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Original Research Article

Hysterectomy in practice: a cross-sectional insight into indications incidence and surgical approaches

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ABSTRACT

Background: Hysterectomy is the second most commonly performed surgical procedure among women, following cesarean section. It is indicated for a variety of benign and malignant gynecological conditions. The choice of indication, surgical route, and associated outcomes varies significantly across clinical and demographic contexts. This study aims to evaluate the clinical patterns of hysterectomy performed at a tertiary care center over six months, with a focus on patient age, common indications, surgical approach, and the requirement for blood transfusion.
Methods: A retrospective, observational study was conducted in the Department of Obstetrics and Gynecology at Cama and Albless Hospital, Mumbai, in which latest fifty patients who underwent elective hysterectomy were included, based on defined inclusion and exclusion criteria. Data regarding patient demographics, indications, surgical routes, and intraoperative details were collected and analyzed using descriptive statistics.
Results: Among 50 patients, the most common age group was 36-45 years (50%). Abnormal uterine bleeding was the leading indication (60%), followed by uterine fibroids (32%) and uterovaginal prolapse (14%). The abdominal route was used in 52% of cases, while 28% underwent vaginal hysterectomy and 20% underwent laparoscopic hysterectomy. Blood transfusion was required in only 12% of patients.
Conclusions: Hysterectomy remains a significant gynecological intervention, most commonly indicated for abnormal uterine bleeding. It should be approached judiciously, with an emphasis on conservative and fertility-preserving alternatives where appropriate. When surgical intervention is necessary, the vaginal or minimally invasive route should be preferred whenever feasible.

Keywords: Hysterectomy, Abnormal uterine bleeding, Uterine fibroid, Vaginal hysterectomy, Abdominal hysterectomy, Laparoscopic hysterectomy

INTRODUCTION

Hysterectomy, the surgical removal of the uterus, remains one of the most frequently performed major gynecological procedures worldwide, ranking just after cesarean section in terms of frequency.[1] It is considered a definitive treatment for a wide spectrum of gynecological conditions, both benign and malignant such as abnormal uterine bleeding (AUB), fibroids, adenomyosis, endometriosis, uterovaginal prolapse, and gynecological cancers.[2] While the surgery can offer significant symptom relief and improve quality of life, especially in cases refractory to medical treatment, it also represents a major milestone in a woman's reproductive life and is associated with important hormonal and psychological consequences.

Globally, there is increasing emphasis on performing hysterectomy only, when necessary, with consideration for conservative and fertility-preserving alternatives. This is especially critical in settings like India, where hysterectomy is often performed at younger ages sometimes before 40 years raising concerns about premature menopause and its long-term health impacts.[4] Concurrent oophorectomy in premenopausal women further amplifies risks such as osteoporosis, cardiovascular disease, and psychosocial disturbances. Even when ovaries are preserved, early menopause can occur due to disrupted ovarian blood flow, with an average onset 3.7 years earlier than in non-surgical menopause.[5]

The route of hysterectomy abdominal, vaginal, or laparoscopic is influenced by multiple factors including uterine size, pelvic anatomy, surgeon expertise, institutional protocols, and patient preference. Minimally invasive approaches such as vaginal and laparoscopic hysterectomy are associated with lower postoperative morbidity, faster recovery, and reduced hospital stay.[3] However, despite these advantages, abdominal hysterectomy remains the most frequently practiced route in many public hospitals in India due to limited access to advanced equipment and training.[22]

Robotic–assisted hysterectomy, though limited in resource–constrained settings, has expanded surgical possibilities by enhancing visualization, dexterity, and precision–particularly in obese patients and those with complex pelvic pathology. Newer platforms with reduced ports or single incision laparoscopy are emerging as potential game-changers in improving cosmetics outcomes and minimizing postoperative discomfort. Additionally, intraoperative navigation tools using augmented reality and fluorescence imaging for ureter and vessel identification are being trialed in high-income settings.

