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ORIGINAL ARTICLE

Comparison of Post-Operative Quality of Life between Vaginal Hysterectomy and Abdominal Hysterectomy

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ABSTRACT

Objectives: To compare the frequency of satisfactory quality of life between vaginal hysterectomy and abdominal hysterectomy.

Study Design: Randomized controlled trial.

Place and Duration of Study: Department of Obstetrics and Gynecology, Niazi Medical & Dental College, Sargodha from 1st April 2020 to 31st December 2020.

Methodology: Ninety patients were comprised and they were divided in two groups; group A (vaginal hysterectomy) and Group B (abdominal hysterectomy) were performed. Hysterectomies (vaginal or abdominal) were performed by consultant gynecologist having experience at having least 5 years).

Results: Mean age of the patients was 49.82±3.207 years, mean age of the patients of group A was 49.82±3.193 years and mean age of the patients of group B was 49.82±3.256 years. Satisfactory quality of life was noted in 38 (84.44%) patients of study group A and 29 (64.44%) patients of study group B. Statistically significant (P = 0.051) difference between the frequency of satisfactory quality of life between the both groups was noted.

Conclusion: Results of this study reveals that post hysterectomy quality of life found more satisfactory in vaginal hysterectomy group as compared to abdominal hysterectomy group. Insignificant association of post hysterectomy quality of life with age group, marital status, parity and socio-economical status was found. Findings of this study also revealed that post hysterectomy satisfactory quality of life is not associated with education of the patients.

Key words: Hysterectomy, Quality of life, abdomen, vagina, WHO, Uterus

INTRODUCTION

Hysterectomy is one of the major surgical procedure and there are many indications to perform this procedure like obstetrical or gynecological reasons.[1] The main purpose of this procedure is to improve the quality of life (QoL) of the patients.[2]Hystrectomy can be performed by abdominal or vaginal route.[3-4]Some studies reported that vaginal hysterectomies are performed in only in 10% patients and abdominal hysterectomies are performed in 70% patients.[4-5]

The only formal guidance is the ACOG guidance on the uterine-size in 1989, which shows that in women with movable uterus not more than 12 weeks' gestational size vaginal hysterectomy is suitable (approximately 280 g).[6] ACOG also recognizes that a surgical indicator, anatomical conditions of the patient, approach data, informed patient preference, expertise and training of the surgeon, should be used to inform the decision of the method.[6] Vaginal hysterectomy is convincingly preferable if either the vaginal or abdominal approach is clinical.[7]

Abdominal approach is not as popular as previously now a days. In modern obstetrics and gynaecology, it is considered as better option because it has great convenience in hospital stay complications patient's economy and finally morbidity and mortality.[8,9]

This study will be conduct to compare the quality of life between vaginal hysterectomy and abdominal hysterectomy in patients admitted in obstetric and gynaecological units. Results of this study will guide us that which method will be better for maintaining the post-operative quality of life of the patients undergoing vaginal or abdominal hysterectomy.

MATERIALS AND METHODS

This randomized controlled trial was conducted at Department of Obstetrics and Gynecology, Niazi Medical & Dental College, Sargodha from 1st April 2020 to 31st December 2020 and comprised 90 patients. All patients of dysfunctional uterine bleeding with failed medical treatment, age 45 to 55 years, uterus of less than 14 weeks size, hysterectomy for benign pathology and primary para, multipara were included. All patients having pelvic malignancy, cardiac diseases, bronchial asthma, hypertension and pelvic inflammatory disease (on history) were excluded. In group A (vaginal hysterectomy) was performed and in Group B (abdominal hysterectomy) was performed. Hysterectomies (vaginal or abdominal) was performed by consultant gynecologist having experience at having least 5 years). Demographic data of all the patients were recorded. After one month follow-up, 12 questions were asked from all patients to assess their satisfactory quality of life in term of yes or no. The data was entered and analyzed through SPSS-24.

