World Journal of Biology Pharmacy and Health Sciences

eISSN: 2582-5542

Cross Ref DOI: 10.30574/wjbphs

Journal homepage: https://wjbphs.com/

(Research Article)

An investigation into the age range of women having hysterectomy in district kullu an observational study

Anupam Thakur * and Vivek Thakur

Department of Obstetrics and Gynaecology, PGI, Himachal Pradesh, India.

World Journal of Biology Pharmacy and Health Sciences, 2023, 13(03), 128–131

Publication history: Received on 05 February 2023; revised on 13 March 2023; accepted on 15 March 2023

Article DOI: https://doi.org/10.30574/wjbphs.2023.13.3.0129

Abstract

Hysterectomy is typically performed on women in their late perimenopausal and postmenopausal years. Indications for hysterectomy include menorrhagia, uterine prolapse, postmenopausal haemorrhage, etc. These symptoms in turn could be brought on by diseases such as endometrial cancer, fibroid uterus, adenomyosis, endometrial polyps, or even endometrial hyperplasia. Age-related pathologies differ from one another. Because of the negative effects of oestrogen loss, hysterectomies performed before the age of 40 should not include oophorectomies. Yet it's also perilous to leave behind an organ that could develop cysts or cancer. Hence, it's necessary to weigh the risks and benefits. Postmenopausal symptoms and their effects continue to be a source of concern that requires constant monitoring and appropriate management because the perimenopausal age group turned out to be the most common one to have a hysterectomy.

Keywords: Perimenopausal; Abdominal; Vaginal; Hysterectomies

1. Introduction

The most frequent major operation on women performed outside of childbirth is a hysterectomy. Abdominal, vaginal, or laparoscopic procedures are frequently used for hysterectomy. Between 20% and 35% of women will have a hysterectomy in their lifetime? A hysterectomy is typically carried out in late perimenopausal and postmenopausal age groups [1]. Menorrhagia, uterine prolapse, postmenopausal haemorrhage, etc. are a few of the reasons why a hysterectomy is performed. The pathologies that are causing these symptoms include endometrial cancer, adenomyosis, endometrial hyperplasia, endometrial polyps, and fibroid uterus. Age affects the type of pathologies that exist. In order to avoid leaving behind a potential organ that could later result in cysts or cancer, a hysterectomy performed around the age of forty or beyond typically includes bilateral salpingo-oophorectomy. Women who have undergone surgery may have postmenopausal symptoms to varying degrees after a variable amount of time. For women who underwent hysterectomies earlier in life, symptoms may be more severe [2]. Having said that, it is important to note that a hysterectomy should be done when there are incapacitating symptoms for which there is no effective medical treatment or when the risk of preserving the uterus is greater than the risk of its removal.

This study will help in knowing the kind of hysterectomy the females had. The number of women using the resources for hysterectomy in a government hospital setting in district kullu, Himachal Pradesh, in these age ranges will be determined by the women who underwent the procedure at these times[3]. The number of women with postmenopausal symptoms, the treatment modalities they are responding to, and even the proportion of this population requiring orthopaedic support or gynaecological surgeries for vault prolapse will be known in future research when these women are followed up. We were looking to assess hysterectomies [4].

* Corresponding author: Anupam Thakur

Copyright © 2023 Author(s) retain the copyright of this article. This article is published under the terms of the Creative Commons Attribution Liscense 4.0.

2. Materials and Methodology

The study was carried out in the Himachal Pradesh area of Kullu for a period of twelve months. The prospective analysis of 100 consecutive hysterectomy instances served as the foundation for the current investigation. based on the applied inclusion and exclusion criteria. The research was conducted in accordance with the predetermined proforma.

2.1. Inclusion Criteria

- Individuals who have a hysterectomy for a variety of medical conditions are eligible for inclusion.
- Patients for whom medical or conservative care had failed and for whom surgery was not contraindicated.
- The patients who endorsed the release form.

2.2. Exclusion Criteria

- Patients who had an obstetric hysterectomy were the first exclusion criteria.
- Patients who refused to sign a consent form to take part in the trial.

Age, parity, and clinical results of patients having hysterectomies at the mentioned department were recorded. Each case's whole history was recorded, then examinations of the general, abdominal, vaginal, and speculum. All patients had Pap smears done. All patients underwent ultrasound examinations. Cases with fibroid uterus, adenomyosis, and occasionally fibroid with adenomyosis, thicker endometrium, adnexal disease, etc. were identified by ultrasonography. Before anyone entered the research, they all provided their consent. Patients received detailed information about the study's objectives, that they wouldn't need any further tests, personal information, treatments, visits, or costs beyond what would be necessary for their therapy alone. Only the management data necessary for such particular instances would be used by us. We also stressed that individuals may withdraw from the study whenever they wanted to, and doing so would not hurt them in any way or force them to pay anything.

