Vaginal Hysterectomy: Study of 75 Cases

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Objectives: To evaluate the outcomes of vaginal hysterectomy in respect of operative, post operative complications. **Study design:** Lady Aitchison Hospital affliated with king Edward medical college Lahore, from January 2004 to December 2005. **Patients and methods.** Out of total 215 hysterectomies performed,75 were vaginal for different conditions. **Results:** The results showed, that at the age of 50 yrs prolapse [48%] was the main indication, while menorrhagia [36%] was the main indication at age of 40 - 50 yrs. Between 30 – 40 yrs Menorragia with prolapse [16%] and below 30 yrs complete prodencia was the indication. 8% intraoperative complications were, 4% operative haemorrage, 1.3% visceral injury, 2.7% return to theature. The post operative complications were maternal death 1.3%, fistula formation (1.3%), return to theature (6.7%), retention of urine (5.3%), pelvic heamatoma (4%), and granulation tissue (2.7%). In 80.1% of cases hospital stay was less than 72 hours **Conclusion:** Vaginal hysterectomy was the safest, low cost procedure in benign conditions with a few intra / post operative complications

Key words: Vaginal hysterectomy [VH], Prolapse, Menorrhagia

Hysterectomy is the most common gynaecological operation performed on the Women being 2nd to caesarean section[1]. There is still controversy over the indications and route, whether abdominal, vaginal or laproscopic assisted vaginal hysterectomy. There are major national, international, regional, and inter hospital variations in the proportion of each type of hysterectomy[2]. The fist planned VH was performed by the Langenbeck in 1817[2]. The vaginal route is preferred in Europe while the abdominal route in USA. The method of hysterectomy is largely accepted by women but the surgeon skill and preference is highly influenced the choice of procedure[4]. The annual rate of 5 – 5.86 per 1000 women has been slightly changed over the last decade[4]. The Mulholand et al 1996[5] found that over all ratio of abdominal to vaginal hysterectomy varied between 2.7 to 6.7 at regional level in Europe.

Methodology:

The study was conducted at Lady Aitchison Hospital affiliated with king Edward medical college Lahore from January, 2004 to December, 2005. Known cases of malignancies and medically unfit were excluded. The management Include detailed history, general physical and systemic examination and pelvic examination was done to assess the degree of prolapsed. The investigations required to all patients were ultrasound, blood chemistry, and intravenous urogram

Results:

The results are summarized in tables 1, 2 and 3

Table 1

Ages	Indication	No.	%age
50 yrs and above	2nd degree prolapse	36	48
40 –50 yrs [perimenopause]	menorrhagia with out Prolapse	24	36
30 – 40 yrs [Reproductive]	menorrhagia with prolapse	12	12
30 yrs and below	2nd degree prolapse	3	04

Table 2: Intra operative complications

Complication	n=	%age
Operative Haemorrhage	3	4
Visceral Injury	1	1.3
Return to theatre	2	2.7
No. complication	69	92

Table 3 postoperative complications

Complications	=n	%age
Severe Complications		
Death	1	1.3
Fistula formation	1	1.3
Examination under anesthesia	3	4
Less Severe Complications		
Urinary tract infection	4	5.4
Pelvic Haematoma	3	4
Granulation tissue	2	2.7
Hospital Stay < 72 hrs	61	81.3

Discussion:

Despite the introduction of modern endometrial ablation techniques, hysterectomy remains the most common major gyaenecological operation performed being 2nd to caesarean section. The VH rate had little changed during the last decades as found by Mulholand et al 1996[5]. The 39.4% VH rate in the study was comparable to 30% of all VHs performed in UK[3]. It was equal to 20% at the age of 40 years[6], increasing to33% at the age of 65 years[7], and 49% at the age of 85 years in different studies[8]. 48% of the VHs were performed at the age of 50 years and the main indication was prolapse at menopause[62%] This was consistent with the study of Vessely et al (1992) that hysterectomy rate showed positive trend with the multiparity[6]. Menorrahgia with prolapse [36%] was the main indication in perimenopause and reproductive age, comparable to different indications for hysterectomy as, uterine fibroids[73.5%],menstrual irregularities [53.4%], endometriosis [45%],in different studies [9]. The abdominal hystrecetomy is the favoruite route for menorrhagia as well

as other treatment modilities like levonorgestrol releasing intrauterine [LNG-IUS] system, endometrial ablations. Both these treatments had similar beneficial effects as compared to hysterectomy[10] but VH proved to be better option. Endometrial ablation had a real risk of recurrence of excessive bleeding, increasing up to 20% at the age of 60 years[11]. VH, if feasible is preferred to abdominal route because it avoids visible scar, is associated with less pain and generally require less post operative hospital stay[12]

The overall operative complication seen in the study was (8%) which are equal to 11.2% and 8% to 16% seen in other studies[13, 14]. The most significant intraoperative complication was operative haemorrage 4% in the study was more as compared to 2% in other studies, due to prevalence of anemia. The visceral injury was 1.37%. These injuries are more in laproscopic assisted VHs[15].

The hysterectomy had a real small risk of postoperative morbidity and maternal mortality. Approximately more than 1/3rd of all cases of VHs have one complication of minor nature[3]. The severe complications 9.3% in study with one maternal death (1.3%) was similar to 0.4% per 1000 cases [0.25 per 1000 for menopausal women with dysfunctional uterine bleeding]. The less severe complications seen in the study were more as compared to other study, like urinary retention [5.3% versus 5.1%], pelvic haematoma [4% versus 1.8%], and return to theater [6.7% versus 1.7%] as most of VHs performed by the trained registrars(13). The hospital stay in 80.1% cases was < 72 hours. This was consistent with the results of large randomized control studies on different routes of hysterectomies in which VH had reduced hospital stay and improved recovery time[15, 16].

Limitations to VH are enlarged uterus and limited space for surgical procedure but in skilled persons it is the procedure of choice in benign conditions

Conclusion:

Vaginal hysterectomy was the safest, low cost procedure for benign gynaecological conditions with insignificant intra / post operative complications.

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