

EMERGENCY HYSTERECTOMY

by

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Emergency hysterectomy though not desirable has to be undertaken as a last resort to save the lives of the mothers sacrificing their reproductive ability. Most of the times the operation is carried out when the condition of the patient is too critical to withstand the risks of anaesthesia or surgery, but proper timing and meticulous care may reduce or prevent the maternal deaths, especially in life threatening haemorrhages. The decision to take such a drastic step is not easy and requires good judgement. The analysis of 54 emergency obstetrical hysterectomies undertaken in Eden Hospital during 1976 to October 1978 is presented.

Observations and Discussions

There were 26525 confinements and total 54 emergency hysterectomies were carried out with obstetrical indications. Besides these 54 cases, 3 other emergency hysterectomies were performed for gynaecological causes such as twisted ovarian cyst. The percentages of obstetrical emergency hysterectomies were 0.2%. The indications were (1) rupture of uterus, 25 (46.3%), (2) uterine perforation during attempted criminal/therapeutic abortions or destructive operations, 9 (16.65%), (3) severe atonic

P.P.H. 5 (9.2%), (4) placenta praevia 3 (5.5%), (5) placenta accreta, 2 (3.7%), (6) sepsis, 6 (11.1%), (7) hydatidiform mole, 3 (5.5%) and (8) broad ligament haematoma, 1 (1.8%). Total hysterectomies were carried out in 19 (35.1%), subtotal in 31 (57.4%) and panhysterectomy in 2 (3.7%) cases. Hysterectomy with unilateral salpingo-oophorectomy were done in 2 cases of ruptured uterus amongst these 54 (3.7%).

Individual Conditions

Rupture of Uterus

Rupture of uterus was the principal indication, 25 cases, which was also the most important cause of emergency hysterectomy in other series (Oumachigui and Nayak, 1976; Sotto and Archambautti, 1957; Gelle *et al*, 1974). In the series of Oumachigui and Nayak, the percentage of emergency hysterectomy due to rupture uterus were 91 against 46.3% of the present series. Though repair of rent is undertaken at times to treat rupture uterus cases, which may ward off radical procedure, the same is not justified when the tear in the uterine wall is irregular and oedematous involving large blood vessels and extending into the broad ligament. The principle in these cases being haemostasis and quick surgery with minimum trauma. Amongst total 30 admissions of rupture uterus

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cases, 25 cases 83% were treated by hysterectomy and 5 cases (17%) were treated by repair and tubectomy. Hysterectomy was the method of treatment in 60, 80 and 29% cases in the series of Prabhavati and Mukherjee (1963), Menon (1962) and Jacob and Bhargava (1971) respectively. Out of these 25 cases where hysterectomy was carried out, 1 was a post caesarean pregnancy, where rupture was detected after forceps application. A spontaneous rupture occurred in a 6th gravida. In other 23 cases, rupture occurred due to obstructed labour in out-lying areas handled by untrained persons. Amongst these 25, 1 was primipara, 24 multipara, 4 being grand multiparas (Para 5+). Sixteen were between 20 and 30 years in while 9 were between 31 to 40 years. Diagnosis was made during admission in 20 cases. Another 4 were diagnosed after admission and in the last case rupture occurred in hospital. Twenty-four had no antenatal check up and were admitted through emergency in labour of 12 to 24 hours duration in multiparas and 8 to 10 hours in grandmultis. Interventions were forceps in 16, oxytocin drip in 2, breech extractions in 2, version in 1, and abdominal pressure in 1. There were 3 cases of contracted pelvis. The etiological factors were hydrocephalus, 2 cases; transverse lie, 8; C.P.D., 6; breech presentations 3, brow 1, deflexed head 1 and spontaneous rupture of post C.S. scar, 1 case. In 3 grandmultiparas labour was prolonged and vaginal manipulations were done. The site of rupture was in upper segment in 2 and lower segment in 23 cases. Amongst these 23 lower segment ruptures, 9 were incomplete and 14 were complete. Subtotal hysterectomy was carried out in 14, total in 10 and pan-hysterectomy in 1 case. Unilateral sal-

pingo-oophorectomy was undertaken in 2 cases, due to involvement of broad ligament on that side. Maternal deaths were 7 cases (28%), 1 after total and 6 after subtotal. The 6 patients who expired after subtotal came in extremely low condition and died shortly after operation, 3 due to shock and 3 due to sepsis. The present mortality rate was higher than that of Menon (10%) but lower than that of Prabhavati and Mukherjee (33.3%).

Perforation of Uterus

There were 9 cases, 6 were admitted following attempts for criminal abortions by vaginal administrations of foreign body and were admitted with shock and haemorrhage. In 2 cases perforation occurred during dilatation and evacuation with abdominal ligation in M.T.P. clinic in this hospital. In the 9th case, the perforation occurred after attempted craniotomy. The size of the perforations indicated hysterectomy. In the 2 indoor fresh cases, total hysterectomy was undertaken and in the other 7 subtotal hysterectomy was performed. Four of them were also associated with intestinal injury, which was repaired along with hysterectomy. There were 5 (55.5%) deaths, 2 due to sepsis, 2 due to haemorrhage following criminal abortion in the postoperative period and 1 due to shock following craniotomy and hysterectomy.

Atonic P.P.H.

