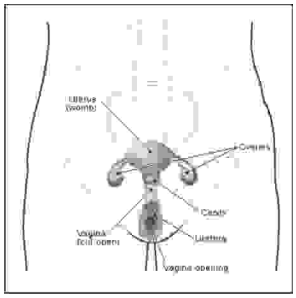
ORIGINAL PROF-589

HYSTERECTOMY;
VAGINAL VERSUS ABDOMINAL



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ABSTRACT... Objective: A study was conducted to evaluate the benefits of vaginal hysterectomy versus abdominal hysterectomy in patient with minimal or no prolapse, no pelvic adhesions and size of uterus not larger than 10 weeks of gestation. **Design:** A retrospective study. **Setting:** The study was conducted at Department of Obstetrics and Gyanecology , Services Hospital Lahore. **Subject And Method:** Total of 70 cases were included out of which 40 were vaginal and 30 were abdominal hysterectomies. **Results:** In vaginal group the morbidity was less, no abdominal scar, shorter hospital stay and less socioeconomic burden on the patient. **Conclusion:** The conclusion made was vaginal procedure is method of choice when ever applicable.

Key words: Vaginal Hysterectomy, Abdominal Hysterectomy, Complications.

INTRODUCTION

The term total hysterectomy means the removal of the uterine body and the cervix. It is carried out through two routes. The removal of the uterus per abdomen is known as abdominal hysterectomy. The removal of uterus through vaginal route and subsequently closing the space previously occupied by the uterus with a shelf of tissues derived from the lateral attachments of the uterus is known as vaginal hysterectomy. In cases where the removal of uterus cervix and both ovaries is carried out is known as total hysterectomy with bilateral salpingo-oophorectomy.

The operation of total abdominal hysterectomy was the routine procedure when it was considered to remove a uterus with benign pathology and abdominal route was chosen. After a decision is made to remove the uterus the route of operation has to be decided. Previously hysterectomy was performed abdominally merely because this had become an accepted procedure in that particular clinic or because few surgeons had mastered this technique. Lately, there has been a change in this trend. Vaginal hysterectomy has a definite place and in certain clinics and schools, now rivals the abdominal operation in the frequency of its performance. For an experienced vaginal surgeon it is feasible to perform a

vaginal hysterectomy easily as an abdominal for benign conditions of the uterus. Apart from the myomata larger than 12 to 16 weeks gestation, chronic inflammatory disease and endometriosis are always more safely and better dealt with by abdominal route.

The ideal patient for vaginal hysterectomy is one in whom the vagina is multiparous and roomy. Where there is some degree of utero vaginal prolapse and where the uterus is not fixed by the concomitant disease. It is not disputed that the expert at vaginal hysterectomy can convert the difficult operation into relatively easy one by enlarging the approach by Schuchardt's incision or by removing the obstructing myoma. These tours-de-force are an unnecessary elaboration of an operation which is much simpler and safer by abdominal route.

MATERIALS & METHODS

This study was conducted at Services Hospital. Majority of the patients were admitted through out-patient department and only three patients were admitted through emergency. After admission a detailed history was taken followed by examination. Initial assessment was done by the house surgeons. Later each patient was seen by registrar and then by consultant. The patient in the ward had certain pertinent investigations. A detailed performa was filled. Any associated medical problem was dealt in by the physician. Patients suffering from any local pathology e.g. fungal infections, trichomonal infection or decubitus ulcer were treated first before rendering them fit for surgery. Alongwith other investigations diagnostic dilatation and curettage was also done in cases where indicated. Depending upon the history, physical findings, investigations and report of dilatation and curettage decision was made.

The route, abdominal or vaginal was decided by taking into consideration size, mobility and descent. The obesity of the patient was also kept under consideration. A preoperative assessment was made by the anesthetist. Blood was cross matched and 2 pints arranged for each case. Most of the patients were given general anesthesia but few were also given epidural and spinal anesthesia.

The hysterectomies were performed by registrars, senior registrars and consultants. The suture material used was chromic catgut # 1 in all cases. Ovaries were conserved in most of the patients and removed only in patients where the ovaries were cystic or the patient was post menopausal. In vaginal hysterectomy anterior and posterior repair were done in patients where required. The antibiotics were Septran DS 800 mg twice a day for 5 days or Ceporex 500 mg 8 hourly For 7 days.

