

An Observational Study to Determine Quality of Life in Women after Peripartum Hysterectomy at SMS Medical College, Jaipur

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Abstract

Background: Peripartum hysterectomy is a life-saving surgical procedure performed to control severe obstetric hemorrhage when conservative management fails. Although advances in obstetric care have improved maternal survival, limited evidence is available regarding the postoperative health-related quality of life (HRQoL) of women following this major obstetric intervention. This study aimed to evaluate the quality of life of women after peripartum hysterectomy using the Short Form-36 (SF-36) questionnaire and to describe their demographic, obstetric, and clinical characteristics.

Methods: A hospital-based prospective observational study was conducted in the Department of Obstetrics and Gynaecology, SMS Medical College, Jaipur, India. Thirty women who underwent peripartum hysterectomy were consecutively enrolled. Demographic, obstetric, and clinical data were collected using a structured case proforma. HRQoL was assessed using the SF-36 questionnaire through face-to-face interviews at baseline and three months after surgery. Continuous variables were expressed as mean $\pm$ standard deviation, categorical variables as frequencies and percentages, and statistical significance was set at $p < 0.05$.

Results: The mean age of participants was 31.43 ± 4.82 years, and most women were multigravida (96.7%), had undergone cesarean delivery (86.7%), and had a previous cesarean section (73.3%). Morbidly adherent placenta (63.3%) was the leading indication for peripartum hysterectomy. Excessive blood loss was the most common intraoperative complication, 90% of women required intensive care unit admission, and the mean blood transfusion requirement was 3.67 ± 1.93 units. Compared with baseline, significant deterioration was observed in all SF-36 domains at three months, including physical functioning, role limitation, bodily pain, social functioning, mental health, emotional wellbeing, fatigue, and general health ($p < 0.001$ for all).

Conclusion: Peripartum hysterectomy is associated with significant impairment in health-related quality of life despite successful maternal survival. Comprehensive postoperative care incorporating physical rehabilitation, psychological counselling, and long-term follow-up should complement routine obstetric management to optimize recovery and improve quality of life among survivors.

Keywords: Peripartum hysterectomy; Quality of life; SF-36; postpartum hemorrhage; Placenta accreta spectrum.

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Introduction

Peripartum hysterectomy (PPHyst) is one of the most challenging and life-saving procedures in modern obstetrics. It is defined as the surgical removal of the uterus at the time of delivery or during the immediate postpartum period, usually performed to control life-threatening obstetric hemorrhage when conservative medical and surgical measures fail. Although relatively uncommon, peripartum hysterectomy remains an important indicator of severe maternal morbidity and a

recognized maternal near-miss event because it is associated with massive hemorrhage, prolonged hospitalization, intensive care admission, and substantial maternal morbidity.[1–3] Advances in anesthesia, blood transfusion services, critical care, and multidisciplinary obstetric management have significantly improved maternal survival over recent decades; however, women surviving peripartum hysterectomy often experience considerable long-term physical, psychological, and social

consequences.[4,5] The epidemiology of peripartum hysterectomy has changed considerably over the past two decades. Earlier, uterine rupture and uncontrolled uterine atony were the predominant indications, particularly in low-resource settings. However, the increasing global rate of cesarean section has resulted in a parallel rise in placenta accreta spectrum (PAS) disorders, making abnormal placentation the leading indication for obstetric hysterectomy in many tertiary care centers.[6–9] Previous cesarean delivery, especially in the presence of placenta previa, is now considered the strongest risk factor for PAS and subsequent peripartum hysterectomy.[7,9] Despite improvements in antenatal diagnosis and planned multidisciplinary management, severe postpartum hemorrhage continues to be one of the leading causes of maternal mortality worldwide, particularly in low- and middle-income countries, where delayed referral, inadequate blood transfusion services, and limited access to comprehensive emergency obstetric care further increase maternal risk.[2,10]

Peripartum hysterectomy is frequently associated with substantial perioperative morbidity. Women undergoing this emergency procedure commonly require massive blood transfusion, prolonged intensive care unit (ICU) admission, and multidisciplinary management. Surgical complications such as bladder injury, ureteric injury, disseminated intravascular coagulation, sepsis, wound infection, and acute kidney injury are frequently reported, particularly in women with placenta accreta spectrum disorders.[8,11,12] Although these complications have been extensively described, contemporary obstetric care increasingly recognizes that successful maternal management should not be evaluated solely by survival but also by the quality of recovery after severe obstetric events.

