



REFINING THE DECISION FOR HYSTERECTOMY CASES REFERRED TO DEPARTMENT OF OBGY TERTIARY LEVEL CARE CENTRE

Dr. Shamrao Ramji Wakode, Dr. Neha Vijay Agrawal* and Dr Roshni Vinod Laddha

Department of Obstetrics and Gynaecology, Dr.S.C.G.M.C; Vishnupuri, Nanded-431606, (MH), India.

***Corresponding Author: Dr. Neha Vijay Agrawal**

Department of Obstetrics and Gynaecology, Dr.S.C.G.M.C; Vishnupuri, Nanded-431606, (MH), India.

Article Received on 30/03/2023

Article Revised on 20/04/2023

Article Accepted on 10/05/2023

ABSTRACT

Background: The most commonest Gynaecological operation performed throughout the world is hysterectomy. Proper evaluation of cases and refining the decision for hysterectomy is required to prevent complications. Aim: To refine the decision about the need of hysterectomy and route of hysterectomy. **Study Design:** cross sectional study. **Methodology:** Cases were evaluated as regards to age & parity, symptoms & signs, indications for hysterectomy, surgical fitness, non-invasive & minimally invasive modalities of investigation & percentage of avoiding the hysterectomies. **Results:** 22 (36.67%) cases out of 60 required operative treatment and majority i.e. 38 (63.33%) could conserve their uterus by using various conservative management techniques, this would have definitely kept these women free of surgical menopausal symptoms which can be troublesome for these patients

KEYWORDS: Hysterectomy, Vaginal route, abdominal, laparoscopic hysterectomy, refining criteria.

INTRODUCTION

The most commonest Gynaecological operation performed throughout the world is hysterectomy may be by various routes that is abdominal, vaginal & laparoscopic. Text book mentions some definitive indications for removal of uterus especially neoplastic lesions of uterus, carcinoma ovary in its early stages as well as benign conditions causing heavy PV bleeding and intractable pelvic pain. But in overall practice the practitioners do not stick to these indications for removal of uterus but indications like white discharge per vaginum, patient demanding hysterectomy or pain in abdomen simply may be due to previous caesarean or tubal ligation, post surgical adhesions; which may not be justifiable. Again the age of patient is also important for selecting candidates for hysterectomy which is not followed meticulously and early age hysterectomies were done, where females suffered surgical menopausal symptoms & troublesome life span of about 30 – 35 years following hysterectomy.

So attempt was done in this study by properly evaluating the basic cause of patients disease and then refine the indication for hysterectomy in referred cases by private practitioners and the junior consultants.

AIMS AND OBJECTIVES

To evaluate

- 1) Indications for hysterectomy
- 2) Minimum & before 35 years hysterectomies.
- 3) To refine the decision about the need of hysterectomy and route of hysterectomy

- 4) The percentage of hysterectomies that can be avoided.
- 5) The complications for hysterectomies.

MATERIALS AND METHODS

This is a facility based cross sectional study conducted in Department of OBGY at Dr.Shankarrao Chavhan Government Medical College, Nanded (Maharashtra), a tertiary level care hospital cases attending Gynaecology OPD who were advised hysterectomy by referring gynaecologist from December 2019 to 2022.

The Protocol of this study was approved by the Institutional Ethical Committee.

Written informed consent was taken from all study subjects before collection of data.

Inclusion Criteria

All cases who were advised hysterectomy by referring gynaecologist.

Exclusion Criteria

Patients who were not willing to participate.

All cases were evaluated as regards to age & parity, symptoms & signs, indications for hysterectomy, surgical fitness, non-invasive & minimally invasive modalities of investigation & percentage of avoiding the hysterectomies.

Cases were evaluated thoroughly by taking detail history, through clinical examinations and confirmed the diagnosis by necessary non-invasive or minimally

invasive investigation modality. This was useful to refine the indication for hysterectomy and possibly avoidance of hysterectomy in that case.

OBSERVATIONS AND RESULTS

Table I: Distribution of cases according to sociodemographic criteria.

Age group	No. of Cases	Percentage
31 – 45	31	51.67
46 -60	20	33.33
61 – 75	09	15
Education		
Illiterate	17	28.33
Primary	33	55.00
Secondary	10	16.67
Residence		
Urban	18	30
Rural	42	70
Parity		
Nullipara	02	03.33
Primipara	04	06.67
Multipara	54	90.00

Table II: According to Presenting Symptoms.

