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Quality of Life among Patients after Vaginal Hysterectomy and Pelvic Floor Repair Operation

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ABSTRACT

Objective: *To find out the complications affecting the quality of life after vaginal hysterectomy and pelvic floor repair operation.*

Methods and Materials: *This is a prospective cross sectional study enrolled from Obstetrics and Gynaecology Department of Shaheed Suhrawardy Medical College and Hospital, Dhaka done with 50 randomly selected cases in the period between July 2009 to 31st December 2009.*

Results- *In this study 100% patients had history of something coming down per vagina. Many patients(40%) had varying degree of urinary problem, stress incontinence was present in a significant number of cases(12%). 20% had some vaginal discharge. The commonest type of prolapse was second degree (76%). In present series no major surgical complication or unexpected haemorrhage occurs postoperatively. There was no mortality in this series, febrile reaction was the commonest minor complication experienced by the postoperative patients. In present series the percentage of urinary tract infection was 16%, most of the patients had to stay in the hospital for about 7days only 24% had to stay for more than 1 week for infection. 4% had stress incontinence & 8% experienced dyspareunia.*

Conclusion: *Most of the patients had average peroperative bleeding (72%) and 50% patients had blood stained pervaginal discharge, 32% had febrile reaction, 16% experienced urinary tract infection in the postoperative period. There was no mortality in this study and average postoperative hospital stay was 7 days. Then follow up of the patient and found only 8% had experienced dyspareunia, 4% had urinary incontinence and no one had vault prolapse within six months postoperatively.*

Keywords: *Quality of life, vaginal hysterectomy & pelvic floor repair operation, dyspareunia, urinary incontinence, vault prolapse.*

Introduction

Genital prolapse is very prevalent in our country and is one of the frequent causes of morbidity in our women. Approximately 20% of all gynaecological operations are for prolapse repair.[1] About half of the normal female population develop utero-vaginal prolapse during their lifetime and need treatment.[2]

The prevalence rates increase with age and pelvic organ prolapse currently affects millions of women.[3] Genital prolapse is in fact a form of hernia.[4] It is downward descent of vagina with or without descent of uterus from normal anatomical position. Vaginal prolapse can occur without uterine prolapse but the uterus cannot descent without carrying the upper vagina with it.[5]

In developing country, like Bangladesh genital prolapse is associated with repeated and mismanaged vaginal deliveries. Main cause is the end result of congenital weakness of uterine support, pelvic floor damage and endopelvic fascia which are stretched during difficult vaginal delivery. Other secondary factors responsible for prolapsed are multiparity, menopause, malnutrition and increased intra-abdominal pressure due to constipation, chronic cough, heavy lifting, ascites or a pelvic mass. Prolapse may occur after surgery, specifically hysterectomy.

In our country poverty, shyness, lack of education about reproductive health play an important role behind complication of prolapse. Several vaginal procedures are available for treating uterine prolapse.[6] Vaginal hysterectomy with pelvic floor repair is usually the surgeons first choice.[6] The quality of life is improved in a patient receiving vaginal hysterectomy with pelvic floor repair operation. Following vaginal hysterectomy with pelvic floor repair operation there may be intra-operative and post-operative complications. The overall complication rate was 14.6%.[7] The intra-operative and post-operative complication rates were 4.1% and 10.5% respectively.[7]

Methods and Materials

A hospital based prospective cross sectional study done with 50 randomly selected cases enrolled from Obstetrics and Gynaecology Department of Shaheed Suhrawardy Medical College and Hospital Dhaka in the period between July2009 to December 2009. All patients admitted with the complaints of utero-vaginal prolapse aged between 40 to 70 years are recruited by detailed history. Pre-operative condition, operative procedure, postoperative care are observed, operation type, time, & any per-operative complication are noted. Taking present address including phone number of the patient for further evaluation regarding symptomatic improvement or any complication following operation such as stress incontinence, dyspareunia or failed operation. Patient with genital prolapse associated with any genital malignancy or medical disorder are excluded. Objective was to find out the complications affecting the quality of life after vaginal hysterectomy and pelvic floor repair operation.

