A Survey of Hysterectomy Patterns in Malaysia

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Hysterectomies in Malaysia: Why are we left behind?

Editor – I was indeed surprise to read in Dr Ravindran's article[1] that only 95 out of 707 cases of hysterectomies carried out in the 14 government hospitals in his study were vaginal hysterectomies. This is very worrying because vaginal hysterectomy is now recognised as the treatment of choice over abdominal hysterectomy. Most hysterectomies can be carried out via the vaginal route. The extremely low proportion of vaginal hysterectomies in the study is because vaginal hysterectomy is carried out only for utero-vaginal prolapsed cases. This is the simplest type of vaginal hysterectomy.

Vaginal hysterectomy is superior to abdominal hysterectomy in terms of post operative recovery [2,3,4]. This is an accepted fact. The role of abdominal hysterectomy is declining worldwide. In Australia[5], between 1990 and 1995, the use of abdominal hysterectomy nationwide had declined from 78% to 57%. This means that in some centres the gynaecologists are carrying out vaginal hysterectomy for up to 90% of their cases. In countries such as Germany, Australia, France and parts of India, vaginal hysterectomy makes up the main portion of hysterectomies.

In order to achieve this, one has to acquire the skills needed to perform vaginal hysterectomy beyond that needed for prolapsed cases. My initial personal series on vaginal hysterectomy published in MJM in 1996 showed that the learning curve is quite sharp[6]. I have also published a few case reports on vaginal hysterectomy for patient with previous Caesarean section[7], fibroids[8] and nulliparous women[9]. Since going into private practice in 1997, 75% (60/79) of my hysterectomies are vaginal hysterectomies. Out of these cases, only 11% (9/79) were laparoscopic assisted vaginal hysterectomies (LAVH).

This traditional mind set regarding the limited role of vaginal hysterectomy must be changed. It is up to those in power to set up a programme to acquire the expertise and teach the trainees in the government service. One can give the excuse that LAVH needs expensive instruments that may be a constrain in the government service. This is however not the case for vaginal hysterectomy which only needs basic instruments.

I hope that our training programmes in the country are responding to this extremely important change. If we continue to neglect this area of training, our patients will lose out and we will continue to be left behind.

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A Survey of Hysterectomy Patterns in Malaysia

Editor – We read with dismay the article "A survey of hysterectomy patterns in Malaysia" by Ravindran et. al[1] . Our concern lies with the following points:

1. Despite involving 14 government hospitals throughout the country, this survey did not include any of the University Hospitals. As tertiary referral centres and leading post graduate training centres where thoughts and practices for budding gynaecologist are shaped, the exclusion of these centres from this survey hardly makes the report representative of any 'patterns' of practice in Malaysia. I provide data for hysterectomies performed at the University Hospital, Kuala Lumpur for the corresponding period of the study, i.e. 1st March 1996 to 31st August 1996 in Table I. Similar data for hysterectomies performed between 1st January 1995 and 31st December 1997 at the University Hospital is displayed in Table II. Had this information been included in the survey, the conclusions would have vastly differed. Hence, readers of the said article must interpret the information in it with caution.

2. As the authors admitted, private hospitals were not included in this survey. Private hospitals provide up to 45% of the health care in Malaysia. Their exclusion will seriously jeopardise the information collection and interpretation.

3. It is disappointing that all 95 vaginal hysterectomies performed in the survey were performed for utero-vaginal prolapse only. Vaginal hysterectomy can be performed for most gynaecological indications and as the authors correctly pointed out, there is a need to improve training in this area.

4. Contrary to the authors' opinion, laparoscopically assisted vaginal hysterectomies (LAVH) is NOT performed by only a handful of Malaysian gynaecologists. Of the 47 LAVH performed between 1.1.95 and 31.12.97 at the University Hospital Kuala Lumpur (Table II), 9 different academic staff were involved as the first surgeons and the first assistants included 5 different senior consultants, 3 different lecturers and 13 different medical officers. We also know of some consultants in government and private practice who do LAVH on a regular basis. The exposure of our medical officers to this surgical technique will definitely encourage its subsequent acceptance in the future. The pool of surgeons skilled in laparoscopic surgery is rapidly increasing and the wide availability of good endoscopie equipment will promote its wider usage. We also believe that usage of the laparoscopie will increase the confidence of gynaecologists to perform more vaginal hysterectomies.

With this information, it is hoped that readers of the article concerned will realise that the pattern of practice of hysterectomies in Malaysia, particularly in teaching hospitals, is indeed different from that which has been suggested from the article.