A close observation of post operative course of patient was made and recorded on a performa. The socioeconomic burden on the patients as a result of duration of stay was evaluated as well as the day on which the patients were discharged were recorded on a performa.

In this series of 70 patients 40 underwent vaginal hysterectomy and 30 had abdominal hysterectomy. Patients were divided into four age groups.

	Age Group	No of Patients
a)	35 to 39 years	4 patients
b)	40 to 45 years	40 patients
c)	45 to 50 years	16 patients
d)	50 to 60 years	10 patients

RESULTS

Out of total of 70 patients, 40 patients underwent vaginal hysterectomy and in 30 patient abdominal hysterectomy was carried out. The age group of the patient ranged from 39-60 years. Most of the patients were in the early forties. The indication for abdominal hysterectomy was DUB. The indication for the vaginal hysterectomy was DUB and prolapse.

The morbidity after vaginal hysterectomy among 40 patients is mentioned in Table-I Which is as follows high grade fever in 2 patients (5%). Post operative vomiting in

1 case (2.5%). urinary retention in 2 cases (5%) cystitis in 3 cases (7.5%) post operative pain in 2 cases (5%) and vault haematoma in 1 patient (2.5%)[1,2,3].

Table-I. Complications of vaginal hysterectomy in 40 patients

Complications	No. of pts.	%age
Pyrexia	2	5%
Ileus	0	0
Vomiting	1	2.5%
Urinary retention	2	5%
Abdominal distension	0	0
Cystitis	3	7.5%
Post operative pain	2	5%
Vaginal haematoma	1	2.5%

Complications after abdominal hysterectomy are mentioned in Table-II. They were respiratory complications in two patients 6.6%, high grade fever in 10 patients (33.3%), primary haemorrhage in 1 patient (3.33%), abdominal distension in 7 patients (23.3%). post operative vomiting in 6 patients (20%), urinary retention in 3 patients (10%) cystitis in 7 patients (23.3%) and post operative pain experienced by 25 patients (73.3%). Wound abscess was seen in 2 patients (6.6%) and wound disruption in 4 patients (13.3%). The vaginal vault granulation occurred in 2 patients (6.6%)[1,2,3].

DISCUSSION

Advantages of vaginal over abdominal hysterectomy: Vaginal hysterectomy was generally safer than abdominal hysterectomy and carries a low morbidity and mortality rate[4]. In our series often the patients with vaginal hysterectomy by the first post operative day scarcely knew that they had an operation. Post operative shock and discomfort was negligible and in our experience the patient with vaginal group were mobile by the evening time.

The operation of vaginal hysterectomy left no abdominal scar and involved little risk of later complications such as adhesions and intestinal obstruction[5]. There were no complications of wound dehiscence or wound abscess. The oral intake of the patient in vaginal group start earlier as compared to abdominal group. Associated prolapse of vagina can be corrected at the same time.

Table-II. Complication of Abdominal Hysterectomy in 30 patients

Complications	No. of pts.	%age
Respiratory Complications	2	6.6%
High grade fever	10	33.3%
Primary haemorrhage	1	3.3%
Abdominal distension	7	23.3%
Vomiting	6	20%
Urinary retention	3	10%
Cystitis	7	23.3%
Post operative pain	25	73.3%
Wound abscess	2	6.6%
Vaginal vault granulation	2	6.6%

Ilieus and abdominal distention type of complication were least in vaginal group and more in abdominal group[6]. The vaginal route was safer for obese patient. There was less socioeconomic problem because of shorter stay at the hospital and early discharge in the vaginal as compared to abdominal group[6,7]. The cost of vaginal hysterectomy was lower than total abdominal hysterectomy and laparoscopic assisted vaginal hysterectomy[7,8].

Vaginal hysterectomy had certain disadvantages due to less wide excision could not be ordinarily carried out for malignant diseases. The operation was difficult in the presence of dense adhesions formed by pelvic inflammatory disease, endometriosis or previous pelvic surgery. Its scope in these cases depends much on the

skill of operator. It offers little opportunity to inspect other abdominal visceras.

It was alleged that vaginal prolapse was more likely after vaginal than after abdominal hysterectomy but according to Stephen et al (1990) transvaginal hysterectomy offers a good opportunity to prevent further vaginal prolapse[9].