Presenting Symptoms	No. of Cases	Percentage
Menorrhagia	20	13.34
Dysmenorrhea	05	08.33
White Discharge PV	02	03.33
Chronic Pelvic Pain	14	23.33
Pain in Abdomen	08	13.33
Uterovaginal Descent	17	28.33

Table- III: Association of type of management and indications for hysterectomy.

Indication	Type of management				Total	P Value
	Operative		Conservative			
	No.	%	No.	%		
Uterine malignancy	03	13.64	00	00	03	0.02
AUB	04	18.18	07	18.42	11	0.98
Leiomyoma	05	22.73	13	34.21	18	0.34
Uterine prolapse	01	04.55	10	26.32	11	0.03
Endometrial Polyp	02	09.09	05	13.16	07	0.63
Adenomyosis	02	09.09	02	05.26	04	0.56
Endometriosis	05	22.73	01	02.63	06	0.01
Total	22	100	38	100	60	

Table IV: Type of management in case of conservatively managed patients.

Type of management	Frequency (no.)	Percentage (%)
Dilatation & curettage	04	10.53
D & C with polypectomy	01	02.63
Laparoscopic adhesiolysis	01	02.63
Laparoscopic cystectomy	01	02.63
laparoscopic cystectomy with adhesiolysis	01	02.63
Laparoscopic salpingectomy	01	02.63
Myomectomy	13	34.21
Polypectomy	04	10.53
Ring pessary	02	05.26
Sling Surgery	10	26.32
Total	38	100

Table V: Distribution of study participants according to indications & type of hysterectomy.

Indications	Type of hysterectomy (n=22)		
	TAH No. (%)	VH No. (%)	TLH No. (%)
Fibroid uterus with 18 weeks size	02 (33.33)	00 (00)	00 (00)
Malignancy	03 (50)	00 (00)	00 (00)
Fibroid uterus with previous 2 LSCS	01 (16.67)	00 (00)	00 (00)
3 rd degree UV prolapsed	00 (00)	08 (61.54)	00 (00)
Adenomyosis	00 (00)	03 (23.08)	00 (00)
Fibroid uterus <12 weeks size	00 (00)	02 (15.38)	00 (00)
Malignancy	00 (00)	00 (00)	01 (33.33)
Fibroid uterus with 14 weeks size	00 (00)	00 (00)	02 (66.67)
Total	06	13	03

Table VI: Surgical details of the study participants.

Surgical details	Types of hysterectomy			P value
	Abdominal (n=09)	Vaginal (n=22)	Laparoscopic (n=07)	
Duration of surgery (Mean \pm S.D.) (min)	71.9 \pm 12	54.9 \pm 7.5	140 \pm 27.4	<0.001
Estimated blood loss during surgery (Mean \pm S.D.) ml	357.3 \pm 63.8	120.8 \pm 20.9	78.5 \pm 12.4	<0.001

Table VII: Association of complications of hysterectomies with types of hysterectomy.

Complication	Types of hysterectomy			Total	P Value
	Abdominal (n=06)	Vaginal (n=13)	Laparoscopic (n=03)		
	Frequency (%)	Frequency (%)	Frequency (%)		
Post op bleeding	01 (16.67)	01 (7.69)	00 (00)	02	0.66
Injury to the bladder	00 (00)	00 (00)	01 (33.33)	01	0.06
Ureteric injury	00 (00)	00 (00)	01 (33.33)	01	0.06
Wound infection	02 (33.33)	00 (00)	00 (00)	02	0.04
Urinary infection	01 (16.67)	01 (7.69)	00 (00)	02	0.66

Table VIII: Distribution of study participants according to estimated number of hysterectomies avoided.

Estimated no. of hysterectomies avoided	Frequency (no.)	Percentage (%)
No. of cases referred for hysterectomy	60	100
No. of hysterectomies that could be avoided	38	63.33
Actual no. of cases operated after refining the decision	22	36.67

DISCUSSION

In India, prevalence of hysterectomy is 3.2% at national level with wide variation at the state level.^[1] Media reports highlighted that Maharashtra's draught prone district Beed hit with high rate of hysterectomies among women especially those who migrate to cut sugarcane. Due to early marriage, repetitive child birth and no menstrual hygiene they want to end the gynaec problem for once and all in the form of hysterectomy. Many contractors are reluctant to hire women who had menstrual irregularities causing weakness and so not able to work with full capacity. So these contractors are referring and/or personally taking these women to private gynaecologists. Many of the hysterectomies are performed for benign indications, some of which are necessary. Some are for non fatal but severe conditions but many of these are unnecessary. So present study

included 60 patients referred for hysterectomy, refined the decision for necessity of hysterectomy in the light of clinical evidence, important findings of which are discussed below.

