ORIGINAL ARTICLE

# A Review of Gynaecological Hysterectomies in a Private Specialist Hospital in Nigeria

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ABSTRACT

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**Background:** Hysterectomy, the removal of the uterus, is practised worldwide. It is a major surgery, which may lead to significant morbidity or even mortality, hence, there must be a justifiable indication before the procedure is undertaken. Symptomatic fibroids and utero-vaginal prolapse are common indications in this environment.
**Objective:** To audit the 30 consecutive gynaecological hysterectomies done in our centre from January 2003 to July 2009, with a view to determining the demographic factors, indications, types of hysterectomies done, and morbidity/mortality associated with the procedures.
**Methodology:** This is a retrospective descriptive study. Data concerning these 30 patients were retrieved from the theatre records and their case notes. The analysis was done using simple tables and percentages.
**Results:** Hysterectomies accounted for 30(28.0%) of 107 major gynaecological operations done during the period under review. Of the 30 hysterectomies 11(36.7%) were vaginal hysterectomies, while total and subtotal abdominal hysterectomies accounted for 13(43.3%) and 6(20%), respectively. Bilateral salpingo-oophorectomy was done in 4(13.3%) patients. The most common indication was uterine fibroids 16(53.3%) followed by utero-vaginal prolapse 8(26.7%). The most common age range of the patients was 40-49year group 16(53.3%), mean age was 45.5±6.7. The most common parity group was para 5-8(53.3%). On the average, the vaginal hysterectomy patients needed less diclofenac injections for pain relief. One bladder injury was encountered. There was no mortality.
**Conclusion:** The indications for, and surgical outcome following gynaecological hysterectomy in a private specialist hospital, is comparable to that from public hospitals. The private hospitals should be considered in manpower development to help improve gynaecological practice.
***Keywords:*** *Abdominal, indications, morbidity, vaginal*

## INTRODUCTION

Hysterectomy is a major gynaecological operation for the removal of the uterus with or without the adnexal structures.[1] It is a common procedure in the United Kingdom and United States of America.[2] In the United Kingdom, 20% of women undergo hysterectomy before the age of 60 years.[3]

Obstetric hysterectomies done as emergencies mostly indicated by rupture of the uterus and severe postpartum haemorrhage secondary to persistent uterine atony, are not part of this study.

In Nigeria, much misconception such as loss of sex drive, menstruation and reincarnating without the uterus, make hysterectomy relatively unacceptable to our women.[4] We have had to perform second and third repeat myomectomy in our centre on women above 40years of age who strongly wished to retain the organ.

Hysterectomy may be done through the vaginal or abdominal route. The abdominal hysterectomy may be total or subtotal when the cervix is not removed. More recently, the laparoscopic procedures were introduced. In the 1940s, 95% of hysterectomies done in the United States of America were subtotal, but with more training and improved skill and desire to prevent cervical cancer, the removal of cervix at hysterectomy became a routine.[5]

However, some workers still emphasize the advantages of subtotal hysterectomy including less mortality, reduced vaginal shortening and vault prolapse and increased sexual satisfaction. But, the pre-operative cervical smear cytology must be normal and subsequent follow-up cervical smears should be guaranteed before subtotal hysterectomy will be advocated. In this part of the world where there is no organized cervical screening programmes, total hysterectomy should be the aim except when it is technically difficult.

Uterine fibroids with or without menorrhagia remain the most common indication for gynaecological hysterectomies in Nigeria.[7] The vaginal procedure has been shown to be associated with less post-operative pain, operative blood loss, less risk for trauma to the adjoining viscus, less hospital stay and earlier return to normal activities.[8, 9]Removal of the ovaries at hysterectomy for benign conditions is still controversial. Some authors consider it reasonable to preserve healthy looking ovaries in a pre-menopausal woman without a history of ovarian or breast cancer in a first degree relative, but, others remove the ovaries once the woman is above 45 years of age.[1]

Laparoscopic procedures for hysterectomy are not yet commonly done in Nigeria, because very few gynaecological surgeons have acquired the skill. This audit was carried out to compare our work with other published works and help us improve our morbidity records.