Technological advancements, including energy-based instruments, ERAS (enhanced recovery after surgery) protocols, and robotic-assisted surgery, have further improved surgical precision and outcomes.[3] In parallel, conservative treatment options like hormonal IUDs, endometrial ablation, uterine artery embolization (UAE), and high-intensity focused ultrasound (HIFU) have shown promising results in managing conditions like AUB and fibroids, thereby reducing the need for surgical intervention.[2] Unfortunately, such alternatives remain underutilized in India due to barriers like high cost, lack of awareness, and inadequate healthcare infrastructure.

Emerging innovations such as artificial intelligence (AI) in surgical planning, patient selection, and risk prediction may further revolutionize gynecologic surgery by enabling more personalized and data-driven care.[21]

Given the complex clinical, social, and technological landscape surrounding hysterectomy in India, it is important to understand local trends and practices to ensure evidence-based, patient-centered care. This study aims to assess the demographic and clinical profile of women undergoing elective hysterectomy at a tertiary care teaching hospital in Mumbai, focusing on common indications, patient age, surgical approach, and perioperative outcomes such as the need for blood transfusion and complication rates.

METHODS

Study design and setting

This study was designed as a Retrospective Observational analysis conducted at Cama and Albless Hospital, Mumbai, a tertiary care teaching hospital and a total of 50 women who underwent elective hysterectomy between November 2024 and May 2025 were included in the study following the application of inclusion and exclusion criteria. The hospital caters to a large urban and semi-urban population, making it a suitable site for studying the indications, incidences and surgical approach for hysterectomy.

Study population

The study population consisted of women who underwent elective hysterectomy at the Department of Obstetrics and Gynecology, Cama and Albless Hospital, Mumbai.

Inclusion criteria

Women aged more than 36 year who underwent elective hysterectomy for benign or malignant gynecologic indication during the study period by vaginal, abdominal or laparoscopic route

Exclusion criteria

Patients who underwent emergency hysterectomy, including those performed during caesarean section (caesarean hysterectomy), postpartum hemorrhage, or for acute complications such as uterine rupture. And Incomplete medical records.

Statistical analysis

Data regarding patient demographics, indications, surgical routes, and intraoperative details were collected and entered into Microsoft excel (Version 2019, Microsoft cooperation, USA) and analysed using descriptive statistics. Frequencies and percentage were calculated for categorical variables, while mean and standard deviation were computed for continuous variable

RESULTS

A total of 50 women, who underwent elective hysterectomy between November 2024 and May 2025 at Cama and Albless Hospital, Mumbai, were included in the study following the application of inclusion and exclusion criteria. The data collected provided insights into patient

demographics, clinical indications, coexisting comorbidities, surgical approaches, and perioperative outcomes such as the requirement for blood transfusion and oophorectomy status.

Demographic profile

The demographic characterics of the study population are summarized in the table. The patient ranged in age from 36 to 70 years, with the majority being in the 36-45 years age group. The mean age at the time of surgery was 47.18 years (± 7.78 years). Parity distribution showed that most women had completed their families, with 58% being Para 3 or above. Comorbidities such as diabetes mellitus and hypertension when present were also recorded as part of the preoperative assessment. These demographic details provide a comprehensive overview of the population undergoing elective hysterectomy in this study.

Table 1: Demographic profile.

Characteristics	Frequency (N)	Percentage (%)
Age group (in years)		
36-45	25	50%
46-55	15	30%
56-65	7	14%
>65	3	6%
Mean age	47.18 years	(±7.78 years)
Parity		
Nulligravida	3	6%
Para 1	8	16%
Para 2	17	34%
Para 3	10	20%
Para 4	3	6%
Para 5	6	12%
Para 6 and more	3	6%
Comorbidities		
Dm	9	18%
Htn	6	12%
Dm + Htn	3	6%

Age group

The patients ranged in age from 36 to 70 years. The most common age group was 36–45 years, accounting for 50% of the study population. The mean age at the time of surgery was 47.18 years (± 7.78 years). This is consistent with national trends where hysterectomy is frequently performed in women during the late reproductive and perimenopausal years.