Health-related quality of life (HRQoL) has therefore emerged as an important outcome among survivors of severe maternal morbidity. The World Health Organization defines quality of life as an individual's perception of their position in life within the context of their culture, value systems, expectations, and personal goals.[13]

Women who undergo peripartum hysterectomy experience an abrupt and irreversible loss of fertility following a traumatic childbirth event, often accompanied by fear of maternal death, prolonged hospitalization, and neonatal complications. Consequently, many women report persistent fatigue, chronic pain, impaired physical functioning, anxiety, depression, altered body image, sexual dysfunction, reduced self-esteem, and social isolation long after surgical recovery.[5,14–17] These problems may be particularly pronounced in countries such as India, where fertility and

motherhood carry substantial cultural and social significance.

The Short Form-36 (SF-36) questionnaire is one of the most widely validated generic instruments for assessing health-related quality of life across multiple domains, including physical functioning, role limitation, bodily pain, vitality, social functioning, emotional wellbeing, mental health, and general health perception.[18] Previous studies have demonstrated significantly lower SF-36 scores among women following peripartum hysterectomy compared with healthy postpartum women, with persistent impairment in physical, emotional, and social domains extending months or even years after surgery.[15,16,19] Qualitative studies have further shown that survivors frequently experience grief related to loss of fertility, emotional distress, difficulties in marital relationships, and reduced participation in family and community activities.[14,17] These findings highlight the need for long-term multidisciplinary follow-up, including psychological counselling, physical rehabilitation, and social support, in addition to routine obstetric care.

Despite growing recognition of these long-term consequences, most published studies have focused primarily on the incidence, indications, surgical techniques, and immediate maternal outcomes of peripartum hysterectomy.[6–9,11] Evidence regarding postoperative quality of life remains limited, particularly from low- and middle-income countries where healthcare resources, cultural perceptions, and social support systems differ considerably from high-income settings.[15,19]

In India, only a few studies have prospectively evaluated health-related quality of life after peripartum hysterectomy using standardized instruments such as the SF-36 questionnaire, and information regarding short-term postoperative recovery remains scarce. Therefore, there is a need for additional prospective studies evaluating the multidimensional impact of peripartum hysterectomy on women's lives.

The present study was undertaken to evaluate the quality of life of women following peripartum hysterectomy using the SF-36 questionnaire at a tertiary care teaching hospital. In addition, the study aimed to assess the demographic and obstetric profile of these women, determine the indications and complications associated with peripartum hysterectomy, and evaluate changes in physical, psychological, and social wellbeing during the first three months following surgery.

Methods

Study design and setting: This hospital-based prospective observational study was conducted in the Department of Obstetrics and Gynaecology,

SMS Medical College and Attached Group of Hospitals, Jaipur, and Rajasthan, India. The study was conducted over a period of one year following approval of the research protocol, with an additional two months allocated for data compilation and statistical analysis. The study population comprised women admitted to the labour room who underwent peripartum hysterectomy during the study period. Ethical approval was obtained from the Institutional Research Review Board and Institutional Ethics Committee before commencement of the study. Written informed consent was obtained from all participants prior to enrolment, and confidentiality and anonymity were maintained throughout the study. The study was conducted in accordance with the ethical principles of the Declaration of Helsinki.

Participants: Women who underwent peripartum hysterectomy during the study period were screened for eligibility. Participants were included if they had undergone peripartum hysterectomy, were able to understand the study procedures, were willing to participate, and provided written informed consent. Women participating in any other research study were also excluded from enrolment. Women with a documented history of psychiatric disorders were excluded to minimize the influence of pre-existing psychological illness on quality-of-life assessment.

The required sample size was estimated to be 30 women based on a previous study that reported a minimum detectable difference of 10.12 in the physical functioning score with a standard deviation of 9.4 [20]. The calculation was performed assuming 80% study power and a two-sided alpha error of 5%. All eligible women meeting the selection criteria during the study period were consecutively enrolled until the required sample size was achieved.

Data collection and study procedure: Baseline demographic characteristics, including age, residence, educational status, occupation, religion, and socioeconomic status, were recorded. Detailed obstetric information, including gravidity, mode of delivery, previous cesarean section, indication for peripartum hysterectomy, operative findings, intraoperative complications, postoperative complications, intensive care unit (ICU) admission, and blood transfusion requirement, was documented using a predesigned case record proforma.

Health-related quality of life (HRQoL) was assessed using the 36-Item Short Form Health Survey (SF-36) administered through face-to-face interviews.

