

Supracervical hysterectomy in Trinidad

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Summary

With mounting evidence of the beneficial effects of the retained cervix, supracervical hysterectomy is gaining popularity worldwide. In this series of 123 patients, obesity and pelvic adhesions were the chief factors that prevented amputation of the cervix at the time of hysterectomy. We propose that these are cogent indications for planned supracervical abdominal hysterectomy in order to minimize damage to the adjacent viscera. This option is best justified by a risk/benefit analysis.

Key words: Cervicectomy; Previous pelvic surgery; Obesity.

Introduction

Subtotal hysterectomy, pioneered in England by Clay in 1843, was the operation of choice for uterine disease for over a century [1], coinciding with the time when gynaecological surgery was the prerogative of the general surgeons. Because of concerns that malignant change may occur in the retained cervical stump [2, 3], the pendulum had swung in the 1950's and total extirpation of the uterus with the cervix became the norm. Several researchers [4-6], recognizing that the risk of stump carcinoma is small, have challenged the wisdom of routine cervicectomy at the time of hysterectomy, in the context of improved techniques for detecting cervical neoplasia.

Peculiar to the West Indies, with its predominantly black population, is the occurrence of pelvic inflammatory disease and large uterine fibroids, which make dissection difficult and hazardous [7]. Despite this drawback, we have always subscribed to the view of British gynaecologists that planned removal of the cervix constitutes an integral part of abdominal hysterectomy [8], and a decision to perform the subtotal procedure is taken only when difficulty is encountered, intraoperatively.

A 5-year review of our experience with supracervical (subtotal) abdominal hysterectomy was undertaken in order to determine what factors influenced the surgeon to abandon amputating the cervix. If certain conditions prevail which countermand the need for the supracervical procedure, then it can be offered electively to these selected cases, after taking the necessary precautions, since the benefits of retaining a normal cervix might outweigh the surgical risks involved in its removal [6, 9].

Materials and Methods

This retrospective analysis was carried out at the Mt. Hope Women's Hospital, where the medical records of all patients subjected to a subtotal hysterectomy for gynaecological disease

during the years 1995 to 1999 were reviewed. Obstetric hysterectomies were excluded from the study. The casenotes were scrutinized in order to establish the primary indication for the hysterectomy, the reasons for the supracervical operation and to determine what complications, if any, occurred before the decision to remove the cervix was retracted.

During the 5-year period, 1,260 abdominal hysterectomies were performed, of which 123 were supracervical, an incidence of 10.2%. All the procedures were performed by a gynaecological Senior Registrar or Consultant. The cervix appeared macroscopically healthy in all patients and preoperative pap smears, done in only 51 women within the previous year, were normal. All patients are being followed-up in the gynaecology clinic and to date, there have been no abnormal pap smear results.

Results

The primary indications for hysterectomy were uterine fibroids (77 patients), adenomyosis or endometriosis (24 patients), chronic pelvic inflammatory disease (14 patients) and ovarian carcinoma (8 patients). There were no patients in whom cervical pathology was an indication.

The Table shows that the commonest reasons for resorting to the supracervical operation were previous pelvic surgery and massive obesity (≥ 90 kg). In many instances, more than one indication was documented. Thirty-two patients had previous lower segment caesarean section causing dense scarring between the bladder and the anterior aspect of the supravaginal cervix. In those who had previous myomectomy, there were multiple adhesions between the bowel and bladder and the uterus.

Pelvic inflammatory disease had caused adhesions obliterating the lower extremity of the uterus in 16 women and severe endometriosis in the Pouch of Douglas rendered the sigmoid colon and the rectum vulnerable to injury in 17 patients. Obesity was cited as the reason for supracervical hysterectomy in 35 patients with a "deep pelvis" rendering the supravaginal portion of the cervix inaccessible. Profuse bleeding and distorted

Table. — Indications for supracervical hysterectomy.

Indications	Number of cases
Previous pelvic surgery	
Caesarean section	32
Myomectomy	20
Pelvic inflammatory disease	16
Severe endometriosis	17
Massive obesity	35
Long supravaginal cervix	11
Ovarian malignancy	8
Cervical and broad ligament fibroids	8

anatomy from cervical and broad ligament fibroids were the reasons in a small number of patients.

Bowel injury was sustained in three cases and the bladder was perforated in a further ten patients.

Discussion

There is a wide variation in the geographical prevalence of supracervical hysterectomy. In a British study, Vessey *et al.* [10] reported an incidence of 0.7%, and a figure of 21% was cited by Nahorst-Boos *et al.* [11] in Sweden, where the validity of routine total hysterectomy has been seriously questioned. In the present investigation, the supracervical procedure became imperative in 10.2% of hysterectomies because of the difficult conditions prevailing at the time of surgery. Our policy is consistent with British gynaecological practice [12, 13], which favours the total procedure except where the bladder and bowel are susceptible to injury, but the rate is 14 times higher in Trinidad.

The popularity of the supracervical operation in Scandinavia is based on the work of Kilkku [14]. Not only are there fewer intraoperative complications and post-operative vaginal prolapses [19], but better orgasmic response [15, 16] and undisturbed bladder function [17] have been reported. Since these potential benefits outweigh the extremely low risk (< 0.3%) of developing stump carcinoma [4], it appears that the most congruent way of deciding which course to follow in each individual patient, is to employ a risk/benefit analysis when confronted with a difficult hysterectomy.

The chief reasons for not proceeding with cervicectomy in the present study were obesity and pelvic adhesions from endometriosis, pelvic inflammatory disease and previous caesarean section or myomectomy. In the massively obese woman, the problem is one of visualizing the supravaginal cervix in a restrictive operative field while in the presence of dense adhesions, there is a distinct possibility of serious damage to the surrounding viscera, as occurred in 13 of our patients. Under these conditions, it would appear prudent to amputate the uterus at the level of the isthmus rather than to persevere with the removal of a normal cervix.

Drife [8] and Thakar *et al.* [18] have advocated planned cervical conservation in selected cases after counselling the patient about the potential risks and benefits, and until the debate on the fate of the cervix is settled scientifically, it appears that the conditions encountered in this study are valid indications for elective intentional supracervical hysterectomy. Follow-up by cytological evaluation is mandatory.

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