The predominance of women in their 30s and 40s suggests that benign gynecological disorders affecting menstrual health such as AUB and fibroids are a major concern during these years. Early hysterectomy, particularly among women under 40, may carry implications related to hormonal changes and quality of life, necessitating careful counseling.

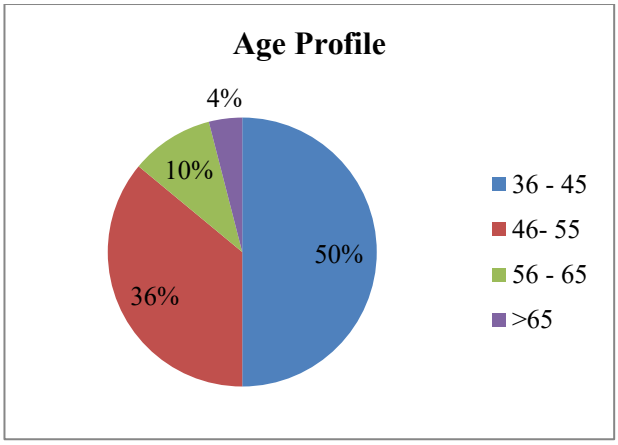

Figure 1: Age profile.

Indication of hystrectomy

The most frequent indication was Abnormal Uterine Bleeding (AUB), reported in 60% (n=30) of cases. This was followed by uterine fibroids (32%), uterovaginal prolapse (14%), and benign ovarian tumors (10%). Other indications included adenomyosis, endometriosis, postmenopausal bleeding, cervical intraepithelial neoplasia, and carcinoma ovary, each contributing to a smaller proportion of cases.

Table 2: Indication of hysterectomy.

Indication	Percentage
Fibroid uterus	32%
Uterovaginal prolapse	14%
Abnormal uterine bleeding	60%
Benign ovarian tumor	10%
Adenomyosis	6%
Endometriosis	4%
Postmenopausal bleeding	2%
Cervical intraepithelial neoplasm	2%
Ca ovary	2%
Endometrial polyp	4%
Placenta in situ	2%

AUB was the most prevalent clinical indication, echoing findings from other Indian studies. Many of these cases could potentially be managed conservatively using hormonal IUDs, endometrial ablation, or minimally invasive interventions, highlighting the need to strengthen access to and awareness of conservative alternatives.

Blood transfusion requirement

Out of 50 patients, 6 patients (12%) required perioperative blood transfusion, while 44 patients (88%) did not require transfusion. The relatively low requirement for blood transfusion suggests effective perioperative management. However, transfusion needs were more common in patients undergoing TAH, especially those with AUB or large fibroids, indicating higher intraoperative blood loss.

Our lower rate may reflect better surgical control and preoperative anemia management.

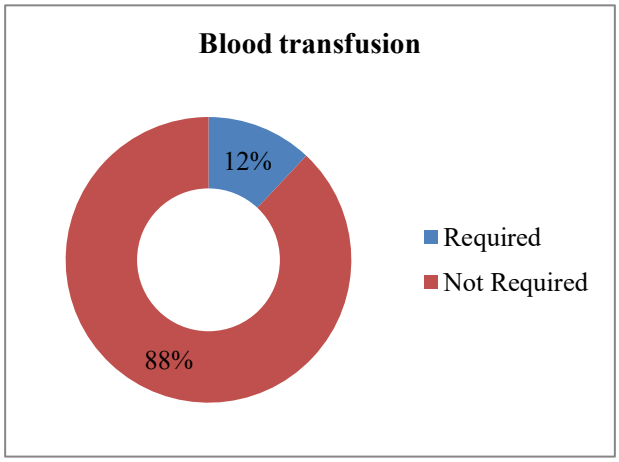

Figure 2: Blood transfusion requirement.

Table 3: Complication of hysterectomy.

Complication	Percentage of occurrence
Bladder injury	4%
Hemorrhage	12%
Infection (wound gape)	10%
Vesico vaginal fistula	2%

Complication of hysterectomy

Out of the 50 women who underwent elective hysterectomy, 14 patients (28%) experienced one or more intraoperative or immediate postoperative complications.

