# HYSTEROTOMY—AN ANALYSIS OF 1000 CASES

by

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During the past decade hysterotomy as a method of termination of pregnancy has lost much of its popularity. Faced with the problem of second trimester pregnancy in a place where prostaglandins are not available, and pregnancy is too advanced for vacuum suction or dilatation and curettage and as saline terminations have been evaluated to be unsafe, hysterotomy as a method of termination of pregnancy is liberally adopted. Besides the above limitations, a distinct advantage is the amenability of women to accept tubectomy simultaneously with very little motivation. Moreover, due to heavy demands on the hospital staff, and the need to train house surgeons, who would eventually man the state health services after one year's training, these operations were mostly performed by senior house surgeons who developed proficiency within a short period of six months.

*Material and Methods*

One thousand cases of pregnancy with multiparity presented themselves to the Govt. Hospital for women with a request for termination of pregnancy and simultaneous tubal ligation. All cases had an average haemoglobin level of 10 gms%, clear urinalysis, and normal bleeding and clotting time. In some cases, blood urea ECG and screening of the chest were done. The period of pregnancy varied from 6 to 20 weeks. In few cases the indications were medical, such as hypertension, tuberculosis or asthmatic bronchitis but in all other cases, socio-economic factors and multiparity made the simultaneous operation of termination with ligation the most acceptable procedure. The simplest type of operation was performed using a median subumblical vertical incision.

Tubal ligation was done first, and then a small vertical incision was made in the upper segment of the uterus and the contents evacuated. Gentle curettage was done followed by passage of a single dilator through the os to ensure ready passage of material out of the uterus. The uterus was then stitched in two layers. Cases were done under spinal anaesthesia (93.9%) unless there was some complication such as hypertension, Cardiac, skin or other systemic disease (6.1%). In these cases general anaesthesia was used.

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*Results*

The age range varied from 20-40 (Average age being 32 years).

*Religion*

Muslim women comprised 85 per cent hysterotomies with tubal ligation. This is in strong contradiction to the prevailing notion that religious taboos are a set back to the family planning programme in developing countries, Hindus contributed to only 10.9% and sikh women were 4.1%. This was directly proportional to the population of these communities in the state and also their better literacy level.

*Marital Status*

All the patients were married except one, where termination with ligation was done in a mentally retarded unmarried teenager at the request of the parents.

*Parity*

The maximum patients were para 3-5 (81.7%). The highest parity was 11 para in 5 women.

*Duration of Gestation*

62.3% of the cases were 10-16 weeks pregnant high-lighting the fact that most women did not report until the second missed period, 7.8% of cases came between 16-20 weeks and less than one third of the cases (20.9%) reported between 6-8 weeks. These cases were mostly the educated middle class who insisted on simultaneous ligation with termination.

*Socioeconomic state*

The majority of the patients were of the low socioeconomic status and almost illiterate (88.2%) only 11.8% of the cases could be ascribed to the middle class. There were no cases of the high income group, as this is a general hospital.

*Discussion*

Various authors report a high complication rate in hysterotomy Tietze and Lewit (1972) in a J.P.S.A. study analysed various methods of termination combined with sterilization, and concluded that the complication rate was highest for hysterotomy (33.3%). They however found no increase in complication rate, when combined with tubectomy. Rao and Najma (1975) found the complication rate in a teaching hospital to be 27.8% for hysterotomy with ligation.

