CAESAREAN HYSTERECTOMY—A REVIEW OF 30 CASES

by

S. K. PAL

and

N. N. ROYCHOWDHURY

SUMMARY

Thirty cases of caesarean hysterectomy are reviewed. Extension of uterine incision, morbidly adherent placenta in the lower segment, uncontrolled postpartum haemorrhage and couvelaire uterus were the main indications.

Introduction

Caesarean hysterectomy was originally proposed and done about 100 years back for fulminating infections in obstructed labours and the operation was 'Porro' type of operation i.e., performing sub-total hysterectomy and attaching the cervical stump to the abdominal wound so that blood and infected materials can adequately drain into the exterior. Hundred years have passed and still we have to carry out occasionally this type of unwanted radical surgery though techniques of the operation have changed considerably.

Material and Methods

The present study is a review of our experience regarding 30 consecutive caesarean hysterectomies which had to be performed at Eden Hospital, Calcutta Medical College, during the years 1980-82.

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Results

TABLE I
Incidence

Total No. of viable births	25, 323	
Total No. of caesarean sections	3, 438	(Caesarean section rate is 13.1%)
Total No. of caesarean hysterectomies	30	(0.87% of all C.S.)
Total No. of rupture uterus cases (of which 35 cases ended in hysterectomy)	50	(1 in 506 deliveries)

We limit our discussion strictly to caesarean hysterectomies and we have not included rupture uterus cases in the present series.

Discussion

In the present review the incidence of hysterectomy was 0.87% of all caesarean sections but if we include rupture uterus cases then incidence comes to 1.8% of all caesarean sections. Three cases were booked and rest were emergency admissions. In the booked cases there was extension of tear in 2 cases and 1 case had fibroid uterus. Total hysterectomy was

TABLE II
Indications

	Total	Per cent
(1) Extension of uterine incision and formation of broad ligament haematoma	9	30.0
(2) Morbidity adherent placenta in the lower segment	6	20.0
(3) Failure of retraction of uterus after extraction of the baby resulting in atonic P.P.H.	6	20.0
(4) Couvelaire uterus	5	16.6
(5) Gross intrapartum sepsis in prolonged labour cases	3	10.1
(6) Multiple corporeal myoma	1	3.3
Total	30	100.00

done in 4 cases and rest 26 had subtotal hysterectomy. Two cases had elective caesarean section and other 28 cases were emergency sections.

Extension of the incision line formed the prime indication of hysterectomy in our series. Out of 9 such cases, 4 cases presented with transverse lie where transverse uterine incision was made. The indication of section in 3 other cases was obstructed labour with jammed foetal head. The remaining 2 cases were elective caesarean sections. All these patients had uncontrollable haemorrhage from the open uterine vessels of broad ligament. Out of 9 such patients 1 died of post-operative shock.

It is considered that thinned out and oedematous lower segment in obstructed labour cases favour extension of the incision line particularly when the foetal head is jammed. In many cases extension of the incision line is preventible if certain principles are carefully followed and adhered to. For instance, cases where the foetal head is jammed it is better to ask an assistant to push the head vaginally prior to extraction of the head. Further, in patients with transverse lie where much liquor has already drained, it is wise to make a low vertical incision rather than insisting on conventional transverse incision in the lower segment which will invariably result into extension of the incision. Thereafter the incision can be extended upwards if necessary. Once extension has occurred and haematoma has formed, surgeon should exercise great patience. Proper expousre is necessary. Usually one or few offending vessels could be identified and ligated individually. If this fails to control bleeding one should seriously consider ligation of internal iliac artery at this stage instead of jumping into hysterectomy straightaway. Ligation of internal iliac artery will considerably reduce the bleeding and thereafter one will be in a better position to locate the offending vessels. Even unilateral ligation of internal iliac artery will suffice in many cases. This conservative approach is essential particularly in primigravid patients where conservation of uterus is so essential.

Accretion of placenta in the lower segment formed the next common indication. There were 6 such cases and of them 3 (50%) had past history of caesarean section. May be that the scar in uterus favoured accretion but no patient in our series had history of manual removal of placenta. It is not an uncommon experience to find welling up of blood fom the

placental site in these cases. Pressure with hot mops, starting oxytocin drip in high doses and placing matteress suture in the bleeding site failed to control bleeding in these 6 cases. Rubenstone and Lash (1963) emphasized that total rather than subtotal hysterectomy should be performed in cases of placenta praevia accreta to avoid further bleeding from the left out lower segment. But our experience is otherwise. We performed subtotal hysterectomy in all these 6 cases and there was no bleeding in the post-operative period. But we place rows of matteress sutures in the left out portion of cervix which is a more quick procedure than total hysterectomy, because by the time decision of hysterectomy is made, her condition is too critical to insist on total hysterectomy. Immediate objective is to save her life.

Atonic PPH was the next common indication. All these cases were emergency admissions with prolonged labour. In the review of Gupta *et al* (1981) there were 7 such hysterectomies out of 927 caesarean sections. But with increasing experience of the surgeon, this type of hysterectomy could be avoided in majority cases. In some cases coagulation disorder may be responsible for such atonic P.P.H. Couvelaire uterus was the indication of caesarean hysterectomy in 5 cases and 1 of them died in the immediate post-operative period. In a retrospective analysis, it was evident that caesarean section could have been avoided in 2 cases. Caesarean section was done in these 2 cases with the pre-operative diagnosis of placenta praevia. Had these patients been diagnosed as abruptio placentae pre-operatively, conventional treatment of abruptio placentae might have been beneficial in these two cases.

Three patients underwent caesarean hysterectomy due to gross intrapartum sepsis. All were emergency admissions. There was 1 case of pregnancy with multiple corporeal fibroid. She was a second gravida with one living child. Her first delivery was normal. In the current pregnancy there was early rupture of membranes with failure to progress in the first stage of labour. Oxytocics were not tried. She was 36 years. Caesarean section followed by total hysterectomy was carried out. The recovery was uneventful.

We lost 2 mothers and thus maternal mortality was (6.6%). Perinatal mortality was 26.6 per cent. There was one case of burst abdomen who eventually recovered.

Conclusion

By and large caesarean hysterectomy is preventible. The incidence of 0.87% hysterectomy amongst all caesarean sections is appreciably high and in some cases hysterectomy was unnecessarily resorted to with the fear of continued haemorrhage either from the extension of incision line or as P.P.H. due to uterine atony. Steps of controlling haemorrhage have been discussed at length.

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