

# VAGINAL HYSTERECTOMY

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## ABSTRACT

**Objectives:** To find out the causes of operative morbidity and mortality, the way to reduce the avoidable causes. **DESIGN:** Prospective study. **Material & Methods:** A total of patients, who underwent vaginal hysterectomy were 31. **Period:** Jan 1996 - Dec 1997. **Setting:** Department of Gynaecology & Obstetrics, LMCH Gynae Unit - I. **Results:** This include 31 of 164 hysterectomies making a figure of 18.90 %. The mean age of patients was  $50 \pm 05$  years (30 - 70 years), mean parity were  $6.1 \pm 2.38$ . 25 were still married at the time of surgery and 12 (39.16 %) were sexually active. 14 (45.16 %) were menopausal and all cases had some degree of uterine descent and other cases had associated problems like irregular vaginal bleeding (16.12 %) and chronic cervicitis (16.12 %) cases. In all cases smaller size and freely mobile uterus was selected, 5 (16.12 %) cases underwent bilateral oophorectomy. General anaesthesia (GA) was given in 51.61 % cases, spinal anaesthesia was given in 48.38 % cases. Intra-operative complication rate was 3.22 %, while postoperative complication rate was 41.93 %, mostly these were minor complication. There was no mortality in our series. The mean hospital stay was  $6 \pm 3$  days. **Conclusions:** In vaginal hysterectomy safety depends on experience of surgeon, modern anaesthesia, procedure and antibiotic prophylaxis.

**KEYWORDS:** Vaginal Hysterectomy - Indications - Procedure - Complications.

## INTRODUCTION

Vaginal hysterectomy is the removal of uterus by the vaginal route and subsequently closing space previously occupied by the uterus with shelf of tissue derived from lateral attachment of the uterus. The choice of the route of operation is determined by specific factor which includes skill of the surgeon, as well as indication for surgery. Vaginal hysterectomy is less invasive and also provides an acceptable alternative to abdominal surgery in medically compromised patients. Moreover, it combines so well with a vaginal repair operation

that it offers more advantage to the women who complain of abnormal uterine bleeding associated with symptoms of genital prolapse.

Vagina route of surgery is associated with fewer complication and faster recovery. It is near ideal procedure because the idea of performing the major surgery without an apparent scar, appeals to the surgeon and the patient alike.

In historical background, vaginal hysterectomy was performed before abdominal hysterectomy was

attempted. Vaginal hysterectomy was done sporadically through the 17<sup>th</sup> and 18<sup>th</sup> century. In late 19<sup>th</sup> century, the technique of vaginal hysterectomy was systemically studied and developed by Czerny, Billroth, Mikulicz, Schroaeda, Kocher, Teuffel and Spencer Wells.

Credit of modern surgery is given to Koeberly. In 1890 Schauta treated carcinoma of cervix by vaginal surgery<sup>1</sup>. In Vaginal route of surgery is associated with fewer early decades of 20<sup>th</sup> century skiltul gynaecologist concentrated on developing newer surgical technique to help their patient.

**MATERIAL & METHODS**

From Jan 1996 - Dec 1997, a total 31 patients underwent vaginal hysterectomy at Liaquat Medical College Hospital Hyderabad in Gynae Unit-I. These patients were admitted through outpatient department with various complaints. They underwent detailed work up to elaborate different medical and surgical problems.

A detailed account of age, social, marital status, coital practice, obstetrical and gynaecological history was taken. Finding on physical examination were also noted. Vaginal hysterectomy was performed in classical manner. Patients were reviewed during the postoperative period and complications were noted. Histopathological reports were reviewed. Hospital stay was also noted. Information was obtained by using proforma especially designed for this study and the data was analyzed at completion of the study.

**RESULTS**

A total of 31 vaginal hysterectomies were performed in this prospective study. During study period, 164 hysterectomies were performed, out of which 31 were vaginal making a percentage of 18.90 % (Table-I) of total hysterectomies. Age incidence shows that, average age of patients was 50±5 years (range 35 - 70 years) (Table-II) and

mean parity 6 ± b (range 1-14) (Table-III).

Table-I. Incidence of Abdominal Versus Vaginal Hysterectomy (n=164)			
Abdominal Hysterectomy	%age	Vaginal Hysterectomy	%age
133	81.09	31	18.90

In all cases of vaginal hysterectomy, uterovaginal prolapse was the main indication. Aassociated problem was present like chronic vaginal discharge with cervicitis in 5 (16.12 %) cases. 6 (19.35 %) cases had medical problems like cardiac disease, respiratory disease, diabetes mellitus, while dysfunction uterine bleeding was present in 5 (16.12 %) and small fibroi 1 was in 2 (6.45 %) cases (Table-IV).

Table-II Age. (n=31)		
Age in years	Number	%age
30-40	07	22.58
50-60	20	64.51
70-above	04	12.90

Table-III Parity. (n=31)		
Parity	Number	%age
Nullipara	Non	Non
Primipara	01	3.22%
Para 2-5	11	35.48%
Grand Multipara	19	12.90

Indication	Number	%age
1. Utero-vaginal		
I°	01	3.22
II°	21	64.51
III°	09	29.03
2. Associated Problems		
-Dysfunctional uterine bleeding	05	16.12
-Chronic vaginal discharge (Chronic cervicitis)	05	16.12
-Fibroid uterus	02	6.45
-High risk patient (Medical problem)	06	19.35

Treated	Number	%age
Vaginal packing	22	70.96
Oestrogen	06	19.35
Ring pessary	03	9.6

Decubitus ulcer and atrophic vaginitis was treated in our ward with vaginal packing 70.96% and in 6 (19.35 %) cases with oestrogen preparation (Table-V). Only in few cases, ring pessary were used. It is routine to do vaginal packing in every patient before undergoes vaginal hysterectomy to reduce congestion.

