ORIGINAL ARTICLE

ABDOMINAL Hysterectomy: A COMMON SURGICAL PROCEDURE FOR BENIGN GYNAECOLOGICAL DISEASE

Meharunnissa Khaskheli and Shahla Baloch

ABSTRACT

OBJECTIVES: To analyze the pattern of abdominal hysterectomies in our set up with regard to cause, type and complications associated with this procedure.

DESIGN: A descriptive study.

SETTING: Department of Gynaecology and Obstetrics (Units II and IV), Liaquat University Hospital Hyderabad/Jamshoro, Sindh – Pakistan; from March 2002 to December 2005.

PATIENTS AND METHODS: Patients were women between 35 and 55 years of age in whom hysterectomy was done for benign lesions. Data was collected through a pre-designed proforma.

RESULTS: Total number of patients admitted during study period at the department were 3519, of which 1684 (47.85%) had the gynaecological disease. Of these 1684 patients, 776 (46.08%) required surgery. Majority of these women (61.86%) were in age group 30-40 years. Two hundred eighty-seven women undergone major surgery which included abdominal hysterectomy in 127 (44.25%) cases. Leiomyoma was the main cause for abdominal hysterectomy. Total abdominal hysterectomy only was performed in 78 (61.41%) cases. Immediate complications associated with surgery were rare while pelvic pain was more frequent late complication.

CONCLUSION: Hysterectomy rate is high in our set up and is commonly performed for benign lesions.


INTRODUCTION

Hysterectomy is the commonest gynaecological operation. It was first performed in 1507 by Berengarius of Bolonga through vaginal route. But the credit for first vaginal hysterectomy was given to Langen back in 1813. The first total abdominal hysterectomy with bilateral salpingo-oophrectomy was done by Clay in 1844. Hysterectomy rate varies according to geographic distribution, patient and physician related factors. It is still considered as the treatment of choice for benign lesions such as myomas, adenomyosis, extensive pelvic infection or adhesions, dysfunctional uterine bleeding (DUB) and obstetric complications. Its ratio is still 1 in 5 cases in women in United Kingdom at some stage of their life. DUB affects 20-30% of women and 60% of women having this problem undergo hysterectomy. In Pakistan, the rate of hysterectomy is quite high because it is the only surgical option available if patient is not responding to medical treatment. However, hysterectomy has major drawbacks and is associated with high morbidity and mortality. Other surgical treatment options like endometrial laser ablation (ELA), transcervical resection of endometrium (TCRE) and uterine artery embolization are widely practised as conservative surgical treatment for benign gynaecological conditions in other countries but in our country, they are not widely available for the non-availability of newer techniques. Hysterectomy continues to be the major treatment for benign gynaecological disease. The rationale of this study was to find out the common gynaecological conditions in which hysterectomy is done and to explore other methods which are less invasive and with low morbidity and mortality.

PATIENTS AND METHODS

A retrospective medical record analysis of all hysterectomies performed during March 2002 to December 2005 in Gynaecology and Obstetrics (Units II and IV) of Liaquat University Hospital Hyderabad/Jamshoro was carried out. Liaquat University Hospital is a major health care facility of Sindh province of Pakistan which caters services to most of the population of Sindh excluding Karachi city. All the women in whom hysterectomy was done for benign gynaecological lesions were included in the study. Exclusion criteria included women with malignancies, uterovaginal prolepse, caesarean hysterectomies, etc. A proforma was designed to collect and analyse the data regarding history, clinical examination, investigations, surgical procedure, complications, histopathological findings and follow up status. All the data were analysed through SPSS version 10.0.

RESULTS

Total number of patients admitted during study period
were 3519, of which, 1684 (47.85%) had the gynaecological disease. Of these 1684 patients, 776 (46.08%) required surgery. Majority of these women (61.86%) were in age group 30-40 years while others in age group of 40-50 years. Minor surgical procedures like D&C, D&E and biopsy were performed in majority (63.01%) of the cases while other underwent major surgery. Two hundred eighty seven women undergone major surgery. It included abdominal hysterectomy in 127 (44.25%) cases, laparotomy for mass, adhesiolysis, torsion ovarian cyst, chocolate cyst, endometriosis, pyosalpinx in 88(30.66%) cases, vaginal hysterectomy in 48 (16.72%) and Manchester repair in 24 (8.36%) cases respectively. Leimyoma was the main cause for abdominal hysterectomy followed by DUB, malignant disease and adenomyosis (Table I). Total abdominal hysterectomy only was performed in 78 (61.41%) cases (Table II). Immediate complications associated with surgery were rare while pelvic pain was more frequent as late complication (Table III).

