Total Abdominal Hysterectomy with Bilateral Salpingo-Oophorectomy with a History of Previous Surgery of Suicidal Intake of Hydrochloric Acid

Mamuna Qayum, Salman Akhtar, Osama Ali*, Waleed Ali, Nomira Waheed, Tatheer Fatima*

Cavalry Hospital, Lahore Pakistan, *Rahbar Medical and Dental College, Lahore Pakistan

ABSTRACT

A patient with a history of previous abdominal surgery is at increased risk of visceral injury due to adhesion and excessive bleeding, which may require surgical repair. The optimal outcome can be achieved with the inter-professional team, patient care after being discharged from the hospital, and follow-up after surgery for eight weeks. Here we present as case of total abdominal hysterectomy with bilateral salpingo-oophorectomy with a history of previous surgery of suicidal intake of Hydrochloric Acid.

Keywords: Bilateral salpingo-oophorectomy, Suicidal intake of hydrochloric acid, Total abdominal hysterectomy.

How to Cite This Article: *Qayum M, Akhtar S, Ali O, Ali W, Waheed N, Fatima T. Total Abdominal Hysterectomy with Bilateral Salpingo-Oophorectomy with a History of Previous Surgery of Suicidal Intake of Hydrochloric Acid. Pak Armed Forces Med J 2022; 72(3): 1148-1150. DOI: https://doi.org/ 10.51253/pafmj.v72i3.7523*

INTRODUCTION

When medical treatment fails, total abdominal hysterectomy is the surgical removal of the uterus for a case of Heavy Menstrual Bleeding (HNB). Fibroid uterus and adenomyosis are the cause of HMB with urinary or bowel symptoms. Total abdominal hysterectomy is the ultimate "cure" for a woman having heavy menstrual blood loss. It is a major surgical treatment requiring a hospital stay and several weeks of recovery time. It became more high risk if the patient had a previous history of lower segment caesarean section and abdominal surgery.[1] The more serious the previous surgery, the greater risk of complications of the involved organ.

CASE REPORT

A 46 years old married female, para 2 with one NVD (2004) and one LSCS (2008), presented with a mass abdomen, pain lower abdomen, and heavy menstrual bleeding with urinary & bowel symptoms for the last five years. She was diagnosed with a case of Fibroid uterus with adenomyosis. Her uterus was 18 weeks in size. She got medical treatment but did not relieve. During this tenure, she was given intravenous iron multiple times and blood transfusion eight times,[2-3] pints of blood at one time due to very low haemoglobin. She came to Cavalry Hospital Lahore. She was diagnosed through history and reports that she had a large fibroid with multiple small fibroids and adenomyosis with multicystic ovaries. She had previous surgery for implantation of the large intestine in place of the oesophagus and stomach and duodenum. She was unable to take a normal quantity of food and fluids. Her day-to-day life was very difficult. She was planned for definitive treatment, i.e., TAH and BSO. Pre-operative workup was done. Her anaemia was treated. She was counselled for post-up risks and intake of fluid & diet especially. The surgeon was also involved in looking after the intestine during surgery. Tests were done before surgeries: pap smear and pelvic USG, which may reveal the size, location & number of fibroid, and ovarian cysts. Special investigations were carried out for coagulation, renal function test and Doppler studies of intestinal vasculature. The patient was sent to an anaesthetist as the oesophagus was replaced with a large intestine, and epiglottis was not there. The anaesthetist decided on spinal anaesthesia as she was at high risk for general anaesthesia. The patient along husband has explained all risks, and consent of TAH and BSO were taken. A previous Pfannenstiel incision was operated on her. Due to the previous caesarean section, there was dense adhesion on the anterior aspect of the lower portion of the uterus with the bladder. There were dense adhesions with the rectum on the posterior wall of the uterus. Total abdominal hysterectomy with bilateral salphingo-oophorectomy was performed after adhesiolysis.

During the post-operative period, she could not take more than half a glass of water and a semi-solid diet of about a half cup-tea after 6-8 hrs. Even with this, she has to sit or walk for 45-60 minutes. She had

Correspondence: Dr Mamuna Qayyyum, House No. 206, Street.3, Sector-A, Phase-5, Lahore-Pakistan

Received: 12 Dec 2021; revision received: 10 Feb 2022; accepted: 14 Feb 2022

constipation and risk of UTI. Due to these reasons, in the post-operative period, she was given I/V fluid, Aminovel infusion, protein powder supplement, laxative, and antibiotics as per protocol. On the tenth post-operative day, stitches were removed. She was advised to take minced meat, soups, and crushed fruits. She had pain in the rectum for a few days while passing stool. USG revealed normal gut and pelvis. It was relieved with an analgesic after 2-3 weeks. Histopathology report mentioned fibroid uterus with adenomyosis and multicystic mucinous cysts without malignancy. After four weeks, she has normal bowel activity. She was advised medicine and diet to prevent menopausal symptoms. She was allowed normal activity and sexual activity at six weeks.