The questionnaire evaluated eight domains of quality of life: physical functioning, role limitation due to physical health, bodily pain, social functioning, and mental health, role limitation due to emotional problems, fatigue (vitality), and general health perception. Baseline quality-of-life assessment was performed, and participants were followed for three months after peripartum hysterectomy. At the three-month follow-up, the SF-36 questionnaire was re-administered to assess changes in physical, psychological, and social well-being.

Outcome measures: The primary outcome was the change in health-related quality of life between baseline and the three-month follow-up as measured by the eight domains of the SF-36 questionnaire. Secondary outcomes included the demographic and obstetric characteristics of the study population, indications for peripartum hysterectomy, intraoperative and postoperative complications, ICU admission, and blood transfusion requirement.

Statistical analysis: Data were entered into Microsoft Excel and analyzed using the Statistical Package for the Social Sciences (SPSS) software version 25.0 (IBM Corp., Armonk, NY, USA). Continuous variables were expressed as mean $\pm$ standard deviation (SD) or median (interquartile range), depending on data distribution, whereas categorical variables were presented as frequencies and percentages. The normality of continuous variables was assessed using the Shapiro–Wilk test. Comparisons between baseline and three-month follow-up SF-36 scores were performed using the paired-samples t-test for normally distributed variables. A two-tailed p-value of <0.05 was considered statistically significant.

Results

A total of 30 women who underwent peripartum hysterectomy were included in the study. The majority of women were aged 26–30 years (56.7%), resided in urban areas (53.3%), and were Hindu (83.3%). Nearly half (43.3%) were graduates or above, while 70.0% were homemakers. Most participants belonged to the middle socioeconomic class (53.3%), were multigravida (96.7%), delivered by caesarean section (86.7%), and had a history of previous caesarean section (73.3%) (Table 1).

Table 1: Sociodemographic and obstetric characteristics of women undergoing peripartum hysterectomy (n=30)

Variable	Category	n (%)
Age (years)	21–25	8 (26.7)
	26–30	17 (56.7)
	>30	5 (16.7)
Residence	Rural	14 (46.7)
	Urban	16 (53.3)
Religion	Hindu	25 (83.3)
	Muslim	5 (16.7)
Education	<8th standard	9 (30.0)
	8th–12th standard	8 (26.7)
	Graduate and above	13 (43.3)
Occupation	Homemaker	21 (70.0)
	Labourer	4 (13.3)
	Professional	5 (16.7)
Socioeconomic status	Lower	14 (46.7)
	Middle	16 (53.3)
Gravidity	Primigravida	1 (3.3)
	Multigravida	29 (96.7)
Mode of delivery	Caesarean section	26 (86.7)
	Vaginal delivery	4 (13.3)
Previous caesarean section	Yes	22 (73.3)
	No	8 (26.7)

Morbidly adherent placenta was the leading indication for peripartum hysterectomy (63.3%), followed by uterine atony (26.7%). Excessive intraoperative blood loss occurred in 56.7% of women, whereas urinary tract infection (30.0%) and

postpartum pyrexia (23.3%) were the most common postoperative complications. Overall, 90.0% of women required ICU admission, and the mean blood transfusion requirement was 3.67 ± 1.93 units (Table 2).

Table 2: Clinical characteristics and perioperative outcomes of women undergoing peripartum hysterectomy (n = 30)

Variable	Category	n (%) / Mean $\pm$ SD
Indication	Morbidly adherent placenta	19 (63.3)
	Uterine atony	8 (26.7)
	Uterine rupture	3 (10.0)
Intraoperative complications	Excessive blood loss	17 (56.7)
	Bladder injury	2 (6.7)
	None	11 (36.6)
Postoperative complications	None	9 (30.0)
	Urinary tract infection	9 (30.0)
	Postpartum pyrexia	7 (23.3)
	Wound infection	4 (13.3)
	Sepsis	1 (3.3)
ICU admission	Yes	27 (90.0)
	No	3 (10.0)
Blood transfusion (units)	Mean $\pm$ SD	3.67 ± 1.93
	Range	1–9

Quality-of-life assessment demonstrated significant deterioration across almost all SF-36 domains three months after peripartum hysterectomy (Table 3). Physical functioning, role limitation, bodily pain, social functioning, mental health, emotional

wellbeing, and general health scores were significantly lower at follow-up than at baseline (all $p < 0.001$). Conversely, fatigue scores increased significantly from 57.56 ± 7.74 to 77.46 ± 9.17 , indicating greater postoperative fatigue ($p < 0.001$).

