HYSTERECTOMY IN OBSTETRICS

by

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Hysterectomy in obstetrics is a logical development. In the past this operation was considered as an emergency heroic measure, but now it is employed frequently to lower the incidence of maternal mortality and morbidity, especially in cases of haemorrhage in Obstetrics. The increased vascularity of uterus and adnexa during pregnancy and labour are not so hazardous as to discourage this operation as was thought to be so earlier. Often hystrectomy is performed as the last resort when patient's condition is too critical to withstand the risk of operation and effects of anaesthesia. Hence it is wiser to interfere earlier. It is a life saving measure in cases of septic abortion, especially when a corrosive has been used as an abortificient.

Fifty-five obstetrical cases who underwent hysterectomy during the period from April 1976 to March 1981, at Kamla Raja Hospital Gwalior are analysed. During this period there were 15,223 deliveries which gives a ratio of 1 in 276 deliveries. Incidence of placenta accrete is in 7611.

Observations and Discussion

The indications for hysterectomy were as follows (Table I).

TABLE I
Indications

S. No.	Indications		No. of cases	Percentage
1.	Rupture of uterus		35	63.9
2.	Gestational trophoblastic disease		6	10.9
	(a)—V. Mole		4)	
	(b)—Choriocarcinoma		2)	
3.	Post-partum haemorrhage		5	9.0
	(a) During and after L.S.C.S.	—4		
	(b) Secondary atonic	—1		
4.	Perforation uterus following M.T.P.		4	7.2
5.	Placenta accreta		2	3.6
6.	Chorioamnionitis		1	1.8
7.	Sterilization (Elective)		2	3.6
	(a) Pregnancy with prolapse	—1		
	(b) Pregnancy with fibroid	—1		
	Total		55	100.0

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Rupture uterus

In this study, rupture of uterus was the most frequent indication for hysterectomy

(63.9%). Similar observations were made by Prabhavati and Mukherji (1963), Singh (1967), Oumachigui and Nayak (1976) and others, while as Esterday (1969) and Barclay (1970) reported only 45 cases out of 1000 hysterectomies. It is obvious from the above observations that in developed countries like United States and Europe hysterectomy is performed electively for sterilization along with repeat caesarean section. Incidence of rupture uterus is low and is confined mainly to scar rupture. This is further lowered by following the dictum "Once a caesarean always a caesarean" at several centres. In India, conditions are entirely different and women in labour are brought to hospitals from miles away in bullock carts, after hours of prolonged labour. Hence rupture of uterus is still a live problem for us and this is the main indication for hysterectomy. Out of 35 cases of rupture uterus, 31 were multiparous with an age range of 21-40 years. Except for cases of previous caesarean section, all were emergency admissions. Out of these 76% were unbooked cases and 68% were rural patients who were brought in prolonged obstructed labour. History of intervention in the form of pressure on abdomen, application of forceps, manipulations by dai was present in majority of cases. There were 9 cases of neglected transverse lie. Amongst 5 cases of C.P.D., there were 2 cases of hydrocephalus, 1 had a monster baby (Teratodyme).

Of the cases who had rupture uteri in the hospital, 2 were due to oxytocin administration, 1 due to ventouse application in a patient who had one normal delivery following previous L.S.C.S. and, 3 followed previous L.S.C.S. elsewhere. Internal version led to rupture uterus in 2 cases. Rupture occurred spontaneously in 6 multiparous patients who had prolonged labour. It is obvious that rupture uterus is preventable by good antenatal and intranatal care.

Gestational Trophoblastic Disease

Hysterectomy for gestational trophoblastic disease was undertaken in 6 patients (10.9%). Out of these, 4 were multiparous patients who presented with vaginal bleeding, but os was tightly closed. In 2 of the cases, hysterotomy with tubectomy was done but due to atonic haemorrhage hysterectomy was done. In other 2 patients, total hysterectomy was planned as they were multiparous patients. Out of 2 patients of choriocarcinoma, 1 primigravida 20 years presented as an acute abdomen with history of expulsion of a vesicular mole 4 months back. Laparotomy was performed and it proved to be perforating choriocarcinoma with haemoperitoneum subtotal hysterectomy was done. The other was a multiparous patient in whom D & C for irregular bleeding revealed choriocarcinoma. Both these patients had low general condition and expired after hysterectomy. Baird (1957) stated that in a case of vesicular mole with woman over 40 years of age, hysterectomy should be done as a prophylaxis to subsequent choriocarcinoma. Mudaliar and Menon (1962) also hold the same view. Our results are comparable with those of Vartak *et al* (1978).

