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Original Research Article

Observation of Morbidities in Post Hysterectomy Patients Attending Gynaecology Department, PMCH, Patna

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Abstract:

Introduction: Hysterectomy i.e, removal of uterus and cervix; is the commonest gynaecological surgery done for various reason mostly in peri-menopausal or menopausal women. Like other surgery, hysterectomy is a major surgical procedure and is not without morbidities.

Aims and Objectives: to study the various types of post hysterectomy morbidities, to assess the risk factors causing these morbidities, to formulate modalities to prevent various morbidities in women who underwent hysterectomy.

Materials and Method: It is an observational study which was conducted in a tertiary care centre, PMCH. 100 post hysterectomy patients who had various symptoms were asked to be a part of our study.

Results: Most common presenting symptoms were lower abdominal pain, low back ache, joint pain and discharge PV along with hormonal deficiency symptoms.

Conclusion: Hysterectomy does not come without its own set of post op complications. But most of these morbidities can be tackled with proper pre-op patient preparations along with post-op management, proper counselling & follow up.

Keywords: Hysterectomy, Morbidities, Prolapse, Fibroid.

Introduction

Hysterectomy is removal of uterus and cervix. It is the second commonest gynecological operation for women, after cesarean section. [1]

It comes with a long history of its own. Before 1940, 95% of all hysterectomies performed in United States were subtotal. [2] wherein, the cervix was left behind to minimise morbidities. [3] In 1930, Richardson MD performed first Total abdominal hysterectomy (TAH) in which the entire uterus and cervix were removed. [4] These operations underwent a constant refinement over the remainder of 19th century and by the mid 20th century had become established as a classic technique. Hysterectomy is a major surgery and can be done by abdominal, vaginal and laparoscopic route. [5] With medical advancements leading to improvements in operation technique, better anesthetic agents, broad spectrum antibiotics & availability of blood transfusion, hysterectomy has become safer. Yet, hysterectomy is also not free of any post-operative morbidities and we as clinicians commonly encounter various spectrum of complains post-operatively.

Aims and Objectives

1. To study the various types of post hysterectomy morbidities
2. To assess the risk factors causing these morbidities
3. To formulate modalities to prevent various morbidities in women who underwent hysterectomy.

Materials and Methods

Study Design: Hospital based prospective observational study

Study Place: GOPD of Department of Obstetrics and Gynecology, PMCH Patna

Study period: 1 year (January 2022 to December 2022)

Inclusion Criteria: Women who underwent hysterectomies for various reasons and consented for the study.

Exclusion Criteria: Women who came for follow up after hysterectomy but had no post operative morbidities.

Women who did not consent for study.

Data Collection: Written & informed consent was subsequently obtained from 100 cases during the period of January 2022 to December 2022.

A detailed questionnaire written in local language and information was collected. Women's age, parity, nutritional status, education status, presenting complains with duration, previous any specialized investigation done before hysterectomy, any treatment regarding previous problem and it's duration, indication, route and duration of hysterectomy, any history of blood transfusion, any associated comorbidities noted. Physical examination and all required investigations done and treated accordingly.

Results

During the study period 100 patients were taken for study. Majority of cases (58%) were in age group of 41 to 50 years followed by (32%) below 40 years of age. Most of them were Para 3 (31%) followed by Para 4 (29%). Para >6 were least i.e 5%.Regarding route of operation, operation done mostly by abdominal route i.e 85% and by vaginal route only 15%.