Poor women due to financial constraints and priority of survival of them and their families cannot object for this surgery. Practitioners involved in malpractice providing some incentives in the form of money to referring contractors. So without proper evaluation of the case by scientific protocol hysterectomies are performed whether they are needed or not even in symptoms like bleeding pv, pain in abdomen, white pv discharge etc and may be at early stage.

In the present study, majority (51.67%) of the cases were from the age group of 31-45 years. Mean age of the

patients was 46.5 ± 10.5 years. Almost 89% of the cases were having low level of education. In our study 70% of the study participants were from rural areas. Majority (90%) of the patients were multi gravid having 2 or more children. These findings are in line with S Desai *et al.*^[2], Halli *et al.*^[3] who reported that high prevalence in 45-49 years age (13.8%) group followed by 30-44 years age (7.7%) group. Prusty *et al.*^[4] noted that as the age & parity advances, odds for hysterectomy also increase. Similar findings were reported by Shekhar *et al.*^[5] in their study i.e. more prevalence in rural areas, low education and linear trend between age, parity and the risk of hysterectomy. TV programme done by actor Amir Khan in Satyamave Jayate also showed the evidence of removal of uterus in women of reproductive age group of 24-40 years. Around 200-300 women were asked to raise hand if they had intact uterus, of which only 7-8 raised hands, rest had no uterus. So hysterectomies were done at early age with minor symptoms.

In our study, Common indications for hysterectomy were Leiomyoma (30%), Uterine prolapse (18.33%), DUB (18.33%), Endometrial polyp (11.67%), Endometriosis (10%), Adenomyosis (6%) & Uterine malignancy (5%). This finding is consistent with Radha K *et al.*^[6], Katarzyna Romanek-Piva^[7], S Desai^[2] *et al.* & Shekhar K *et al.*^[5] According to Kim H *et al.*^[8] three major indications for hysterectomy were uterine leiomyoma, pelvic organ prolapse, and adenomyosis.

As well as the insurance schemes covering surgical procedures (like Rajiv Gandhi Arogya Yojana, MJPAY) has increases the rates of hysterectomy as patient has no financial botheration due to the schemes available and

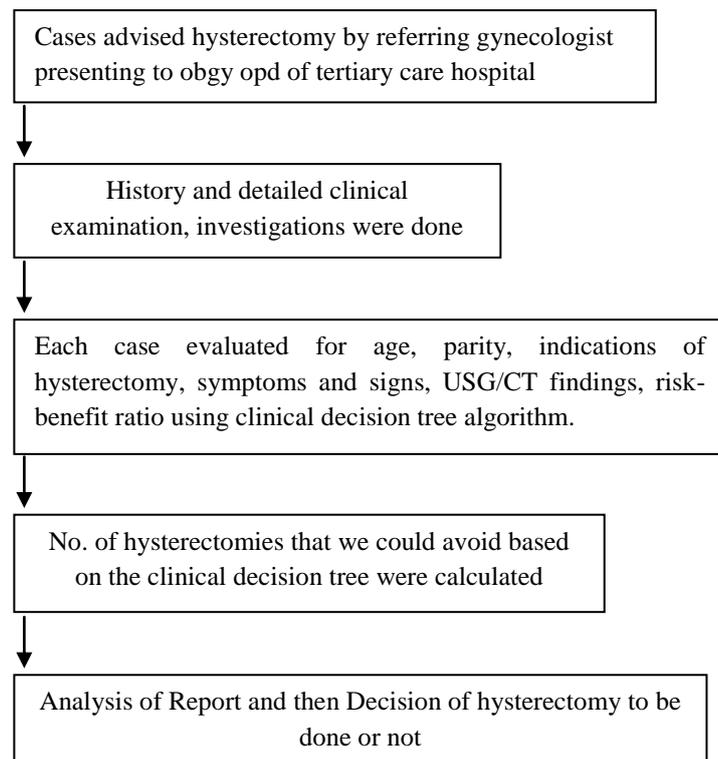
practitioners with the temptation of earning more money doing major surgery of hysterectomy so frequently even without full evaluation.

