

Original Research

Assessment of outcome of 68 vaginal hysterectomy performed in tertiary care centre

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ABSTRACT:

Background: A substantial number of women undergo hysterectomy annually, and 70 % of hysterectomies are performed for benign indications. The present study was conducted to determine outcome of 68 vaginal hysterectomy performed in tertiary care centre. **Materials & Methods:** 68 female patients were selected for vaginal hysterectomy. Factors such as operation details, duration of surgery, blood loss during surgery, intra operative & post-operative period blood transfusion, intra operative complications like bladder, uterus and bowel injury, the vertical and horizontal lengths of the vagina upon retraction of the vaginal orifice, and uterine descent were recorded. **Results:** Age group 20-40 years had 16 (23.5%) cases, 40-60 years had 20 (29.4%) and group >60 years had 32 (47.1%) cases. The mean weight was 57.2 kgs, height was 160.4 cm, depth was 1.2 cm, previous vaginal operation was present in 46, weight of uterus was 254.2 grams, operative time was 34.2 min and vertical length was 5.8 cm. Common complication of procedure was ureter injury in 2, paralytic ileus in 1, wound infection in 1 and bladder injury in 1 case. The difference as significant ($P < 0.05$). **Conclusion:** Vaginal hysterectomy is common surgical procedure after cesarean section.

Key words: Cesarean section, gynaecological, Vaginal hysterectomy

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INTRODUCTION

Hysterectomy is a very common gynaecological operation in which the uterus may be completely removed (total hysterectomy), partially removed preserving the cervix (sub-total hysterectomy), or may be removed with the tubes and ovaries (total hysterectomy with bilateral salpingoophorectomy).¹

A substantial number of women undergo hysterectomy annually, and 70 % of hysterectomies are performed for benign indications, including leiomyoma, adenomyosis, severe dysmenorrhea and uterine prolapse.² The surgical approach of hysterectomy is the most important factor responsible for postoperative morbidity. Until the present, the approaches for hysterectomies are vaginal, abdominal, laparoscopic and robotic assisted laparoscopic hysterectomy. If feasible, vaginal hysterectomy is associated with a shorter duration of hospital stay,

speedier recuperation, fewer unspecified infections or febrile episodes than abdominal hysterectomy.³

Recently, due to the introduction of laparoscopy, as well as advances in laparoscopic techniques, laparoscopic hysterectomy or laparoscopically assisted vaginal hysterectomy (LAVH) has been performed in many cases; thus it has become possible to benefit from several advantages of vaginal hysterectomy and to overcome some of its limitations.⁴ However, when compared with vaginal hysterectomy, laparoscopic hysterectomy or LAVH has its drawbacks, including increased operative time and costs. Vaginal hysterectomy (VH) is commonly utilized to treat uterine prolapse, but despite proven safety and effectiveness, it remains underutilized for the surgical treatment of non-prolapse conditions.⁵ The present study was conducted to determine outcome of 68 vaginal hysterectomy performed in tertiary care centre.

MATERIALS & METHODS

The present study was conducted among 68 female patients selected for vaginal hysterectomy. They were enrolled after they gave their written consent for the study considering all risk factors.

Information related to patients such as name, age, etc. was recorded. Factors such as operation details, duration of surgery, blood loss during surgery, intra operative & post- operative period blood transfusion, intra operative complications like bladder, uterus and

bowel injury, the vertical and horizontal lengths of the vagina upon retraction of the vaginal orifice, and uterine descent were recorded. Operative time was from the incision time of the vagina to the placement of the last suture of the vaginal incision. The average hospital stay was calculated from the day of surgery to the day of discharge. Results were tabulated and subjected to statistical analysis. P value less than 0.05 was considered significant.

RESULTS

Table I Age distribution

Age group (Years)	Number	Percentage
20-40	16	23.5%
40-60	20	29.4%
>60	32	47.1%

Table I shows that age group 20-40 years had 16 (23.5%) cases, 40-60 years had 20 (29.4%) and group >60 years had 32 (47.1%) cases.

