

Burden of gynaecological disease: three years audit of inpatient department in a tertiary care hospital

M N Arvikar^{1*}, V D Bhole²

¹Professor, ²Associate Professor, Department of OBGY, Dr Ulhas Patil Medical College and Hospital, Jalgaon, Maharashtra, INDIA.

Email: mnarvikar@gmail.com

Abstract

Introduction: Reproductive health problems constitute the leading cause of ill health in women of reproductive age group worldwide especially to those in developing countries. It accounts for 21.9% of the disability adjusted life years lost by women aged 15–45 years **Aims and Objectives:** To find the Burden of Gynaecological Disease admitted in the OBG department and to find out the various treatment modalities applied for the same. **Material and Method:** Retrospective hospital record based study carried among the 1715 female patients admitted from various causes in the department of Obstetrics and Gynaecology from January 2012 to December 2014 in a Tertiary care Hospital were included. Data was collected from the Gynaecology Inpatient's records, in which the presenting symptoms, clinical diagnosis and investigations were recorded. Information on various symptoms, ages, clinical findings, diagnosis and the various treatment modalities applied among 1715 women were recorded. **Results:** The findings of the present study shows that the majority of the patients were between the age group of 40-44 years (15.80%) followed by 35-39 years (15.69%) and the least belonged to the age group of less than 20 years (1.11%). Majority of the patients admitted were having DUB (30.55%), followed by Prolapse uterus (23.56%), Ovarian cyst (19.24%), Fibroid (14.23%), Bulky uterus (7.52%). The most common Treatment modality applied among Patients admitted from a variety of reasons were Total Abdominal Hysterectomy (61.63%) followed by Ovarian cystectomy (18.72%) and Vaginal Hysterectomy (18.48%) **Conclusion:** - There is a need for a multi-pronged and multi-sectoral concentrated effort to address problems of Gynaecological morbidities as the determinants for care range from economic to social issues.

Keywords: Age, DUB, Prolapse uterus, Hysterectomy, Bulky uterus, Fibroid.

*Address for Correspondence:

Dr. M N Arvikar, Associate Professor, Department of OBGY, Dr Ulhas Patil Medical College and Hospital, Jalgaon, Maharashtra, INDIA.

Email: mnarvikar@gmail.com

Received Date: 04/07/2015 Revised Date: 14/08/2015 Accepted Date: 02/09/2015

Access this article online	
Quick Response Code:	Website: www.statperson.com
	DOI: 07 September 2015

INTRODUCTION

A healthy reproductive life is an essential component of the general health and well-being of a woman¹. Reproductive health problems constitute the leading cause of ill health in women of reproductive age group worldwide especially to those in developing countries². It accounts for 21.9% of the disability adjusted life years lost by women aged 15–45 years³. Gynaecological morbidity has been defined as the structural and functional disorder of the Genital tract which is not

directly related to the pregnancy, delivery and puerperium. It includes menstrual disorders, reproductive tract infections, cervical cell changes, genital prolapse and other related morbidities⁴. An analysis of self reported symptoms of gynaecological problems in Karnataka, India among 3600 women, reported that one third of all women mentioned at least one current symptom, the most common being the feeling of weakness and tiredness, Menstrual disorders, white or coloured vaginal discharge, lower abdominal pain and discharge with fever⁵. Other community – based studies in India report menstrual disorders such as Heavy, Light, irregular, painful menstruation or spotting as the major gynaecological problems. Which were ranging from a low of 33% in rural West Bengal to 60% or more in rural Maharashtra and Karnataka⁶. A study on the prevalence of gynaecological morbidity in Pakistani women reported that nearly 17% had cervical infections, erosions or ulceration and 10.9% had Uterovaginal-Prolapse⁷. Prevalence of other gynaecological morbidities such as UTI - 4% and uterine prolapse - 8% has been reported

from community-based studies conducted in India and Egypt⁸. Several studies among rural Indian women report the prevalence of white or colored vaginal discharge and malodorous vaginal discharge or itching/irritation and fever ranging from 16% to 44% of hospital admissions in gynaecological wards were due to PID⁹. The major risk factors for PID in developing countries were behavioural or socioeconomic. For example, reports from South India, show that women were more likely to report menstrual disorders, dyspareunia, prolapse, ND and UTI had poor behavioural factors like poor personal hygiene, or unsanitary household conditions, or low exposure to health information⁵. There were marked differences in the prevalence of reported gynaecological morbidity from 24.4 % to 74.1 % at various regions of India^{10,11}. Kerala state in India is often quoted as a model for the developing world because of its achievements in the field of health. Health seeking behaviour was reported to be high in Kerala for antenatal care services with 99 % institutional deliveries and 94% had at least 3 antenatal visits¹². A survey by Indian Council for Medical Research reported that proportion of women having any gynaecological complaints in South Kerala was 29.1%¹⁰.

