

ORIGINAL RESEARCH

Gynecological Profile of Women Undergoing Hysterectomy

K. Lakshmi Devi¹, P. V. RamanaBai²

ABSTRACT

Introduction: More and more women are opting for hysterectomies due to varied reasons. Some women are going for hysterectomy for reasons to avoid post menopausal effects even though it is not indicated. With modern techniques available like laparoscopic surgeries, more options are available for gynecologists to go for hysterectomy. Objective of the study was Hence present study was conducted to describe the gynecological profile of women undergoing hysterectomy.

Material and Methods: A descriptive hospital based observational study was conducted among 90 women who underwent hysterectomy during the study of period of two years. Detailed history, clinical examination and investigations were carried out.

Results: Maximum incidence of hysterectomies was found in the age group of 41-50 years. Of these, LAVH were common. This was followed by 31-40 years in which TAH was common. It was noted that maximum number of hysterectomies were performed in para 4 and above which is about 52.2% and in that maximum underwent VH. Only one case of VH was recorded in nullipara. Maximum number of women had complaints of menstrual disturbances (57.7%) followed by mass per vaginum (15.5%). Few had pain lower abdomen, mass per vaginum with urinary disturbances and mass per abdomen and white discharge and post menopausal bleeding. Of the 90 cases that underwent hysterectomies, maximum i.e. 42.2% were with fibroid uterus and 22.2% were with UV prolapsed and the third common indication was DUB. Among fibroid uterus cases, maximum (60%) of them underwent TAH, 53% LAVH and among prolapsed uterus most of them underwent VH 63%. Among cases with DUB, most of them underwent LAVH.

Conclusion: Maximum incidence of hysterectomies was found in the age group of 41-50 years. Maximum number of hysterectomies were performed in para 4 and above. Maximum number of women had complaints of menstrual disturbances. Maximum i.e. 42.2% were with fibroid uterus.

Keywords: Profile, Hysterectomy, Para

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INTRODUCTION

Hysterectomy is one of the common major operations after cesarean sectional some references to hysterectomy have been made in 5th century BC in the times of Hippocrates. Soranus of Ephesus is said to have amputated a gangrenous uterus vaginally in 2nd century AD. Vaginal hysterectomy was performed in many countries before abdominal hysterectomy was attempted. Andrea dellacorce of Spain in 1960 performed vaginal hysterectomy. The earliest hysterectomies were vaginal and usually done for uterine prolapsed or inversion – many were performed by midwives also.¹

As told PerivalWillouby in 1670 about a coal miner's daughter cutting of the prolapsed uterus herself and suffered from urinary incontinence and died several years later uncured. Vaginal hysterectomies were done sporadically through the 17th and 18th centuries. Langenbeck a German surgeon did a successful vaginal hysterectomy for uterine cancer in 1813 and also by Herman and Wernerberg in 1832 in Pittsburg. Sauters for the first time used ligatures on broad ligament in 1822.²

In United States 1st vaginal hysterectomy was performed by John Collins Warren of Harvard University in 1829, but the patient died on 4th postoperative day. In 1843, Esselman of Nashville successfully removed an inverted myomatous uterus vaginally. In 1825, Langerbeck performed abdominal hysterectomy for, advanced cervical cancer in 7 minutes and patient died several hours later. In Manchester, abdominal hysterectomies were performed by Charles Cly in August 1843 and Health AM in November 1843 for ovarian tumors, later found to have leiomyomas, but both patients died of hemorrhage.³

Heath was first to ligate arteries which were forgotten for almost 50 years, as hemorrhage was lethal postoperative problem. In January 1844, Clay removed uterus and both ovaries for fibroid uterus and bilateral ovarian cysts. Unfortunately patient had a fall on the 13th post operative day and died 2 days later. WatterBurham of Lowell Massachusetts is credited with performing 1st successful abdominal hysterectomy

though unplanned for uterine leomyomas on 26th June 1853. The preoperative diagnosis was ovarian tumor. After abdominal incision, patient vomited and extended the leomyomatous uterus through the incision.⁴

On September 1853, G. Kimball of Lowell, Massachusetts was the 1st person to deliberately and successfully perform an abdominal hysterectomy for a correct preoperative diagnosis of uterine leomyomas. On 30th January 1878, WA Frund performed first operation for carcinoma of the uterus using anesthesia, antiseptic and haemostatic techniques. He made use of posture, which was later perfected by Trendelenberg.⁵

In 1881, Benderherner who was familiar with Freund’s cancer operation performed the 1st pan hysterectomy by abdominal route for leomyomatous uterus. In 1889, Simston described a technique to secure individual ligation of uterine and ovarian arteries. Vaginal hysterectomy was occasionally done in the early part of the 19th century to treat cancer of the cervix. In America Dr. May ADixon Jones on 16th February 1888 performed successful abdominal hysterectomy for uterine fibroids, although it seems that the uterine corpus was removed abdominally and the cervix was removed vaginally. In 1893, Schuchardt of Germany performed the 1st extensive vaginal hysterectomy for cervical cancer. The abdominal operation was refined by Werthiem and the vaginal by Schauta, both of Vienna. The pioneering work of both these masters in gynecologic surgery was a monumental advance in the treatment of women with invasive cervical cancer.⁶

With this background, present study has been conducted to study the gynecological profile of women undergoing hysterectomy.

MATERIAL AND METHODS

Place of study: Department of Obstetrics and Gynecology, Niloufer Hospital, Osmania Medical College, Hyderabad

Duration of study

Two years, Type of study: Observational Descriptive study
Ethical considerations: Institutional Ethics Committee permission was obtained and informed consent was taken from all women who were fit for inclusion in the present study.