Table II Characteristics of patients

Characteristics	Number
Weight (Kg)	57.2
Height (cm)	160.4
Depth (cm)	1.2
Previous vaginal operation	46
Weight of uterus (gram)	254.2
Operative time (min)	34.2
Vertical length	5.8

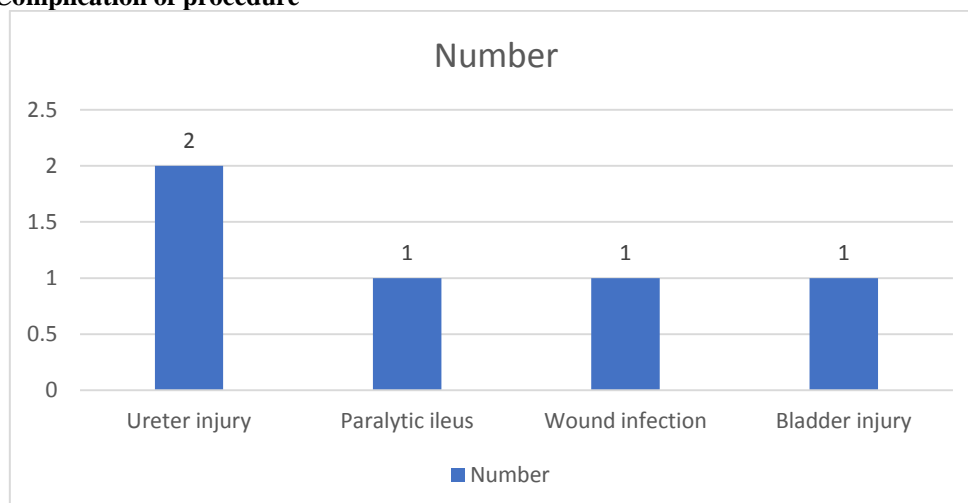
Table II shows that mean weight was 57.2 kgs, height was 160.4 cm, depth was 1.2 cm, previous vaginal operation was present in 46, weight of uterus was 254.2 grams, operative time was 34.2 min and vertical length was 5.8 cm.

Table III Complication of procedure

Complication	Number	P value
Ureter injury	2	0.08
Paralytic ileus	1	
Wound infection	1	
Bladder injury	1	

Table III, graph I shows that common complication of procedure was ureter injury in 2, paralytic ileus in 1, wound infection in 1 and bladder injury in 1 case. The difference as significant (P< 0.05).

Graph I Complication of procedure



DISCUSSION

Vaginal hysterectomy has advantages when compared with abdominal hysterectomy, such as esthetic advantages, rapid recovery, and an early return to routine life activities. Nevertheless, vaginal hysterectomy is known to have many limitations, such as the size of the uterus and accompanying lesions within the abdominal cavity (adhesions and endometriosis).⁶ In the field of obstetrics and gynecology, hysterectomy is the second most frequently performed surgery after cesarean section. Initially, vaginal hysterectomy was used as a treatment method for uterine prolapse, and gradually the indications were extended. Feroze⁷ suggested the following absolute indications for vaginal hysterectomy: Cases with benign uterine diseases in which the size was not greater than the size of a 12 weeks pregnancy and accompanied with uterine prolapse, cases with a small-size uterine leiomyoma, and cases with functional uterine bleeding or severe dysmenorrhea accompanying uterine prolapse. The present study was conducted to determine outcome of 68 vaginal hysterectomy performed in tertiary care centre.

In present study, group 20-40 years had 16 (23.5%) cases, 40-60 years had 20 (29.4%) and group >60 years had 32 (47.1%) cases. Shanthini et al⁸ found that one hundred and seventy- six cases of TAH were performed during study period. 53 cases of VH performed during study period. Age distribution of cases studied were 25.3% in between 30 - 39 years, 65.5% in between 40 - 49 years and 9.2% in between 50 - 59 years.

We found that mean weight was 57.2 kgs, height was 160.4 cm, depth was 1.2 cm, previous vaginal operation was present in 46, weight of uterus was 254.2 grams, operative time was 34.2 min and vertical length was 5.8 cm. Silva et al⁹ reported a major complication rate of 1.5% and a minor complications rate of 11.5%.

