

COMMONEST INDICATION AND COMPLICATIONS IN CASES OF HYSTERECTOMIES PERFORMED IN COMBINED MILITARY HOSPITAL RAWALPINDI

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ABSTRACT

Objective: To outline major indications and post operative complications in patients undergoing hysterectomy with a benign condition in Combined Military Hospital (CMH) Rawalpindi.

Study Design: A descriptive study

Place and Duration: The study was carried out in the department of obstetrics and gynaecology CMH Rawalpindi from January 2008 to January 2010.

Material and Methods: A total of 321 patients were selected for enrollment in study out of 510 hysterectomies done in Combined Military Hospital Rawalpindi for various indications. The age of the women ranged between 40-65 years. Among the indications were dysfunctional uterine bleeding (DUB), uterine fibroids, post menopausal bleeding and uterovaginal prolapse. All other cases with advanced pelvic malignancies and endometriosis were excluded. Record was maintained with detailed profile of all the patients. Operative findings and complications were recorded in profile data by principal investigator and co-researchers.

Results: Dysfunctional uterine bleeding remained the top most indication of hysterectomy (45 %) and the complication rate remained 8.7%.

Conclusion: With DUB as the commonest cause of the hysterectomy, the researchers need to work more in medical conservative techniques to avoid surgical morbidity, associated with hysterectomy.

Keywords; Complications, DUB, Hysterectomy, Indications

INTRODUCTION

Hysterectomy is surgical removal of the uterus. The first abdominal hysterectomy was performed by Charles Clay in 1943 and first vaginal hysterectomy was performed by Soranus of Ephesus in 120 A.D. Advances in anaesthesia¹, transfusion services, surgical techniques and availability of antibiotics led to hysterectomy becoming the most common non pregnancy related major surgical procedure in women².

According to the standard text books of gynaecology the common indications of hysterectomy include uterine fibroids, endometriosis, pelvic inflammatory disease, endometrial hyperplasia, dysfunctional uterine bleeding, dysmenorrhoea, intractable post partum haemorrhage, ruptured tubo-ovarian abscesses, endometrial hyperplasia with atypia

and malignancies^{3,4,5}.

Route of hysterectomy depends on the indication and the skill of the operator doing the procedure⁶. However hysterectomy is a reasonably safe, and routine surgical procedure but associated with less than 10% major complications⁷. Among major complications the most serious is haemorrhage (0.2-2%) and other less serious are visceral injury (5-14%) and febrile morbidity and infections (10%)⁸. Complications associated with vaginal hysterectomy are 2.38 times less as compared to abdominal hysterectomy⁹. Visceral injury in TAH is 0.7-1.8%¹⁰, whereas it is 0.1% in VH¹¹. Psychological manifestations like depression, anxiety, hot flushes and psychosexual problems are the few ones which were encountered¹². The objective of the study was limited to only highlight the commonest indication of hysterectomies done in our setup and to enumerate operative and postoperative complications.

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PATIENTS AND METHODS

This descriptive study was carried out in the Department of Obstetrics and Gynaecology unit II Combined Military Hospital Rawalpindi from January 2008 to January 2010. Total 321 cases were included. Pre operative information included patient's age, relevant past medical history, previous gynaecological management and indication of hysterectomy. Inclusion criteria was all non-responders to medical treatment, benign pelvic pathology and uterovaginal prolapse. All cases with known advanced pelvic malignancy and endometriosis were excluded.

All selected cases consented to be included in study and pre operative investigations were advised and endorsed. Patients who needed transfusion pre operatively to raise hemoglobin to 11g/dl were not included in those requiring transfusion due to blood loss per operatively. Operative informations included details of hysterectomy route, findings and complications. All cases included were given broadspectrum injectable antibiotics for 24 hours post operatively and hemoglobin was assessed on second post operative day. Patients were managed 2-5 days post operatively in hospital and advised to visit on tenth post operative day for removal of stitches, evaluation of histopathology and any other complication. Later on patients were advised for follow up after three months.

Data was analyzed using SPSS version 15. Descriptive statistics were used to describe the data.

RESULTS

All surgeries were performed by two consultants. Vaginal hysterectomies done were 41 (12.8%) cases, mainly for uterovaginal prolapse and had overall complication rate of 4.9%.