In our study the total complications rate was 10.61% (Table II) including

TABLE II

*Complications per 100 women*

| | |
|---|---|
| Headache | 6.31 |
| Pyrexia | 0.60 |
| Serous discharge | 0.60 |
| Diarrhoea | 0.30 |
| Chest complications | 0.3 |
| Urinary tract inf. | 1.1 |
| Meningismus | 0.3 |
| Endometriosis | 0.5 |
| Total | 10.61 |

TABLE I

*Shows the religion, parity, Gestation period, Socio economic status and Anaesthesia used in the various undergoing tubectomy*

| Religion | | | Parity | | Pregnancy in weeks | | | Socio Economic | | Anaesthesia | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Muslim | Hindu | Sardar | 3-5 | 6+ | 6-8 | 5-16 | 16-20 | Low | Mid | Spinal | General |
| 850 | 109 | 41 | 817 | 183 | 299 | 623 | 78 | 883 | 117 | 839 | 161 |

minor problems such as headache. Complications such as urinary tract infections could only be explained as a flare up of previous dormant infections in patients as there were no catheterisation and all patients had normal urinalysis preoperatively. Nottage and Liston (1975) reported a 3% incidence of thrombolism. They had 13 patients with pulmonary embolism and 3 had ilio-femoral thrombosis which required thrombectomy. They also encountered 1 death due to massive pulmonary embolism (0.14%) and subsequently administered prophylactic anticoagulants in at least 90% of the patients.

In our study no proplylactic anticoagulants were given, but there was no case of phlebothrombosis or thrombophlebitis. There was no mortality in the entire series. Undoubtedly we are faced with a vastly different situation than western authors and the plausible reason may be some inherent protection against hypercoagulable states in asian women. This theoretic explanation is also supported by the results of Tsakok (1974) who worked on theomboenbolic diseases in women (Asian). The highest complication recorded 6.31% was postoperative headache which was due to spinal anaesthesia and could be minimised by using a single prick with a fine needle, and giving due attention to hydration in the immediate postoperative period while keeping the foot end elevated. The rate of sepsis, serious discharge and pyrexia (total 1.8%) was not high considering that our patients came from low socioeconomic strata, and were far from well nourished, having a very poor idea of personal cleanliness Antibiotics (penicillin except in cases of allergy) was given prophylactically during the first 5 days. There were however 5 cases of endometriosis and we attribute this to inadequate toilet of abdomen in the earlier part of the study. Greater attention to this point and isolating the uterus with swabs has already reduced this complication.

There are not many reliable reports about the mortality figures of women undergoing simultaneous abortion with tubal ligation. Anklesaria (1970) reported four deaths out of 5000 cases of postabortal abdominal sterilization. This would give a mortality figure of 68/1,00,000. Presser, in the same year reviewed 10 studies from at least 6 countries, and estimated a mortality rate of 25/100,000 operations. These cases were not all postpartum. Tietze (1969) estimated the figure to be 33 deaths/100,000 operations. In our series of 1000 cases there were no deaths. Moreover the risk of sterilization with hysterotomy is to be taken only once in a lifetime, and is to be weighed against the effect of prolonged and repeated exposure to oral contraceptives, and frequently performed abortion over a reproductive period of 10 years, as the mean age for hysterotomy and ligation was about 32 years.

Tietze and Guttmacher (1973) analysed the total mortality for New York state in the first two years after liberalization of abortion to be about 52/100,000 cases. Some authors Langer *et al* (1975) have even advocated caesarean hysterectomy as a method of sterilization. However, we feel their approach is too drastic and not to be recommended when load of operation is so high and resources so limited.

*References*

1. Anklesaria, S. B.: Proceedings of the International Seminar on Maternal Mortality, Family Planning and Biology of Reproduction. Eds: Purandare, B. N. and Jhaveri, C. L., p. 181, 1970.

2. Basker Rao, K. and Najma, G.: J. Obstet. & Gynaec. India. 25: 671, 1975.
3. Nottage, B. J. and Liston, W. A.: J. Obstet. & Gynec. Brit. C'wealth. 82: 310, 1975.
4. Presser, H. B.: Rep. Popul. Fam. Plann. 5: 1, 1970.
5. Tietze, C.: Studies in Family Planning, 45: 6, 1969.
6. Tietze, C. and Lewit, S.: Studies in Family Planning, 3: 1, 1972.
7. Tietze, C. and Guttmacher, A. F.: Lancet, 1: 105, 1973.
8. Tsakok, F. H. M.: Annals Accademy of Medicine, 3: 399, 1974.