

CLINICOPATHOLOGICAL REVIEW OF GYNAECOLOGICAL HYSTERECTOMIES - LOCAL EXPERIENCE

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ABSTRACT

Objective: To share clinicopathological spectrum of hysterectomies performed at CMH Rawalpindi.

Study Design: A cross sectional descriptive study.

Place and duration of the study: This study was carried out at Obstetrics and Gynaecology department CMH Rawalpindi, from October 2010 to June 2012.

Material and Methods: Total of 54 patients who underwent hysterectomy were selected for the study. Detailed history and examination of the patient pre and post-operatively were carried out to observe the indications and complications of hysterectomy.

Results: In total 54 hysterectomies were carried out; all of which with the exception of one were total abdominal. The patients who underwent hysterectomies were in the 4th decade of life. The most common (48%) indication of hysterectomy in our study was found to be menstrual irregularities like menorrhagia, irregular vaginal bleeding, DUB and post-menopausal bleeding give frequently of complication as well. Delayed wound healing was the most common complaint (7%). Histopathology carried out on the uterine specimen showed adenomyosis 17(31%) being the most common finding.

Conclusion: Abdominal hysterectomies carried out in our setup are most commonly done for menstrual irregularities and complication rate is low.

Keywords: Hysterectomy, menorrhagia

INTRODUCTION

Hysterectomy for benign¹ gynecological conditions is one of the most commonly performed procedure world-wide however the rates vary for different regions²⁻⁴. Abdominal, vaginal and laproscopic hysterectomies are the three commonly employed types of hysterectomies⁵. Abdominal hysterectomy is carried out in cases of malignancies⁶, enlarged uterus and other gynaecological disorders⁷ like menstrual irregularities, endometriosis and adhesions. Vaginal hysterectomy¹ which is considered to be less invasive than abdominal hysterectomy is usually indicated in gynecological disorders where the uterus is of small size and most commonly for prolapsed uterus⁸ cases of and should be preferred to abdominal hysterectomy if possible.⁹ Laproscopic hysterectomy which is gaining popularity as procedure of choice amongst the gynaecologists due to several advantages, involves a part of the operation being

performed laproscopically¹⁰⁻¹¹. However not all centers are equipped and technical know how to carry out this procedure is also not commonly available. The present study aims to critically analyse the hysterectomies which were carried out in our setup in the light of the indications for which the surgery was carried out, the age group of the patients, the choice of procedure i.e whether abdominal or vaginal hysterectomy, the histopathological results of the uterine specimens and complications suffered by the patients.

MATERIAL AND METHODS

This descriptive study was carried out at Obstetrics and Gynecology department CMH Rawalpindi from October 2010 to June 2012. Fifty four patients who underwent abdominal/vaginal hysterectomy were through non probable convenience sampling included in the study. Detailed history of the patient was taken. Pelvic examination and ultrasonography pelvis was carried out in all the patients. Baseline blood/urine, radiological investigations, E.C.G was done in all cases as a pre-requisite for pre-anaesthetic evaluation. Pre-anaesthesia assessment was carried out by

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consultant anaesthetist. After getting written and informed consent, prophylactic antibiotics were administered and surgery was carried out at gynaecology operation theatre CMH Rawalpindi under spinal/general anesthesia. For abdominal hysterectomy supra-pubic transverse incision was made in patients having

undergoing hysterectomy from October 2010 to June 2012 were included in the study. Statistical analysis was done by SPSS 20.0 and results were expressed in percentages.

RESULTS

In total 54 abdominal / vaginal hysterectomies were included in the study. All

Table-1: Indications for hysterectomy (n=54).

Indications	Frequency	Percentage
Menorrhagia and irregular vaginal bleeding/ post-menopausal bleeding/DUB	26	48%
Fibroid- (were these silent-fibroid)	15	28%
Ovarian mass complex	2	4%
Pelvic Endometriosis	2	4%
Uterine malignancy	3	5%
Genital prolapse	1	2%
Pelvic Inflammatory disease	5	9%

Table-2: Distribution of complications (n=54).

Complications	Frequency	Percentage
Delayed wound healing	4	7%
Pyrexia	3	6%
Wound infections	2	4%
Urinary tract infection	1	2%
Haemorrhage requiring transfusion	1	2%
Re-operation for bowel injury	0	0%
Re-operation for ureteric injury	0	0%
Re-operation for intra-abdominal bleeding	0	0%
No complications	43	80%

Table-3: Description of histopathological findings (n=54).

Histopathological Findings	Frequency	Percentage
Fibroids	15	28%
Adenomyosis	17	31%
Endometrial hyperplasias	9	17%
Malignancies (uterine and ovarian)	5	9%
Cervicitis/pelvic inflammatory disease	6	11%
Endometriosis	2	4%

non-malignant indications, while mid-line incision was made for patients having pelvic malignancies. For vaginal hysterectomy inverted T and V incisions were made and anterior and posterior colporrhaphy were carried out for cases where there were cystoceles and rectoceles. After surgery patients were kept in post op ITC for 24-48 hours and put on intravenous antibiotics and are then shifted to the gynaecology ward and put on oral antibiotics on discharge. Patients were called for follow-up after 07-10 days. All patients

the hysterectomies were total abdominal except one, for genital prolapse, which was conducted through vaginal approach. Maximum patients (50%) were in 4th decade followed by 5th (22%), 3rd (19%) and the 6th (7%) decade and only one (2%) patient was in 7th decade. The most common (48%) indication for hysterectomy in our study was found to be menstrual irregularities followed by fibroid uterus in 15 (27%) patients. Other indications included pelvic endometriosis, genital prolapse, uterine malignancy, ovarian mass and pelvic

inflammatory disease (Table-1). Complication noted were transfusion for hemorrhage, mild pyrexia, wound infections, delayed wound healing and post-operative urinary tract infection (Table-2). Histopathology carried out on the uterine specimen showed the presence of fibroids, adenomyosis, endometrial hyperplasia, malignancy, cervicitis, and endometriosis (Table-3).

