



Case Report

Total abdominal hysterectomy followed by bilateral salpingo-oophorectomy and submucous fibroid removal

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ABSTRACT

There was abnormal uterine bleeding and recurrent lower abdominal pain in a 50 year-old female. A bilateral salpingo-oophorectomy is surgery to extract ovaries and fallopian tubes of both the sides. By the age of 60, more than a third of women in the US have had a hysterectomy. The expected anatomy, the patient's body habits, the degree of pelvic relaxation, the need for concurrent abdominal and vaginal procedures, and the surgeon's expertise all play a role in deciding the uterus delivery technique and route. The hysterectomy and bilateral salpingo-oophorectomy will both be done during one procedure. The uterus, ovaries, cervix & fallopian tubes are remove through surgery. For a large sub mucous fibroid uterus, the patient opted to have a complete abdominal hysterectomy along bilateral salpingo-oophorectomy. Abdominal hysterectomy & bilateral salpingo-oophorectomy were performed in midline vertical incision under general anesthesia. A uterus with sub mucous fibroid (polyps) was confirmed by pathology. The option of surgical method in a hysterectomy based on clinical conditions, the professional skill of the surgeon, and the preference of patients. As this case indicates, for many patients, abdominal hysterectomy is an important choice where the use of other methods may pose a serious danger. This method may be sufficient for the treatment of sub-mucous fibroids. There are broad range of studies that demonstrate beneficial effects in the various therapies created, serving as a basis for guiding physiotherapeutic approaches in hysterectomy, aiming at complementary tools for better treatment of the patient undergoing this procedure.

Keywords: Total Abdominal Hysterectomy, Submucous Fibroid, Physiotherapy, Women's Health.

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INTRODUCTION

Abdominal hysterectomy indicate to the removal of the uterus, either subtotal (supracervical) or complete (uterus including the cervix). In the United States, abnormal uterine bleeding (AUB), uterine leiomyomas, malignant and premalignant disease, pelvic organ prolapse & pelvic pain or infection (e.g. endometriosis, pelvic inflammatory diseases) are one of the most often carried out surgical procedures usually indicated [1]. Symptoms can be extreme like prolonged menstrual bleeding & pain are most frequently associated with fibroids. The treatment is myomectomy approach depends on size, location and number of fibroids for those patients who want fertility (hysteroscopic, laparoscopic, abdominal). Options include myomectomy and hysterectomy if the above treatments are not effective and/or patients want surgical care [2]. With physiotherapy interventions complications such as postoperative pulmonary

complications and prolonged immobility are potentially preventable. Patients undergoing abdominal surgery are routinely treated by physiotherapists [3]. Total hysterectomy, however is choose for patients who do not want to have children and for patients who have massive or multiple fibroids.

Patient information

A 50 year old woman, gravida 3, a body mass index (BMI) of $\text{Weight/Height}^2 = 27.6$ (overweight). Past surgical history included the history of hospitalisation and surgery 5 years back (removal of fibroids). Presently patient complains of pain at the incision site (lower abdomen) which is burning and constricting in nature, aggravates on sneezing, coughing and during mobility and relieves in supine lying position. On NPRS (numerical pain rating scale) patient rated 5/10. Patient has a complain of heavy menses with severe abdominal pain

and heavy bleeding lasting for 15 days for that sonography was done and mass i.e. fibroids were detected and was operated for the same 5 years back. Then 1 year back patient again started experiencing heavy bleeding with clots, pain and weakness so initially she took medicine but didn't felt relief so she came here, here sonography was done and fibroids was seen and hysterectomy was advised so surgery was performed under general anesthesia. On local examination patient was in supine lying position with no external apparatus attached. No deformity, muscle wasting was seen. Horizontal (pfannenstiel) incision was present at lower abdomen, length of scar on inspection was approx. 25 cm with bandage. Wound is healthy and there was no oozing and discharge present. On palpation grade 2 tenderness was present. For further management the patient was referred for physiotherapy treatment.

Clinical finding

On Posture evaluation, shoulders were bilaterally symmetrical, no cervical lordosis, no kyphosis was present. There was increased lumbar lordosis. ASIS was symmetrical and no knee deformity was seen and foot was neutral.

Table 1. Range of motion assessment on 1st day of treatment

Movements	Active ROM	Passive ROM
Hip flexion	0-90 ⁰	0-100 ⁰
Hip abduction	0-20 ⁰	0-25 ⁰
Hip adduction	0-20 ⁰	0-30 ⁰
Knee flexion	0-100 ⁰	0-110 ⁰
Ankle dorsiflexion	0-15 ⁰	0-10 ⁰
Ankle plantarflexion	0 ⁰	0 ⁰

Table 2. Manual muscle testing assessment on 1 day of treatment

Hip muscle	Flexion	2
	Extension	2
Knee muscle	Flexion	3+
	Extension	3+
Ankle muscle	Dorsiflexion	3
Toe muscle	Extension	3

Pain on 1st day of treatment: NPRS 5/10

Plan of care

1st Week

Breathing exercises: Deep breathing exercises help to reduce the effects of an anesthetic and increases the lung capacity, prevent complications related to the lungs, such as collapse and pneumonia.

