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Indications for hysterectomy: descriptive clinical study

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Abstract
Vaginal hysterectomy is the procedure of choice in parous women unless this route is contraindicated. Laparoscopic hysterectomy is associated with faster postoperative recovery and shorter hospital stay compared with abdominal hysterectomy. The highest rate of hysterectomy is between the ages of 40 and 49 years with an average age of 46.1 years. The data for the study was collected from women who are posted for Hysterectomy. History was taken from the patients. Clinical diagnosis was made, necessary investigations was done followed by Hysterectomy. Specimen was sent for HPE. Then all the findings were correlated and evaluated. In our study, Fibroid uterus, Pelvic Inflammatory disease, Dysfunctional uterine bleeding, Prolapse uterus were commonest indications for which hysterectomy was indicated.

Keywords: Indications, hysterectomy, parous women

Introduction
Hysterectomy is one of the most common surgical procedures performed after cesarean delivery. Hysterectomy may include removal of the uterine corpus and cervix, termed total hysterectomy, or may include only the uterine corpus, called supracervical hysterectomy. The term subtotal hysterectomy refers to the supracervical type but is not the preferred terminology. And if removed with the tubes and ovaries then its total hysterectomy with bilateral salpingo ophorectomy. Salpingo-oophorectomy at the time of hysterectomy for benign disease in pre-menopausal women at average risk for ovarian malignancy is associated with an increase in long-term patient mortality from cardiovascular disease, and ovarian conservation should be strongly considered in these patients [1, 2].
The uterus can be removed by a variety of different approaches including the abdominal route (laparotomy), transvaginally, or using minimally invasive surgical techniques and by notes.
Selection of the operative approach is based on many factors including the physical properties and topography of the uterus and pelvis, the indication for surgery, patient body habitus and medical comorbidities, and the presence or absence of adnexal pathology [3].
Vaginal hysterectomy is the procedure of choice in parous women unless this route is contraindicated. Laparoscopic hysterectomy is associated with faster postoperative recovery and shorter hospital stay compared with abdominal hysterectomy. The highest rate of hysterectomy is between the ages of 40 and 49 years with an average age of 46.1 years. The most common diagnoses among women undergoing hysterectomy are uterine leiomyomata (41%), endo-metriosis (18%), uterine prolapse (15%), and cancer or hyperplasia (12%). Other indications for hysterectomy include adenomyosis, pelvic inflammatory disease, chronic pelvic pain, and pregnancy-related conditions [4].

Methodology
The data for the study was collected from women who are posted for Hysterectomy. History was taken from the patients. Clinical diagnosis was made. Necessary investigations was done followed by Hysterectomy. Specimen was sent for HPE. Then all the findings are correlated and evaluated.

- **Study Design:** Present study was a prospective study of all cases undergoing hysterectomy
- **Study Period:** One year (12 months) study period.
- **Sampling Method:** All cases posted for Hysterectomies for benign conditions.

Eligibility Criteria
Inclusion Criteria
- All cases posted for Hysterectomy for benign conditions

Exclusion Criteria

- Patients with a diagnosis or history of cancer.

The data for the study was collected from women who were posted for Hysterectomy. History was taken from the patients. Clinical diagnosis was made. Necessary investigations were done followed by Hysterectomy. Specimen was sent for HPE. Then all the findings are correlated and evaluated.

Results

Table 1: Indications for Hysterectomy

Indications	Frequency	Percentage
AUB	64	25.2
fibroid	54	21.4
PID	58	22.8
Endometrial polyp	08	03.1
Prolapse uterus	60	23.6
Ovarian pathology	10	03.9
Total	254	100

The indications for surgery AUB in 64 cases 25.2 percent, fibroid in 54 cases 21.4, PID in 58 cases 22.8, endometrial polyp in 08 cases 03.1, prolapse uterus in 60 cases 23.6, others 10 cases 03.9.

