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Original Research Article

Clinical governance of hysterectomies in a rural tertiary health care centre

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ABSTRACT

Background: Hysterectomy remains one of the most performed gynecological surgeries worldwide. Despite the availability of medical therapy and minimally invasive procedures, hysterectomy continues to be widely practiced, particularly among rural women. Understanding the clinical determinants influencing hysterectomy and evaluating the adequacy of prior conservative treatment is essential for improving gynaecological care. Objectives were to assess the clinical and sociodemographic factors influencing hysterectomy and to evaluate the provision and adequacy of conservative management prior to surgery in a rural tertiary care setting.

Methods: This hospital-based cross-sectional analytical study included 200 women who underwent hysterectomy at MGIMS Sewagram, Maharashtra during the study period. Data were obtained from medical records and included sociodemographic characteristics, presenting symptoms, uterine size, menopausal status, histopathological findings, type of hysterectomy, oophorectomy status, and prior conservative management.

Results: Most women were aged 40-50 years (66.0%) and multiparous (76.0%), with 91.0% residing in rural areas. Abnormal uterine bleeding was the most common presenting symptom (40.1%). Leiomyoma was the predominant histopathological finding (41.5%). Abdominal hysterectomy was the most frequently performed procedure (66.0%). Only 49.0% of women received conservative management prior to surgery, of whom just 18.0% received treatment for more than six months, indicating limited adequacy of medical therapy.

Conclusions: Hysterectomy in this rural population was performed for benign gynecological conditions, with inadequate utilisation of conservative treatment in many cases. Strengthening early diagnosis, ensuring adequate trials of medical therapy and expanding access to minimally invasive approaches may help reduce potentially avoidable hysterectomies.

Keywords: Abnormal uterine bleeding, Conservative management, Cross-sectional study, Hysterectomy, Leiomyoma, Oophorectomy, Rural health, Surgical determinants

INTRODUCTION

Hysterectomy is one of the most frequently performed major gynaecological procedures worldwide. It is used for benign indications such as abnormal uterine bleeding, fibroids, prolapse and endometriosis as well as for obstetric emergencies and gynaecological cancers. While it has been life-saving in many settings, the procedure is also associated with short- and long-term morbidities

including adhesions, infections, pelvic organ dysfunction, cardiovascular disease and early menopause.¹ Consequently, many health systems have sought to restrict hysterectomy for benign conditions to cases where conservative treatments have failed. Despite these efforts, the procedure continues to be common. In the United States, a recent population-based study of four states reported an overall rate of 49 hysterectomies per 10 000 hysterectomy-eligible women, with rates peaking in women aged 40-49 years; rates varied markedly across

hospital service areas (12.9-106.3 per 10 000) and were higher in areas with government-sponsored insurance.^{2,3} Similar age-standardised declines have been reported in other high-income countries such as Australia, Denmark, Israel, the Netherlands, Switzerland and the UK, indicating a global move towards more conservative management and minimally invasive techniques.⁴⁻⁹

Data from low- and middle-income countries are more heterogeneous. A cross-sectional cohort from Iran (2024) reported an overall hysterectomy prevalence of 10.6% among women aged 35-70 years, with risk factors including advancing age, higher socioeconomic status, higher parity and a history of tubectomy.¹⁰ In India, concern has grown over reports of rising hysterectomy rates, particularly among younger women and those from disadvantaged communities. The National Family Health Survey (NFHS-5, 2019-2021) documented that 3% of women aged 15-49 years had undergone a hysterectomy, with state-level prevalence ranging from 2 to 63 per 1000 women; two-thirds of the surgeries were performed in private facilities and prevalence increased sharply with age. A comparative analysis of NFHS-4 and NFHS-5 showed that the prevalence remained high in Andhra Pradesh, Telangana and Bihar and even increased in Telangana and Bihar.^{11,12} These findings highlight geographic variation and potential provider-driven factors. Excessive menstrual bleeding and fibroids were the most frequently reported reasons for hysterectomy, while sociodemographic determinants included urban residence, higher wealth quintiles and obesity. A recent national analysis using the longitudinal ageing study in India (LASI) estimated a prevalence of 11.35% among women aged ≥ 45 years; hysterectomy was more common in urban women (14.6%) than rural women (9.8%), and the leading indication was excessive menstrual bleeding followed by fibroids.¹² Together, these data suggest that hysterectomy rates in India are higher than previously recognised and may be rising in certain states.

