16 |
| 3 months – 2yrs | 33 | 48 |
| >2yrs | 30 | 36 |

16% admitted within 3 months of surgery, 48% between 3 months and 2 years of surgery, 36% after 2 years of surgery.

Table 3: Cases

| Parameters | n=75 | Percentage |
|---------------|------|------------|
| Institutional | 15 | 20 |
| Referral | 60 | 80 |

20% were institutional hysterectomy, 80% referral Post hysterectomy.

Table 4: Routes of Hysterectomy

| ROUTES | n=75 | PERCENTAGE |
|------------|------|------------|
| Abdomen | 30 | 40 |
| Vaginal | 33 | 44 |
| Wertheim's | 12 | 16 |

40% underwent abdominal hysterectomy, 44% vaginal, and 16% Wertheim's hysterectomy.

Table 5: Indications for hysterectomy

| Indications | n = 75 | Percentage |
|---------------------------|--------|------------|
| Prolapse | 27 | 36 |
| Carcinoma of Cervix | 06 | 08 |
| Fibroid Uterus | 18 | 24 |
| Carcinoma Endometrium | 03 | 04 |
| Ovarian Tumour | 12 | 16 |
| Abnormal uterine bleeding | 06 | 08 |
| Tubo Ovarian Mass | 03 | 04 |

36% cases were operated for prolapse of uterus as indication, 24% cases for fibroid uterus, 16% of cases for ovarian tumour, 8% cases for carcinoma of cervix and abnormal uterine bleeding, 4% of cases for tubo ovarian mass and carcinoma of Endometrium.

Table 6: Post operative complications

| Complications | n=75 | Percentage |
|---------------------------|------|------------|
| Infection(a) S.S.I | 09 | 12 |
| Carcinoma of stump cervix | 03 | 04 |
| Vault Prolapse | 06 | 08 |
| Ovarian Tumour | 15 | 20 |
| Urinary symptoms | 09 | 12 |
| Bowel symptoms | 03 | 04 |
| Carcinoma of vault | 09 | 12 |
| VVF | 03 | 04 |
| Psychological disturbance | 09 | 12 |
| Dysperunias | 03 | 04 |
| Retention of urine | 03 | 04 |
| Osteoporosis | 03 | 04 |

20% cases reported with ovarian tumour, 12% cases with psychological disturbances, infection, carcinoma of vault, and urinary symptoms, 8% with vault prolapse, and 4% with vesicovaginal fistula, carcinoma of stump cervix, dysperunia, retention of urine, bowel symptoms and osteoporosis.

DISCUSSION

Historically hysterectomy started its voyage from a vaginal route (VH) in 15th, 16th and 17th century to an abdominal route (AH) in 18th, 19th and 20th century to revisit the vaginal route in 21st century with or without the help of laparoscopic assistance (TVH, LAVH and TLH). In fact Laproscopically assisted vaginal hysterectomy needs prolonged operative management and increased cost. Hysterectomy is one of the most commonly performed major operations next to caesarean delivery. Indications depend upon socio-cultural problems, education and medical problems as per population. AUB and fibroids are most common indications of hysterectomy in rural population followed by prolapse of uterus and Ovarian malignancy. Route of hysterectomy cannot be generalised and individualisation of case is important to minimise complications by constant process of evaluation and learning upholding the principles of modern medicine. Female pelvic organs have two portals of entry; one is vaginal which is natural orifice and other surgically created-abdominal. The vaginal approach is the hallmark of gynaecological surgeon. Despite convincing evidences that vaginal hysterectomy is preferable when either vaginal or abdominal route is clinically appropriate, the only formal guideline available is the uterine size guideline by ACOG which

suggest that the vaginal route is most appropriate in women with mobile uteri not larger than 12 weeks gestational age (approximately 280 gm)^{7,8} ACOG also acknowledges that the choice of approach should be based on the surgical indication, anatomical condition, informed patient preference and the surgeons expertise and training. More specific guidelines incorporating uterine size, risk factors and uterine and adnexal mobility and accessibility can help surgeons select the best route of hysterectomy and reduce the number of abdominal operations. The position and mobility of the uterus are more critical than only the size in deciding the route of approach. For several decades, the abdominal approach has been the most common route of hysterectomy despite the well documented benefits of vaginal hysterectomy in terms of lower complication rates, shorter length of stay and convalescence and more favourable quality of life outcomes including reduced mortality^{9,12}.

