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Research Article

AN ASSESSMENT OF IMPACTS BETWEEN VAGINAL & ABDOMINAL HYSTERECTOMY WITH RESPECT TO AGE, MARITAL STATUS AND SOCIOECONOMIC DISTRIBUTION

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Abstract:

Objectives: To see the impacts of vaginal hysterectomy and abdominal hysterectomy in females who delivered in obstetric and Gynae units of Mayo Hospital, Lahore.

Results: We conducted this comparative research at Gynecology and Obstetrics Department of Mayo Hospital, Lahore from October 2016 to July 2017. To determine the impacts, we divided the research sample population in Group – I and II with a respective mean age of (49.820 ± 3.1930) years and (49.820 ± 3.2560) years, so overall the mean age of both groups was (49.82 ± 3.207) years. After doing the brief study it was noted that 38 (84.44%) of the patients in Group-I expressing the post result impacts on their life was normal same feelings of impacts also absorbed in 29 (64.44%) patients of Group II. Enumeration of difference in superlative life between both the groups was notably ($P = 0.051$) which is very significant.

Conclusion: Results of this study shows that after hysterectomy quality of daily routines of life found more satisfying in vaginal hysterectomy Group-I in comparison of Group-II patients who went through an abdominal hysterectomy. No such link of after hysterectomy quality of life with Marial status, age group, similarity and socioeconomic status found. The academic status of the patients also found not affecting the post hysterectomy quality of life.

Keywords: Abdomen, Vagina, Uterus, World Health Organization (WHO) and Hysterectomy of Life.

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INTRODUCTION:

In surgical procedures the hysterectomy is one of the foremost parts, obstetrical or gynaecological identify the need of the surgical procedures. To ensure the patient's good health this surgical procedure is needed [1]. Two routes abdominal and vaginal used in hysterectomy procedures [2]. Certain research described the vaginal hysterectomies are done on only (10%) patients and (70%) patients went through abdominal hysterectomies [3 – 4]. According to the ACOG IN 1989, there is only one proper uterine size guideline, ACOG recommends that the vaginal hysterectomy suitable in those females which have mobile uteri vaginal not larger than 12 weeks and gestational size (approx. 280g) [4 – 5]. The surgical indication recognized by ACOG are patient's structural organization condition, reason supporting the hysterectomy of the uterus, prioritizing patients' choice, experience and training of the surgeon [6]. It will not be wrong that vaginal hysterectomy is more preferred than abdominal hysterectomy due to the amount of evidence and it's clinically appropriate also [6]. The trend of abdominal hysterectomy is not as common as it was back in old days [7]. The convenience in a stay at the hospital to monitor the complications of the patient, cost of the procedure and lastly the low rate of morbidity and mortality makes it a good choice in the light if modern gynaecological and obstetrics. The need of this study was to identify the difference between the quality of life of vaginal and abdominal hysterectomy in patients admitted in obstetric and gynaecological units [8]. Through this, it can be studied various method that supports in maintaining the quality of life of the patients after the surgical procedure of vaginal or abdominal hysterectomy. To see the level of pain that a patient is suffering through due to the surgical procedure a Visual Analogue Scale came handy the less the number means no to less pain and the higher the number means high to extreme level of pain, the series of number printed on the scale helping in measuring the condition of pain from no pain to an onset of extreme pain.

Post hysterectomy satisfactory quality of life:

It will be considered positive if (70%) of the patient's positive answers equal to (70%) of the question asked to them about the satisfactory quality life (8/12 questions).

Abnormal Uterine Bleeding (AUB):

Any reported bleeding incidence of varying severity in the absence of clinically diagnosed organic pelvic pathology-tumour, pregnancy or inflammation.