## METHODOLOGY

This is a retrospective study. All the major gynaecological surgeries done in this centre during this period were performed by a consultant gynaecologist.

The case notes of the 30 patients that had gynaecological hysterectomy were retrieved and analyzed for their biodata, indications for the operation, type and extent of hysterectomy, blood transfusion and morbidity/mortality records, using simple percentages.

## RESULTS

Out of the 30 patients studied, majority 16(53.3%) were in the age range of 40-49years, while 2(6.7%) patients did not know their correct ages, as shown in Table I. The mean age was 45.5±6.7years. There was no nulliparous woman among the study population, rather, majority 20(66.6%) were grand-multiparous (para 5 and above), see Table 2.

Total abdominal hysterectomies were 13(43.3%), subtotal 6(20%) and vaginal hysterectomies 11(36.7%). Only 4(13.3%) of the patients had bilateral salpingo-

oophorectomy in addition (Table 3).The most common indication for hysterectomy in our centre was uterine fibroids with or without menorrhagia (53.3%), followed by utero-vaginal prolapse (26.7%). The least indication was acute torsion of ovarian cyst in an elderly woman 3.3% (Table 4).

Post-operative pyrexia was encountered in 33.3% of the patients, while wound infection occurred in only one patient (3.3%); similarly, only one patient had trauma to a viscus (bladder) as shown in Table 5. A total of 7 patients received blood transfusion, and there was no mortality.

**Table 1.**Age distribution of the patients

| Age Group (years) | No. | % |
|---|---|---|
| 30 - 39 | 4 | 13.3 |
| 40 - 49 | 16 | 53.3 |
| ≥50 | 8 | 26.7 |
| Not stated | 2 | 6.7 |
| **Total** | **30** | **100** |

**Table 2.**Parity of the patient**s**

| Parity Range | No. | % |
|---|---|---|
| 0 | 0 | 0 |
| 1 - 4 | 10 | 33.3 |
| 5 - 8 | 16 | 53.3 |
| > 8 | 4 | 13.3 |
| **Total** | **30** | **99.9 ≈ 100** |

**Table 3.** Types of hysterectomy

| Type of Hysterectomy | No. | % |
|---|---|---|
| Total Abdominal Hysterectomy | 13 | 43.3 |
| Subtotal Abdominal Hysterectomy | 6 | 20.0 |
| Vaginal Hysterectomy | 11 | 36.7 |
| **Total** | **30** | **100** |

**Table 4.** Indications for surgery

| Indications | No. | % |
|---|---|---|
| Uterine Fibroids | 16 | 53.3 |
| Abnormal Uterine Bleeding | 3 | 10.0 |
| Uterovaginal Prolapse | 8 | 26.7 |
| Abnormal cervical Cytology | 2 | 6.7 |
| Ovarian Cyst | 1 | 3.3 |
| **Total** | **30** | **100** |

**Table 5.** Morbidities recorded / blood transfusion

| Type of Morbidity | No. | % |
|---|---|---|
| Mortality | 0 | 0 |
| Wound Infection | 1 | 3.3 |
| Pyrexia | 10 | 33.3 |
| Trauma to the Bladder | 1 | 3.3 |
| Blood Transfusion Rate | 7 | 23.3 |

DISCUSSION

Hysterectomy is the most common major gynaecological operation in the United States, with approximately 600,000 hysterectomies performed each year.[3]In our centre, it constituted 28% of all the major gynaecological operations. This figure is much higher than the 8.5% reported in Ilorin, Nigeria[10], and 20% reported by Emembolu working in Northern Nigeria.[11] Majority of our patients (53.3%) were in their 5th decade of life. This is consistent with other reports.[10,11] Most women at this age in our society would have stopped procreation and are more likely to consent to hysterectomy. Regarding their parity, 66.6% were grand multiparous and as much as13.3% had parity >8.

