

OBSTETRIC HYSTERECTOMY IN MODERN DAY OBSTETRICS : (A REVIEW OF 30 CASES OVER A PERIOD OF 5 YEARS)

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SUMMARY

The following is an analytical review of 30 cases of Obstetric hysterectomy done at Nowrosjee Wadia Maternity Hospital, Parel, Bombay 400 012 in a period of 5 years from 1988 to 1992. The total number of deliveries in 5 years were 53,638 giving an incidence of 0.056%. Majority of patients were booked. Atonic post partum haemorrhage was the commonest indication contributing to 50% of the total cases. There were 6 deaths (20%) due to DIC (3 cases), hypovolemic shock (2 cases), and cardiorespiratory arrest (1 case).

INTRODUCTION

The operation of obstetric hysterectomy was originally devised more than two hundred years ago as a surgical attempt to manage life threatening obstetric haemorrhage and infection. Joseph Cavallini, Horatio Storer, Eduardo Porro, Lawson Tait etc. were pioneer workers in developing this operation. (Sturdee D.V. 1987). With the advent of newer drugs like prostaglandins, antibiotics and blood transfusion, the

incidence of obstetric hysterectomy is going down. Postoperative morbidity and mortality is also decreasing. In some countries caesarean hysterectomy is done electively for sterilization. Occasionally it is performed for pregnancy with co-existing cervical or ovarian malignancy.

MATERIAL AND METHODS

Thirty cases of obstetric hysterectomy performed at Nowrosjee Wadia Maternity Hospital from 1988 to 1992, were studied. These hysterectomies included emergency and elective procedures. They were

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performed at the time of caesarean section or post vaginal delivery. They were analysed in terms of age, parity, registration status, presence of any high risk antenatal factor, type of delivery, indication for obstetric hysterectomy, complications during surgery, units of blood transfused and maternal outcome.

OBSERVATIONS, ANALYSIS AND DISCUSSION

Incidence :

The total number of deliveries being 53,638 the incidence of obstetric hysterectomy was 0.056%.

Incidence reported by Allahabadia et al (1991) from Sion Hospital, Bombay was 0.19%. Incidence in our hospital was low because unregistered patients are not accepted in our hospital as a routine.

Incidence in a study by Sturdee & Rushton (1986) from Birmingham Maternity Hospital was 0.07%.

Age:

The cases in the age group of 20 to 25 years were 43.3% while only 6.6% were in the age group of 35 to 40 years. The youngest patient was 22 years old and the oldest patient was 39 years old. This is observed because of social custom of early marriage and early childbearing in Indian society.

Parity :

Thirteen cases were primiparae, one case was ninth para.

Booked/Unbooked :

Twenty three cases were booked and seven cases were unbooked which were

referred from private nursing homes.

High risk antenatal factor:

Eleven cases were of previous LSCS. Previous LSCS is a high risk factor because of higher incidence of rupture uterus, placenta previa and repeat LSCS.

Type of delivery :

On twenty cases (66%) hysterectomy followed a caesarean delivery, 4 (13%) cases were of instrumental delivery and 6 (20%) cases were following normal vaginal delivery.

Indication : (Table I)

There were fifteen cases of atonic PPH, four of rupture uterus, three of traumatic PPH excluding rupture uterus, four with placenta previa, two of placenta accreta, one with placenta percreta and one of abruptio placenta. One case was adherent placenta with scar dehiscence and one elective caesarean hysterectomy was performed for previous 2 LSCS with placenta previa. Indications in other studies from India are also given in Table I.

Operative details :

In this study, 22 cases were subtotal and 8 were total hysterectomies. In 8 cases internal iliac artery ligation was attempted to control the PPH, failing which hysterectomy was resorted to. In one case of rupture uterus; the uterine tear had extended into the cervix and urinary bladder. After separating the bladder from the lower uterine segment, the bladder rent was closed carefully and the bladder was drained with suprapubic cystostomy postoperatively. All the cases of rupture uterus were that of previous LSCS with irreparable tears. On an average

Table I
Indications of Obstetric Hysterectomy in present series and other studies from India. 1,2,3

Indications	Present series (%)	Allahabadia et al (%)	Ambiye et al (%)	Kaul's series (%)
1. Post partum haemorrhage				
-Atonic	50	16	8.4	9.0
-Traumatic (excluding rupture uterus)	10			
2. Rupture uterus	13.3	20	67.8	63.9
3. Placental causes				
-Previa	13.3	4	-	3.6
-Acreta	6.6	-	-	-
-Percreta	3.3	-	-	-
-Abruptio	3.3	2	-	-
4. Chorioamnionitis	-	4	0.9	1.8
5. Prolonged labour	-	9	-	-
6. Perforation following MTP	-	-	10.3	7.2
7. Septic abortion	-	46	8.4	-
8. Gestational tumour	-	-	0.9	10.9
9. Secondary abdominal pregnancy	-	-	0.9	-
10. Cancer cervix	-	-	1.8	-
11. Sterilization	-	-	-	3.6

In present series one case was with adherent placenta with scar dehiscence and one case was elective caesarean hysterectomy for previous 2 LSCS with placenta previa.

1250 ml blood was needed to be transfused to the patients. One case of abruptio placentae leading to DIC received 3300 ml of fresh blood however she expired on the table on completion of the obstetric hysterectomy. All the cases were given postoperative antibiotic cover, blood transfusion, fresh frozen plasma and platelets whenever required.

Maternal outcome : (Table II)

There were total 6 maternal mortalities (20%) (Table II), 3 due to DIC, 2 from haemorrhagic shock and one because of cardiorespiratory arrest.

In Allahabadia et al (1991) series there were total 16 deaths out of 50 cases of

vesicovaginal fistulae. The morbidity encountered was febrile morbidity in 6 cases and wound dehiscence in 3 cases.

CONCLUSION

With increasing awareness of antenatal care, availability of blood transfusion, advent of new drugs and timely performance of caesarean section to avoid difficult vaginal delivery the incidence of obstetric hysterectomy is going down.

Qualified specialists are available in most of the places and therefore postoperative morbidity and mortality is also decreasing. Performance of caesarean hysterectomy can be the difference between life and death for the patient, so every obstetrician should

Table II

Causes of Mortality	No. of cases	Percentage
1. DIC	3	50
2. Haemorrhagic shock	2	33.3
3. Cardiorespiratory arrest	1	16.7

obstetric hysterectomy; giving an incidence of (32%). Eighteen percent cases were due to septic abortion, 6% due to rupture uterus and 8% cases of PPH expired because of DIC and pulmonary embolism.

In a study of Sturdee & Rushton (1986) from Birmingham Maternity Hospital, there were 47 hysterectomies in 15 years with not a single maternal mortality.

Louisiana State University series, records 6 maternal deaths in 912 caesarean hysterectomies (0.66%). (Planche W.C. 1986).

Patients who survived did not have any major morbidity like urethrovaginal/

be trained to perform this procedure.

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