AN AUDIT OF HYSTERECTOMIES IN HMC PESHAWAR

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ABSTRACT

BACKGROUND: An audit of gynecological hysterectomies was carried out in Gyne C department of Obstetrics & Gynecology Hayatabad Medical Complex Peshawar. Among the patients admitted for major Gynecological operations, those undergoing hysterectomy were entered in to study programme. This study was carried out to assess the reasons and other related features of patients who underwent hysterectomies in Gyne-C Unit of Hayatabad Medical complex, Peshawar.

METHODS: It was retrospective study of hysterectomies at Gyne C unit of Hayatabad Medical Complex Peshawar, from January 2013 to December 2013. The indications for hysterectomy were evaluated. Patients were studied and observed preoperatively, during surgery and postoperatively till their stay in hospital. The follow up visit was also recorded with histopathology report after 6 weeks

RESULTS: The incidence of hysterectomy among major operations was almost 22%. Ratio of abdominal to vaginal route was almost 6:1. The complication rate and postoperative hospital stay was seen more in the former group. Most of the operations were done electively. Majority of indications were benign in which surgery could have been avoided reflecting non availability of other effective medical treatments.

CONCLUSION: There is a need to increase the number of vaginal hysterectomies for better outcomes. But still with all these limitations in our setup hysterectomy proved curative and acceptable form of therapy to most of the patients.

Key Words: Complications, Histopathology, Hysterectomy.

INTRODUCTION.

Hysterectomy means removal of uterus from the body and is practiced both in Gynecology and Obstetrics¹. The most common major surgical procedure performed in Gynecology is Hysterectomy. A part from being performed through abdominal and vaginal routes it is now performed through a laproscope which is preferred and cost effective procedure with less postoperative stay and analgesia². Hysterectomy procedure carries low morbidity and mortality but this procedure provides the patients a quick relief of symptoms and more satisfaction of getting cure from the disease³. Because of this there has been a tremendous increase in the number of operations performed on women of the reproductive age around the world and in Pakistan over the past few decades. In England rate for hysterectomy from 1989 - 90 was 30.4 per 10000 surgeries⁴. It is estimated that 25% females in England undergo hysterectomy before the age of 65⁵. While for USA it is calculated

that 01 out of 03 females lose their uterus by the age 60. Modern anesthesia and aseptic techniques contributes to its safety but the morbidity rates are still significantly high i.e. 25 to 50% with mortality rate between 4.1 to 14.6 per 10,000 surgeries.⁶ The ratio of abdominal to vaginal hysterectomy varies 04: 01 or less. In 1989 in all England 17.4% out of 73280 hysterectomies were performed vaginally.⁷

METHODOLOGY.

This study was conducted in Gynae C unit of Hayatabad Medical Complex Peshawar. Total 779 patients were admitted for major Gynecological list. Patients undergoing hysterectomy had evaluation in their preoperative, intraoperative and postoperative period. Records from history sheets and files of patient admitted in the gynecology ward for hysterectomy during the last two years from 1st January 2013 up to 31st December 2013 were collected. Obstetrical hysterectomies were

excluded from the study. Information was gathered regarding age, parity, clinical diagnoses, presenting complaint, menstrual history and preoperative diagnosis/indications of hysterectomy and any complications found. They were interviewed to evaluate psychological impact of operation and post treatment satisfaction. They were followed 06 weeks later with their histopathology report and their diagnosis noted. Data was analyzed by using percentages.

RESULTS.

Out of 779 patients 148 had abdominal while 22 had vaginal hysterectomy. Abdominal hysterectomy was performed with conservation or removal of one or both ovaries depending upon age and indication.

Major indication for abdominal hysterectomy was dysfunctional uterine bleeding followed by fibroid (Table 1).

TABLE -1: INDICATIONS

INDICATIONS	NUMBERS
Dysfunctional uterine bleeding	95
Fibroids	26
Malignancies	06
Adnexal cysts	14
Prolapse	22
Other causes	7

Reasons for doing such a large number of operations for these benign conditions were mostly due to failure of medical treatment and lack of compliance by the patients. In case if malignancies more radical approach was applied to attain maximum clearance. Major indication for vaginal hysterectomy was utero-vaginal prolapse while few patients with small fibroid and dysfunctional uterine bleeding also had vaginal hysterectomy.