Table 3: SF-36 quality-of-life scores at baseline and 3-month follow-up (n = 30)

Domain	Baseline Mean $\pm$ SD	3-month Mean $\pm$ SD	P value
Physical functioning	92.50 $\pm$ 5.78	68.86 $\pm$ 8.65	<0.001
Role limitation	90.00 $\pm$ 7.42	65.40 $\pm$ 9.11	<0.001
Bodily pain	87.66 $\pm$ 6.38	62.13 $\pm$ 9.45	<0.001
Social functioning	90.66 $\pm$ 5.43	80.90 $\pm$ 6.17	<0.001
Mental health	80.70 $\pm$ 4.52	62.06 $\pm$ 6.55	<0.001
Emotional wellbeing	90.00 $\pm$ 5.86	73.23 $\pm$ 8.76	<0.001
Fatigue*	57.56 $\pm$ 7.74	77.46 $\pm$ 9.17	<0.001
General health	81.90 $\pm$ 8.94	52.10 $\pm$ 10.45	<0.001

*Higher fatigue scores indicate greater fatigue.

Discussion

The present prospective observational study evaluated the health-related quality of life (HRQoL) of women following peripartum hysterectomy using the SF-36 questionnaire while documenting their demographic profile, obstetric characteristics, indications, and perioperative outcomes. The findings demonstrate that although peripartum hysterectomy remains a life-saving intervention for uncontrolled obstetric hemorrhage, it is associated with substantial impairment in physical, psychological, and social well-being during the early postoperative period. The study also reflects the changing epidemiology of peripartum hysterectomy, with previous cesarean section and morbidly adherent placenta emerging as the leading risk factors.

Most women were in their early thirties (mean age 31.43 ± 4.82 years), and almost all were multigravida, consistent with previous studies by Pathiraja and Jayawardane [20] and Ravi et al. [21]. Advancing maternal age has been consistently associated with placenta accreta spectrum (PAS), repeat cesarean delivery, severe postpartum hemorrhage, and increased risk of peripartum hysterectomy [5,11,22]. These findings highlight the importance of identifying older pregnant women as a high-risk group requiring careful antenatal surveillance.

Cesarean delivery was performed in 86.7% of women, and 73.3% had a previous cesarean section. Similar observations have been reported by Kalyankar et al. [23], Singh et al. [24], and Pathiraja and Jayawardane [20]. Previous cesarean section is recognized as the strongest independent risk factor for PAS disorders, with the risk increasing after each subsequent cesarean delivery [7–9]. Therefore, reducing unnecessary primary cesarean sections remains an important strategy to decrease future peripartum hysterectomy rates.

Morbidly adherent placenta was the commonest indication for hysterectomy (63.3%), followed by uterine atony and uterine rupture. This pattern agrees with recent studies showing that abnormal placentation has replaced uterine rupture as the leading indication for obstetric hysterectomy

[23,25]. Earlier reports from developing countries identified uterine rupture and atony as the major causes, reflecting differences in obstetric practices and cesarean section rates [5]. The increasing incidence of PAS emphasizes the need for early antenatal diagnosis, multidisciplinary planning, and delivery at tertiary care centers with experienced surgical teams and adequate blood bank support [7–9]. Perioperative morbidity remained considerable. Excessive blood loss was the most frequent intraoperative complication, urinary tract infection was the commonest postoperative complication, 90% of women required ICU admission, and the mean blood transfusion requirement was 3.67 ± 1.93 units. Similar findings have been reported by Bateman et al. [11], Shellhaas et al. [12], Pathiraja and Jayawardane [20], and van den Akker et al. [5]. These studies emphasize that standardized obstetric hemorrhage protocols, multidisciplinary care, and timely availability of blood products are essential for reducing maternal morbidity [26].

The findings also indicate that maternal survival alone should no longer be considered the sole measure of successful management. Although advances in obstetric care have reduced maternal mortality, survivors frequently experience persistent physical, psychological, and social limitations. The WHO maternal morbidity framework recognizes long-term quality of life as an important outcome following severe obstetric complications [19,27]. Consequently, HRQoL assessment provides valuable insight into the true burden of peripartum hysterectomy.

The SF-36 assessment demonstrated significant deterioration across all domains three months after surgery. Physical functioning, role limitation due to physical health, bodily pain, social functioning, mental health, emotional well-being, and general health scores declined significantly, while fatigue increased, indicating reduced vitality. These findings confirm that the impact of peripartum hysterectomy extends beyond physical recovery and affects multiple dimensions of women's lives, consistent with previous prospective studies and systematic reviews [20,21,28,29].

