

Hysterectomy Following Tubal Sterilization

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In a study of two hundred patients undergoing hysterectomy for non malignant conditions fifty eight patients (29%) had previous tubal sterilization. In most of these patients the gynaecological problem necessitating hysterectomy antedated the sterilizing procedure. Proper counselling, thorough examination and investigations should be carried out prior to tubal sterilization to exclude any underlying gynaecological disorder. The aim of this study was to attempt to identify circumstances where two operations could have been avoided by consideration of any possible indication for hysterectomy at the time when initial sterilization was requested.

Key words: Tubal sterilization, hysterectomy

One of the biggest problem facing developing countries is population control. Various methods have been advocated. One out of those methods is Tubal Sterilization. Women are often brought in groups by health workers for tubal sterilization which is carried out without proper gynaecological assessment.

Surgical sterilization for social rather than medical indications has recently become more acceptable to relatively young women. Concurrently the indications for hysterectomy have expanded to include dysfunctional uterine disorders or simply sterilization^{1,2}.

Our daily gynaecological practice shows that many women who come for hysterectomy for non malignant conditions have already been sterilized.

The purpose of this study was to identify circumstances where repeat surgery could have been avoided by consideration of any possible indication for hysterectomy at the time when sterilization was requested.

Patients and Methods

All patients undergoing hysterectomy for non-malignant disease in Gynaecology and Obstetrics Unit-I, Liaquat Medical College Hospital, Hyderabad were prospectively studied over a period of sixteen months from May 1996 to September 1997.

Results

A total of two hundred patients had hysterectomy, out of these fifty eight patients (29%) were previously sterilized and one hundred and forty two were non sterilized.

Table I

Age in Years	Previously sterilized		Non sterilized	
	No.	%age	No.	%age
35-40	40	68.96	15	10.56
41-45	14	24.13	82	57.74
46-50	3	5.17	40	28.16
50 & above	1	1.72	5	3.52

Forty patients (68.96%) belonged to 35-40 years age group in the previously sterilized group, whereas eighty two patients (57.74%) belonged to 41-45 years age group in the non-sterilized group (Table I). This revealed that previously sterilized women were having hysterectomy at a younger age. The main indications for hysterectomy are listed in Table II.

Table II

Indications	Previously sterilized		Non sterilized	
	No.	%age	No.	%age
Dysfunctional uterine bleeding	34	58.626	86	60.56
Fibroid uterus	15	25.86	32	22.53
Abnormal cervical cytology	3	5.17	6	4.22
Dysmenorrhoea	6	10.34	5	3.52
Uterovaginal prolapse	-	-	8	5.63
Endometriosis	-	-	5	3.52

More than half of the patients in both groups were having hysterectomy because of dysfunctional uterine bleeding i.e. menorrhagia, polymenorrhea, irregular cycles and inf ew patients continuous bleeding per vaginum.

Fifteen patients (25.86%) who were previously sterilized wee now having hysterectomy becaus eof fibroid uterus within five years of sterilization. Thus could be explained by failure to diagnose fibroid at the time of sterilization (Table II).

The frequency of abnormal cervical cytology was nearly same in both the groups. Other indications for hysterectomy in the non sterilized group were uterovaginal prolapse and endometriosis.

Table III

Type of Hysterectomy	Previously sterilized		Non sterilized	
	No.	%age	No.	%age
Total hysterectomy + Bilateral salpingo-oophorectomy	20	34.48	102	71.83
Total hysterectomy	38	65.51	32	22.53
Vaginal hysterectomy	-	-	8	5.63

In the non-sterilized group one hundred and two patients had total hysterectomy + bilateral salpingo-oophorectomy whereas in the previously sterilized group only twenty patients (34.48%) required total abdominal hysterectomy + bilateral salpingo-oophorectomy (Table III). This could be explained by the fact that previously sterilized women were having hysterectomy at a younger age.

