

# Hysterectomy for Obstetric Emergencies

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## Summary

Emergency hysterectomy in obstetric practice is indicated mainly when the life of the mother is threatened by unrelenting haemorrhage or by rupture of the uterus. It is used as a life saving measure when all other means have failed. A review of 183 cases is presented with an aim to study the indications, complications, morbidity and mortality. It was found that the condition for which the operation was done, and not the operation, was responsible for mortality and morbidity.

## Introduction

Emergency hysterectomy in obstetric practice has become relatively infrequent. The indications are mainly those in which the life of the mother is threatened by unrelenting haemorrhage or by rupture of the uterus. Severe infection of the pregnant uterus and its contents sometimes requires hysterectomy.

With improved technique, availability of powerful broad spectrum antibiotics and blood transfusion facilities, it is used as a life saving measure when all other means have failed. Though maternal mortality is reduced, it may be a difficult decision, since the patient's reproductive capacity is sacrificed.

A review of 183 cases of hysterectomy for obstetric causes is presented, with an aim to study the indications, complications, morbidity and mortality.

## Material and methods

Hundred and eighty three emergency hysterectomies for obstetric indications were performed at the Patna Medical College Hospital, Patna during the 5 year period, 1993 to 1997 have been analysed. Hysterectomy for any indication during pregnancy, labour and the puerperium has been included.

## Observations

**Incidence:** Out of 48157 confinements there were 183 emergency hysterectomies, the incidence being 0.38% i.e. 1 in 263.

**Age and Parity :** As shown in Table I, 59.9% patients were between 26 and 35 years. One patient was less than 20 years old. She required hysterectomy for *Ch. Welchii* infection of the uterus, following criminal abortion.

**Table I**  
Relation of Age and Parity

Age (Years)	Parity					Total
	1	2	3	4	5+	
20	1	-	-	-	-	1
21-25	-	6	18	11	-	35
26-30	-	12	21	15	6	54
31-35	-	7	14	23	8	62
35	-	3	9	7	12	31
Total	1	28	62	56	36	183

Fifty nine percent cases were para 3 or 4, while 19.7% were grandmultiparae.

#### Indications

Table II shows that the most common indication was rupture uterus (69.9%). Scar dehiscence was seen in 48.4% of these cases (Table III). Dehiscence of a previous caesarean scar was present in 55 out of 62 such cases. Traumatic rupture was seen in 29.8% cases. Injudicious

use of oxytocics was the cause in 26 out of 38 such cases. Prolonged labour caused rupture in 19.5% cases, CPD led to rupture in 15 of 25 cases. Atonic PPH necessitated hysterectomy in 18 cases. Most of these cases followed obstructed labour. There were two cases following APH.

Twenty three cases of morbidly adherent placenta (MAP) required hysterectomy. Table IV depicts that previous manual removal of placenta and previous C.S. formed more than 69% of these cases. In 4 caesarean

**Table II**  
Indications

Indications	No.	%
Rupture uterus	128	69.92
Atonic PPH	18	9.83
Placental causes	23	12.57
Chorioamnionitis	2	1.08
Septic abortion	1	0.54
Perforation following MTP	6	3.28
Angular pregnancy	1	0.54
Broad ligament haematoma	4	2.16
Total	183	100.00

**Table III**  
Causes of rupture uterus :

Spontaneous rupture due to		25 (19.5%)
CPD	15	
Malpresentation	8	
Hydrocephalus	2	
Traumatic rupture due to		38(29.0%)
Forceps	4	
Breech delivery	2	
Internal podalic version	5	
Oxytocics	26	
Scar dehiscence due to		62 (48.4%)
Previous CS	55	
Repair of rupture uterus	3	
Repair of MTP Perforation	4	
No obvious cause		3 (2.3%)
Total		128

**Table IV**  
**Etiology of morbidly adherent placenta:**

Cause	No.	%
Previous manual removal of placenta	9	39.1
Previous MTP	3	13.0
APH	2	8.7
H/O severe sepsis	3	13.0
Previous CS	7	30.2
Total	23	100.0

cases, the placenta was adherent to the scar anteriorly causing profuse haemorrhage necessitating hysterectomy. There was one case of placenta praecura. In 6 cases, hysterectomy was done in early pregnancy (Table II), for injury to the uterus at the fundus and lateral wall during MTP. These cases had multiple perforations. In one case of previous CS, there was a cruciate tear on the anterior surface of the uterus. Extension of uterine incision leading to uncontrollable broad ligament haematoma was treated by hysterectomy in 4 cases.

#### Post-Operative complications

About a third of the patients had no post-operative complication. The most common complication was febrile illness in 54 cases (Table V), followed by paralytic ileus in 35.

**Table V: Post-operative complications:**

Sl. No.	No.	%
1. Fever 101 F for 24 hrs.	54	29.5
2. Paralytic ileus	35	19.1
3. Peritonitis	10	5.5
4. Wound infection	17	9.3
5. Pelvic cellulites	7	3.8
6. Ureterovaginal fistula	1	0.5
7. Vesicovaginal fistula	2	1.1
8. Deep Vein Thrombosis	6	3.3
9. Burst abdomen	5	2.7
10. Endotoxic shock	1	0.5

There were 17 cases of wound infection and 5 cases of burst abdomen. Most patients had more than one complication.

#### Maternal mortality

**Table VI: Causes of maternal mortality**

Cause	No.
DIC	4
Pulm Embolism	2
Haemorrhagic shock	5
Total	11

This was only 6.01%. Of the 11 deaths haemorrhagic shock was the cause in 5 patients, while DIC was responsible for 4 (Table VI).

#### Hospital stay

On an average this was 12 days. Only 2 patients had to be hospitalized for 21 days. They had associated bladder rupture which was also repaired.

Ninety percent cases were unbooked, referred from outside. Delay in transport and late referral contributed to their moribund condition. Total hysterectomy could be performed in 18 cases, while supracervical hysterectomy was done in the remaining 165.

#### Discussion

Caesarean hysterectomy still remains a necessary tool for the obstetrician. Knowledge of this operation and skill at its performance saves lives in catastrophic rupture of the uterus or intractable post partum haemorrhage.

We found a much higher incidence viz. 0.38% than reported by Sikdar and Mandal (1980) viz. 0.2% or by Mantri et al (1993) viz. 0.32%.

Most of our cases were referred from outside in moribund condition after complications occurred.

Rupture uterus was the commonest cause in 69.9%. This is similar to the 67.2% incidence reported by Mantri et al (1993), 67.8% by Ambiyé & Venkatraman (1988) and 63.9% by Kaul (1982). Allahabadia et al (1991) reported a lower incidence of 20%.

In infected cases, hysterectomy removes the potentially infected thrombotic area of placentation. Hysterectomy gives the best result in Cl. Welchii infection. (Douglass and Beckman, 1966).

The mortality rate among our patients was only

6.01%, much lower than 14% reported by Mantri et al (1993) and 32% by Allahabadia et al (1991). Sturdee and Rushton (1986), reported no mortality in their series from U.K.

It is not the operation, but the condition for which the operation has been done, that is responsible for morbidity and mortality.

### Conclusion

Availability of quality blood transfusion and timely referral to a larger hospital go a long way in reducing morbidity and mortality among the parturient patient. Importance of availing antenatal care and identification of high risk cases is important in avoiding catastrophic outcomes.

Injudicious use of oxytocin needs to be deplored. The rising incidence of MTP and CS, reflect the increase in cases of morbidly adherent placenta.

When hysterectomy is required, though the specific surgical objective is total hysterectomy, a quick subtotal hysterectomy may save a life in the face of blood loss and shock.

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### References

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