Atonic Postpartum Haemorrhage

Hysterectomy as treatment of severe postpartum haemorrhage is a radical and an undesirable procedure. The time when it is undertaken has great importance since it is performed as a last resort when patients condition is too critical to withstand the risk of operation and anaesthe-

sia. In the present series a young primigravida who had undergone caesarean section for prolonged labour had severe postpartum haemorrhage on 13th day of operation and all conservative measures failed to control the bleeding. Patient was subjected to hysterectomy because the uterus had sloughed out. In spite of her stormy post operative recovery she survived. In 2 patients severe postpartum haemorrhage occurred few hours after caesarean section and these were subjected to repeat laparotomy and hysterectomy. One of these revealed a big broad ligament haematoma and she ultimately collapsed due to anuria. The other 2 patients had atonic P.P.H. during caesarean section and hysterectomy was performed when conservative measures failed. Sotto and Archambault (1957) reported 10 cases of emergency hysterectomy to control P.P.H. In Barclay's study (1970) of 200 cases, atonic P.P.H. leads the list of indications for hysterectomies. Internal iliac artery ligation is a better alternative measure to prevent hysterectomy but due to lack of practice of performing this operation it was not done in any patient.

Perforation of Uterus

There were 4 cases (7.2%) of perforation of uterus following termination of pregnancy, two out of these followed illegal induction of abortion elsewhere. In both these there were multiple perforations (2-3) with intestinal injury. Hence hysterectomy with resection of intestines and end to end anastomosis was performed. The other 2 cases had perforated uterus during suction evacuation in this hospital. As both of these had completed family life, hysterectomy was done. Perforation of uterus is not an infrequent accident during dilatation and curettage. Eduljee (1975) reported 3 cases in her series who required hysterectomy. Oumachigui and Nayak (1976) reported 2 cases of emergency hysterectomy for perforation following illegal abortion. This incidence can be lowered by contraceptive advice.

Placenta Accreta

Placenta previa accreta is a rare complication and incidence varies from 1 in 948 to 1 in 70,000 deliveries (Diamsi and Golddrick, 1963). In the present series of 2 patients (3.6%), 1 had placenta accreta over the previous caesarean section scar and in the other case L.S.C.S. was performed for antepartum haemorrhage. After the delivery of baby placenta previa accreta was found and hence hysterectomy was performed. Barclay (1959) has reported an incidence of 1.5% while Sotto *et al* (1957) have reported a high incidence of 20% of all hysterectomies. Our series are comparable with those of Oumachigui and Nayak (1976).

Chorioamnionitis

In the present series, 1 patient (1.8%) was subjected to caesarean hysterectomy because after delivery of baby during caesarean section for prolonged labour, frank pus was seen in the uterus. She had a very smooth postoperative period. This seems a sound indication because an infected uterus left behind may act as a re-reservoir of infection and these patients usually have peritonitis and paralytic ileus in post-operative period.

Sterilization

Hysterectomy was undertaken as an elective procedure for sterilization in 2 patients (3.6%). One of these had a

pregnancy of 12 weeks size with fibroid and another one had 10 week's pregnancy with prolapse. Vaginal hysterectomy was done, the dissection was quite easy. Barclay (1959)[2] performed 800 cases of elective caesarean hysterectomies out of 1000 cases. Esterday (1969) reviewed 113 cases and elective hysterectomy was done in 65 cases. The operation should not be done exclusively for sterilization, a gynaecological indication at the time of caesarean section seems to be most appropriate elective indication.

Type of Surgery

In this series, subtotal hysterectomy was performed in 42 cases (76.3%) and total hysterectomy in 13 cases (23.7%). Subtotal hysterectomy with unilateral or bilateral salpingo-oophorectomy was performed in 6 cases and vaginal hysterectomy in 1 patient. Total hysterectomy is the best mode of intervention so that cervix no more remains a source of infection but we were forced to be satisfied with a subtotal hysterectomy in majority of cases due to low general condition of patients. Lawson and Strewart (1967) state that in tropics where rupture uterus follows obstructed labour and the condition of patient is low, no attempt should be made to remove cervix. In only 6 patients subtotal hysterectomy was combined with salpingo-oophorectomy (5 cases of gestational trophoblastic disease) and 1 case was having ecchymosis of tubes and ovaries with rupture uterus.

Complications

In 41 cases (74.5%) there were no complications during operation. There was excessive haemorrhage and shock and collapse in 3 patients. During post-operative period wound infection occurred in 14 cases (25.3%). Two patients had vesicovaginal fistula, one had rectovaginal fistula. All of them were asked to come for repair after 3 months. One patient developed pleural effusion and another one had thrombophlebitis of leg veins. Overall complication rate was 25-30% which is very encouraging.

Maternal Mortality

There were 8 deaths (14.5%), four deaths occurred during or immediately after operation. In 3 patients the cause was fulminating septicaemia, with paralytic ileus and peritonitis. In 1 patient death occurred on 14th day due to pleural effusion.

Summary and Conclusion

1. Fifty-five obstetrical cases who under-went hysterectomy are analysed and indications discussed.

2. From the rate of mortality and morbidity recorded it is clear that hysterectomy must be performed early enough and not as a last resort when patient goes into irreversible shock.

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