AIMS AND OBJECTIVES

1. To find the Burden of Gynaecological Disease admitted in the OBG department.
2. To find out the various treatment modalities applied for the same.

MATERIAL AND METHOD

Study Design

The present study was a Retrospective hospital record based study carried among the female patients admitted from various causes in the department of Obstetrics and Gynaecology in a Tertiary care Hospital.

Study Participants

1715 patients who were admitted in the Obstetrics and Gynaecology Department from January 2012 to December 2014 were included in the study

Inclusion Criteria

Patients admitted during January 2012 and December 2014 and women reporting with Gynaecological problems.

Exclusion Criteria

Women reporting to the outpatients department with non Gynaecological problems were excluded. As abortions are part of obstetric morbidity they were also not included.

Setting

This study had approval from the Research and Ethics Committee to conduct this study at the department of

Obstetrics and Gynaecology. The study took three months to complete. (Jan 2015 to March 2015)

Data Collection

Data was collected from the Gynaecology Inpatient's records, in which the presenting symptoms, clinical diagnosis and investigations were recorded. Information on various symptoms, ages, clinical findings, diagnosis and the various treatment modalities applied among 1715 women were recorded. Gynaecological morbidity was classified into reproductive tract infections, Prolapse uterus, menstrual irregularities, Fibroids, gynaecological cancers, menopausal symptoms and others. Frequency of each morbidity was calculated separately.

Statistical analysis

Statistical tests used were percentages and proportions. All data analysis had been done by using SPSS software for windows.

RESULTS

Table 1: Age wise distribution of the Study subjects

Sr No	Age	Number	Percentage
1	less than 20	19	1.11
2	20-24	134	7.81
3	25-29	207	12.07
4	30-34	241	14.05
5	35-39	269	15.69
6	40-44	271	15.80
7	45-49	194	11.31
8	50-54	130	7.58
9	55-59	76	4.43
10	>60	174	10.15
	Total	1715	100.00

Age wise distribution of the patients admitted in the OBG department shows that the majority of the patients were between the age group of 40-44 years (15.80%) followed by 35-39 years (15.69%), 30-34 years (14.05%), 25-29 years (12.07%) and the least belonged to the age group of less than 20 years (1.11%).

Table 2: Distribution of the patients based on the diagnosis of illness at the time of admission

Sr No	Illness	Number	Percentage
1	Prolapse Uterus	404	23.56
2	Bulky Uterus	129	7.52
3	Amenorrhoea	11	0.64
4	DUB	524	30.55
5	Fibroid	244	14.23
6	PID	38	2.22
7	Procedentia	13	0.76
8	Rectocoel	8	0.47
9	Ovarian Cyst	330	19.24
10	Others	14	0.82
	Total	1715	100.00

The Majority of the patients admitted were having DUB (30.55%), Followed by Prolapse uterus (23.56%), ovarian cyst (19.24%), Fibroid (14.23%), Bulky uterus (7.52%) and the least were having rectocoel (0.47%) as their chief complaints.

Table 3: Distribution of the patients based on the Treatment modality applied

Sr No	Treatment Given	Number	Percentage
1	Vaginal Hysterectomy	317	18.48
2	Total Abdominal Hysterectomy	1057	61.63
3	Ovarian cystectomy	321	18.72
4	Repair of Uterus	11	0.64
5	Others	9	0.52
	Total	1715	100.00

The most common Treatment modality applied among Patients admitted from a variety of reasons were Total Abdominal Hysterectomy (61.63%) followed by Ovarian cystectomy (18.72%) and Vaginal Hysterectomy (18.48%).