### Table I: Causes for Abdominal Hysterectomy (n=127)

<table>
<thead>
<tr>
<th>Lesion</th>
<th>Number of Patients</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leiomyoma</td>
<td>48</td>
<td>37.79</td>
</tr>
<tr>
<td>DUB</td>
<td>45</td>
<td>35.43</td>
</tr>
<tr>
<td>Adenomyosis</td>
<td>6</td>
<td>4.72</td>
</tr>
<tr>
<td>Other causes (Carcinomas of cervix and ovary and endometrium)</td>
<td>24</td>
<td>8.36</td>
</tr>
</tbody>
</table>

### Table II: Distribution of Abdominal Hysterectomy with or without Oophrectomy (n=127)

<table>
<thead>
<tr>
<th>Hysterectomy with or without oophrectomy</th>
<th>Number of Patients</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total abdominal hysterectomy only</td>
<td>78</td>
<td>61.41</td>
</tr>
<tr>
<td>Total abdominal hysterectomy with unilateral salpingo-oophrectomy</td>
<td>28</td>
<td>22.04</td>
</tr>
<tr>
<td>Total abdominal hysterectomy with bilateral salpingo-oophrectomy</td>
<td>21</td>
<td>16.53</td>
</tr>
</tbody>
</table>

### Table III: Complications Associated with Surgery (n=127)

<table>
<thead>
<tr>
<th>Complication</th>
<th>Number of Patients</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anaesthesia</td>
<td>2</td>
<td>1.57</td>
</tr>
<tr>
<td>Hemorrhage</td>
<td>1</td>
<td>0.78</td>
</tr>
<tr>
<td>Late</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pyrexia</td>
<td>15</td>
<td>11.81</td>
</tr>
<tr>
<td>UTI</td>
<td>6</td>
<td>7.72</td>
</tr>
<tr>
<td>Chest Infections</td>
<td>8</td>
<td>6.29</td>
</tr>
<tr>
<td>Wound haematoma</td>
<td>25</td>
<td>19.68</td>
</tr>
<tr>
<td>Pelvic pain</td>
<td>30</td>
<td>23.62</td>
</tr>
</tbody>
</table>

### Discussion

DUB affects 20-30% of women, accounts for 12% of gynaecological referral and within 5 years of referral, 60% of women will have to undergo hysterectomy making it the commonest major gynaecological problem. In this study, 35.53% had hysterectomy due to DUB. The high rate of hysterectomies due to DUB in our set up could be because of non compliance with medical therapy and non-availability of minimal invasive techniques for the treatment of DUB. Even in advanced countries, medical treatment is effective in 50% of women. The hysterectomy has high rate of satisfaction and is the definitive treatment but now the ablative methods are preferred due to shorter hospital stay and quick return to full activities. These techniques have been extensively evaluated in randomised trials. Based on these trials, endometrial ablative techniques have been given grade A recommendation by the Royal College of Obstetricians and Gynaecologists for the treatment of heavy menstrual bleeding. Other common indication for which hysterectomy was done in our set up, was the Leiomyoma (37.79%). Majority of patients in this study were more than 35 years of age, had completed family and preferred this operation due to their long lasting symptoms, poverty and recurrent nature of the fibroids after myomectomy. Same finding is reported in the study conducted at Khyber Hospital, NWFP - Pakistan where hysterectomy for fibroids was done mostly in multiparous women. The uterine artery embolisation
was first advocated as a treatment for uterine fibroids. It is less invasive option for those who want to conserve uterus but in our public sector set up, these facilities are not available. In this study, 4.72% patients had hysterectomy for adenomyosis as this is the definitive treatment for it. Adenomyosis may present with symptoms similar to uterine fibroids but usually the diagnosis is made post operatively on the basis of histopathology. Although, embolization has been advocated for adenomyosis but no data suggest that embolisation is effective in this condition. In this study, operative complications were in the form of haemorrhage (0.75%) and anaesthesia (1.57%). Post operative complications included infections like urinary tract infection 7.72%, chest infection 6.29%, pyrexia 11.81% etc. The commonest complication was infection which can be due to poor resistance and long lasting anaemia due to menstrual irregularities and poverty in our population. Meanwhile, in a Swedish study for gynaecological surgery, the risk factors for infection were non use of prophylactic antibiotics under 40 years and obesity. Late complications were pelvic pain (23.62%) and psychological disturbances (18.11%) like depression, insomnia, and dyspareunia 3 to 6 months post operatively. They were given symptomatic treatment, reassurance and sympathetic support. These psychological disturbances were more common in women who had pre-operative depression about their problems and anxiety about surgery. Same had been reported by Gath D, et al. and Martin RL, et al. but counselling and proper selection of patients for surgery improves the problem.

CONCLUSIONS

Hysterectomy rate is high in our set up and is associated with high morbidity. Hence, it is recommended that modern techniques (second generation) like endometrial ablation including resection and uterine artery embolisation should be introduced in health care set ups as ours. Further studies shall also be carried out to compare different treatment options in our setup.

REFERENCES


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