Table 1 Age distribution of the sample

Age	Frequency	Percentage
Less than 40	12	12%
41-50	43	43%
51-60	21	21%
61 and above	24	24%
Total	100	100%

Table 2 Type of hysterectomy among the subjects

Hysterectomy Type	Frequency	Percentage
TAH	3	3%
Vaginal Hysterectomy	25	25%
TAH & BSC	72	72%
Total	100	100%

3. Results

In terms of age, there were 12 (12.0%) patients under the age of 40, 43 (43.0%) patients between the ages of 41 and 50, 21 (21.0%) patients between the ages of 51 and 60, and 24 (24.0%) patients above the age of 60. Its worth of z is 2.8465. 0.00438 is the value of p. At p .05. the outcome is noteworthy. The patients' average age (mean standard deviation) was 51.0800 8.1954 years. TAH was performed on 3 (3.0%) patients, 72 (72.0%) patients underwent TAH with BSO, and 25

(25.0%) patients underwent a vaginal hysterectomy. Z is 6.6498, the value. P is less than.00001. At p .05. the outcome is noteworthy.

4. Discussions

We discovered that 43 patients (43.0%), who were substantially older than other age groups (Z= 2.8465; p= 0.00438), were between the ages of 41 and 50. The average age of the patients was 51.0800 8.1954 years. Prolapsed cases and cases of postmenopausal haemorrhage are those who are older than 60.

Cases of uterovaginal prolapse underwent a vaginal hysterectomy. The scope of this page does not include information on clinical presentation in detail. That is a component of our entire investigation and will be covered in upcoming papers. The average age of the cohort, according to Saleh et al. (2012)[5], was 49.1 years, however, 107 patients underwent hysterectomy alone, and 30 underwent hysterectomy along with bilateral salpingooophorectomy. A potentially cancer-prone organ like the ovary is left behind at the perimenopausal age when patients have a hysterectomy alone, with a mean age of roughly 50 years. In their study, the incidence of the abdominal route was 89% and the vaginal route was only 11%, therefore the higher percentage of the single hysterectomy group was not due to the vaginal route. Follow-up for potential ovarian tumours in such circumstances, whether they are malignant or not, is critical. The most prevalent age group (41%) was determined to be 40-49 years old by Gangardharan V et al (2016),[6]. 72% of hysterectomies were performed vaginally, while the remaining Pervez S. N. et al. (2014),[7], reported the peak incidence (51%) in the 31–40 year age group, which was a relatively young age for hysterectomy. In our analysis, we discovered that just 12% of women under the age of 40 had hysterectomies. Peak age incidence was determined to be between 41 and 50 years old. According to Ebinesh A. et al. [8] the age range between 41 and 50 years old was the most common for abdominal hysterectomy. According to Abdullah LS et al. [9], the patients' ages ranged from 23 to 90, with a 49-year-old median.

5. Conclusion

The age group going through a hysterectomy most frequently turned out to be postmenopausal. In this age group, a hysterectomy may result in postmenopausal symptoms and consequences. Therefore, it is essential from both the patient's and the surgeon's viewpoints to receive thorough counselling prior to the procedure. If different treatment approaches are adequate for the instance concerned, that is to be sought after. If surgery is the sole option, risk against benefit should be considered, and choices should be tailored to the person. If a hysterectomy is performed, it will be difficult to minimise the physical and psychological morbidity, especially for women who are having oophorectomy during pre- and perimenopausal age.

Compliance with ethical standards

Acknowledgments

The authors acknowledge the support provided by the staff and the patients of the hospital in Kullu.

Disclosure of conflict of interest

None

Statement of informed consent

Informed consent was obtained from all individual participants included in the study.

References

[1] Farquhar CM, Sadler L, Harvey SA, Stewart AW. The association of hysterectomy and menopause: a prospective cohort study. BJOG: An International Journal of Obstetrics & Gynaecology. 2005 Jul;112(7):956-62.

[2] Hickey M, Ambekar M, Hammond I. Should the ovaries be removed or retained at the time of hysterectomy for benign disease?. Human reproduction update. 2010 Mar 1;16(2):131-41.

[3] Prusty RK, Choithani C, Gupta SD. Predictors of hysterectomy among married women 15–49 years in India. Reproductive health. 2018 Dec;15:1-1.

[4] Moorman PG, Myers ER, Schildkraut JM, Iversen ES, Wang F, Warren N. Effect of hysterectomy with ovarian preservation on ovarian function. Obstetrics and gynecology. 2011 Dec;118(6):1271.

[5] Saleh SS, Fram K. Histopathology diagnosis in women who underwent a hysterectomy for a benign condition. Archives of Gynecology and Obstetrics 2012;285(5):1339-43

[6] Gangadharan V, Prasanthi C. Hysterectomy - a clinicopathological correlation in a rural setting. Indian J Basic Appl Med Res 2016;5:8-15.

[7] Pervez SN, Javed K, Obald M. Hysterectomy: a clinicopathological correlation. KJMS 2014;7(2):295-7.

[8] Ebinesh A, Sharada MS, Krishna MC. Clinico-pathological correlation of abdominal hysterectomy specimens. Int J Sci & Res 2015;4(6):1084-9.

[9] Abdullah LS. Hysterectomy: a clinicopathologic correlation. Bahrain Medical Bulletin 2006;28(2):1-6