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Table I
Hysterectomies by indication for surgery performed at the University Hospital from 1.3.96 to 31.8.96 (percentage in brackets)

Indication	Abdominal Hysterectomy	Vaginal Hysterectomy	LAVH	Total (%)
Leiomyomata	42	5	2	49 (23.33)
Endometriosis/Adenomyosis	20	7	2	29 (13.81)
DUB	13	2	4	19 (9.05)
Pelvic Inflammatory Disease (PID)	3	0	0	3 (1.43)
Chronic Pelvic pain	1	0	0	1 (0.48)
Pre-malignant Diseases	6	0	0	6 (2.86)
UV Prolapse	1	30	2	33 (15.71)
Malignancies	50	0	0	50 (23.81)
Benign Ovarian Cysts	16	0	0	16 (7.62)
Others	4	0	0	4 (1.90)
Total	**156 (74.3)**	**44 (21.0)**	**10 (4.7)**	**210 (100.00)**

LAVH: Laparoscopically assisted vaginal hysterectomy

Table II
Hysterectomies by indication for surgery performed at the University Hospital from 1.1.95 to 31.12.97 (percentage in brackets)

Indication	Abdominal Hysterectomy	Vaginal Hysterectomy	LAVH*	Total (%)
Leiomyomata	348	12	24	384 (32.13)
Endometriosis/Adenomyosis	146	13	7	166 (13.89)
DUB	69	9	10	88 (7.36)
Pelvic Inflammatory Disease (PID)	11	0	1	12 (12.0)
Chronic Pelvic pain	4	0	0	4 (0.33)
Pre-malignant Diseases	28	1	0	29 (2.43)
UV Prolapse	4	96	5	105 (8.79)
Malignancies	279	0	0	279 (23.35)
Benign Ovarian Cysts	70	0	0	70 (5.86)
Others	57	1	0	58 (4.85)
Total	**1016 (85.0)**	**132 (11.0)**	**47 (4.0)**	**1195 (100.00)**

** LAVH: laparoscopically assisted vaginal hysterectomy*

Author's Reply

Editor – We are glad to see that our article has generated a great deal of interest in hysterectomy patterns in this country. We wish to thank EBS Soh & KB Ng for their data on the hysterectomy patterns in their institution. Our study was initiated as a result of a decision taken at a Consultant's Conference of the Ministry of Health and thus was confined to government hospitals. No research grants were available for the study and therefore no attempt was made to survey private or university hospitals. No claims were made to the contrary and we clearly stated that the results were from 14 government hospitals as well as that the study could not be directly extrapolated to reflect hysterectomy patterns for the whole of Malaysia. Be that as it may, we believe that the University of Malaya Medical Centre's figures are not vastly different from the figures that we have shown. Our survey showed that 86% of hysterectomies were performed abdominally and the rest vaginally. For the corresponding period 74.3% of the hysterectomies at University of Malaya were performed abdominally and 25.7% vaginally with 4.7% of these utilising laparascopic assistance. The figures over a three year period indicate that 15% utilised the vaginal approach and 85% used the abdominal route. The main difference has been in the use of the laparascope to assist in hysterectomies. The thrust of our article has been to advocate the vaginal route for more hysterectomies and we stated that: "In this era of evidence based medicine, there is enough evidence to show that vaginal hysterectomy is a more appropriate approach. A change in the national preference for abdominal hysterectomy will require more enthusiasm and training courses from competent vaginal surgeons in this country. There is obviously a need for gynaecologists in this country to review their practice patterns." We do not think that our conclusions would have vastly differed with the inclusion of the data provided by Soh & Ng.

Practice patterns in the private sector may be vastly different from that presented in our study. TGK Teoh reports that 75% of hysterectomies are performed vaginally in his practice. At the end of 1997, the Ministry of Health reports that there were 1451 specialists in the private sector as compared to 964 in the public sector but there were more patients who sought treatment from government hospitals. A study on the utilisation of specialist medical manpower reported that the private sector specialists saw 14.1% of complex cases in the case-mix seen by obstetricians and gynaecologists compared to nearly 60% of such complex cases in the public sector [1]. This could easily influence the way in which hysterectomies are performed in view of the comparative workload in each sector.

We agree with Teoh that vaginal hysterectomy should be carried out more often in view of the obvious advantages of which we also alluded to. Within the contraints of the service in public hospitals, there needs to be a change in the direction of vaginal hysterectomies even for indications for which the vaginal route used to be contraindicated in the traditional training of gynaecologists. We would then see a difference in the pattern of indications for which vaginal hysterectomy is performed. We were surprised to note that in a centre where "thoughts and practices for budding gynaecologists are shaped" there were 9 cases out of 105 UV prolapses where abdominal hysterectomy and LAVH were performed for that indication.

What is evident is that there is a need for an effective database that captures the patterns of hysterectomy in all sectors in this country. Only then can we calculate hysterectomy rates that can be compared internationally and within regions in this country. We believe our study could be the catalyst for such an effort.

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