Among those 280 (87.2%) who had undergone total abdominal hysterectomies complication rate was 3.1%. The highest number of TAH done were for dysfunctional uterine bleeding (45%) and other indications are shown in table 1.

Table1: Indication of Hysterectomy (n=321)

Indications(n=321)	Frequency	Percentage
DUB	145	45.2
Fibroids	109	34
Prolapse	41	12.8
Adenomyosis/ endometriosis (stage I&II)	16	5
Chronic Pelvic Inflammatory Diseases	6	1.9
Other	4	1.2

Table2: Complications of hysterectomies

Complications of Hysterectomies	Vaginal hysterectomy (n=41)	Abdominal hysterectomy (n=280)
Infections		
-wound	0 (0%)	3 (1.1%)
-UTI	2 (4.9%)	6 (2.1%)
Blood transfusion	2 (4.9%)	9 (3.2%)
Gut injury	0 (0%)	1 (0.4%)
Bladder Injury	0 (0%)	3 (1.1%)
Re laparotomy	0 (0%)	2 (0.7%)
Over all rate	4 (9.8%)	24 (8.6%)

Detailed comparison of complications in cases of vaginal or abdominal hysterectomies is shown separately in table 2. Total operative complication were encountered in 28 (8.7%) patients. There was no ureteric injury or vesico vaginal fistula formation in any of the patients. Gastrointestinal symptoms like abdominal distension, dyspepsia and constipation were common but improved with medications and these symptoms were not considered as complications. Relaporotomy was done in two patients because of post operative haemorrhage and preoperative in both patients it was found to have slippage of a ligature as the cause of haemorrhage, however both the patients made satisfactory recovery after words. Fifty one patients (15.9%) developed postmenopausal/ psychosexual symptoms including hot flushes, depression, mood swing and loss of libido.

DISCUSSION

The three choices are abdominal (TAH), Vaginal (VH) and laparoscopically assisted vaginal hysterectomy (LAVH) with first being the most common¹³. Since vaginal hysterectomy

is associated with less physical complications¹⁰, women commonly opt for abdominal hysterectomy (TAH). We performed TAH in 280 cases for benign pelvic pathologies and 41 VH for uterovaginal prolapse. LAVH is not yet being done in our setup.

The study revealed the commonest benign condition requiring hysterectomy was dysfunctional uterine bleeding (45.2%). The reason being non compliance of the treatment prescribed and non availability of ablative procedures in most of our hospitals. The MIRENA IUS reduces menstrual blood loss upto 96%¹⁴. Results are comparable with endometrial resection¹⁴ and can be employed as an alternative to hysterectomy,¹⁵ but because of limited economic resources in our population and being muslims having postinsertion spotting MIRENA is found to be not a very much acceptable option in most of our women. Some of other indications were uterine fibroids (34%), adenomyosis (5%) and chronic pelvic inflammatory disease (1.9%). Others included cases with benign postmenopausal bleeding, polyps etc. A small number of women (4) had hysterectomy for ovarian pathology, but overall commonly found vasomotor symptoms with bilateral oophorectomy¹⁶ were less in our study.

Younger age of group has inverse relationship of symptoms with surgery in terms of social class and education¹⁷ whereas in our study the age limit was between 40-65 years and despite being educated class, patients had more inclination towards definitive treatment like hysterectomy. Complications associated with hysterectomy are often under estimated because of varying factors¹⁸.

Febrile illness with infections and blood transfusion are the most common minor complications. Major complications considered are the injuries to other organs or re-operations¹⁹.

The VALUE study in England and Wales is a recent assessment of complications^{9,13}. Over all operative complications occurred in 3.5% with 9% getting a post operative complications where as in our study, it was 8.7 % which is optimal. That study included large number of patients as compared to ours however it is still

comparable. No death was reported in this study, where as it was 0.38% in VALUE study by 6 weeks post surgery. visceral damage was about 0.3-0.7 in TAH cases and no visceral damage in cases undergone VH. In a study conducted at Shaikh Zaid Hospital Lahore Ikram et al reported bladder injury approximately in 1% cases²⁰. In our study no vesicovaginal fistula were found where as it has high prevalence in VH²¹. As the study was focused mainly on physical operative and post operative complications, however, myth of psychiatric morbidity increases with hysterectomy has been refuted by various prospective studies²².