In fact laproscopically assisted vaginal hysterectomies need prolonged operative time and increased cost¹³. Traditionally vaginal hysterectomies have been the procedure of choice for women with uterine weight up to 280 gm when benign disease is confined to the uterus¹⁴. Vaginal hysterectomy can be performed in women with uterine weight of at least 450gm¹⁵. Repeated controlled studies indicate that hysterectomy can result in psychiatric conditions such as depression and anxiety¹⁶. Hysterectomy can complicate a woman's psychological state, and some women develop immediate post operative symptoms of severe anxiety that significantly impact on their quality of life^{17,18}. However, the procedure may improve psychiatric and psychosexual well-being in some women, especially those who underwent hysterectomy for indications that, although benign, caused great discomfort^{19,21}. Recent prospective studies have determined that no negative effects resulted from its overall²¹. Some authors have found positive effects of hysterectomy on the psychosocial and sexual well being of women^{19,20}. Hysterectomy as a treatment for benign indications should be critically and comprehensively re-evaluated to assess its potentially negative short and long term psychological consequences as well as its effects on psychosexual function^{22,23}. Donogue et al.^{23,24} concluded that pre operative depression improved in many women after hysterectomy. Ewalds-Kvist ET al.²⁵ also reported that married nulliparous women experienced more severe depression after hysterectomy. In at least 1 study no differences were noted at 6 months in the psychological well being of women who underwent laparoscopic compared with women who underwent abdominal hysterectomy²⁵. Such differences in outcome may result from differences in study design, including retrospective v/s prospective design, length of follow up and population selection. Moreover, most of these studies were conducted in industrialized countries. Lalinec-Michaud and Engelsmann²⁶ suggested that cultural factors may contribute to the reaction to hysterectomy of women of different ethnic backgrounds. Despite these limitations, there is a significant co-relation between hysterectomy and

psychiatric morbidity inappropriate hysterectomies referrals are on rise and challenge to physician. This is preventable by PAP smear/ Colposcopy/ Directed biopsy, in cases of abnormal vaginal bleeding. A detailed history, clinical examination and simple blood tests can detect various non pelvic causes of menorrhagia. However, less commonly the bleeding may be due to undiagnosed underlying coagulation defects²⁷, endocrine disorders or systemic disease. Therefore it is very important that patient having menorrhagia without obvious pelvic pathology should be routinely studied to diagnose underlying endocrine and hemostatic disorder Menorrhagia is the most common menstrual irregularity in hypothyroid women. T3, T4, TSH estimation should be made mandatory in cases of abnormal uterine bleeding to detect apparent and occult hypothyroidism. Menorrhagia may be the first and only clinical manifestation of an inherited bleeding disorder²⁸.

Yet coagulopathies are not appreciated as aetiology of menorrhagia by gynaecologists and unintentional surgical intervention is done without getting the patients investigated for coagulopathies²⁹. A gynaecologist's awareness and inclusion of detailed history, clinical examination and simple laboratory tests in day to day practice can prevent unnecessary hysterectomies in women with menorrhagia. Thus proper selection of cases, preoperatively prepare for any eventually and intraoperative proficiency can decrease vaginal hysterectomy complications. Hysterectomy, inspite of much alternative management, remains the most commonly chosen mode of treatment for many gynaecological disorders. Vaginal hysterectomy is preferred by gynaecologists for uterovaginal prolapse where anterior colporrhaphy and posterior colpoperineorrhaphy can be conveniently performed along with. Currently vaginal route for non descent uterus has become popular as it has got distinct advantages. This route is associated with less febrile morbidity, less risk of haemorrhage³⁰, fewer blood transfusions³¹, shorter hospitalisation and quick convalescence³² as compared to abdominal route. There is a major recommendation to medical council to discourage inappropriate surgical management of gynecological condition by physicians, who are not trained in that area.

CONCLUSION

Gynaecologists should make great efforts to use less invasive treatments, many of which are becoming more available, as alternate options to hysterectomy for benign conditions. Non invasive methods are being reported for management of benign diseases of uterus. But in rural set up hysterectomy is still most practiced for all this conditions. Thus proper selection of cases, preoperative preparation with knowledge, confident study, purposeful and determined actions and proficiency in variety of techniques is the successful outcome of hysterectomy. In near future the AICOG 56 slogan of "Save the girl child" will turn to "Save the uterus".

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