An Overview of Gynaecological Geriatric Indoor Patients

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Summary

A retrospective study of female patients aged 60 years and above admitted in one of the three units of the Department of Obstetrics and Gynecology, Safdarjang Hospital, New Delhi; was done over a period of 18 months, to analyze the incidence, diagnosis, treatment given, morbidity and mortality. A total of 78 patients were admitted, comprising 6.64% of the 1175 Gynecological admissions. The commonest disease was genital tract malignancies (44.8%), followed by uterovaginal prolapse (34%). Incidence of benign diseases was 21.2%. There was no mortality in the post-operative period and the post-operative period was uneventful except in 4 patients who developed pyrexia. It was seen that 84.7% patients of malignancy came in an advanced stage which calls for regular gynecological check up & screening for malignancies after the age of 40.

Introduction

Today we can expect to become old. We are on the verge of becoming a rectangular society. Society used to be a true pyramid in 1900 but with the passage of time is gradually becoming more rectangular. In advanced countries the shape will be nearly a perfect rectangle by 2050.

In a rectangular society nearly all individuals reach an advanced age and then succumb rather abruptly over a narrow range centering about 85.

In 1000 BC life expectancy was only 18 years. By 100 BC, at the time of Julius Caesar, it had reached 25 years. In 1900 life expectancy still had reached only 24 years / 49 years in developing & developed countries respectively. But by 1987 the average life expectancy had reached 57 years / 75 years. Today a man of 65 years and a woman of 70 years can expect to reach an age of 70 years and 80 years respectively. (Richard et al, 1990).

In 1900 only 5% population was over 60 years of age while it is expected that by the year 2040 population of the elderly will reach 25%.

A good general definition of elderly is 60 years and older, although it is not until age 75 that a significant proportion of older people show the characteristic decline in health and resulting problems. The aim of the present study was to analyse incidence, diagnosis, treatment given, morbidity and mortality in females aged 60 years or more.

Materials and Methods

A retrospective study of female patients aged 60 years or more admitted in one of the three units of the Department of Obstetrics and Gynecology, Safdarjung Hospital was done over a period of 18 months from 1st Jan 1999 to 30th June 2000.

Observations

Seventy Eight patients were aged 60 years or more amongst total admission of 1175 comprising an

incidence of 6.64%. Majority of them (79.7%) were between 60-65 years of age. Thirteen patients were 65-70 years of age and only 3 patients (3.7%) were more than 70 years of age.

Distribution of geriatric patients was done under three groups (Table I). The first group comprised 35 patients (44.8%) with genital tract malignancies. Patients of uterovaginal prolapse 27 (34.2%) were in the second group. The third group consisted of 16 patients (21%) with other benign disorders.

Table II depicts that out of 35 cases of group A 30 i.e., 85.7% patients came in advanced stage of malignancy and they were referred to the department of Radiotherapy and Chemotherapy. Only 5 patients (14.3%) had early malignancy for which the requisite surgery was done.

Group B (Table III) comprised 27 patients of uterovaginal prolapse. Vaginal hysterectomy with repair was done in 22 cases. In 4 patients who were not fit for vaginal hysterectomy due to cardiac or respiratory problems, pursestring sutures in the introitus were applied under local anesthesia. One patient who was obese, diabetic with retention of urine and having fracture of right fibula with plaster leg was sent back after pessary insertion with the advice to come back after the removal of the cast.

Table IV gives details of patients in Group C.

Table V gives the types of surgery in the study. It is seen that 31 major surgeries including vaginal

Table I: Group of diseases

Group	Disease	No. of patients	Percentage
A	Genital tract malignancies	35	44.8%
B	Uterovaginal prolapse	27	34.2%
C	Other benign disorders	16	21%

Table II: Group A – malignancies

Group A	Genital tract malignancies		
Diagnosis	No. of cases	Early stage	Advanced stage
Carcinoma cervix	24	1	23
Carcinoma body uterus	7	3	4
Ovarian carcinoma	1	1	-
Carcinoma vagina	2	-	2
Carcinoma vulva	1	-	1

Table III: Group B – Uterovaginal Prolapse

Group B	Uterovaginal prolapse	
Surgery	No. of patients	Percentage
Vaginal hysterectomy with repair	22	81.48%
Pursestring sutures	4	11.11%
Pessary application	1	3.70%
Total	27	

Table IV: Other Benign disorders

Group C	Other benign disorders	
Disease	No. of patients	Percentage
Chronic cervicitis	4	25%
Chronic endometritis	2	12.5%
Pelvic inflammatory disease	3	18.7%
Submucus polyp	2	12.5%
Fibroid uterus	1	6.25%
Unexplained Postmenopausal bleeding	4	25%
Total	16	

hysterectomy, Wertheim hysterectomy, panhysterectomy and laparotomies and 58 minor surgeries were done on these patients, without mortality. Four patients developed pyrexia post-operatively which subsided with symptomatic treatment and all patients were discharged on the 7th to 9th day in satisfactory condition.

Table V: Types of surgeries

Surgery performed	Number
Vaginal hysterectomy	22
Wertheim's hysterectomy	01
Panhysterectomy	03
Laparotomy	05
Cervical biopsy	28
Endometrial sampling	17
Dilatation & Curettage and polypectomy	02
Vaginal biopsy	01
Vulval biopsy	01
Pyometra drainage	05
Introital tightening	04

Discussion

In the present study, malignancy was the commonest problem followed by uterovaginal prolapse. Similar findings have also been reported by Sharma et al (1990) and Arora and Oumachigue (1992) who had 92.9% & 86.7% cases of advanced malignancy amongst their malignant group as against 85.7% in our series. This highlights the great importance of screening for malignancy in earlier years.

Cases of prolapse uterus can be markedly reduced by proper obstetric care.

Physicians who interact with women during menopause may play a great role by entering them into a regular health care system, maintenance of continuity of care, appropriate referrals when needed and supervision of cost effectiveness of care.

References

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