Sample size

A total of 90 women were recruited in the study. They were divided into three groups of 30 each. One group underwent abdominal hysterectomy, second group underwent vaginal hysterectomy and the third group underwent laparoscopic assisted vaginal hysterectomy.

Methodology

A detailed history, complete clinical examination, and investigations were performed for all the included patients. All three groups were similar in characteristics like age, parity etc.

Statistical analysis

The data was entered in the Microsoft Excel worksheet and analyzed using percentage. Chi square test was applied where applicable. P value less than 0.05 was considered as significant.

RESULTS

Maximum incidence of hysterectomies was found in the age group of 41-50 years. Of these, LAVH were common. This was followed by 31-40 years in which TAH was common. It was noted that maximum number of hysterectomies were

Age (years)	TAH	VH	LAVH	Total
21-30	1 (3.3%)	1 (3.3%)	1 (3.3%)	3 (3.3%)
31-40	16 (53.3%)	8 (26.6%)	11 (36.6%)	35 (38.8%)
41-50	9 (30%)	11 (36.6%)	17 (56.6%)	37 (41.1%)
> 50	4 (13.3%)	10 (33.3%)	1 (3.3%)	15 (16.6%)
Total	30	30	30	90

Table-1: Age wise distribution of study subjects

Parity	TAH	VH	LAVH	Total
Nulliparous	0	1	0	1
Para 1	4	2	1	7
Para 2	8	3	4	15
Para 3	7	4	9	20
Para 4 & above	11	20	16	47
Total	30	30	30	90

Table-2: Parity wise distribution of study subjects

Chief complaints	Number	%
Abnormal menstrual flow	52	57.7
Pain lower abdomen	14	15.5
White discharge	4	4.4
Dysmenorrhoeal	5	5.5
Urinary disturbances associated with prolapsed	5	5.5
Mass per vaginum	14	15.5
Post menopausal bleeding	3	3.3
Mass per abdomen	2	2.2

Table-3: Symptom wise distribution of study subjects

Indication	TAH	VH	LAVH	Total
Fibroid uterus	18	4	16	38
Dysfunctional uterine bleeding (DUB)	2	4	9	15
UV prolapsed with cystocele	0	19	1	20
Chronic cervicitis	1	0	0	1
Adenomyosis	3	0	1	4
Ovarian cyst	2	0	1	3
Post menopausal bleeding	2	2	0	4
Archileiduralatypia	1	1	2	4
Pelvic inflammatory disease	1	0	0	1

Table-4: Distribution of study subjects according to indications for hysterectomy

performed in para 4 and above which is about 52.2% and in that maximum underwent VH. Only one case of VH was recorded in nullipara.

Chi square = 0.52, df = 2, $p < 0.76$ (Not significant)

Maximum number of women had complaints of menstrual disturbances (57.7%) followed by mass per vaginum (15.5%). Few had pain lower abdomen, mass per vaginum with urinary disturbances and mass per abdomen and white discharge and post menopausal bleeding.

Of the 90 cases who underwent hysterectomies, maximum i.e. 42.2% were with fibroid uterus and 22.2% were with UV prolapsed and the third common indication was DUB.

Among fibroid uterus cases, maximum (60%) of them underwent TAH, 53% LAVH and among prolapsed uterus most of them underwent VH 63%. Among cases with DUB, most of them underwent LAVH.

DISCUSSION

In this study emphasis was laid on the study of gynecological profile of 90 randomly selected cases.

We found that maximum number of hysterectomies were performed in the age group of 41-50 years (41.1%) and least in the age group of 21-30 years (3.3%). Similar results were observed by Shawarby et al¹ who reported 79% of hysterectomies in 31-40 years of age group and 45% in 41-50 years of age. In a study by Amirika in² similar results were reported with 73% of hysterectomies in the age group of 31-50 years. In a study done by Bharatnur S et al³, majority of patients were in the age group of 40-49 years (54%).

In the present study, maximum number of hysterectomies were performed in para 4 and above (52.2%) and only one was in nulliparous woman (1.1%). Majority of para 4 and above women underwent VH. Majority of para 3 underwent LAVH. VH was preferred in highly parous women, because the perineum was lax and VH was easier to perform in these women, but nulliparity is no way a contraindication to VH. Shawarby et al¹ reported high incidence of hysterectomies in parous women (75.5%) whereas in nulliparous it was only 23.7%. Edwards et al⁴ reported high incidence of (90%) hysterectomy in parous women and only 9.7% in nullipara. Bharatnur S et al³ shown similar results as 58% of para 2 to para 4 underwent hysterectomies and least incidence in nulliparous i.e. 3%. Seth et al⁵ found that 93% of patients were para 2 and above.

The commonest symptom in the present study was abnormal menstrual flow i.e. 57.7%. Shawarby et al¹, Persson et al⁶, Barlow J⁷, Garry et al⁸ have also reported that abnormal menstrual flow was the commonest symptom as 41.1%, 43.2%, 35.7%, 57.7%, 53.1%, and 51% respectively.

The next common symptom in the present study was mass per vaginum in 15.5% of cases. Pain abdomen was seen in 15.5%. Similar incidence was reported by Shawarby et al¹ with 7.1% complaining of pain abdomen. Barlow J et al⁷ and Garry et al⁸ also reported it to be 16%.

Dysmenorrhea was seen in 5.5% of cases in the present study. In the present study, 42.2% had fibroid uterus. Similar result of 47% was reported by Barlow J et al⁷ in 2005.

CONCLUSION

Maximum incidence of hysterectomies was found in the age group of 41-50 years. Maximum number of hysterectomies were performed in para 4 and above. Maximum number of women had complaints of menstrual disturbances. Maximum i.e. 42.2% were with fibroid uterus.

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