CONCLUSION

With DUB as the commonest cause of the hysterectomy, the researchers need to work more in medical conservative techniques to avoid surgical morbidity, associated with hysterectomy.

REFERENCES

- Schindlbeck C, Klausar, Dian D, Janni W, Friese K. Comparison of total laproscopic, vaginal and abdominal hysterectomy. Arch Gynaecol Obstet 2008;277:331-7.
- Edozein LC. Hysterectomy for benign conditions. BMJ 2005;330:1457-8.
- Sprlisbury K, Hammond I, Bulsara M, Semmens JB. Morbidity outcomes of 78577 hysterectomies for benign reasons over 23 years. BJOG 2008;115:1473-83.
- Merrill RM. Hysterectomy surveillance in the United States, 1997 through 2005. Med Sci Monit 2008;14:CR24-CR31.
- Saha R, Sharma M, Padhye S, Karki U, Pande S, Tharpa J. Hysterectomy: an analysis of perioperative and post operative complications. Khathmandu Univ Med J 2003;1:124-7.
- Kulkarni M, Met al. Vaginal Hysterectomy for Benign Disease without prolapse. Clin Ox G 2010 53;1:5-16.
- Jennifer Heisler RN, About.Com guide updated February 19, 2009
- Dawood NS, Mahmood R, Haseeb N. Comparison of vaginal and abdominal hysterectomy: peri and post-operative outcome. J Ayub Med Coll Abbotabad 009; 21:116-20.
- Mepherson K, Metcalfe MA, Herbert A, Maresh M, Casbard A, Hargreaves J, Bridgeman S, Clarke A. Severe complications of hysterectomy: The VALUE study BJOG 2004;111:688-94.
- Ottosen, Lingman G, Ottosen L. Three methods for Hysterectomy, a randomised prospective study of short term outcome. Brit J Obstet- Gynaecol 2000;107:1380-5.
- Bashir R, Parveen Z, Sultana R, Khan B. Two year audit of complications of hysterectomy at Ayub teaching hospital Abbotabad. J Ayub Med coll Abbotabad 2005;17:47-9.
- Ewalds-Kvists, Beatrice M, Hirvo Nen, Tolvo Kvist, Martin, Levtoala, Kaarlo, Nirmla, Pirkko. Depression, anxiety, hostility and hysterectomy. Journal of Psychosomatic obstetric plus gynecology; 2005;26:193-204.
- Lethaby A, Augood C x Duckitt (2002) non steroidal anti inflammatory drugs for heavy menstrual bleeding Cochrane Database Syst Rev 1, CD000400.
- Rauramo I, ELO I x Istre O (2004) Long term treatment of menorrhagia with Levonorgestrel intrauterine system versus endometrial resection. Obstet Gynaecol 104,1314-21.

15. Hurslainen R (Teperi J, Rissanen Pet al. (2001) Quality of life and cost effectiveness of Levonorgestrel - releasing intrauterine system versus hysterectomy for treatment of menorrhagia: a randomized trial. *Lancet* 357,273-7.
16. Parker W. Bilateral oophorectomy versus Ovarian Conservation. Effects on long term women's Health. *JMI G* 2010;17:161-165.
17. Marshall SF, Hardy, RJ x Kuh D (2000) Socioeconomic variation in hysterectomy upto age 52: national, population based prospective cohort study. *Br Med J* 320, 1579.
18. Myers ER, Steege JF. Risk adjustment for complications of hysterectomy limitations of routinely collected administrative data. *Amj obset Gynecol* 1999;181:567-75.
19. Harkkip, KurkiT, Sjoberg J, Titinen A. Safety aspects of laproscopic hysterectomy. *Acta obset ZGynecol Scand* 2001;80:383-91.
20. Ikram M, Saeed Z, Saeed R, Saeed M. Abdominal versus vaginal Hysterectomy. An audit, *Professional Med J* Dec 2008, 15(4); 486-491.
21. Gray LA. Views and reviews-Indications, techniques and complications in vaginal hysterectomy. *Obst and Gynae*, 28:714-722.
22. Thakar R, Ayers S, Georgakapolou A, Clarrksp, Stanton S x Manyondal (2004) Hysterectomy improves quality of life and decreases Psychiatric symptoms: a prospective and randomised comparison of total versus subtotal hysterectomy. *BJOG* 111, 1115-20.

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