Results

This study deals with 50 cases of uterovaginal prolapse who were admitted in Shaheed Suhrawardy Medical College & Hospital, Dhaka, in Obstetrics & Gynaecology department over a period of 6 months

and the findings are subsequently presented in tables.

Table-I Symptomatology of genital prolapse (n=50)

Presenting symptoms	**Number of patients**	**Percentage**
Something coming down per vagina	50	100%
Urinary problem	20	40%
Low backache	18	36%
Defaecation problem	15	30%
Discharge per vagina	10	20%
Urinary incontinence	6	12%

Table-I shows that all (100%) of the patients had the common complaints of something coming down per vagina. About 40% suffered from urinary problem, of them majority used to micutrate by manipulating the prolapsed mass upward with fingers.

Table-II Examination findings (n=50)

Findings	**Number of patients**	**Percentage**
Uterine prolapse		
➢ 1st degree	7	14%
➢ 2nd degree	38	76%
➢ 3rd degree	5	10%
Cystocele		
➢ Mild	12	24%
➢ Moderate	32	64%
➢ Severe	6	12%
Rectocele		
➢ Mild	30	60%
➢ Moderate	5	10%
➢ Severe	0	0
Enterocele	5	10%
Other changes		
➢ Hypertrophied	26	52%
cervix	7	14%
➢ Eongated cervix	15	30%
➢ Decubitus ulcer	33	66%
➢ Uterine atrophy	39	78%
➢ Lax perineum		

Out of 50 cases, 76% had 2nd degree, uterine prolapse associated with varying degree of cystocele in 100% cases and rectocele in 70%. 52% cases had hypertrophied cervix, decubitus ulcer in 30%. 10% cases had enterocele. Many patients had more than one problem.

Table-III Morbidities during and immediate after operation (n=50)

Complications	**Number of patients**	**Percentage**
Haemorrhage		
Minimal	4	8%
Moderate	36	72%
Blood stained vaginal discharge	25	50%
Febrile reaction	16	32%
Urinary tract infection	8	16%
Urinary retention	2	4%

Table-III shows during operation 72% had moderate amount of bleeding, 47 patients got preoperative, peroperative, postoperative blood transfusion. 50% had blood stained vaginal discharge after operation. 32% had raise of temperature. 16% cases experienced urinary tract infection only 2 patients had urinary retention. Many patients had more than one problem.

Table-IV Late morbidities after operation (n=50)

Morbidity	No of patients	Percentage (%)
Dyspareunia	4	8%
Urinary incontinence	1	2%
Vault prolapse	0	0

Table-IV shows, late complications (6 months postoperatively) were minimum, only 8% had dyspareunia in milder form and 2% had stress incontinence. No one had vault prolapse.

Table-V Duration of stay in hospital after operation (n=50)

Postoperative stay in days	No of patients	Percentage (%)
7	38	76%
7-20	12	24%

The duration of postoperative hospital stay was 7 days in 76% cases.

Discussion

The present series is dealt with quality of life among patients after vaginal hysterectomy and pelvic floor operation on 50 cases over a period of six months from July to December 2009.

Though such a small study is not enough to deal with all the aspects of the genital prolapse, the important points were noted down during history taking, which is briefly mentioned below:

Pelvic organ prolapse frequently co-exist with other pelvic floor disorders, anterior wall prolaplse causes urinary incontinence and posterior wall prolapse causes dysfunction of defaecation that affect the quality of life.[15]

In this study 100% patients had history of something coming down per vagina. Many patients (40%) had varying degree of urinary problem, stress incontinence was present in a significant number of cases (12%). 20% had some vaginal discharge (Table-I). This observation is consistent with many other workers in this country.[9,10,11,12,13,14]

