

Obstetric Hysterectomy Analysis of 34 Cases

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Summary

An analysis of 34 cases of obstetric hysterectomy performed at L.T.M.G. Hospital, over a period of 3 years, is presented here. Incidence of obstetric hysterectomy was 0.18%. Rupture uterus was most common indication. Total hysterectomy was performed in 38% cases. There were 4 maternal deaths. The various steps to decrease the morbidity and alternative procedures are discussed.

Introduction

In no other gynecological or obstetrical surgery is the surgeon in as much a dilemma as when deciding to resort to an emergency hysterectomy. On one hand it is the last resort to save mothers life, and on the other hand, the mothers reproductive capability is to be sacrificed. Many a times it is a very difficult decision and requires good clinical judgement. 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. The maternal outcome greatly depends on timely decision to perform obstetric hysterectomy.

Materials and Methods

We present here an analysis of 34 cases of emergency hysterectomies done for obstetric indications over three years period at L.T.M.G. Hospital, Sion, Mumbai - 400 022.

A detailed analysis of the condition of the patient, indication for obstetric hysterectomy and

intraoperative and postoperative complications was made. The data was obtained from indoor sheets, investigation and treatment charts and operation notes.

Observation and Results

During the study period, there were total 18,113 deliveries. The incidence of obstetric hysterectomy was found to be 0.18% which is slightly higher than other studies because our hospital is the first big tertiary hospital on the highway and patients with complications are routinely sent to our institute. The incidence reported by Agashe et al (1995) was 0.056%.

Out of 34 cases, only 14 patients were registered and 20 were unregistered; 22 cases were transferred from other hospitals.

Most of the patients were between the age group of 20-30 years.

Three patients were primis and rest were multiparas. Of these three were grandmultiparas, which

in itself is a high risk factor for postpartum haemorrhage and rupture uterus (Table-I).

Table-I: Parity

Parity	No. of Patients
Prim	03
II	07
III	14
IV	07
V	03

Period of gestation is shown in Table-II. The 3 patients who were in their first trimester had an invasive mole, a cornual pregnancy and an MTP perforation respectively.

Table II: Gestational Age.

Gestational Age (Weeks)	No. of Patients.
<12	03
13-20	02
21-28	04
29-36	12
>36	13

There were 6 vaginal deliveries, 2 were outlet forceps and 1 was twin delivery. In 7 patients hysterectomy was required following caesarean section and 13 patients required laparotomy for rupture uterus.

Rupture uterus and postpartum haemorrhage were the two major indications for obstetric hysterectomy in our study (Table III)

Table-III: Indications for Obstetric Hysterectomy

Indication	No. of Patients
Rupture uterus	13
PPH	11
Morbid adhesions of placenta	02
Extension of uterine incision during I SC S	02
Secondary abdominal pregnancy	01
Septic abortion	01
Ectopic pregnancy	01
MTP perforation	01
Invasive mole	01

In a study by Agashe et al (1995) postpartum haemorrhage was the commonest indication. While Pati et al (1998) reported rupture uterus as the commonest indication for obstetric hysterectomy. Prior caesarean section and placenta previa were the significant high risk factors found in these cases (Table IV). In placenta previa, the placenta is attached to the lower uterine segment which does not contract well after separation which leads to the sinuses remaining open after delivery leading to PPH. Operative intervention and a high incidence of adherent placenta are also contributory factors for PPH.

In 62% of our patients, subtotal hysterectomy was performed. It is not always possible to do a total abdominal hysterectomy as patients general condition is often poor. Besides, leaving the cervix behind may have a positive influence on her future sexual life. However in certain cases where the bleeding occurs from lower uterine segment or cervix, it becomes necessary to remove the cervix.

One of the patients with rupture uterus had bladder tear, which was sutured. The patient with an MTP perforation, required repair of bowel injury along with the hysterectomy. It is important to ligate the stump

Table-IV: High Risk Factors

Rupture Uterus (17)	PPH (11)	Morbid Adherent Placenta (3)
Previous I SC S-8	Placenta previa-5	Previous I SC S-1
Grand multipara-3	Accidental haemorrhage-3	Placenta previa-1
Oxytocin abuse-1	Prolonged labour-2	History of retained placenta-1
Prolonged labour-1	Multiple pregnancy-1	
Obstetric manipulation-1		
Accidental haemorrhage-3		

doubly and carefully, as tissues are more vascular and oedematous; this can lead to bleeding in the postoperative period. Altered coagulation often contributes to more bleeding. In our study, 3 patients required repeat exploration for achieving haemostasis, of which 2 required internal iliac artery ligation (Table-V).

Table-V: Additional Surgical Procedure.

Procedure	No. of Patients
Adenectomy	04
Repair of bladder tear	01
Hypogastric ligation	03
Repair of bowel injury	01
Ureteric injury repair	01

Postoperative complications are summarised in Table-VI. Five patients had postoperative septicemia and 3 had wound infection of which 1 had complete wound dehiscence. DIC was found to be the commonest complication amongst these patients.

Table-VI: Complications

Complications	No. of Patients
DIC	06
Septicaemia	05
Renal failure	02
UTI	05
Wound infection	03
Wound dehiscence	01
Gluteal abscess	01
Thrombophlebitis	02
Vesicovaginal fistula	01

There were 4 maternal deaths. Maternal mortality was 11.1% in our study. These resulted from septicemia, DIC following acute blood loss and hypovolemic shock.

There were 15 still births, 9 live births and 3 neonatal deaths in our study.

Discussion

Ever since Edward Porro performed first obstetric hysterectomy, the procedure has been widely used to save maternal life. Postpartum haemorrhage and rupture uterus are the most common indications. A

rapidly increasing incidence of caesarean section is a contributing high risk factor. The presence of a prior caesarean section scar is a risk factor for rupture uterus, placenta previa and morbidly adherent placenta amongst other complications.

Stanco et al (1993) found that prior caesarean section increases the risks of emergency hysterectomy by 15-20 times. Hence probability of caesarean hysterectomy must be kept in mind while dealing with patients with previous caesarean section.

Also, identification of high risk factors, active management of labour and early intervention can be helpful in decreasing the need for this procedure.

Early transportation to tertiary referral centres, timely decision to perform hysterectomy before deterioration of patient's general condition, adequate infusion of blood and blood products and use of higher antibiotics will decrease the morbidity and mortality in these cases.

Availability of skilled qualified doctors and adequate training of resident doctors in this regard is of prime importance.

Though hysterectomy in such conditions is life saving, the obstetric future of these patients is sacrificed. Hence alternative measures to control bleeding like suturing of the rent, ligation of uterine vessels and hypogastric artery ligation, should always be considered before taking a decision to remove the uterus.

Acknowledgement

We thank our Dean and Head of Department for allowing us to publish the hospital data.

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