The most common complication was hemorrhage, observed in 12% of patients, particularly among those with abnormal uterine bleeding or large fibroids, where increased vascularity and distorted anatomy may contribute to higher intraoperative blood loss. These cases often required closer intraoperative monitoring and postoperative observation, with some requiring blood transfusion.

Bladder injuries (4%) are less frequent but highlight the need for careful dissection and anatomical awareness, especially in densely adherent or fibrotic tissues. Infections, wound infections or wound gape, were seen in 10% of patients and were more prevalent in those with co morbidities such as diabetes mellitus or obesity.

Route of hysterectomy

The abdominal route (TAH) was used in 26 patients (52%), vaginal hysterectomy (VH) was performed in 14patients (28%), laparoscopic hysterectomy 10 patients (20%). Robotic-assisted hysterectomy was not performed during the study period due to limited resources and institutional protocols.

The continued dominance of the abdominal route in our setting reflects institutional training patterns and limitations in access to advanced minimally invasive technologies and possibly surgeon familiarity. However, vaginal hysterectomy and laparoscopic hystrectomy when feasible should be promoted due to its shorter hospital stay, reduced morbidity, and quicker recovery. Training and resources should be aligned to increase vaginal hysterectomy and laparoscopic hystrectomy adoption.

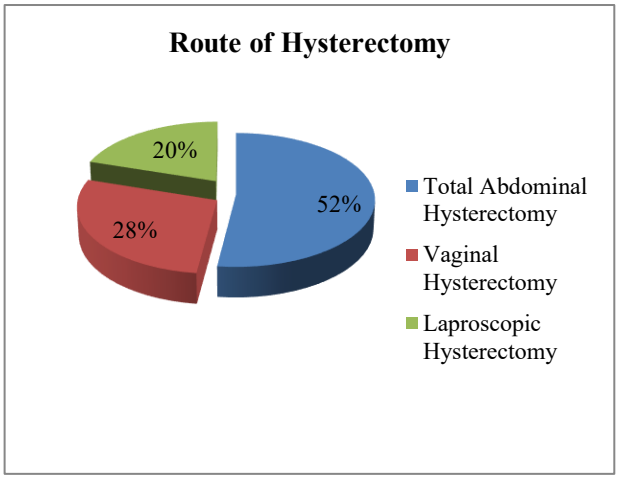

Figure 3: Route of hysterectomy.

Parity profile of patients

Parity status was assessed for all 50 patients, with results indicating that higher parity was significantly associated with hysterectomy incidence.

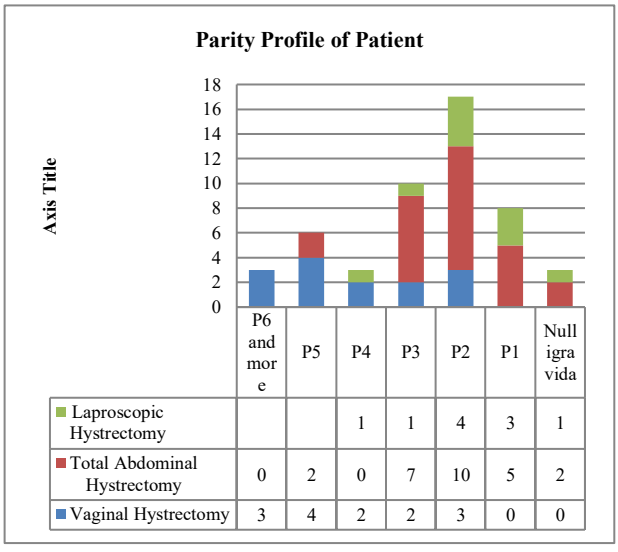

Figure 4: Parity profile of patient.

Majority of patients (58%) were Para 3 or above, suggesting that women tend to opt for hysterectomy once they have completed their desired family size. This trend also reflects a clinical and cultural pattern in India, where

definitive surgical treatments are often considered more acceptable once childbearing is completed.