In our study, 16 (51.61 %) cases of vaginal hysterectomy were performed under G.A and 15 (48.38 %) cases under spinal anaesthesia. Spinal anaesthesia was considered in patients with medical problems like chronic obstructive airway disease (Table-VI).

Anaesthesia	Number	%age
General Anaesthesia	16	51.61
Spinal Anaesthesia	15	48.38

Procedure	Number	%age
Vaginal Hysterectomy - Anterior repair	04	12.90
Vaginal Hysterectomy - Anterior repair - Posterior repair	21	65.51
Vaginal Hysterectomy - Anterior repair - Oophorectomy	01	3.22
Vaginal Hysterectomy - Anterior repair - Posterior repair - Oophorectomy	04	12.90
Vaginal Hysterectomy - Posterior repair	01	3.22

In this study, 21 (64.51 %) cases had vaginal hysterectomy with anterior and posterior repair, because these cases had laxity of vagina with some degree of uterine descent. In 4 (12.90 %) cases of vaginal hysterectomy only anterior repair was performed. Vaginal hysterectomy with oophorectomy was performed in 4 (12.90 %) cases, in these cases, ovaries were cystic, while normal looking ovaries were preserved (Table-VII).

In our study, complication rate during surgery was low. One case had haemorrhage due to slipped ligature, bleeding was controlled transfixing pedicle properly. Postoperative complications were found in 31 cases, 6 (19.35 %) cases had urinary problem, in which 5 developed urinary tract infection and one

case had voiding difficulty (Table-VIII). Vault abscess and vaginal discharge were treated according to culture and sensitivity report.

Table-VIII. Complications (n=31)		
Complication	Number	%age
Intra Operative		
- Haemorrhage	01	3.22
Postoperative		
- Haemorrhage	01	3.22
- Urinary	06	19.35
- Vault Abscess	03	9.67
- Vaginal discharge	03	9.67
No complication observed	17	54.83

**DISCUSSION**

In gynaecological surgery, hysterectomy is the commonest procedure. Vaginal hysterectomy has no scar and better cosmetic results. The choice of route for operation, is determined by specific factors like ability of surgeon and indication for surgery. Vaginal hysterectomy is less invasive and also provides an acceptable alternative to abdominal surgery in patients with associated medical problem like diabetes mellitus, hypertension and cardiovascular disease. In our study, all cases of vaginal hysterectomy had some degree of uterine descent. Indication for vaginal hysterectomy was utero-vaginal prolapse (64.28%) in Arif Tajamal study<sup>2</sup>.

Another study was conducted by Dutta D.K, in which, surgical management of 200 cases of genital prolapse were reviewed<sup>3</sup>. It showed that vaginal hysterectomy with vaginal repair was performed in 70 (35 %) cases and was the choice of treatment in pre and postmenopausal patients in Watson P.S

study, vaginal hysterectomy with repair had proved satisfactory in majority of patients (83 %) <sup>23</sup>. In our series, most of patients who underwent vaginal hysterectomy had normal size uterus except two cases. In Mogan et al (series from U.K) only 3.9 % of hysterectomies for fibroid uterus were carried out vaginally<sup>5</sup>.

The uterine size alone is not a contraindication to vaginal hysterectomy. The safety of a well performed procedure in uteri up to 14 week size is well documented. There is need for surgeon to try their skills in this accord. The size of fibroid is not as important as the size to which the uterus is enlarged and how accessible the fibroid. Kovac performed intramyometrial coring in 76 % of vaginal hysterectomy<sup>3</sup>. Additional steps of vaginal oophorectomy do not add to morbidity of vaginal hysterectomy and it is recommended that routine oophorectomy be considered for postmenopausal women having vaginal hysterectomy<sup>23</sup>.

In our series, oophorectomy was carried out in 5 (16.12%) patients. When we consider prophylactic oophorectomy at the time of vaginal hysterectomy, the influencing factors are obesity, multiparity, decreased vaginal space, lack of uterine descent, increase uterine size and tubo-ovarian disease<sup>6</sup>. Whenever, it is feasible, one can combine laparoscopic assisted bilateral salpingo-oophorectomy alongwith vaginal hysterectomy<sup>6,7,8</sup>.

Laparoscopic surgery has made tremendous progress since the last decade and laparoscopic hysterectomy has gained immense popularity amongst the gynaecologist. It is proving to be a viable alternative to abdominal hysterectomy. It is suggested 'hat in a patient with a more than pelvic support, sacrospinous fixation should be performed *as* adjuvant to other steps taken to prevent post hysterectomy prolapse<sup>2,9,10</sup>.

Complications like infection, haemorrhage, urinary

tract infection, intestinal injury and pulmonary embolism, can be avoided by use of proper technique, prophylactic antibiotics and good suture material. Self retaining retractors facilities, good exposure and better visibility significantly reduce operation time, blood loss and morbidity. In most of centres, mortality of vaginal hysterectomy is 0.1 - 0.2 %<sup>13</sup>. There was no mortality in our series.

### **CONCLUSION**

It is mandatory for every gynaecologist to attain such a degree of operating skill by the different route. Since the reason for or against doing hysterectomy vaginally or the advantage or disadvantage to the patients, who is the only one to be considered. Presented with benefits of modern anaesthesia, resuscitation and antibiotics, it is an operation that has proven to be remarkably safe.

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