RESULTS

Mean age of the patients was 49.82±3.207 years, mean age of the patients of group A was 49.82±3.193 years and mean age of the patients of group B was 49.82±3.256 years. In group A, satisfactory quality of life was noted in 38 (84.44%) patients and in Group B, satisfactory quality of life was noted in 29 (64.44%) patients. Statistically significant (P = 0.051) difference between the frequency of satisfactory quality of life (Table 1)

Twenty seven patients of age group 45-50 years, satisfactory quality of life was noted in 23 (85.19%) patients, 26 patients of age group 45-50 years, satisfactory quality of life was noted in 18 (9.23%) patients. Statistically insignificant (P = 0.2021) difference of satisfactory quality of life was noted between the both study groups. Out of 18 patients of age group 51-55 years, satisfactory quality of life was noted in 15 (83.33%) patients. Out of 19 patients of age group 51-55 years, satisfactory quality of life was noted in 11 (57.89%) patients. Statistically insignificant (P = 0.1510) difference of satisfactory quality of life was noted between the both study groups (Table 2)

In group A, 39 patients were married and in group B, 41 patients were married. Satisfactory quality of life noted in 32 (82.05%) patients and 27 (65.85%) patients respectively in group A and B. Statistically insignificant (P = 0.1296) difference between satisfactory quality of life was noted between the both study groups. Total 6 patients of group A and 4 patients of group B was unmarried. Satisfactory quality of life was noted in 6 (100%) patients of group A and 2 (50%) patients of group B and the difference was statistically insignificant with p value 0.1333. (Table 3)

There were 9 primary paras in group A and 12 in group B. Satisfactory quality of life was noted in 9 (100%) patients of group A and 8 (66.67%) patients of group B but the difference was insignificant with p value 0.1038. There were 36 multiparas in group A and 33 in group B. Satisfactory quality of life was noted in 29 (80.56%) patients of group A and 21 (63.64%) patients of group B but the difference was insignificant with p value 0.1771. (Table 4)

Table 1: Comparison of satisfactory of life between the both groups (n=90)

Group	Satisfactory quality of life		P value
	Yes	No	
A	38 (84.44%)	7 (15.56%)	0.051
B	29 (64.44%)	16 (.56%)	

Table 2: Comparison of satisfactory quality of life between the both groups for age

Age (years)	Group	Satisfactory quality of life		P value
45-50	A	23 (85.19%)	4 (14.81%)	0.202
	B	18 (9.23%)	8 (30.77%)	
51-55	A	15 (83.33%)	3 (16.67%)	0.151
	B	11 (57.89%)	8 (42.11%)	

Table 3: Comparison of satisfactory quality of life between the both groups for marital status

Marital status	Group	Satisfactory quality of life		P value
Married	A	32 (82.05%)	7 (17.95%)	0.129
	B	27 (65.85%)	14 (34.15%)	
Unmarried	A	6 (100%)	-	0.133
	B	2 (50%)	2 (50%)	

In group A and B, 16 and 13 patients were poor and satisfactory of life was noted in 13 (81.25%) patients and 10 (76.92%) patients. But the difference was insignificant with p value 1.0000. In group A and B, 11 and 18 patients were belonged to middle class and satisfactory of life was noted in 9 (81.82%) patients and 8 (44.44%) patients. But the difference was insignificant with p value 0.0641. In group A and B, 18 and 14 patients were belonged to high class and satisfactory of life was noted in 16 (88.89%) patients and 11 (78.57%) patients. But the difference was insignificant with p value 0.6313. (Table 5)

Table 4: Comparison of satisfactory quality of life between the both groups for primary para

Para	Group	Satisfactory quality of life		P value
Primary paras	A	9 (100%)	-	0.103
	B	8 (66.67%)	4 (33.33%)	
Multiparas	A	29 (80.56%)	7 (19.44%)	0.177
	B	21 (63.64%)	12 (36.36%)	

Table 5: Comparison of satisfactory quality of life between the both groups for socio-economic status

Para	Group	Satisfactory quality of life		P value
Poor patients	A	13 (81.25%)	3 (18.75%)	1.000
	B	10 (76.92%)	3 (23.08%)	
Middle class patients	A	9 (81.82%)	2 (18.18%)	0.064
	B	8 (44.44%)	10 (55.56%)	
High class patients	A	16 (88.89%)	2 (11.11%)	0.631
	B	11 (78.57%)	3 (21.43%)	