Grand multiparity (≥5) was seen in 10% of women, and has been associated in the literature with increased risk of pelvic organ prolapse, uterine atony, and fibroid degeneration, all of which may contribute to surgical indications such as AUB and prolapse.

Only 2 patients (4%) were nulliparous, highlighting the conservative approach generally adopted when considering hysterectomy in women who have not had children, likely due to the irreversible loss of fertility. In such cases, surgical intervention was reserved for complex or refractory conditions like large benign tumors or severe endometriosis.

Oophorectomy practice

Bilateral and Unilateralsalpingo - oophorectomy was performed in 13 cases (26%), Unilateral in 5 cases and Bilateral in 6 cases, primarily in postmenopausal women or in those with suspicious and also benign adnexal pathology. The majority of patients underwent hysterectomy with ovarian conservation.

The selective approach to oophorectomy is a positive trend, especially in premenopausal women, as early removal of ovaries has been associated with increased cardiovascular, skeletal, and psychosocial risks. This conservative approach may help preserve long-term hormonal function and quality of life.

Overall clinical implication

The study reveals that elective hysterectomy is predominantly performed in perimenopausal women for benign conditions, particularly abnormal uterine bleeding and fibroids. Despite growing evidence supporting less invasive approaches, abdominal hysterectomy remains the most commonly practiced technique, underscoring the need for skill development in vaginal and laparoscopic methods. Comorbidities such as diabetes and hypertension are common and must be factored into preoperative planning. Conservative management options for AUB and fibroids should be more widely implemented in public sector hospitals to reduce unnecessary hysterectomies, especially in younger women.

DISCUSSION

Hysterectomy remains a commonly performed gynecologic surgery in India, particularly for benign conditions like AUB and fibroids. In our study, the most affected age group was 36–45 years, with a mean age of 47.18 years, consistent with findings by Desai et al, Medhi et al and Pandey et al.[6-8] Early hysterectomy, especially in the reproductive or perimenopausal years, carries long-term risks, particularly if oophorectomy is performed concurrently thus highlights the need for improved access to conservative management and informed decision-making.

AUB was the leading indication (60%), followed by fibroids (32%) and prolapse (14%), consistent with studies by Sawke et al, Rather et al, and Pranita et al.[9,10] The high proportion of AUB-related hysterectomies may reflect underutilization of alternatives like LNG-IUS, endometrial ablation, and Uterine Artery Embolization. The predominance of surgical intervention underscores a gap in access, training, or patient awareness regarding conservative therapies especially in reproductive age group, as noted in Sharma et al. and Deshmukh et al.[2,22]

In terms of surgical approach, our study revealed a preference for abdominal hysterectomy (52%), followed by vaginal (28%) and laparoscopic (20%) routes. This trend mirrors findings in several Indian studies and reflects institutional factors such as surgeon training, equipment availability, and case selection patterns.[7,9,10] The preference for abdominal route, despite known higher morbidity, contrasts with recommendations from global authorities like the Cochrane review by Johnson et al., which advocates vaginal hysterectomy as the first-line surgical approach when feasible due to its lower complication rate and faster recovery.[12] Laparoscopic hysterectomy, although utilized in 20% of our patients, was limited by infrastructural and resource constraints. Robotic-assisted hysterectomy was not performed at our center during the study period, similar to findings reported by Sharma et al.[2]

The parity profile revealed that a majority of patients were Para 3 or higher (58%), consistent with literature suggesting that women tend to undergo definitive surgical treatment once family completion is achieved. Grand multiparity (≥5) was seen in 10% of our cohort and has been associated with prolapse and fibroid degeneration. Similar associations were observed by Sharma et al. and Medhi et al.[2,7] Only 4% of patients were nulliparous, reflecting a cautious approach toward fertility-sparing in young or childless women.