Five (9.2%) hysterectomies were carried out for atonic P.P.H., 2 subtotal and 3 total. Gelle *et al* (1974) reported the incidence as 13% and Oumachigui and Nayak (1976) as 1.8%. In the study of Barclay (1970) atonic P.P.H. led the list of indications for emergency obstetrical hysterectomies. All of these cases were confined outside and

were multiparas, 2 being grandmultiparas. Two each belonged to age groups of 20 to 30 and 30 to 40 and 1 was below 20. Retained placenta was present in 3 and in 2 placental bits remained inside the uterus. Manual removal was carried out in all these cases after resuscitation but massive haemorrhage continued due to atony of uterus. Emergency hysterectomy had to be undertaken when other methods of treatment failed to save their lives.

Placenta Praevia

There were 3 cases, a 36 years old grandmultipara, with type IV, a para 2, aged 20, with type II posterior and a 4th para, aged 40 with type III associated with pre-eclampsia and past bad obstetric history. In all of them severe P.P.H. occurred and blood loss amounted to more than 1000 ml. The bleeding continued inspite of syntocinon, ergometrine, blood and fluid. Total and subtotal emergency hysterectomies were undertaken in 2 and 1 case respectively following L.U.C.S.

Placenta Accreta

There were 2 cases, both post caesarean pregnancies. One had A.P.H. with breech presentation and anencephaly, where bladder was also adherent to the uterine scar and was injured during hysterectomy. The placenta in both cases was implanted all over the anterior part of the lower uterine segment and no part of it could be removed easily. There was also severe haemorrhage when hysterectomy had to be undertaken to save lives.

Placenta accreta as a source of haemorrhage has been considered rare. In the present series its incidence amongst emergency hysterectomies is approximately 3% against 1.9% as reported by

Oumachigui and Nayak (1976). According to Sumawong *et al* (1966) mortality rate is very high with conservative treatment in such cases. Even if these patients survive the complications during next pregnancy cannot be avoided. Reviewing the literature and 10 cases of their own Sumawong *et al* concluded that no death occurred when hysterectomy was performed. However, in the present series there was 1 death (50%) even after hysterectomy.

Hydatidiform mole

In 3 cases of hydatidiform mole emergency hysterectomy had to be undertaken, in 2 for perforating mole and in 1 for severe haemorrhage. All of them were multiparas aged between 30 and 40 years. Panhysterectomy was decided upon for preventing the possibility of development of choriocarcinoma in future.

Sepsis

In 4 cases (7.4%) hysterectomy was undertaken in patients admitted with obstructed labour having interferences and signs of severe sepsis, manifested by frank or encysted collections of pus in the peritoneal as well as in the uterine cavities. All were multigravidas and subtotal hysterectomy following L.U.C.S. was undertaken. The exact incidence of caesarean hysterectomies for sepsis is not known in our country but at Arakans Medical Centre, 18% of caesarean hysterectomies were done for uterine sepsis with prolonged rupture of membranes. The maternal mortality rate is also not much greater compared to elective sections or for that matter abdominal or vaginal hysterectomies in non-pregnant condition (Reid and Christian 1974). Thus in case of severe intrauterine sepsis removal of uterus may save the life of the patient by removing the

source of infection. This also holds true in some cases of septic abortions.

Besides these 4 cases, in 2 (3.7%) other situations, subtotal hysterectomy was undertaken in the postoperative period after L.U.C.S. indicated for severe sepsis. One had burst abdomen on the 6th postoperative day after L.U.C.S. due to sepsis. She had pyometra and underwent hysterectomy, still the sepsis could not be eradicated and the patient died on the 12th day. The second one had paralytic ileus and signs of septicaemia on the 4th postoperative day after L.U.C.S. when laparotomy and subtotal hysterectomy was done. The patient survived.

Broad Ligament Haematoma

During L.U.C.S. in a case of multipara with obstructed labour for brow presentation, the left angle of the incision extended to the left broad ligament while extracting the baby. Subtotal hysterectomy had to be done to control bleeding from the left uterine artery and its branches.

Types of Surgery

Though total hysterectomy is considered to be the method of choice to avoid future cervical malignancy, yet subtotal hysterectomy had to be undertaken in 31 cases considering the condition of the patient. Lawson and Stewart (1967) and Oumachgui and Nayak (1976) felt that where rupture of the uterus follows obstructed labour and the condition of the patient is poor, no attempt should be made to remove the cervix. Gelle *et al* (1974) suggested that a subtotal hysterectomy is to be performed to secure haemostasis and attempt to remove the cervix is to be made if the condition of the patient improves.

Total hysterectomy was undertaken also where cervix and vagina were involved either by injury or by attachment of placenta, which is also suggested by Singh (1967), Prabhavati and Mukherjee (1963) and Oumachgui and Nayak (1976). Unilateral salpingo-oophorectomy was done to achieve haemostasis.

Maternal Mortality and Complications

There were 14 deaths amongst 54 cases (25.9%), which were higher than those of Oumachgui and Nayak (1976) viz. 16.5%. Causes of deaths were septicaemia (8 cases), haemorrhagic shock (5 cases) and unexplained shock (1 case); eleven deaths occurred after subtotal and 3 died after total hysterectomy. Amongst remaining 30 survivals, complications such as abdominal wound infections (6 cases), paralytic ileus (7 cases) and urinary tract infections (5 cases) occurred.

Summary

Fifty-four cases of emergency obstetrical hysterectomies were presented. Rupture of uterus followed by perforation were the principal indications. Maternal mortality was 25.9%.

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