Uterine fibroids (with or without menorrhagia) was the most common indication for hysterectomy in our centre accounting for 53.3% of cases, this finding is similar to what was reported in Kaduna, Northern Nigeria where uterine fibroids accounted for 46.8% of all hysterectomies.[9] In a study in Benin, Nigeria, fibroids accounted

for 62.3% of cases of hysterectomy.[12] Utero-vaginal prolapse was the next common indication in our centre representing 26.7% of cases, while in the Kaduna and Benin studies it accounted for 8.5% and 13.1%, respectively.[7, 12]

We carried out total abdominal hysterectomy in 43.4% of our patients. Our subtotal hysterectomy rate was 20% which is similar to the rate of 19.6% reported by the workers in Benin, Nigeria.[12] Our vaginal hysterectomy rate was 36.7%, this is higher than the rates of 22% and 16.8% reported in the Ilorin and Benin studies, respectively.[10,12] All the patients that had subtotal hysterectomy in our centre were those whose surgery turned out to be very difficult from severe adhesions usually as a result of previous surgeries, mostly previous myomectomies and caesarean sections.

Vaginal hysterectomy has been widely reported to have some advantages over abdominal hysterectomy. The mean estimated blood loss, the intra and post-operative complications and hospital stay have been shown to be significantly less in vaginal hysterectomies when compared to the abdominal procedures.[8,9,13] The usual indication for vaginal hysterectomy in our environment is utero-vaginal prolapse, however, experienced gynaecological surgeons aim at using the vaginal route especially in obese women.[1] Total abdominal hysterectomy may prove technically difficult in obese women because of the 'depth' the surgeon needs to work in.

We carried out more vaginal hysterectomies than the number of cases of utero-vaginal prolapse we had (36.7% versus 26.7%). The authors preferred the vaginal route whenever it was considered feasible and safe, because of the advantages. However, the size and mobility of the uterus must be considered. History of previous abdominal surgeries is a relative contraindication. With the introduction of laparoscopic-assisted vaginal hysterectomy (LAVH) the fear of adhesions from previous surgeries as a hindrance to vaginal hysterectomy has been overcome especially in the hands of experienced laparoscopic surgeons. The blood loss, hospital stay and complications in LAVH are closely similar to those of vaginal hysterectomy, though LAVH requires a longer operating time.[8,9]

Morbidities recorded in this study were pyrexia (33.3%), wound infection (3.3%) and trauma to the bladder (3.3%). The patient that had bladder trauma had 4 previous caesarean sections with morbid adhesion of the bladder to the cervix. She presented with abnormal cervical cytology which made total hysterectomy mandatory. The study in Benin had wound infection rate of 4.9% and pyrexia was found in 14.8% of their patients.[13]

We did not record any mortality, though we did not carry out any radical procedure which usually leads to more morbidity and mortality. Patients that presented with established gynaecological malignancies that may require radical hysterectomy, were referred to tertiary centres, since they would benefit from multi-disciplinary management available in such centres.

Some gynaecologists regard hysterectomy as an over-treatment for pre-malignant cervical lesions, which may be effectively treated using ablative or excisional techniques where the skill and equipments are available.

However, hysterectomy will be justified when cervical pre-malignant lesions coexist with other gynaecological problems such as prolapse, fibroids and endometriosis, or there is an extension of the pre-malignant lesion to the vagina, or an abnormal cytology persists despite excisional or ablative treatment, or in

patients with poor compliance for follow-up or those with cancer phobia.[14]

## CONCLUSION

Hysterectomy is a relatively safe procedure within the private specialist hospital setting. With proper training and experience the vaginal and laparoscopic procedures should be performed more than the abdominal hysterectomy because of the reported advantages.

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