MATERIAL AND METHODS:

We conducted this comparative research at Gynecology and Obstetrics Department of Mayo Hospital, Lahore from October 2016 to July 2017. After examining numerous patients ninety patients having dysfunctional uterine bleeding with an unsuccessful medical treatment selected for the study, Patients ages are from 45 – 55 years, less than fourteen weeks uterus size determined by USG and those patients who required a hysterectomy. The patients with the history of heart diseases, history of bronchial asthma, history of hypertension, patients with a history of pelvic inflammatory diseases and patients with the pelvic malignancy appeared on scan not selected for this study. The patients after selections divided into two Groups-I and II. Vaginal hysterectomy is done on the patients of Group- I whereas abdominal hysterectomy performed on patients of Group-II. Either vaginal or abdominal hysterectomies can only be performed by those was performed by gynaecologist specialist having a minimum of five-year experience. Performa used for the demographic information of all the patients. To determine the satisfactory status of life of the patients after the period of one-month twelve questions asked from them by having the answers in only yes or no form. For the statistic, a form of analysis the data feed into the SPSS software. A quantifiable variable like the quality of life and age score presented as mean \pm SD. Planned series of questions used to determine the quality of life. In this study, frequencies and percentages of all question calculated for socioeconomic status, academic qualification level, parity and satisfactory level of life and marital status. The satisfaction part was the variable through which the outcome modifier like marital status, age, socioeconomic status and academic qualification level controlled. In order to determine the frequency comparison of quality of life between both Groups the Chi-square test applied. Significant P value was \leq 0.05.

RESULTS:

To determine the impacts, we divided the research sample population in Group – I and II with a respective mean age of (49.820 \pm 3.1930) years and (49.820 \pm 3.2560) years, so overall the mean age of both groups was (49.82 \pm 3.207) years. So, overall the mean age of both groups was 49.82 more or less 3.207 years. After doing the brief study it was noted that 38 (84.44%) of the patients in Group-I expressing the post result impacts on their life was normal same feelings of impacts also absorbed in 29 (64.44%) patients of Group II. Enumeration of difference in superlative life between both the groups was statistically significant with (P = 0.051). The difference of satisfactory quality

of life between Group-I and Group-II. Twenty-Seven patients of age group 45 to 50 years split decisions. Out of twenty-seven patients 23 (85.19%) of the patients of Group-I given the positive feedback about the satisfactory quality of life, out of twenty-six patients of age group 45 to 50 years only 18 (9.230%) patients of Group-II express the quality of life as satisfactory. Statistically insignificant ($P = 0.20210$) difference of satisfactory quality of life was noted between both study groups. Patients of age group 51 to 55 years were eighteen out of this eighteen satisfactory quality of life seen in 15 (83.330%) patients Group-I. Patients of age group 51 to 55 years were nineteen out of these nineteen, satisfactory quality of life seen in 11 (57.890%) patients Group-II. Statistically insignificant ($P = 0.15100$) difference between both groups. Thirty-nine of the patients in Group-I were married whereas forty-one patients were married in Group-II. Satisfactory quality of life seen in the patients of Group-I are 32(82.050%) whereas the same result has been observed in Group-II 27 (67.85%) as well. Statistically insignificant ($P = 0.12960$) difference between the satisfactory quality of life was noted between both study groups. The number of patients unmarried in Group-I and Group-II is 6 and 4 respectively. The number of unmarried patients in

Group-I seen satisfied are 6(100%) and in Group-II same results observed in 2 (50%) patients, the difference between both Groups was statistically insignificant (with $P=0.13330$). The patients with primary paras in Group-I and Group-II were 9 and 12. Positive results were seen in Group-I and Group-II is 9 (100%) and 8 (66.67%) respectively whereas the difference recorded was insignificant with ($P=0.10380$). Patients with multiparas in both Group-I and Group-II were 36 and 33. And the positive satisfactory quality of life was observed in 29 (80.56%) patients of Group-I and the same results observed in patients of Group-II are 21 (63.64%) whereas the difference was insignificant with ($P=0.17710$). The patients of both Group-I and Group-II were 16 and 13 and the unsatisfactory quality of life noted in 13 (81.25%) and 10 (76.92%) patients, the difference between both groups was insignificant with ($P=1.00$). In group A and B, 11 and 18 patients 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 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 – I: Vaginal and Abdominal Hysterectomy Comparison

Group	Yes		No		P-Value
	Number	Percentage	Number	Percentage	
Vaginal Hysterectomy Group - I	38	84.44	7	15.56	0.051
Abdominal Hysterectomy Group - II	29	64.44	16	0.56	