Only 12% of patients required blood transfusion, indicating good surgical control. Complications were mainly hemorrhage (12%), infection (10%), and bladder injury (4%). These findings are comparable to those reported by Yakasai and Garry et al.[4,14]

Selective oophorectomy (26%) reflects a positive trend, particularly in premenopausal women. Preservation of ovaries is crucial, as early oophorectomy is linked to increased cardiovascular and bone-related morbidity and sexual dysfunction.[5,17]

Overall, the data support a shift towards more individualized, conservative, and minimally invasive approaches to hysterectomy. Enhanced recovery after surgery (ERAS) protocols, better training in vaginal and laparoscopic techniques and broader adoption of

conservative alternatives are key to reducing unnecessary surgeries and improving outcomes for Indian women. The integration of artificial intelligence in surgical planning, as noted by Gupta et al also holds future promise in refining decision-making and risk assessment.[21]

Table 4: Comparison of studies.

Study / year	Age group	Main indications	Surgical route	Transfusion (%)	Complications	Parity	Oophorectomy	Minimally invasive use
Present study (2025)	47.18 yrs; 36–45 yrs (50%)	AUB (60%), Fibroids (32%), Prolapse (14%)	Abdominal (52%), Vaginal (28%), Lap (20%)	12%	Hemorrhage (12%), Infection (10%)	58% Para ≥3	26%, selective	Lap in 20%, no robotics
Desai et al (2011)[6]	Avg 37 yrs	AUB	Mostly abdominal	Not reported	Not reported	High parity	Not discussed	Limited access
Medhi et al (2016)[7]	40–49 yrs	AUB, Fibroids	Mixed	Not reported	Not reported	High parity	Not discussed	Not discussed
Pandey et al (2014)[8]	48 ± 9.9 yrs	Fibroids, AUB	Abdominal predominant	Not reported	Not reported	Not detailed	Not reported	Not discussed
Rather et al (2013)[10]	41–50 yrs	AUB, Fibroid	Abdominal common	18–20%	Bleeding, infection	Not discussed	Not reported	Not discussed
Sawke et al (2015)[9]	41–45 yrs	AUB	Abdominal common	Not reported	Not reported	High parity	Not discussed	Not discussed
Yakasai et al (2013)[4]	Not specified	Prolapse, Fibroid	Abdominal common	Not specified	Bladder injury, infection	Not discussed	Not reported	Not discussed
Bala et al (2013)[17]	Not specified	Mixed	Abdominal predominant	Not reported	Not reported	Not reported	BSO in 87%	Not discussed
Johnson et al (2006)[12]	Not specified	Surgical approach focus	Vaginal preferred	Not specified	Fewer complications vaginally	Not discussed	Not specified	Vaginal preferred
Sharma et al (2014)[2]	Not specified	AUB, Prolapse	Vaginal in rural	Not reported	Not discussed	High parity	Not discussed	Vaginal favoured

Limitations of the study

This was a retrospective single-centre study with relatively small sample size. Therefore, findings may not be generalizable to other regions or healthcare settings, especially rural area where hysterectomy pattern may differ. Moreover, long-term follow-up data on postoperative outcome, patient information, patient satisfaction, and complication were not available, limiting the ability to assess surgical success from holistic perspective.

CONCLUSION

This study highlights the ongoing reliance on hysterectomy as a primary surgical treatment for benign gynecological conditions, particularly abnormal uterine bleeding and fibroids, with the majority of procedures performed in premenopausal women aged 36-45 years. Despite the proven advantages of vaginal and laparoscopic approaches, abdominal hysterectomy remains the most commonly practiced route in our setting, reflecting institutional and resource limitations. The relatively low transfusion rate and manageable complication profile indicate satisfactory preoperative care. However, the higher complication rates associated with abdominal surgeries underscore the importance of expanding minimally invasive surgical training and infrastructure. Our data also reflect a positive trend in ovarian conservation, particularly in premenopausal women, which is essential for preserving long-term hormonal and cardiovascular health. Higher parity was a common characteristic among women undergoing hysterectomy,

consistent with national trends. In conclusion, while hysterectomy remains a critical option in gynecologic surgery, its use should be carefully evaluated against conservative alternatives. Strengthening access to non-surgical treatments, improving surgical route selection, and promoting patient-centered care are vital steps toward more judicious and equitable hysterectomy practices in India.

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