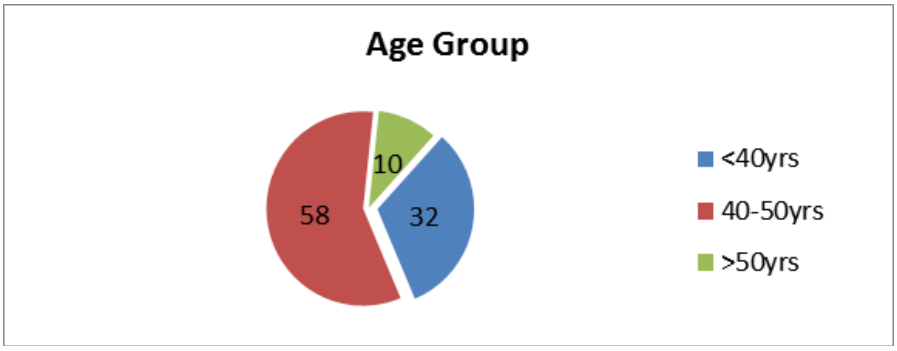


Diagram 1: Age groups

Graph 1: Parity

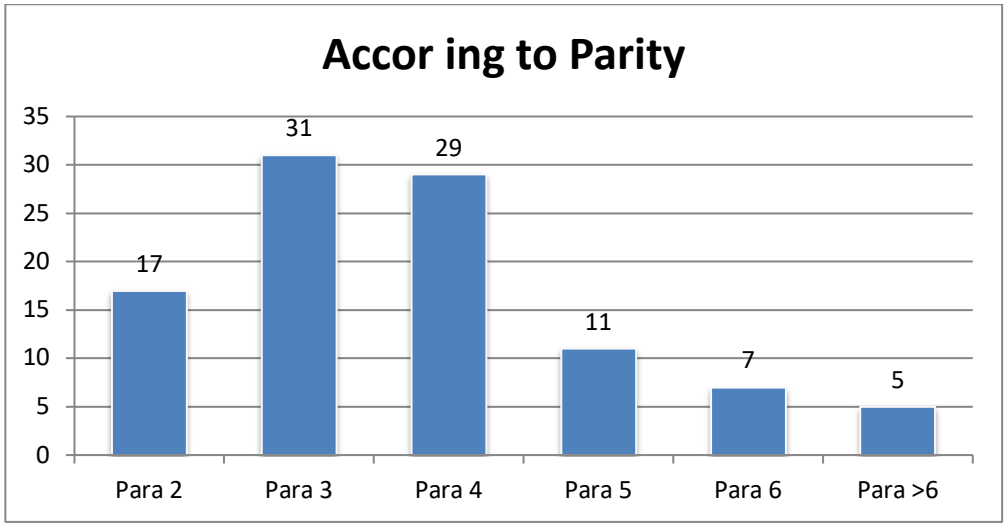
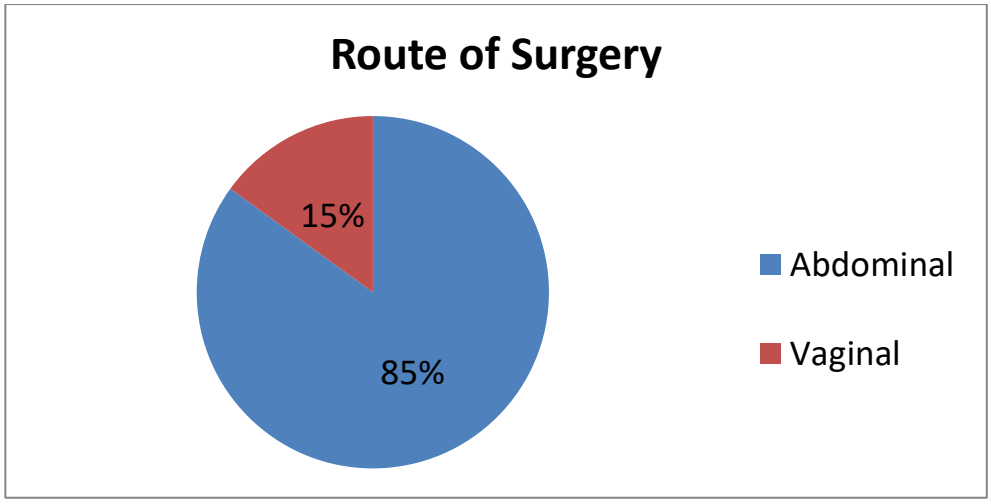


Diagram 2: Route of surgery



Regarding indication for hysterectomies, mostly were done for heavy and prolonged menstrual bleeding, for fibroid (n=21) and adenomyosis (n=11) followed by PID (n=17) and prolapse (n=15) & least number of cases done for CIN. CIN II were 3 in number whereas there was 1 case of CIN III.