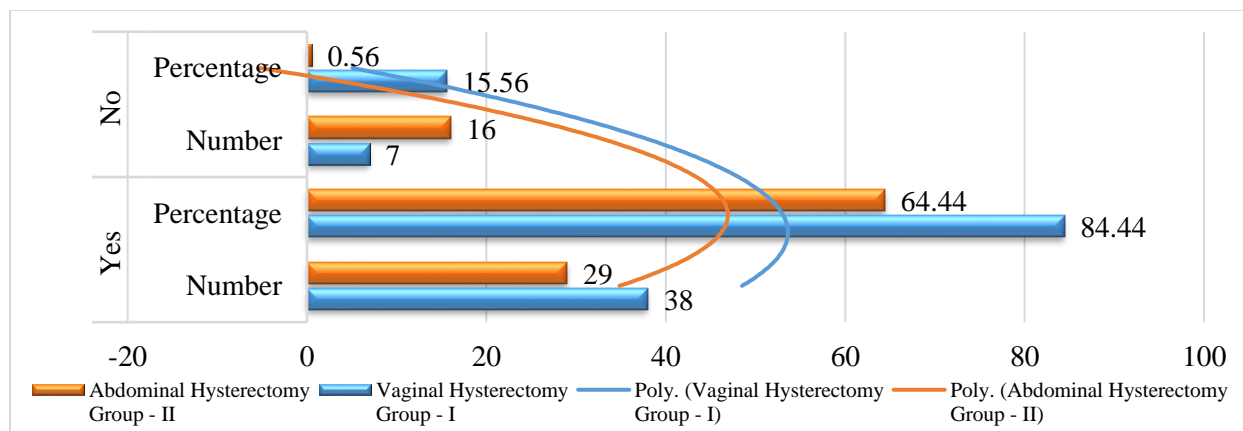
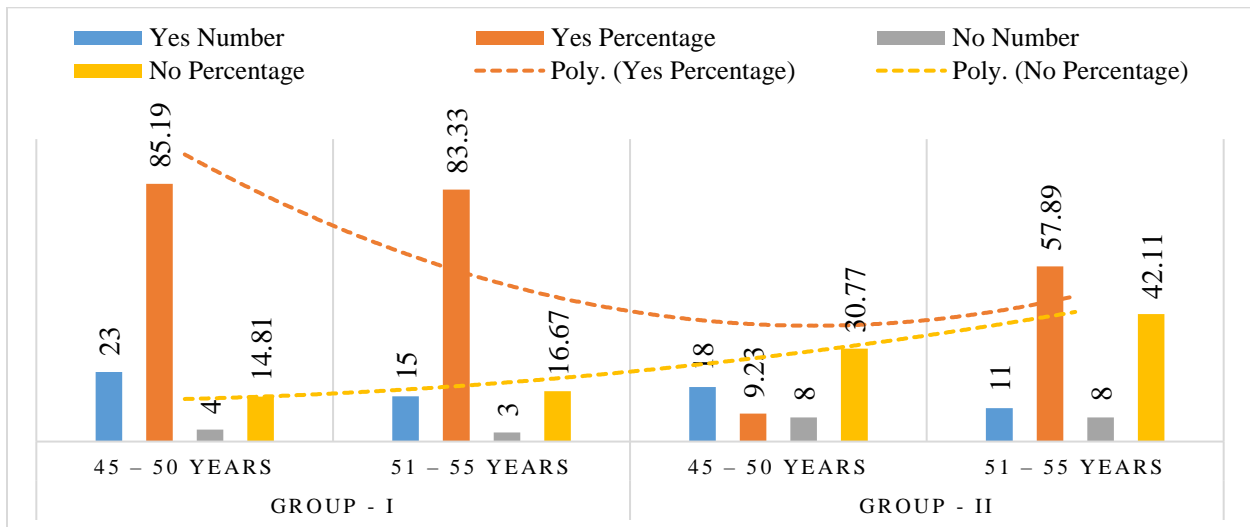


