

CAESAREAN HYSTERECTOMY

by

KALA VASISHTA,* M.D.

and

REKHA KHATRI,** M.D., D.G.O.

Prior to the availability of blood bank facilities and antibiotics in the early 1940's, caesarean hysterectomy was seldom performed except as a life saving operation. However, the hazards of caesarean hysterectomy are greatly diminished today due to the easy availability of blood and potent antibiotics.

Material

The present study was undertaken to review our experience regarding caesarean hysterectomy over a period of 5 years, from January 1969 to December 1973, from the department of Obstetrics and Gynaecology, Nehru Hospital attached to Postgraduate Institute of Medical Education and Research, Chandigarh.

Incidence

Nineteen cases of caesarean hysterectomy were performed out of 927 caesarean sections, giving an incidence of 2% of all caesarean sections and 0.24% of all deliveries during this period.

In 11 cases, caesarean hysterectomy was done for rupture uterus. All the caesarean hysterectomies were carried out as emergency procedures.

*Assistant Professor.
Registrar.

Department of Obstetrics and Gynaecology,
Postgraduate Institute of Medical Education and
Research, Chandigarh.

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Age and Parity

The age range was 19-45 years with maximum cases between 21-30 years of age. However, the commonest parity was 4, 12 cases, while 5 cases were para 5 and above.

Indications for Caesarean Hysterectomy

In the present series the commonest indication for caesarean hysterectomy was rupture uterus (11 cases) as shown in Table I. It was spontaneous rupture in

TABLE I
Indications for Caesarean Hysterectomy

Indications	No. of cases
1. Spontaneous rupture uterus	8
2. Traumatic rupture uterus	2
3. Rupture classical caesarean section scar	1
4. Atonic post-partum haemorrhage	7
5. Gross intrapartum sepsis	1
Total	19

8 cases (23.7%), rupture of previous caesarean section scar in 1 case while in 2 cases there was traumatic rupture of uterus. Both these cases were administered syntocinon drip for induction of labour in the hospital when the uterus ruptured, eventhough they were para 2. In the "spontaneous rupture" group, cephalopelvic disproportion due to big baby or contracted pelvis was the cause in 6

cases, while malpresentation was the cause in 2 cases. The rent in all these cases was in the lower segment except in 1 case where the previous classical caesarean section scar gave way. In the remaining 8 cases caesarean hysterectomy was done for atonic postpartum haemorrhage in 7 cases and for gross intra-partum sepsis in 1 case. In 2 cases syntocinon drip was administered for induction of labour for intrauterine death, which failed. However, lower segment caesarean section was done and the patients had atonic postpartum haemorrhage which was not controlled by the usual measures. There was another case with intrauterine death, she delivered a macerated baby and had postpartum haemorrhage with retained placenta for which caesarean hysterectomy was done. In another case en bloc caesarean hysterectomy was done for gross amnionitis in a parous women. In the remaining 4 cases initially caesarean section was done or routine cases but then they had atonic P.P.H., not controlled by usual measures, requiring caesarean hysterectomy.

Post-Operative Morbidity

In all the 11 cases of rupture of uterus requiring caesarean hysterectomy the postoperative period was hectic with high fever. Four cases had general peritonitis and later 2 developed wound dehiscence, while in the atonic P.P.H. group post-operative period was relatively smooth.

In one case bladder was cut accidentally during the operation and the patient had vesico-vaginal fistula subsequently. Another patient had pulmonary Koch's initially and later developed tubercular infection of the wound. The hospital stay was more than 16 days in 10 cases.

Maternal Mortality

There were 2 maternal deaths. One

each in the rupture uterus and the P.P.H. group. First case had caesarean hysterectomy for spontaneous rupture uterus, she did not come out of anaesthesia and died 9 hours after the operation. The other case had caesarean hysterectomy for atonic P.P.H., caesarean section having been performed for a major degree placenta previa. She developed cardiac arrest twice on the operation table and could not be revived.

Discussion

The incidence of rupture uterus varies from 1 in 137 as shown by Lavery (1955) to 1 in 1961 as shown by Brierton (1950). Incidence given by Sheth (1969) from Bombay is 1 in 1180 (0.09%) of all deliveries. In the present study the incidence of caesarean hysterectomy was 1 in 440 (0.24%) of all deliveries which is higher than that reported by Sheth (1969) even though the criteria for selection of patients was the same.

As regards the incidence of caesarean hysterectomy in western literature it varies from 0.06% (Velasco *et al* 1973; Morton, 1962) to 25.3% (Barclay 1970). In the series by Morton (1962); Webb and Gibbs (1968) and Barclay (1970) caesarean hysterectomy was performed electively in cases where sterilization was needed. In addition all these authors support the view that if the uterus is diseased it should be removed at the time of caesarean section. Such caesarean hysterectomy is named as 'Elective Caesarean Hysterectomy', and in Barclay's series (1970) the incidence of elective caesarean hysterectomy was 82.4% of all caesarean hysterectomies. All these authors prefer to remove the uterus in the cases of repeat caesarean section, wherever tubal ligation was indicated. In such situations the type of hysterectomy preferred is total hysterectomy rather

than subtotal. Webb and Gibbs (1968) claim that the main advantage of removing the uterus at caesarean section is that it reduces the need for additional operations at a later date for excessive bleeding, fibromyoma and other pathological conditions.

In our series, there was no case of elective caesarean hysterectomy, as our approach is conservative. Tubal ligation at caesarean section is preferred over caesarean hysterectomy because of lowered post-operative morbidity and preservation of menstrual function. If the uterus is diseased elective surgery is postponed for a later date. Careful monitoring of syntocinon drip is imperative even in the low parity group as in our series there were 2 cases of spontaneous rupture of uterus, especially in cases with intrauterine death and intrapartum sepsis. In such cases the morbidity can be decreased by the use of potent antibiotics, early recognition of rupture uterus and early intervention.

Place of bilateral internal iliac ligation in uncontrollable cases of post partum haemorrhage is worth considering, where the general condition of the patient is poor, blood is not available or the child

bearing function of the woman has to be preserved.

Summary

1. Nineteen cases of caesarean hysterectomy during a five year period have been revived.

2. Commonest indication for caesarean hysterectomy was rupture of uterus. (11 cases), next being atonic P.P.H. (8 cases).

3. Caesarean hysterectomy is associated with increased postoperative morbidity in cases of rupture uterus.

4. Place of caesarean hysterectomy as a family planning procedure is discussed.

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