Holley R.L (1994) experienced that uterosacral sacrospinous ligaments fixation supports the vaginal apex and provides pelvic surgeon with an additional prophylactic measures against post hysterectomy vaginal prolapse[10]. Hoffman et al (1994 Aug) stated that transvaginal hysterectomy is better even if morecellation for the removal of moderately enlarged uteri than abdominal hysterectomy because of increased morbidity associated with abdominal hysterectomy[5].

In table-III a comparison of two types carried out. According to this table pyrexia of high grade in vaginal group was among 2 patients (5%) out of 40 patients and in abdominal group 10 patients (33.3%) among 30.

Table-III. Comparison of complications of Hysterectomies

Complications	No. of pts.	%age
Pyrexia	2(5%)	10(33.3%)
Primary haemorrhage	0	1(3.3%)
Vomiting	1(2.5%)	6(20%)
Abdominal distension	0	7(23.3%)
Urinary retention	2(5%)	3(10%)
Cystitis	3(7.5%)	7(23.3%)
Severe post operative pain	2(5%)	25(73.3%)
Wound abscess	0	2(6.6%)
Wound disruption	0	4(13.3%)
Vaginal vault haematoma	1(2.5%)	0
Vaginal vault granulation	0	2(6.6%)

Abdominal distention and colic was not observed in vaginal group (10%) where as in abdominal group it was seen in 7 cases (23.3%).

Post operative vomiting was seen in 7 abdominal cases (20%) and only 1 (2.5%) in vaginal group. Urinary retention and cystitis in 5 cases (13.5%) in vaginal group and in abdominal group were 7 cases 23.3%. it was noticed that the morbidity after abdominal hysterectomy was greater than vaginal hysterectomy[6,11].

CONCLUSION

The conclusion made was vaginal route procedure appeared to be a method of choice when ever applicable[12].

1. The pelvic floor repair can be done at the same time and step can be taken to prevent recurrence of prolapse[9].
2. It is a safe procedure in experienced hands with less morbidity, earlier mobility and discharge from hospital.
3. It has low socioeconomic burden on patient.

REFERENCES

1. Gitsch E et al. **Various effect of abdominal and vaginal hysterectomy.** Eur J Obstet O Gyanecol- Re Prod Biol 1990 Sep; 36(3) 259-63.

2. Alkardri HM. Al Turki HA, Saleh AM. **Short and long term complication of abdominal and vaginal hysterectomy for benign disease.** Saudi Medical Journal. 23(7): 806-10, 2002 July,

3. Varol N. Healey M, Tang P, Sheehan P, Maher P. Hill D. **Ten years review of hysterectomy morbidity and mortality Australian and Newzealand Journal of Obstet and Gyanceloelgy:** 41(3): 295-203, 2001 August.

4. Stummovoll W et al. **Hysterectomy: Is vaginal approach safer than abdominal.** Gyancol 1989 29 Sep Z: 54-7.

5. Hoffman MS, Decesal S, Kalthe C. **Abdominal hysterectomy vs Vaginal Hysterectomy for removal on enlarged uteri.** Am J Obstet Gyanecol 1994 Aug; 171(2): 309-13.

6. Vancoverden. **Morbidity after total abdominal**

hysterectomy. S Afr. Med J 1983 April 2: 63(14) 515-6.

7. Hancock KW, Scott JS. **Early discharge following vaginal hysterectomy.** Br. J Obster Gynacol 1993; 100(3): 262-6.

8. Ivirin J. Reiner MB. **Early discharge after vaginal hysterectomy AM J Obstet Gyanae.** 1988; 416-18.

9. Stephen et al. **Trans vaginal hysterectomy good opportunity to prevent vaginal prolapse.** Am Journal Obstet Gynaecol 1990 October:1012-24.

10. Holley JR, Enterocele. A review obstet gyancol survey 1994, April 94(4): 284-93.

11. Naylor AC. **Hysterectomy analysis of 2901 personally performed cases.** S. Afr Med J 1984 Feb. 18; 65(7) 242-50.

12. Cohen MM, Young W. **Cost of hysterectomy dues surgical approach make a difference.** Journal of Women Health 7(7): 885-92 1998 Sep.

Life is a tragedy for those who feel,
and a comedy for those who think