Table – II: Comparison of Age

Life Quality Satisfaction		Yes		No		Total	P-Value
		Number	Percentage	Number	Percentage		
Group - I	45 – 50 Years	23	85.19	4	14.81	27	0.2021
	51 – 55 Years	15	83.33	3	16.67		
Group - II	45 – 50 Years	18	9.23	8	30.77	26	0.1510
	51 – 55 Years	11	57.89	8	42.11		

**Table – III:** Marital Status Comparison

Life Quality Satisfaction		Yes		No		Total	P-Value
		Number	Percentage	Number	Percentage		
Married	Group – I	32	82.05	7	17.95	39	0.1296
	Group – II	27	65.85	14	34.15		
Un-married	Group – I	6	100	0	0	6	0.1333
	Group – II	2	50	2	50		

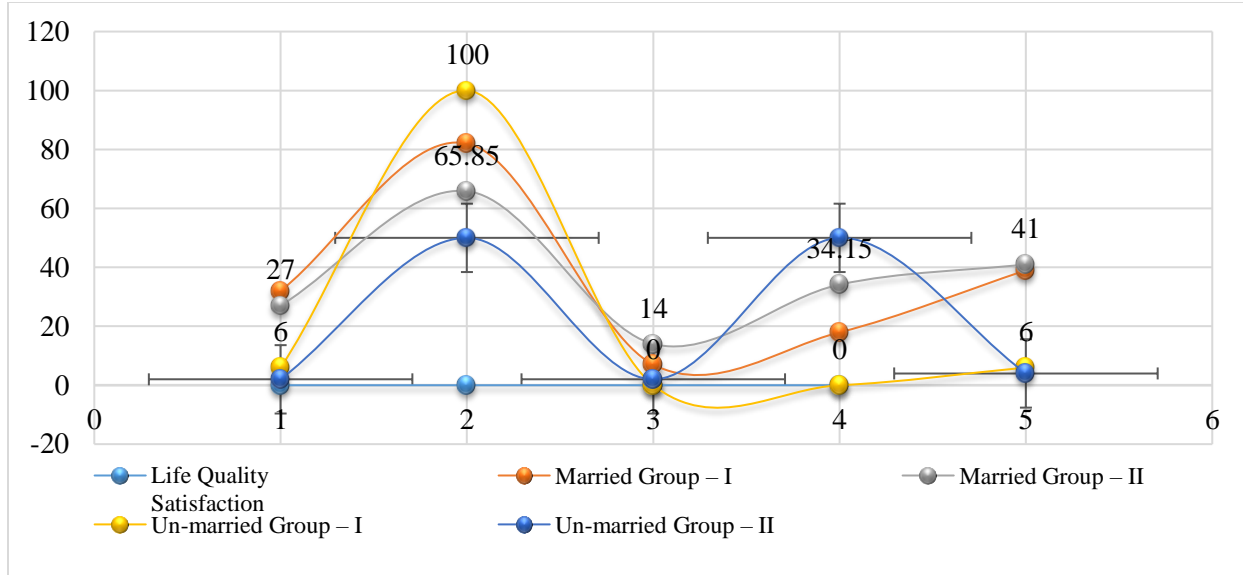


Table – IV: Parity Status Comparison

Life Quality Satisfaction		Yes		No		Total	P-Value
		Number	Percentage	Number	Percentage		
Primary Paras	Group – I	9	100	0	0	9	0.1038
	Group – II	8	66.67	4	33.33	12	
Multiparas	Group – I	29	80.56	7	19.44	36	0.1771
	Group – II	21	63.64	12	36.36	33	