Physical functioning declined significantly, likely because of major abdominal surgery, severe hemorrhage, postoperative pain, anemia, and prolonged recovery. Similar reductions have been reported by Pathiraja and Jayawardane [20], Ravi et al. [21], and Grover et al. [28], with impairment persisting for years in some women. A systematic review by Jayawardane et al. [29] also identified reduced physical functioning as one of the most consistent long-term consequences. These findings support the need for structured rehabilitation, nutritional support, anemia correction, and physiotherapy.

Role limitation due to physical health also worsened significantly, indicating difficulty in resuming occupational, household, and family responsibilities. Similar impairments have been documented by Pathiraja and Jayawardane [20], Ravi et al. [21], Grover et al. [28], and Jayawardane et al. [29]. These observations suggest that postoperative care should focus on restoring functional independence in addition to surgical recovery. Persistent postoperative pain was reflected by significantly lower bodily pain scores. Ongoing pain may reduce mobility, disturb sleep, and impair daily activities. Comparable findings have been reported by Pathiraja and Jayawardane [20], Ravi et al. [21], Grover et al. [28], Keenan et al. [30], and Jayawardane et al. [29], highlighting the importance of effective pain management and continued rehabilitation after hospital discharge.

Social functioning also declined significantly. Prolonged recovery, altered body image, emotional distress, and permanent loss of fertility may adversely affect interpersonal relationships and community participation. Similar reductions have been reported by Pathiraja and Jayawardane [20], Ravi et al. [21], Grover et al. [28], and Jayawardane et al. [29]. De la Cruz et al. [14] additionally described impaired maternal bonding, communication difficulties, and delayed emotional recovery. These findings indicate that recovery requires both family support and psychosocial interventions.

Mental health and emotional well-being were significantly impaired. Women surviving emergency peripartum hysterectomy often experience anxiety, depression, grief, loss of fertility, reduced self-esteem, and concerns regarding future family life. Similar psychological consequences have been reported by Pathiraja and Jayawardane [20], Ravi et al. [21], Furuta et al. [17], and Jayawardane et al. [29]. These findings support routine psychological assessment and counseling as part of postoperative follow-up.

Fatigue increased significantly, while general health perception declined. Persistent fatigue is likely related to severe hemorrhage, anemia, major

surgery, prolonged hospitalization, and the demands of newborn care. Similar deterioration in vitality and general health has been reported by Pathiraja and Jayawardane [20], Ravi et al. [21], Grover et al. [28], and Jayawardane et al. [29]. These findings reflect the combined physical and psychological burden experienced during recovery.

The clinical implications of this study are significant. As survival following severe postpartum hemorrhage continues to improve, the focus of care should expand beyond maternal survival to include long-term physical rehabilitation, psychological support, and social reintegration. Women undergoing peripartum hysterectomy should receive multidisciplinary follow-up involving obstetricians, mental health professionals, physiotherapists, nutritionists, and social workers. Early identification of PAS, planned delivery in tertiary centers, standardized hemorrhage protocols, and comprehensive postoperative rehabilitation may improve both maternal outcomes and long-term quality of life.

The study has some limitations. It was conducted at a single tertiary care center with a relatively small sample size, limiting generalizability. Follow-up was restricted to three months, preventing assessment of long-term recovery, and HRQoL was measured using a self-reported questionnaire, introducing the possibility of response bias. Nevertheless, the prospective design, use of the validated SF-36 questionnaire, and complete follow-up provide valuable evidence regarding the multidimensional impact of peripartum hysterectomy on women's quality of life in the Indian setting.

Conclusion

Peripartum hysterectomy remains a life-saving intervention for the management of severe obstetric hemorrhage; however, its impact extends far beyond the immediate surgical outcome. The present study demonstrated that most women undergoing peripartum hysterectomy had previous cesarean delivery and morbidly adherent placenta, reflecting the changing epidemiology of this obstetric emergency.

Although maternal survival was achieved, women experienced significant deterioration in multiple domains of health-related quality of life, including physical functioning, role limitation, bodily pain, social functioning, mental health, emotional wellbeing, fatigue, and general health during the first three months after surgery. These findings underscore the need for comprehensive post-discharge care that integrates physical rehabilitation, psychological counselling, and social support in addition to routine obstetric follow-up. Early identification of women at high risk for placenta

accreta spectrum disorders, planned multidisciplinary management, and structured long-term follow-up may improve recovery and optimize quality of life among survivors of peripartum hysterectomy.

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