Table IV

Sterilization - Hysterectomy Interval in years	Previously Sterilized n=58	
	No.	%age
Less than 5 years	32	55.17
5-10 years	20	34.48
11-15 years	5	8.62
16-20 years	1	1.72

In thirty two patients (55.17%) the sterilization-hysterectomy interval was less than five years. It could be deduced that the ultimate indication for hysterectomy had been present at the time of sterilization (Table V)

Table V

Symptoms Prior to Sterilization	Previously Sterilized n=58	
	No.	%age
Menorrhagia	28	48.27
Irregular cycles	7	12.06
Scanty periods	3	5.17
Pain in lower abdomen	6	10.34
No symptoms	14	24.13

Twenty eight patients (48.27%) had heavy periods before they were sterilized and seven patients (12.06%) had irregular menstrual cycles. Out of fifty eight patients thirty five patients (60.34%) had an underlying problem at the time of sterilization.

Discussion

The results of our study confirm that omission of proper and thorough gynaecologic assessment including cervical cytology prior to sterilization leads to an unnecessarily high incidence of subsequent hysterectomy for unsuspected disease.

In the United States, approximately 650,000 women of reproductive age undergo tubal sterilization each year and some of these women later have hysterectomies little is known about risk factors for having hysterectomy after tubal ligation. Women with a history of menstrual complaints, leiomyomata, ovarian cysts, or endometriosis before their tubal sterilization had an increased risk of hysterectomy compared with women without such a history³.

Long term risk of hysterectomy after tubal sterilization was analysed by Goldhaber et al⁴. Sterilized women were significantly more likely than were comparison women to undergo hysterectomy. Higher relative risks were not associated with greater tissue-destructive methods of tubal occlusion. Relative risks were

highest for women who were young, but declined steadily as age increased. Reasons for elevated risks may be related to greater willingness of sterilized women to forgo their uteruses.

Menstrual irregularities was the most common indication for hysterectomy in majority of our sterilized patients. This was often the result of diminished tolerance of menstruation, especially when cessation of oral contraceptives or pregnancy immediately preceded sterilization^{5,6}.

Caesarean hysterectomy is a safe procedure with some, long-term advantages, therefore this option should be discussed with women who ask for tubal sterilization at the time of caesarean section⁷. The particular advantages of hysterectomy as a sterilizing procedure include avoidance of future risks of uterine malignancy and menstrual symptoms⁸. Hysterectomy is certainly not the method of choice for young women, those with unstable marriage or in the puerperium⁹.

Conclusion

With increasing appreciation of the risks of long term hormonal contraception more couples are likely to consider sterilization.

Tubal sterilization is safe and reliable method of permanent contraception. Women are usually motivated to undergo this procedure during pregnancy, labour and puerperium. Detailed menstrual history thorough examination and investigations should be carried out prior to sterilization. It should not be a hurried decision, rather it should be a sufficiently long decision process accompanied by individual medical consultation. Hysterectomy should be considered as the most appropriate sterilizing procedure when a gynaecologic problem exists especially when the patient is over 35 years of age.

References

- Burdell, RC: Decision regarding hysterectomy. *Am J Obstet Gynaecol*, 1977; 127: 113.
- Hysterectomy and sterilization (editorial) 1977 *Br Med J* 2: 715.
- Kendrick JS, Rubin GL, Lee NC, Schulz KF, Peterson HB: Hysterectomy performed within 1 years after tubal sterilization. *Fertil - Steril* 1985; 44(5):606-610.
- Goldhaber MK, Armstrong MA, Golditch IM, Sheehy PR, Petitti DB, Friedman G: 1993 Oct 1: Long term risk of hysterectomy among 80,000 sterilized and comparison women at Kaiser Permanente, 1971-1987. *Am J Epidemiol*, 138(7):508-521.
- Chamberlain GV, Foulkes J: Late complications of sterilization by Laparoscopy. *Lancet*, 1975; 1:878.
- Late complications of female sterilization (editorial) 1976. *Lancet* 1:573.
- Bukovsky I, Schneider DF, Langer R, Arieli S, Caspi E: Elective caesarean hysterectomy. Indications and outcome. A 17-year experience of 140 cases. *Aust N.Z.J. Obstet-Gynaecol* 1989 Aug; 29(3Pt2):287-290.
- Muldoon MJ: Gynaecological illness after sterilization. *Br Med J* 1:84.
- Winston RM: Why 103 asked for reversal of sterilization. *Br Med J* 2:305.