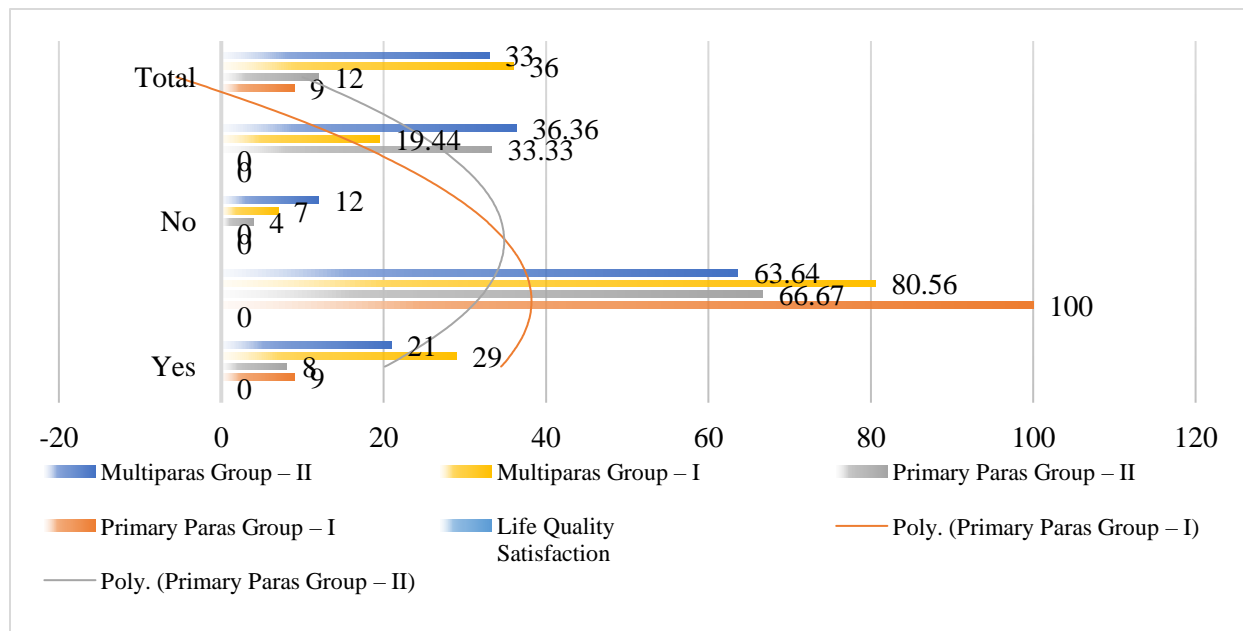
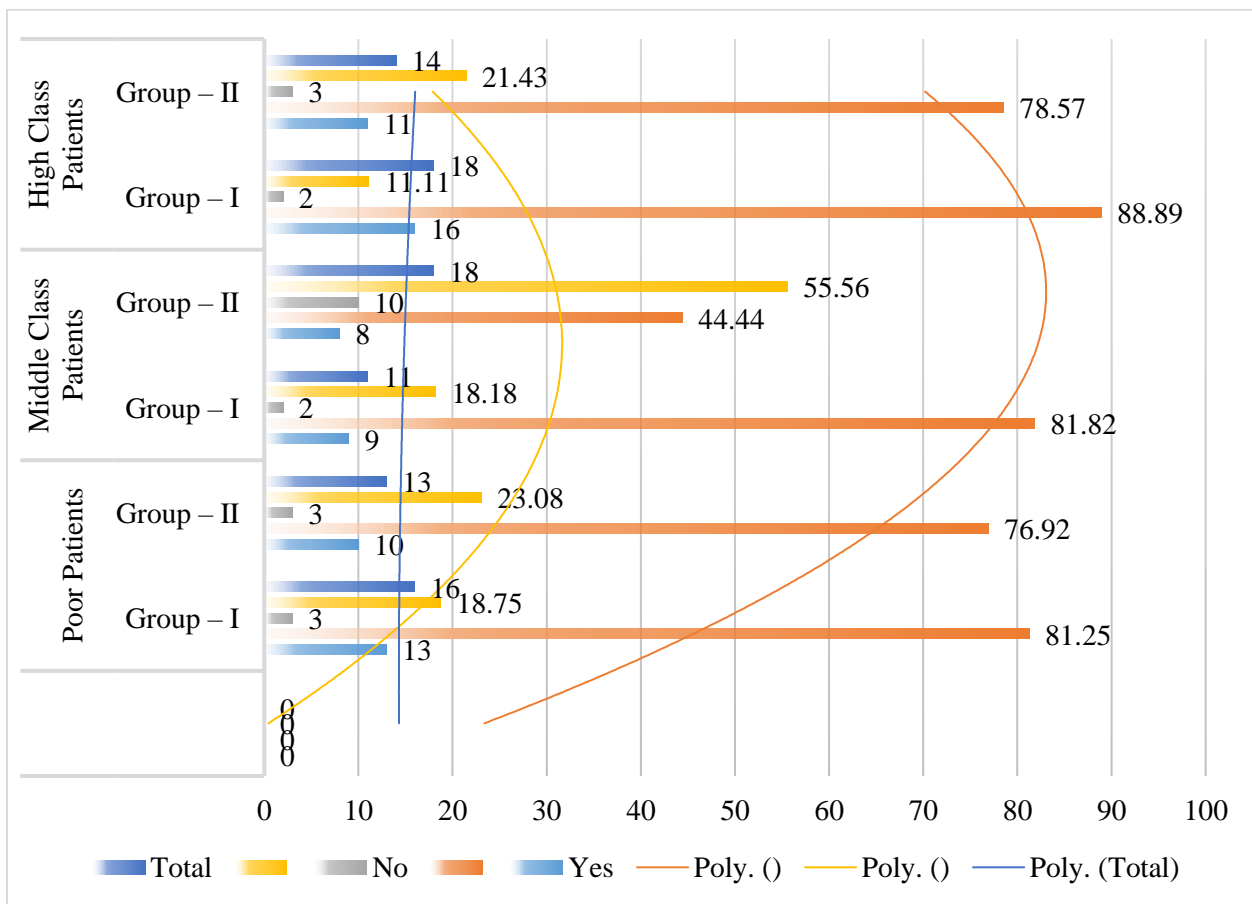