DISCUSSION

Hysterectomy is the surgical procedure which is performed in gynaecology departments for malignant and benign conditions.[10] Many types of hysterectomies are there in different indications, mainly vaginal and abdominal one. Few other techniques are also becoming popular including laparoscopic assisted vaginal, total and subtotal laparoscopic hysterectomies. Modern approach is minimally invasive which provide better choice for doctors and patients. However, it relies on patient's health and over all conditions. Psychological needs of the patients were the utmost priority for the doctors now-a-days particularly future life of the patients.[11] Final decision of hysterectomy is depend upon hysterectomy indication, patient anatomy, patient concern, surgical expertise etc.[11]

Mostly vaginal hysterectomy is performed in patients having good uterine activity, uterus size not greater than 12 weeks of gestation. No history of pelvic surgery, normal adnexa, wide maternal pelvis and at the end there should be no anaesthetic or surgical contra indication in this approach.[12-13]

In present study comparison of satisfactory quality of life between vaginal hysterectomy and abdominal hysterectomy was done. In vaginal hysterectomy, satisfactory quality of life was noted in 38 (84.44%) patients and in abdominal hysterectomy, satisfactory quality of life was noted in 29 (64.44%) patients. Statistically significant (P = 0.051) difference between the frequency of satisfactory quality of life between the both groups was noted. Mehtha et al[9] reported that satisfactory quality of life was found in 65.5% patients who underwent vaginal hysterectomy and 90% patients who underwent abdominal hysterectomy.

CONCLUSION

Post-hysterectomy quality of life found more satisfactory in vaginal hysterectomy group as compared to abdominal hysterectomy group. Insignificant association of post hysterectomy quality of life with age group, marital status, parity and socio-economical status was found. This study also revealed that post hysterectomy satisfactory quality of life is not associated with education of the patients.

REFERENCES

1. Yakasai IA. Complications of hysterectomy: a review. Br J Sci 2013;9(2):78-87.
2. Nilsson L, Wodlin NB, Kjølhede P. Risk factors for postoperative complications after fast-track abdominal hysterectomy. Austr NZ J Obstet Gynaecol 2012;52(2):113–20.
3. Einarsson JI, Suzuki Y. Total laparoscopic hysterectomy: 10 steps toward a successful procedure. Rev Obstet Gynecol 2009;2(1):57–64.
4. Chen B, Ren D-P, Li J-X, Li C-D. Comparison of vaginal and abdominal hysterectomy: a prospective non-randomized trial. Pak J Med Sci 2014;30(4):875-9.
5. Parveen T, Kausar T, Iqbal T, Batool A. Comparison of outcome between vaginal and abdominal hysterectomy. PJMHS 2013; 7(4): 1150-53.
6. Precis IV. An update in obstetrics and gynecology. Washington, DC: American College of Obstetricians and Gynecologists, 1989.
7. Panda S, Behera AK, Jayalaskshmi M, Rao N, Indira G. Choosing the route of hysterectomy. J Obstet Gynaecol India 2014; 65(4): 251-4.
8. Mittal P, Andiliya A, Bansiwal R, Suri J, Singal S. Enlarged uterus through a natural orifice: worth an effort? A randomized controlled trial. Int J Reprod Contracep Obstet Gynecol 2014;3(4):1076.
9. Mehtha K, Prakash O, Fatehpuriya DS, Verma L. Comparative study of abdominal hysterectomy and vaginal hysterectomy in non-descent cases a prospective study. IJRCOG 2017; 6(4): 1265-70.
10. Kulkarni MM, Rogers RG. Vaginal hysterectomy for benign disease without prolapse. Clin Obstet Gynecol 2010;53:5-16.
11. Nieboer TE, Johnson N, Lethaby A, Tavender E, Curr E, Garry R, et al. Surgical approach to hysterectomy for benign gynaecological disease. Cochrane Database Syst Rev 2009;(3):CD003677.
12. Sirota I, Tomita SA, Dabney L, Weinberg A, Chuang L. Overcoming barriers to vaginal hysterectomy: An analysis of perioperative outcomes. J Turk Ger Gynecol Assoc 2019; 20: 8-14.
13. Sutasanasuang S. Laparoscopic hysterectomy versus total abdominal hysterectomy: a retrospective comparative study. J Med Assoc Thai 2011;94:8-16.