Table 2: Ultrasound Findings in this Study Cases

Ultrasound findings	Numbers
Fibroid Uterus	54
PID	48
Endometrial polyp	07
Endometrial hyperplasia	18
Ovarian cyst	28
Adenomyosis	02
UV prolapse	60
Normal study	37
	254

In our study USG findings were as shown in the table.

Table 3: Procedure- Route

Procedure- Route	Frequency	Percentage
Laparoscopic Hysterectomy	2	0.79%
TAH	179	70.47%
Vaginal Hysterectomy	73	28.74%
Total	254	100.00%

Vaginal route was used in 73 cases 28.74%, TAH in 179 cases 70.04%, and laparsocopic route was used in 2 cases o, 79%.

Table 4: Types of Hysterectomy

Types of hysterectomy	Number	Percentage
TAH	122	48.0
TAH with BSO	44	17.3
TAH with USO	15	05.9
NDVH	16	06.3
VH	55	21.7
LAVH	02	0.8
Total	254	100

TAH was done in 122 cases 48.0%,TAH with BSO was done in 44 cases 17.3%,,TAH with Right SO was done in 08 cases 03.1%,, TAH with LEFT SO was done in 06 cases 02.4%,,NDVH was done in 16 cases 06.3%,,VH was done in 55 cases 21.7%,, LAVH was done in 03 cases 01.2%,

Discussion

- Mangala Gowri *et al* [5] noted that 221(85.3%) were abdominal hysterectomy with bilateral salphingo-opharectomy specimens remaining 38 (14.7%) were only hysterectomy specimens.
- In the present study abdominal route is used in 49 cases 90.7% laparoscopic route is used in 01 case 01.9 and vaginal in the rest of cases. Kothapalli Indira Surya Kumar *et al* [6] of 81 patients 61 are underwent for TAH with BSO, 31 underwent only for TAH, 2 underwent for lap assisted vaginal hysterectomy, one for vaginal hysterectomy., radical hysterectomy 2, modified radical hysterectomy 2, extended TAH+BSO 2.
- In ours study vaginal hysterectomy was done in 86%. Storer performed the first cesarean hysterectomy in the US. Soon thereafter, Porro of Milan described the first cesarean hysterectomy performed to control uterine hemorrhage and prevent peritonitis, in which the infant and mother survived; the procedure is frequently referred to as the Porro operation in his honor [7].
- Historically, Langen Beck performed the first abdominal hysterectomy in 1825. Porro first performed the subtotal caesarean hysterectomy successfully in 1876, where Wertheim performed his first abdominal hysterectomy in 1898. Vaginal hysterectomy was performed more than 250 years prior to the first abdominal hysterectomy [8].
- Ephraim McDowell in Kentucky in 1809. The first abdominal hysterectomy was performed by Charles Clay in Manchester, England in 1843; unfortunately the diagnosis was wrong and the patient died in the immediate post-operative period. The following year, Charles Clay was almost the first to claim a surviving patient, however she died post-operatively and it was not until 1853 that Ellis Burnham from Lowell, Massachusetts achieved the first successful abdominal hysterectomy although again the diagnosis was wrong [9].
- Vaginal hysterectomy dates back to ancient times. The procedure was performed by Soranus of Ephesus 120 years after the birth of Christ, and the many reports of its use in the middle ages were nearly always for the extirpation of an inverted uterus and the patients rarely survived. During the 1930s, Richardson introduced the total abdominal hysterectomy to avoid serosanguineous discharge from the cervical remnant and the risk of cervical carcinoma developing in the stump [10].
- Apart from this innovation, and the transverse incision introduced by Johanns Pfannenstiel in the 1920s, there was little advance in hysterectomy techniques until the advent of endoscopic surgery and the performance of the first laparoscopic hysterectomy by Harry Reich in Kingston, Pennsylvania in 1988.

Conclusion

In our study, Fibroid uterus, Pelvic Inflammatory disease, Dysfunctional uterine bleeding, Prolapse uterus were commonest indications for which hysterectomy was indicated

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