DISCUSSION

The findings of the present study shows that the majority of the patients were between the age group of 40-44 years (15.80%) followed by 35-39 years (15.69%), 30-34 years (14.05%), 25-29 years (12.07%) and the least belonged to the age group of less than 20 years (1.11%). The Majority of the patients admitted were having DUB (30.55%), Followed by Prolapse uterus (23.56%), ovarian cyst (19.24%), Fibroid (14.23%), Bulky uterus (7.52%) and the least were having rectocoel (0.47%) as their chief complaints. The most common Treatment modality applied among Patients admitted from a variety of reasons were Total Abdominal Hysterectomy (61.63%) followed by Ovarian cystectomy (18.72%) and Vaginal Hysterectomy (18.48%). A study done by Fatima Sajan and Fariyal F showed that Approximately 55% of the women in this study reported having at least one gynaecological morbidity¹³. Similar observations were noted by studies reported from various studies done in India where the magnitude of gynaecological morbidities ranged from 33% to as high as 92%⁶. A study done by Pooja Patil and Abhijeet Patil showed that the mean age of women with prolapse was 52.2¹⁴. Where as a study done by Shergil et al¹⁵ showed that the Maximum number of women who underwent hysterectomy were in the age group of 31-50 years. Abnormal menstrual flow was the most common complaint (66%). Clinically main indications for hysterectomy were fibroid (34%), dysfunctional uterine bleeding (DUB) (26%) and uterine prolapse (24%).

Abdominal hysterectomy was the procedure of choice in conditions other than uterovaginal prolapse.

CONCLUSION

There is a need for a multi-pronged and multi-sectoral concentrated effort to address problems of Gynaecological morbidities as the determinants for care range from economic to social issues. These issues include raising awareness to address the “culture of silence”, adverse social attitudes and practices regarding child bearing, low status of women.

REFERENCES

1. Guidelines on Reproductive Health. Report of United Nations Population information network. Available at: <http://www.un.org/popin/unfpa/taskforce/guide/iatfrehph.gdl.html>. [Last accessed on 1/11/2012]
2. Improving reproductive health. Population issues. UNPFA. Available at: <http://www.unfpa.org/rh/index.htm>. [Last accessed on 26/08/2014]
3. Abouzahr C, Vaughan JP. Assessing the burden of sexual and reproductive ill health: Questions regarding the use of disability adjusted life years. *Bulletin of World health Organization*. 2000;78(5)
4. Bhatia, J.C., Cleland, J., Bhagavan, L., et al. Levels and determinants of gynecological morbidity in a district of South India. *Stud Fam Plann*. 1997; 28, 2: 95-103.
5. Bhatia, J.C. and Cleland, J. Self-reported symptoms of gynecological morbidity and their treatment in South India. *Stud Fam Plann*. 1995; 26, 4: 203-216.
6. Patel, P. Illness beliefs and health-seeking behavior of the Bhil women of Panmahal District, Gujarat State. *Listening to women talk about their health. Issues and evidence from India* Gujarat, 1994; 55-66.
7. Khan, T. Family formation and maternal health: Pakistan. In: Omran AR, Standley CC, ed. *Family formation patterns and health--further studies: an international collaborative study in Colombia, Egypt, Pakistan, and the Syrian Arab Republic*. Geneva, World Health Organization, 1981; 287-95.
8. Younis, N, Khattab, H, Zurayk, U. A community study of gynecological and related morbidities in Rural Egypt. *Study in Family Planning*, 1993; 24 (3), 175-86.
9. Ratnam AV, Din SN, Chatterjee IK. Gonococcal infection in women with pelvic inflammatory disease in Lusaka, Zambia. *American Journal of Obst and Gynecology*, 1980; 138: 965-68.
10. Kambo IP, Dhillon BS, Singh P, Saxena BN, Saxena NC. Selfreported gynecological problems from twenty three districts of India (An ICMR Task Force Study). *Indian J Community Medicine*. 2003; 28(2):67-73.
11. Latha K, Kanani SJ, Maitra N. Prevalence of Clinically Detectable Gynecological Morbidity in India: Results of Four Community Based Studies. *The Journal of Family Welfare*. 1997; 43(4):8-16.
12. Antenatal care, Maternal Health. International Institute for Population Sciences and Macro International.

- National Family Health Survey, India, Kerala. Report number: 2005- 06:3.
13. Fatima Sajjan, Fariyal F. Fikree .Perceived Gynaecological Morbidity among Young ever-married Women living in squatter settlements of Karachi, Pakistan. Journal of Pakistan medical association, 1999; 49: 92-97.
 14. Pooja Patil, Abhijit Patil. Evaluation of Pelvic Organ Prolapse in Indian Females. Journal of Evolution of Medical and Dental Sciences. October 2013; 2(13): 7613-20.
 15. Shergill SK, Shergill HK, Gupta M, Kaur S. Clinicopathological study of hysterectomies. Journal of the Indian Medical Association ,2002; 100(4):238-246

Source of Support: None Declared
Conflict of Interest: None Declared