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Original Research Article

Audit of pre-hysterectomy medical treatment

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ABSTRACT

Background: Variations in rates of hysterectomy have been observed and have been associated with women demographic characteristics such as race, socio-economic status, educational status and geographic location. However, with the advent of novel medical and conservative measures, there are doubts on justification of hysterectomy. Aims and objectives were to study prior treatment taken with respect to clinical profile in women undergoing hysterectomy in a tertiary care centre.

Methods: An observational study was conducted by collecting data from medical records of 72 consenting subjects undergoing hysterectomy for benign gynaecological reasons in a tertiary care centre over a period of 12 months after ethics approval.

Results: Out of 72 subjects, only 34 subjects (47.22%) had taken a prior medical treatment before undergoing hysterectomy. 100% of the subjects with endometriosis, chronic PID and DUB had taken some form of prior treatment whereas 27.5% of subjects with fibroid and 68.75% of subjects with adenomyosis had taken prior treatment.

Conclusions: Our study indicates that prior medical management is not being adequately discussed and trialled among women undergoing hysterectomy. Hence, improving the counselling and understanding the women's perspective for resistance towards medical management is an important area for research in improving quality of health care.

Keywords: Fibroid, Hysterectomy

INTRODUCTION

Hysterectomy is on one of the most frequently performed surgical procedure among women of reproductive age group worldwide after cesarean section.¹ Majority of the gynecological hysterectomies are done for benign conditions like fibroids, adenomyosis and abnormal uterine bleeding. In India, prevalence of hysterectomy was 9.2% among age group 40-49 years with excessive menstrual bleeding and pain as self-reported primary indication as per NFHS-4.² Variations in rates of Hysterectomy have been observed and have been associated with women demographic characteristics such as race, socio-economic status, educational status and geographic location. Hysterectomy has been described as "one size fits all" solution for benign gynaecology.³ However, with the advent of novel medical and

conservative measures, there are doubts on justification of hysterectomy. Evidence indicates a higher risk amongst poor, less educated women in rural areas and unnecessary hysterectomies performed in cases where medical or non-invasive treatment would have been sufficient.

Aims and objectives

To study prior treatment taken with respect to clinical profile in women undergoing hysterectomy in a tertiary care centre.

METHODS

An observational study was conducted by collecting data from medical records of 72 consenting subjects undergoing hysterectomy for benign gynaecological

reasons in a tertiary care centre, Government medical college and New civil hospital, Surat over a period of 12 months from October 2020 to October 2021 after ethics approval.

Inclusion criteria

Women undergoing hysterectomy for benign gynecological reasons.

Exclusion criteria

Women undergoing obstetric hysterectomy and women undergoing hysterectomy for uterovaginal prolapse and genital malignancy.

All eligible consenting women were counselled regarding the purpose of data collection. Baseline details of the study subjects was noted in study proforma. A detailed history of prior treatment taken for the same complaint and its duration was elicited. All eligible consenting women were counselled regarding their diagnosis, alternatives available for management, risks, benefits and various routes of the surgery. All details required for the study were noted in the proforma and data entry and analysis were done using SSPS software version 26.

RESULTS

Baseline details of the study subjects were noted and summarized in Table 1 below.

Table 1: Baseline details.

Characteristics		
Age	No. of subjects (n=72)	Percentage
<40	25	28
40-60	46	61
>60	1	10
Education status of study participants		
Illiterate	32	46
Primary schooling	37	50
Graduate	3	3.10
Socio-economic status of study participants		
Lower middle class	10	9.52
Upper lower	39	56.34
Lower	23	34.12
Current address of study participants		
Rural	13	18.05
Urban	59	81.94
Parity of study participants		
Nullipara	03	3.96
Primipara	03	5.50
Multipara	66	90.40

Among the 72 participants studied, detailed history was taken regarding any prior treatment taken or not, if taken

duration of treatment was noted. Only 34 subjects had taken a prior medical management before undergoing hysterectomy as shown in Figure 1.

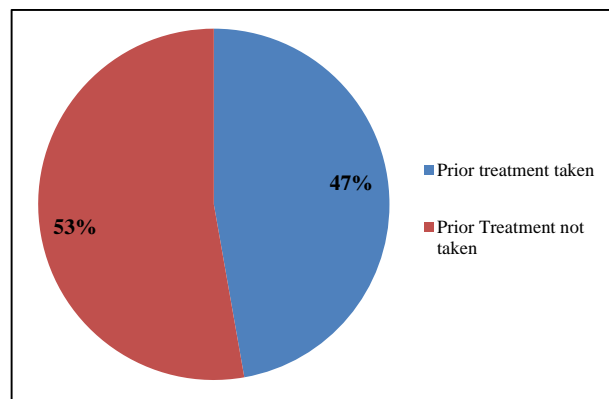


Figure 1: Prior treatment taken.

The socio-demographic profile of subjects like socio-economic status, education status, parity and distance of their residence from tertiary care centre was noted with respect to prior treatment taken or not. The results are summarized in Table 2.

Table 2: Socio-demographic profile of study subjects with respect to prior treatment taken.