Overall complications rate was higher in abdominal as compared to vaginal route e.g. infection, hemorrhage, hematomas, ileus etc. Specific problems like urinary retention and

dyspareunia were higher in vaginal cases. Table2

TABLE -2COMPLICATIONS

Complications	Abdominal	Vaginal
Febrile morbidity	52	08
Excessive hemorrhage.	01	01
Respiratory infections	04	01
Anemia	10	03
Hematomas	04	05
Wound dehiscence	10	0
Injury to urinary tract	01	0
Injury to gut	01	0
Ileus	06	0
Postoperative hemorrhage	02	02
Urinary retention	04	06
Deep vein thrombosis	01	0
Embolism	0	0
Dyspareunia	0	06

Similarly number of transfusions, postoperative analgesia and hospital stay was longer in abdominal cases as compared to the vaginal. Table 3,4and 5.

TABLE - 3 BLOOD TRANSFUSION

Volume of blood	Abdominal	Vaginal
One pint	80	08
Two pint	22	01
More than two pints	02	0

TABLE - 4POST- OP ANALGESIA

Time Period	Abdominal	Vaginal
First 24 hours	148	22
24 hours stay in hospital	100	10
After 6 weeks	12	0

Routinely preoperative cases were admitted in evening before surgery. Simple abdominal cases were discharged on 5th postoperative day while

vaginal cases were sent home on 3rd postoperative day.

TABLE – 6 AVERAGE HOSPITAL STAY

Days	Abdominal	Vaginal
03-05	148	22
06 – 10	34	04
More than 10	04	0

DISCUSSION.

Hysterectomy is highly effective in treating symptoms due to nonmalignant gynecological conditions and so is associated with a considerable improvement in quality of life with very few problems reported⁸. It avoids the need of long term medical treatment and also reduces the risk of carcinoma ovary considerably by altering its blood supply⁹. Hysterectomy is a safe procedure and most of the deaths occurring in such patients are associated with cancer and medical disorder. Abdominal route is used frequently than vaginal but now the trend is towards increasing the number of vaginal hysterectomy as it is associated with reduced morbidity. For a gynecological surgeon it should be the preferred choice provided there are no contraindications. Ideally preoperative laparoscopy can be done to have a look at the pelvic viscera to support the decision¹⁰. Laparoscopic hysterectomy performed by Reich et al in 1989 initially is as safe as abdominal or vaginal hysterectomy¹¹. In this postoperative convalescence time is short and it is an acceptable alternative method¹².

Hysterectomy is done for many conditions usually as an elective procedure. Myomas accounts for the commonest indications for hysterectomy. In series of studies 35% of hysterectomies were performed for Myomas¹³. Trial of use of gonadotropin releasing hormone analogues showed that hysterectomy was technically easy and removal of Myomas was possible through a smaller incision due to regression in size¹⁴. Dysfunctional uterine bleeding is another common indications but its management depends upon a lot of factors¹⁵.

Noble was of the opinion that hysterectomy has a worthwhile place in management of menorrhagia¹⁶. It also removes any possibility of unsuspected malignancy¹⁷. About 20% of hysterectomies are done for prolapse, endometriosis, pelvic infections, premalignant and malignant conditions of uterus cervix and ovaries are other important indications¹⁸. Hysterectomy for cervical intraepithelial neoplasia is considered an excessive form of therapy¹⁹. There are also some disadvantages associated with hysterectomy. It affects the patients physically, psychologically and economically. Also there is loss of reproduction, libido and postoperative depression. In spite of its safety there is significant morbidity. The reported incidence of bladder injury is 1-2%²⁰ bowel injury and intestinal obstruction secondary to post hysterectomy adhesions are other recognized complications of hysterectomy²¹.

CONCLUSION

Hysterectomy is a major gynecological operation and inspire of its safety it should only be performed when a proper indication is justified. Patients should be prepared properly both physically and mentally to reduce the impact of complication. In simple cases vaginal route should be preferred choice. Conservative form of treatment should be brought into practice to reduce the incidence of operative treatment.

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