Honestly, practicing for 30 years in this field of gynaecology is of opinion that any gynaec case with symptoms like bleeding pv, white discharge pv, chronic pelvic pain should be evaluated as per scientific protocol, i.e. by making the clinical diagnosis and confirmation by ultrasonography, CT scan, laparoscopy and histopathological examination of the tissue like cervix and endometrium biopsy and then only decide whether to conserve uterus or not.

As it is observed by referring letters, prescriptions and notes written by junior consultants on OPD case paper mentioning only few symptoms like pv bleeding, pv discharge, pain in abdomen and straightaway advising hysterectomy by convincing verbally to patients or by documenting it.

Because of low level of education of rural women as well as relatives, they are accepting practitioners opinion regarding removal of uterus. As a medical practitioner it is their duty to follow scientific protocol of evaluation of the patient to know the route cause of problem and considering severity of symptoms, nature of lesion by histopathology, age of patient and future problem of postsurgical menopausal symptoms and then decide whether to conserve uterus or take it out.

By evaluating the study group. by following flowchart and investigations and finally coming to the conclusion



In present study of 60 cases, the commonest indication for hysterectomy was symptomatic leiomyoma (30%), AUB (18.33%), uterine prolapse (18.33%), endometrial polyp, adenomyosis, endometriosis (28.34%) and 5% for uterine malignancy.

These indications were refined in all cases by evaluating above mentioned flow chart.

After complete evaluation for refining the indication for hysterectomy it was found 22(36.67%) cases out of 60 required operative treatment and majority i.e. 38(63.33%) could conserve their uterus by using various conservative management techniques, this would have definitely kept these women free of surgical menopausal symptoms which can be troublesome for these patients.

If you review the study data as per indication for hysterectomy and conservative VS operative management it is found that cases having uterine malignancy 3 (13.6%), AUB 4 (18.11%), leiomyoma 05 (22.7%); uterine prolapse 1 (4.5%). Endometrial polyp 2 (9.09%), adenomyosis 2(9.9%) and endometriosis 5 (22.7%) required operative treatment in the form of hysterectomy as patients had severe symptoms like menorrhagia not responded to conservative management. Large size myomas, multiple myoma, intractable dysmenorrhea or chronic pelvic pain and when patient got frustration and exhausted of medical line of management are reasons for operative treatment.

However majority 38 cases were treated with conservative approach. These patients of perimenopausal AUB just simply due to hormonal imbalance having endometrial hyperplasia or irregularly shedded endometrium, small polyp, mild adenomyotic changes responded to proper counselling, correction of anaemia & minimally invasive approach like D and C and hormones. As per indications young cases of 30 – 35 years age of uterine prolapse after assessing their cervical status by pap smear were treated by sling surgery; leiomyoma by myomectomy, functional & hormone secreting simple ovarian cysts by laparoscopic cystectomy, D and C and polypectomy and by these means it was possible to conserve the uterus and in their follow up for 6 months patient got cured symptom wise and mentally also. Consistent results noted by English *et al.*^[9] who reported that conservative approaches were oophorectomy, excision of endometriosis, lysis of adhesions etc.

Those who needs definitely hysterectomy the route of hysterectomy decision depends on expertise and skill of surgeon, size of uterus, associated adhesion and sometimes choice of patient after counselling.

In present study it was possible to do non descent vaginal hysterectomy for benign uterine conditions and vaginal hystrectomy with repair for prolapse in 13 (59.09%). Large size fibroids, multiple fibroids and chronicle

pelvic pain due to fixed uterus due to endometriosis and genital TB cases, needed abdominal hysterectomy 6 (27.22.1). As we had good laparoscopic setup, TLH/LAVH was done in 3 (13.64)% cases.

Route of hysterectomy if chosen minimally invasive, may reduce operative time, hospital stay and postoperative pain and complications, but it depends on surgeon's skill.

Overall during this procedure of hysterectomy very few postoperative complications were present like UTI, wound infection and in one case bladder injury. This was nill in laparoscopic total hysterectomies as vision is clear and one case each of abdominal & NDVH.

CONCLUSIONS

So overall study concludes-

Any Gynaec case with symptoms, you must treat as follows –

- Detailed history & clinical examination
- Documentation in case record
- Do necessary investigation to clear your doubt of diagnosis and if needed surgical treatment to assess general health of patient for surgical fitness.
- As per age group below 40 years treat by conservative approach like counselling of patient and relatives. Minimally invasive methods like D and C, polypectomy, myomectomy, sling surgery, hormonal treatment as per indication.
- To prevent troublesome post surgical menopausal symptoms for 30 – 35 years avoid hysterectomy.

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