	Prior treatment taken (n=34)	Prior treatment not taken (n=38)	P value
Socio-economic status and prior treatment taken			
Lower middle class	4	6	0.54
Upper lower	17	22	
Lower	13	10	
Educational status and prior treatment taken			
Illiterate	15	17	0.78
Primary schooling	17	20	
Graduate	2	1	
Residence and prior treatment taken			
Rural	7	6	0.59
Urban	27	32	
Distance from hospital and prior treatment taken			
<20 km	25	28	0.53
20-100 km	5	3	
>100 km	4	7	

The indications for which study subjects underwent Hysterectomy was noted and were classified with respect to prior treatment taken or not and duration of treatment as summarized in Table 3.

Subjects were also classified on the basis of age of subjects undergoing hysterectomy and prior treatment taken. The results are summarized in Table 4.

Table 3: Indications of hysterectomy and duration of prior treatment taken.

Indications	Prior treatment taken with duration (months)			Prior treatment not taken
	<1	1-3	>3	
Fibroid (n=40)	10	01	00	29
Adenomyosis (n=16)	07	04	00	05
Endometrial hyperplasia (n=7)	03	00	00	04
Endometriosis (n=4)	00	01	03	00
Chronic PID (n=3)	00	00	03	00
DUB (n=2)	00	02	00	00
Total (n=72)	20	08	06	38

Table 4: Age of study subjects and prior treatment taken.

Indication for hysterectomy	Age of subject who had taken treatment before hysterectomy		
	<40 years (n=25)	40-60 years (n=46)	>60 years (n=1)
Fibroid (n=40)	03/10	08/29	00/01
Adenomyosis (n=16)	06/06	05/10	00
Endometrial hyperplasia (n=7)	02/02	01/05	-
Endometriosis (n=4)	04/04	-	-
Chronic PID (n=3)	03/03	-	-
DUB (n=2)	-	02/02	-
Total (n=72)	18/25	16/46	00/01

DISCUSSION

Hysterectomy is commonly performed for benign conditions such as excessive menstrual bleeding, fibroids, uterine disorder. However, in the study conducted by Singh et al, most of the cases could be given a trial of medical management and surgery could be avoided.⁴ As mentioned in Table 1, 61% of the subjects belonged to age group 40-60 years with average age of 51 years as compared to 46 years and 35.8 years observed in Broder et al and Desai et al respectively.^{5,6} On detailed history taken from study participants, it was observed that only 34 subjects (47.22%) has taken a prior medical treatment before undergoing hysterectomy. This shows that almost half of our subjects had not taken any medical treatment for the presenting complaints prior to hysterectomy.

As mentioned in Table 2, out of 10 subjects belonging to lower middle class, only 4 subjects has taken a trial of prior medical management. Also among 3 subjects who were graduate, only 2 subjects had taken prior medical management indicating the need to strengthen the

counselling for all alternative options available to patients. Distance of the care centre from their residence also plays the major role regarding the role of prior medical management. Out of 53 subjects residing within 20 km from care centre, 25 subjects took prior medical management emphasizing the need to strengthen the health seeking behaviour among general population. When p value was calculated for socio-economic status, education, address and distance from the hospital with respect to prior treatment taken, it was not significant indicating that the women's decision for hysterectomy was independent of its socio-demographic profile.

Fibroid was the most common indication (55.55%) for which women underwent hysterectomy in our study whereas the self-reported indication for hysterectomy was excessive menstrual bleeding/pain (56%) in a study conducted by Shekhar et al.⁷ Many subjects with menstrual disorders (fibroid, adenomyosis), lower abdominal pain or mass had taken some form of previous treatment. Also as mentioned in Table 3, 100% of subjects with endometriosis, chronic PID and DUB had taken some form of prior treatment whereas only 27.5% of subjects with fibroid had taken prior medical management as compared to 16.67% observed in study conducted by Sriram et al.⁸ As mentioned in Table 3, treatment for more than three months was taken by all subjects with Chronic PID and 75% subjects with endometriosis, probably because these subjects were younger and some of them were desirous of further childbearing. Both subjects with DUB had taken treatment for less than three months, probably because of side-effects of medications, inconvenience of follow-up visits or desire for cessation of menstrual bleeding by surgery. Majority of subjects with fibroid (10 out of 11) and adenomyosis (7 out of 11) who had taken treatment had taken it for less than one month, probably to arrest acute bleeding episode and were not willing to try medical management or any alternative treatment further. This emphasizes the need to strengthen availability of alternative treatment at economical rates and counselling to attempt alternative methods where applicable. When age of the subjects was compared with prior treatment taken, it was observed that 18 subjects out of 25 subjects (72%) had taken prior medical treatment below 40 years of age as compared to 16 subjects out of 47 (34%) in age above 40 years i.e., younger subjects were more likely to have taken prior treatment before hysterectomy as compared to older subjects.

The limitation in this study was the number of cases were limited due to covid pandemic.

CONCLUSION

Our study indicates that prior medical management is not being adequately discussed and trialled among women undergoing hysterectomy. Hence, improving the counselling and understanding the women's perspective for resistance towards medical management is an important area for research in improving quality of health

care. With advent of novel medical therapies, LNG-IUS and newer less invasive options, it is important to offer all the available alternatives for benign gynaecological pathologies. This will further help in reducing the incidence of hysterectomy.

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Ethical approval: The study was approved by the Institutional Ethics Committee

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