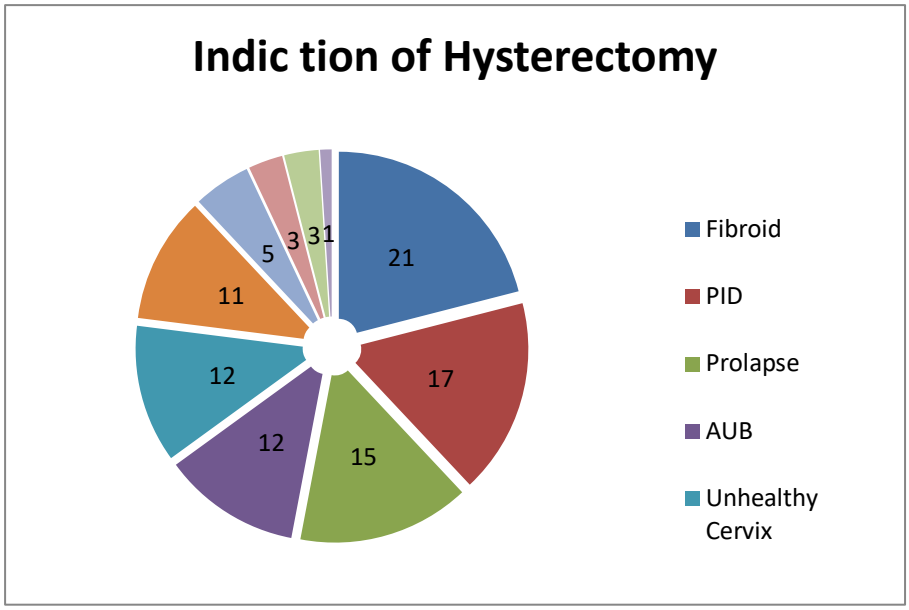


Diagram 3 : Indication of Hysterectomy

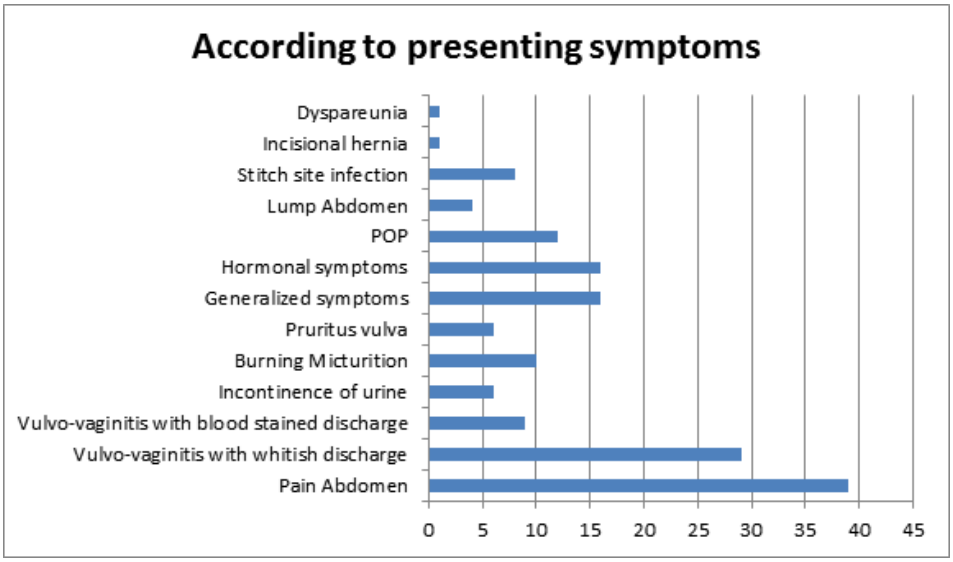
According to their presenting symptoms: Most of them came to GOPD for pain lower abdomen (n= 39), followed by urogenital symptoms like Vulvovaginitis with whitish/foul smelling discharge (n=29)and with blood stained discharge (n=9), incontinence of urine (n=6), burning micturtion with or without dysuria (n=10), pruritus vulva (n=6) and dyspareunia (n=1) came for advice.

Women came for follow up with general complaint like weakness, body ache, low back ache, dyspepsia, anorexia, bloating abdomen were 16 in number, women complaining for hot flushes and night sweats were 16 in number.

Women came with prolapse of pelvic organ (POP) following hysterectomy were 12 in number.

Women with lump abdomen following hysterectomy were 4 in number.

Few women also came with pain and discharge from stitch side (n=8) and one with incisional hernia .Most of patients had more than one symptoms.



Graph 2: Presenting Symptoms

Table 1 : Duration of presenting symptoms post hysterectomy.