DISCUSSION

In the present study it has been found that in our setup the abdominal approach is still the preferred choice of operation while internationally the trends have shifted towards vaginal and laproscopic approaches. Studies have shown that vaginal hysterectomy has better results as compared to abdominal hysterectomies as far as complication rates, morbidity and mortality is concerned¹². The use of antibiotics chemoprophylaxis leads to very low incidence of post-operative infections, a finding which is similar to studies conducted elsewhere¹³ and has been included in Cochrane protocols¹⁴. Hysterectomies carried out without antibiotic chemoprophylaxis carry higher rates of infection¹³. In our part of the world where infections are still a major cause of morbidity and mortality having such a low incidence of infections indicates the importance of having a mandatory and effective antibiotic chemoprophylaxis. Menstrual irregularities were the most common indication for hysterectomy in our study. Hysterectomy remains a very effective treatment for curing menorrhagia and has high patient satisfaction^{15,16}.

CONCLUSION

Menstrual irregularities and fibroids remain the major indication for hysterectomies in our patients. Low rate of intra-operative

complications indicate satisfactory level of surgical expertise. But the international trends of vaginal and laproscopic hysterectomy needs to be introduced so as to offer less invasive procedures to our patients thus further decreasing the complication rates in our setup.

REFERENCES

1. Lundholm C, Forsgren C, Johansson AL, Cnattingius S, Altman D. Hysterectomy on benign indications in Sweden 1987-2003: a nationwide trend analysis. *Acta Obstet Gynecol Scand* 2009; 88(1):52-8.
2. Stang A, Merrill RM, Kuss O. Nationwide rates of conversion from laparoscopic or vaginal hysterectomy to open abdominal hysterectomy in Germany. *Eur J Epidemiol* 2011; 26(2):125-33.
3. Whiteman MK, Hillis SD, Jamieson DJ, Morrow B, Podgornik MN, Brett KM, et al. Inpatient hysterectomy surveillance in the United States, 2000-2004. *Am J Obstet Gynecol* 2008; 198(1):34 e1-7.
4. Spilsbury K, Semmens JB, Hammond I, Bolck A. Persistent high rates of hysterectomy in Western Australia: a population-based study of 83 000 procedures over 23 years. *BJOG* 2006; 113(7):804-9.
5. Nieboer TE, Johnson N, Lethaby A, Tavender E, Curr E, Garry R, et al. Surgical approach to hysterectomy for benign gynaecological disease. *Cochrane Database Syst Rev*. 2009(3):CD003677.
6. Geetha P, Nair MK. Laparoscopic, robotic and open method of radical hysterectomy for cervical cancer: A systematic review. *J Minim Access Surg* 2012; 8(3):67-73.
7. Merrill RM. Hysterectomy surveillance in the United States, 1997 through 2005. *Med Sci Monit* 2008; 14(1):CR24-31.
8. Brett KM, Marsh JV, Madans JH. Epidemiology of hysterectomy in the United States: demographic and reproductive factors in a nationally representative sample. *J Womens Health* 1997; 6(3):309-16.
9. Johnson N, Barlow D, Lethaby A, Tavender E, Curr E, Garry R. Surgical approach to hysterectomy for benign gynaecological disease. *Cochrane Database Syst Rev* 2006; (2):CD003677.
10. Li G, Yan X, Shang H, Wang G, Chen L, Han Y. A comparison of laparoscopic radical hysterectomy and pelvic lymphadenectomy and laparotomy in the treatment of Ib-IIa cervical cancer. *Gynecol Oncol* 2007; 105(1):176-80.
11. Shin JW, Lee HH, Lee SP, Park CY. Total laparoscopic hysterectomy and laparoscopy-assisted vaginal hysterectomy. *JLS* 2011; 15(2):218-21.
12. Kovac SR. Hysterectomy outcomes in patients with similar indications. *Obstet Gynecol*. [Research Support, Non-U.S. Gov't]. 2000; 95(6 Pt 1):787-93.
13. Leung PL, Tsang SW, Yuen PM. An audit on hysterectomy for benign diseases in public hospitals in Hong Kong. *Hong Kong Med J*. 2007; 13(3):187-93.
14. Marjoribanks J JV, Calis K. . Antibiotic Prophylaxis for elective Hysterectomy. (protocol) *Cochrane Database Syst Rev*. 2004; Issue 1:CD004367.
15. Coulter A, Peto V, Jenkinson C. Quality of life and patient satisfaction following treatment for menorrhagia. *Fam Pract*. [Research Support, Non-U.S. Gov't]. 1994; 11(4): 394-401.
16. Protheroe J. Modern management of menorrhagia. *J Fam Plann Reprod Health Care*. [Research Support, Non-U.S. Gov't Review]. 2004; 30(2): 118-22.