Route of Hysterectomy at Croydon University Hospital: a retrospective audit

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Background

- Since the publication of the RCOG’s Patterns of Benign Gynaecology Care Report 2015-16, there has been a significant onus on Trusts to audit mode of hysterectomies, length of stay and readmission rates locally.
- The RCOG recommended that hysterectomy should be performed using a minimally invasive or vaginal route where technically feasible.
- Our aim was to perform a local audit and identify opportunities to improve clinical care and patient choice within our unit.

Objectives

- To quantify the proportion of hysterectomies being performed through each surgical route at Croydon University Hospital (CUH) and compare these to national Hospital Episode Statistics (HES) data
- To analyse factors influencing the route of hysterectomy
- To determine patient length of stay and factors contributing to discharge delay
- To determine the rate of postoperative emergency readmission within 30 days

Results

A total of 223 hysterectomies were performed at CUH between July 2017 and July 2018.

Length of stay and discharge delay:
Median length of stay (rights) was 3 for open procedures, 2 for vaginal procedures and 1 for endoscopic procedures.

Discharge delay was considered for laparoscopic and vaginal hysterectomy if women were staying >1 night, or >2 nights for abdominal procedures. The most frequent category for discharge delay was “not recorded” (26.1%) followed by “bowel related” (17.6%) and “failed trial without catheter” (12.6%).

Complications:
One patient suffered a postoperative haemorrhage requiring blood transfusion and re-laparotomy following abdominal hysterectomy.

4 (1.8%) women had emergency readmissions within 30 days - 3 were postoperative infections post laparoscopic hysterectomy and 1 was a wound dehiscence following abdominal hysterectomy.

Conclusions

- 40% of hysterectomies are performed abdominally at CUH - 7% lower than the national average.
- CUH’s high rate of vaginal hysterectomy is likely two fold – we have a prominent urogynaecology unit, and perform a greater proportion of hysterectomies for benign indications.
- Although there are six consultants capable of performing laparoscopic hysterectomy, 42% of women did not have a normal sized uterus and 4.5% had contraindications to laparoscopic hysterectomy.
- A small number of women with a small uterus (s12/40 size) underwent abdominal hysterectomy without a clear indication. All of these women were under the care of a consultant not trained in performing laparoscopic hysterectomy.

Recommendations

- To increase our laparoscopic rate and offer more patient choice, women opting for hysterectomy with a uterus s12/40 size should be offered referral to a consultant trained in performing hysterectomy via a minimally invasive route.
- Documentation of discussions with women regarding mode of hysterectomy should be improved.
- Documentation of reasons for delayed discharge should be improved, so these issues can be addressed or anticipated.
- A re-audit in 2 years is recommended.

Methodology

Retrospective electronic case note review of all hysterectomies performed between July 2017 and July 2018 at CUH.

Audit Standard: Hospital episode statistics collected between 2011-2017 for all hysterectomies and all indications in England (Madhvani et al. 2018). We compared our data to the 2017 figures.

Data collected:
- Intended mode of hysterectomy
- Actual mode of hysterectomy
- Length of stay
- Lead surgeon
- Factors potentially influencing route of hysterectomy – uterine size, comorbidities, previous abdominal surgery including Caesarean sections
- Intraoperative difficulties and complications
- Factors contributing to patient discharge delay
- Emergency readmission rates within 30 days

References