Duration	<6 months	6m-2yrs	2-5yrs	5-10yrs	>10yrs
No. of cases	29	28	13	15	15

Discussion

As shown in our study, most of patients fall in the age group of 41 to 50 years (52%). The mean age of hysterectomy in present study was 42.59 yrs. Study was comparable to S M Taylor[6] and Tariq Miskry et al.[7] Hysterectomy done mostly in women of Para-3 (27%) and Para-4 (32%) which is comparable to those reported by Bharatnur et al [8]. The mean parity was found to be 3.77. Most of the patients underwent hysterectomy through abdominal route (85%) followed by vaginal route (15%) which is comparable to those reported by Bala et al in 2013. [9]

Our study indicated that mostly hysterectomy was done for benign reason, in which most common indication was fibroid > PID > prolapse >AUB. Similar results were evident in findings of Wright JD et al [10] and Pandey et al. [11] CIN II CIN III and unhealthy cervix all found in about 16% of cases. Commonly presented symptoms were generalized body pain, low backache, joint pain (indicating Osteopenia and Calcium deficiency) and cardiovascular symptoms like hot flushes, night sweats, depression, mood swings due to hormone deficiency were treated accordingly. Follow up cases also presented with general complain like anorexia, dyspepsia, weakness, peptic-ulcer syndrome and they were treated with symptomatic treatment and nutritional supplement. Vaginal vault prolapse (cystocele, rectocele and enterocele) were also found following TAH or VH. Similar results were reported by Husby KR et al [12]. Bleeding per vaginum or discharge PV was also evident in some patients, causes of which were ranging from foreign body like thread, granulation tissue, polyp to Ca vault. Bacterial vaginosis is also an important cause for discharge per vaginum. Itching at perineum and burning micturition was also evident.

Dribbling of urine and incontinence of urine were a rare complication and were evident in patient after operation. Few patients presented with lump abdomen or ovarian cyst of size ranging from 8 to10 weeks upto 32 weeks size serous cyst adenoma.

Some of them came to OPD with stitch site pain/ itching or, discharge for which treated accordingly. Incisional hernia found in one case, whereas Dyspareunia also found in one case. Patients came to OPD within 6 months post-surgery mostly for follow up with complains of anorexia, dyspepsia, stitch site infection, pain in lower abdomen, blood stained vaginal discharge and dribbling of urine.

Patients presenting with symptoms after 5 years of surgery were mainly lump abdomen, POP, incisional hernia and low back ache.

Risk Factors

It is a very old saying that while we should always hope for the best, we should also be prepared for the worst. This is also applicable to a surgical team during a surgery where we have to be prepared for any unforeseen complications.

Risks after hysterectomy are multifactorial and can be discussed under three broad categories, namely -- Patient's factors, Environmental factors & Surgeon's factors.

Patient's factors: Patient's age, body mass index, socioeconomic condition, financial status,

malnutrition, illiteracy, hygiene & local customs, myths and practices.

Environmental factor: High patients burden, compromised patients care

Surgeon's factors: Surgery of ill-prepared patients, no blood supplement, no nutritional supplement, faulty technique of surgery, poor counselling of patients, inexperienced surgeon.

Formulating Modalities To Prevent Morbidities: Pre op assessment and treatment of risk factors like anemia, urinary and vaginal infection, prophylactic use of antibiotics is mandatory. Awareness of problems, anticipation of complications, timely intervention by experienced surgeon and adequate blood transfusion reduces morbidity. There are some alternative treatment for patients with heavy bleeding and for fibroid to decrease the frequency of hysterectomy. Women with benign uterine condition have more options including medical treatment, endometrial ablation, uterine artery embolism (UAE), minimum invasive procedure (MIP). Laparoscopic hysterectomies are now preferred method for most benign gyneacological diseases. But Laparoscopic surgery comes with its own set of complications which needs to be dealt with accordingly. Most recent development in hysterectomy has been the introduction of technique involving surgical robots. All important in formations should be given to them about alternative procedure. Patients can decide themselves what is best for them.

Conclusion

The associations identified in this study highlight the importance of addressing key events in the reproductive life span of women and their interlinkages with later health. The potential contribution of hysterectomy in this burden calls for critical appraisal of how the surgery is utilized, and for whom, along with feasible alternatives that protect women's health and enhance their well-being.

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