Hong et al¹⁰ in their study found that overall, the average uterine weight was 297.7 ± 163.4 g, with a range from 84-1,020 g. The mean operation time was 36.3 minutes, with a range from 17-107 minutes. The weight of the resected uterus was < 500 mg in 156 cases, and > 500 mg in 18 cases. Based on uterine weight, body weight, the history of surgery, concomitant surgery (adenectomy), penetration of the posterior cul de sac during surgery, and uterine descent, the average uterine weight showed a significant difference, and together with uterine weight, such variables affected vaginal hysterectomy. Age, number of vaginal deliveries, height, the presence of endometriosis, opening of the anterior cul de sac during surgery, and the vertical and horizontal lengths of the uterus did not have an effect on the progression of surgery.

We observed that common complication of procedure was ureter injury in 2, paralytic ileus in 1, wound infection in 1 and bladder injury in 1 case. Amy¹¹

reported 14 cases of vaginal hysterectomy involving uteri 380-1,100 g with an average weight of 639 g, and did not detect a difference in postsurgical complications. Mistrangelo et al¹² performed 99 cases of vaginal hysterectomy on patients with leiomyomas > 250 g with the application of LigaSure bipolar diathermy. Bharatnur et al¹³ shows that overall post-operative complications are more in abdominal hysterectomy group than in vaginal hysterectomy.

CONCLUSION

Authors found that vaginal hysterectomy is common surgical procedure after cesarean section.

REFERENCES

1. Nezhath F, Nezhath C, Gordon S, Wilkins E. Laparoscopic versus abdominal hysterectomy. *J Reprod Med.* 1992;37:247-50.
2. Raju KS, Auld BJ. A randomised prospective study of laparoscopic vaginal hysterectomy versus abdominal hysterectomy each with bilateral salpingo-oophorectomy. *Br J Obstet Gynaecol.* 1994;101:1068-71.
3. Richardson RE, Bournas N, Magos AL. Is laparoscopic hysterectomy a waste of time? *Lancet* 1995;345:36-41.
4. Summitt RL, Stovall TG, Lipscomb GH, Ling FW. Randomized comparison of laparoscopy assisted vaginal hysterectomy with standard vaginal hysterectomy in an outpatient setting. *Obstet Gynecol.* 1992;80:895-901.
5. Kovac SR, Cruikshank SH. Guidelines to determine the route of oophorectomy with hysterectomy. *Am J Obstet Gynecol.* 1996;175:1483-8.
6. Sheth SS. The place of oophorectomy at vaginal hysterectomy. *Br J Obstet Gynecol.* 1991;98:662-6.
7. Feroze RM. Vaginal hysterectomy and repair. *Clinic in Obstet Gynecol.* 1978;5:546-52.
8. Shanthini NF, Poomalar GK, Jayasree M, Bupathy A. Evaluation of complications of abdominal and vaginal hysterectomy. *Int J Reprod Contracept Obstet Gynecol* 2012; 1:7-11.
9. Silva, Soriano D, Cohen SB, Nervo P, Canis M, Botchorishvili R, et al. The learning curve of total laparoscopic hysterectomy: comparative analysis of 1647 cases. *J Am Assoc Gynecol Laparosc.* 2002; 9:339-45
10. Hong DG, Seong WJ, Lee YS, Cho YL. Analysis of factors affecting vaginal hysterectomy. *Minimally Invasive Therapy & Allied Technologies.* 2009 Dec 1;18(6):317-21.
11. Amy JJ. Vaginal hysterectomy. *Natl Med J Ind.* 1997;10:126-7.
12. Mistrangelo E, Febo G, Ferrero B, Ferrero S, et al. Safety and efficacy of vaginal hysterectomy in the large uterus with the LigaSure bipolar diathermy system. *Am J Obstet Gynecol.* 2008;199:1-5.
13. Bharatnur S. Comparative Study of Abdominal Versus Vaginal Hysterectomy In Non- Descent Cases. *The Internet Journal of Gynecology and Obstetrics* 2011;15(2).