Huffing/ Coughing: Coughing places tension on your stomach & pelvic floor muscles, so it is better to huff to clear secretion from the chest.

Ankles Bend & stretch the ankles up and down firmly and rapidly ×5 times, static quadriceps for 5 times repetition.

2nd Week

Tighten your buttocks to relieve pressure bottom ×5 times, initially all exercises carried out in lying position, knees bent & shoulder apart, feet flat on the bed followed by abdominal exercise, pelvic tilting and knee rolling. Strengthening the muscles hold and lift for up to 10 seconds then rest for 5 second. You may feel stomach

muscles get tighten, repeat ×10 times. Exercise should practise three to four times a day.

3rd Week

To get out of bed

By shifting your shoulders and knees together, bend both knees and turn onto your side use upper limb to lift your trunk and lower limb out of the bed. Sit on the side of the bed, then stand with the supported legs and hands pulled up.

Posture and back care

Being conscious of posture and taking extra care around three weeks after the operation is very necessary. Sitting upright in a comfortable chair, with the both feet should together on the ground, with a good posture will help avoid backache and don't slouch. Placing a folded towel on your back to provide support can be helpful.

Household activities –Dos and don'ts

Do personal hygiene; easy housework, such as washing and drying dishes; cooking light meals; independent personal hygiene.

Don'ts include high elevation; shifting the heavy bedding; using the oven to prepare a big meal; heavy housework.

Outcome and follow up

After four months of therapy the muscle strengthened to grade 4/5. All the clinical assessment, diagnostic tool were taken post treatment showed significant progress in patients outcome measures

Table 3. Manual muscle testing (strength) post treatment

Assessment		Pre- assessment	Post-assessment
Hip muscle	Flexion	2	3+
	Extension	2	3+
Knee muscle	Flexion	3+	4
	Extension	3+	4
Ankle muscle	Dorsiflexion	3	4+
Toe muscle	Extension	3	4+

Table 4: Range of motion assessment post treatment

	Active ROM	Passive ROM
Hip flexion	0-115 ⁰	0-125 ⁰
Hip abduction	0-35 ⁰	0-45 ⁰
Hip adduction	0-40 ⁰	0-50 ⁰
Knee flexion	0-125 ⁰	0-135 ⁰
Ankle dorsiflexion	0-15 ⁰	0-20 ⁰
Ankle plantarflexion	0-35 ⁰	0-45 ⁰

Pain on post treatment: NPRS 8/10

DISCUSSION

In a hysterectomy, the choice of surgical technique depends on clinical conditions, the professional skill of the surgeon, and patient preference [4]. While minimally invasive hysterectomies are now favored by vaginal and laparoscopic methods due to reduced hospital stays and post-surgical recovery times, individual care plans for patients should be appraised based on the size of the uterus and the risk of not obtaining sufficient exposure, resulting in complications [5]. We believe that she already had a sub mucous fibroid at that time and that prior to the appearance of abdominal pain, ischemic changes had occurred, although it is unknown when the fibroid prolapsed into the

vagina^[6]. The use of auricular TENS in hysterectomy-related locations has shown minimization of postoperative pain, revealing itself as an important alternative to non-medication for this reason. Hysterectomy can lead to change in the bladder and decreased quality of life^[7,8]. Despite the fact that fibroid is the most recurrent pelvic tumor in reproductive-age women (20%), cervical fibroid is just 1–2% of the time^[9]. Similar complication risks have been identified in following case series involving abdominal myomectomy and abdominal hysterectomy procedures^[10].

CONCLUSION

Overall, emerging trends and guidance support the use of procedures that are minimally invasive. These procedures have studied advantages when selecting a route for a hysterectomy in disease and ignore true absolute contraindications. However, this case shows, the aim of abdominal hysterectomy is still an essential choice for those patients where there might be a substantial risk of using other methods. This wide range of studies showing beneficial results in the various treatments serves as a basis for guiding physiotherapeutic approaches to hysterectomy, with the goal of offering additional services to improve care for the patient undergoing this procedure. In order to deliver these programs, physiotherapy services depend not just on the balance of evidence but on the balance of resources.

AUTHOR'S CONTRIBUTION

All authors contributed equally to the manuscript.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

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INFORMED CONSENT

Written & Oral informed consent was obtained from the patient included in the study.

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