Pelvic organ prolapse is a benign condition and serious complications can be avoided by timely assessment and management.[16] Often pelvic organ prolapse is associated with stress incontinence and concomitant operations may be needed to correct all pelvic floor defects and associated symptoms.[17]

Table-II is showing that the commonest type of prolapse was second degree (76%). This may be due to the fact that the third degree prolapse mainly occurs after several years of menopause when the uterus become small, atrophied and there is failure of uterine supports due to hormone deficiency. In many studies in our country, second degree prolapse is commoner than third degree prolapse.[9,10,11,12,13,14]

In this study, all patients were treated by vaginal hysterectomy with pelvic floor repair. This type of operation was associated with less morbidity and minimum complication rate. In the present series of 50 cases of vaginal hysterectomy no major surgical complication or unexpected haemorrhage occurs postoperatively. There was no mortality in this series, febrile reaction was the commonest minor complication experienced by the postoperative patients. In present series the percentage of urinary tract infection was 16% (Table-III). Most of the patients had to stay in the hospital for about 7 days (postoperatively). Only 24% patients had to stay for more than 1 week for infection (Table-V). This

observations are almost similar with the observations of Begum R.[12] and Ara I[11].

Postoperative complications were comparatively less and all were managed conservatively. Comparatively fewer complications were found in this study, possibly due to better screening of patients, well preparedness for surgery, better surgical technique and use of regional anaesthesia. Improvement in postoperative care was also an important factor in reducing complications.

A prospective randomized study on 95 women done in Royal Women's and Mater Hospitals, Brisbane, Australia, showed that after vaginal hysterectomy and pelvic floor repair operation, there was significant improvement in the quality of life of the patients.[18] In that study more than 4% of women experienced stress incontinence after prolapse repair and dyspareunia occur after surgery in approximately 5-7% cases.

In present series, 4% had stress incontinence and 8% experienced dyspareunia (Table-IV). Mild to severe dyspareunia are reported in upto 14% of women after a vaginal hysterectomy with pelvic floor repair operation.[6] After surgical correction of genital prolapse one third of patients who stopped their sexual activity preoperatively resumed their sexual activity.[18] Approximately 40% of women with preoperative dyspareunia had relief of the discomfort after surgery.[18]

Vaginal hysterectomy with pelvic floor repair operation is unlikely to cause bladder and bowel dysfunction.[6] The occurrence of stress incontinence was reported in between 0% and 22% of women.[6]

Vault prolapse may impair quality of life following vaginal hysterectomy and pelvic floor repair operation. The prevalence rate of vault prolapse was 0.8% after surgery for genital prolapse.[8] In this study nobody developed vault prolapse within six months of postoperative period (Table-IV). This observation is also similar to that of Akter H.[8]

The reasons for vault prolapse are inadequate repair, failure to correct enterocele during the primary repair, inadequate operative tissue support, poor tissue tone, oestrogen and protein deficiency, anaemia, chronic recurrent respiratory tract infections etc.[8]

As vaginal hysterectomy with pelvic floor repair operation affect the local nerve supply and anatomical relationships of the pelvic organs, it has been thought that the functions of these organs may be affected after surgery.[6] However, questionnaires are used to detect urogenital symptoms and to determine the quality of life.[6] Improvement was found in all urogenital symptoms like urinary incontinence, overactive bladder, increased frequency and incomplete voiding of urine. Quality of life was also improved including mobility, physical functions, social and emotional functions.[6]

Conclusion

Most of the patients had average peroperative bleeding (72%) and 50% patients had blood stained pervaginal discharge, 32% had febrile reaction, 16% experienced urinary tract infection in the postoperative period. There was no mortality in this study and average postoperative hospital stay was 7 days. Then follow up of the patient and found only 8% had experienced dyspareunia, 4% had urinary incontinence and no one had vault prolapse within six months postoperatively.

After surgical procedure for uterine prolapse, there was improvement in all urogenital symptoms and also physical, social, emotional functioning, thereby ensuring good quality of life. So, surgical treatment is recommended for all cases of genital prolapse.

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