Table – V: Socio-Economic Status Comparison

Life Quality Satisfaction		Yes		No		Total	P-Value
		Number	Percentage	Number	Percentage		
Poor Patients	Group – I	13	81.25	3	18.75	16	1.0000
	Group – II	10	76.92	3	23.08	13	
Middle Class Patients	Group – I	9	81.82	2	18.18	11	0.0641
	Group – II	8	44.44	10	55.56	18	
High Class Patients	Group – I	16	88.89	2	11.11	18	0.6313
	Group – II	11	78.57	3	21.43	14	



DISCUSSION:

The need for hysterectomy surgery needed on the patients of Gynecological units with infectious and benign conditions. There are various types of surgical hysterectomies depending on the symptoms of the patients in which the commons are vaginal and abdominal [10]. Some other methods of hysterectomies are also getting famous like Laparoscopic-assisted vaginal hysterectomy and total

or subtotal Laparoscopic-assisted vaginal hysterectomy. Doctors and patients due to modern advancements in the gynaecological units about the procedure, which gives both a better option to operate and choose the method. Conversely, the whole procedure truly depends on the condition of the patient. Mental requirements of the patients are the ultimate importance for the doctors now days specifically post hysterectomies quality of life of the

patients. Split behaviour also observed over the method of Vaginal and abdominal laparoscopic available nowadays [11]. The whole procedure depends on the symptoms of the patients, patient examination, patient concern and surgical expertise of consultant etc. Vaginal hysterectomy is commonly done on the patients with good uterine activity and the size of the uterus not greater than 12 weeks of gestation, no previous pelvic surgery, normal adnexa, wide motherly pelvis and no previous analgesic or surgical contra symptoms in this method [11]. This research covers the similarity between Group-I and Group-II vaginal and abdominal hysterectomies impacts on quality of life of patients [12 – 13], After doing the brief study it was noted that 38 (84.44%) of the patients in Group-I expressing the post result impacts on their life was normal same feelings of impacts also absorbed in 29 (64.44%) patients of Group II. Enumeration of difference in superlative life between both groups (P-Value 0.051). Silva-Filho reported quality of life among 65.5% and 90% of patients who experienced vaginal and abdominal hysterectomy. On the internet, only one study was found expressing the different quality of life between vaginal hysterectomy and abdominal hysterectomy search done using the relevant topic and no studies found except the above-mentioned one [9].

CONCLUSION:

Results of this study show that after hysterectomy quality of daily routines of life found more satisfying in vaginal hysterectomy Group-I in comparison of Group-II patients who went through an abdominal hysterectomy. No such link of after hysterectomy quality of life with Marital status, age group, similarity and socioeconomic status found. The academic status of the patients also found not affecting the post hysterectomy quality of life.

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