Her surgical history starts in 2010 when at the age of 35 years, she was taken in an emergency to a hospital. She made an imprudent suicidal attempt with hydrochloric acid consumption after a conflict with her husband in 2010 at Lahore. The emergent medical management and hospitalization were administrated under the diagnosis of corrosive esophagitis and gastritis. Total gastrectomy was done as the stomach was not viable. The lower end of the oesophagus and duodenum was closed, and a feeding Jejunostomy was placed. Arrangements were made in a few months for reconstructive surgery in Taiwan. Then the patient was referred to Chang Gung Memorial Hospital (CGMH) Taiwan. Following procedures were carried out during reconstructive surgeries. The written notes of procedures were taken from CGMH Taiwan's original ward files and photocopies with patient records.

In CGMH, the investigation carried out before surgery were anaerobic culture, aerobic culture, and CT of the chest without & with contrast. In addition, radiography of the chest showed an emphysematous change of bilateral lung with pleural effusion. ECG was found with sinus tachycardia. Her pathological report showed; esophagectomy, fibrous adhesion, lymphoid hyperplasia, terminal ilium resection, small intestine, jejunostomies revision and fibrosis oesophagus, stump resection and erosion.

Esophagoscopy was performed, and stitches of anastomosis were removed. The reconstructed oesophagus was checked and dilated with a balloon dilator. Then the fibre optic band above the reconstructed orifice was lysed by microscopic directed laryngoscopy CO2 laser. The contralateral adhesive laryngopharyngeal band was also lysed. The reconstructed oesophagal orifice was exposed after the procedure. No immediate complication was noted after the whole procedure.

The patient had an ingestion problem immediately in the post-operative period. She was kept on a liquid diet for six months and taught how to twist her tongue for swallowing to prevent inhalation. After that, she took a normal diet in small quantities. She sat for 45-60 minutes or walked for an hour, so food moved to the small intestine.

DISCUSSION

The history of abdominal hysterectomy dates back to England in 1843, but the patient died. In 1853 Ellis Burnham from Massachusetts performed a subtotal hysterectomy patient survived. Improvement of medical & surgical methods, antisepsis and antibiotics was gradually replaced by total abdominal hysterectomy.[2] Fibroids and adenomyosis in the uterus cause bleeding, anaemia, pelvic pain, and pressure on the bladder and rectum, leading to urinary and bowel symptoms. Total Abdominal hysterectomy is a permanent treatment for adenomyosis and fibroids.[3] The risks of complications are intra-operative and post-operative bleeding, Infection, Reaction to anaesthesia drugs, visceral injury during surgery, venous thromboembolism, genitourinary, gastrointestinal injury, nerve injury and vaginal cuff dehiscence.[4]

A patient with a history of previous abdominal surgery is at increased risk of visceral injury due to adhesion and excessive bleeding, which may require surgical repair.[5] The most important angle is surgically induced menopause, which requires follow-up to prevent complications.[6] The optimal outcome can be achieved with the inter-professional team, patient care after being discharged from the hospital, and follow-up after surgery for eight weeks.[7]

Since history is very important in such cases, its discussion is very important. The industrial product Hydrochloric acid (HCL; pH=1) is used in many countries as a toilet cleaner. Cases of accidental or suicidal ingestion of undiluted HCL can lead to a life-threatening emergency. In adults, it is a mainly suicidal attempt with undiluted. In such a case, treatment comprised close clinical monitoring, symptomatic therapy with gastric lavage, and management of acidosis, pain and hemolysis. Surgical intervention is mandatory in case of suspected or detected perforation to prevent mortality. Early oral dilution of the ingested agent is not recommended to prevent further corrosion, aspiration and damage to the oesophagus due to intubation. Inducing vomiting is avoided because the second

contact with the oesophagus might aggravate mucosal and tissue damage.[8] Admission to a tertiary care hospital with endoscopic evaluation and permanent clinical re-evaluation is crucial in management. Another important aspect is to prevent blind insertion of a gastric tube for drainage due to the risk of perforation and induction of regurgitation and vomiting.[9]

HCL should be avoided for household use to prevent accidental and suicidal intake. Life is very difficult, and any other medical or surgical treatment is challenging and hazardous. If the gynaecological patient with HMB had suicidal history, she should be provided definitive treatment to make her life easy and comfortable.

Conflict of Interest: None.

Authors' Contribution

MQ: Data Collection, SA: Data Design, OA: Data writing, WA: Data analysis, NW: Interpretation of data, TF: Proof reading.

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