Globally, there is increasing emphasis on conservative treatments such as hormonal therapies, levonorgestrel intra-uterine systems and minimally invasive surgeries. However, access to these options is limited in many parts of India and evidence from NFHS-5 suggests that women often undergo hysterectomy at relatively young ages. Unnecessary hysterectomy can have profound health and social consequences, including loss of fertility, early menopause, increased cardiovascular risk and psychological distress. There is also concern about inequities: women with low education, from backward classes or without health insurance may face barriers to conservative care. Thus, understanding the demographic patterns, clinical indications and health-system factors driving hysterectomy is essential.

The present study was conducted at Mahatma Gandhi Institute of Medical Sciences (MGIMS), Sewagram, Maharashtra to evaluate the indications for hysterectomy, the types of procedures performed, and the associated peri-

operative outcomes. By analysing clinical records from this tertiary care centre, the study aims to describe the demographic and clinical profile of women undergoing hysterectomy and to examine factors influencing the choice of surgical approach. Understanding these patterns is important for assessing current clinical practices, identifying gaps in the utilization of conservative management, and evaluating the appropriateness of surgical decision-making. The findings from this hospital-based analysis may help improve patient counselling, optimize treatment strategies, and support evidence-based management of gynecological conditions.

METHODS

Study design and setting

This study was conducted as a hospital-based clinical audit of hysterectomies performed at Mahatma Gandhi Institute of Medical Sciences, Sewagram, Wardha, Maharashtra; a rural tertiary care teaching hospital catering predominantly to women from surrounding rural and semi-urban communities. The institution serves as a referral centre for primary and secondary health facilities in the region and manages a high volume of gynecological cases. The audit was undertaken to systematically evaluate indications, preoperative management pathways, surgical practices, and postoperative outcomes of women undergoing hysterectomy during the defined study period.

Study duration

The audit included all eligible hysterectomy cases performed over a period of 6 months from February 2026 to July 2026. The defined time frame ensured adequate case volume for meaningful evaluation of clinical patterns and governance practices.

Sample size

The sample size was calculated using a single proportion formula assuming a prevalence of 50% (as no prior estimate was available), 95% confidence level, and 7% absolute precision. The minimum required sample size was 196, which was rounded to 200 participants.

A total of 200 women who underwent hysterectomy during the defined study period were included.

Study population

Inclusion criteria

The study population comprised women who underwent hysterectomy for benign gynecological indications at the study centre during the specified period. Only complete medical records with adequate documentation of clinical indications, prior management, and surgical details were included in the final analysis.

Exclusion criteria

Patients undergoing hysterectomy for obstetric emergencies, malignancies, or life-threatening conditions requiring immediate surgical intervention were excluded to allow focused evaluation of elective and potentially preventable procedures.

Data collection

Data were collected from hospital medical records, operative registers, inpatient case sheets, and discharge summaries. A structured audit proforma was used to extract relevant information, including sociodemographic characteristics, reproductive history, presenting complaints, prior conservative management, surgical route, intraoperative findings, and postoperative outcomes. Where available, outpatient records were also reviewed to assess duration and adequacy of non-surgical management prior to hysterectomy.

Variables assessed

Sociodemographic variables included age, parity, educational status, socioeconomic background, and rural or semi-urban residence. Reproductive profile variables included age at menarche, age at marriage, parity, and contraceptive history. Clinical variables included presenting symptoms, duration of complaints, primary diagnosis, and indication for hysterectomy. The audit also evaluated prior conservative management such as hormonal therapy, intrauterine devices, endometrial ablation, myomectomy, or other medical interventions before opting for definitive surgery.

Surgical characteristics assessed included route of hysterectomy (abdominal, vaginal, or laparoscopic), type of procedure performed, concomitant salpingo-oophorectomy, operative duration, and perioperative complications. Postoperative variables included length of hospital stay, early complications, and documented patient feedback where available.

Outcome measures

The primary outcome of the study was to assess the factors contributing to hysterectomy and to identify opportunities for reducing potentially avoidable procedures. In addition, the study evaluated the provision and adequacy of conservative management prior to hysterectomy, including whether appropriate medical or non-surgical treatment had been attempted before proceeding to surgical intervention.

The secondary outcomes included assessment of the distribution of clinical indications for hysterectomy, the sociodemographic profile of women undergoing the procedure, and the types of surgical approaches used. The study also examined other clinical and contextual

determinants that may influence the decision to perform hysterectomy in routine clinical practice.

Statistical analysis

Data were entered into Microsoft Excel and analyzed using SPSS version 27.0. Descriptive statistics were used to summarize sociodemographic and clinical variables. Categorical variables were expressed as frequencies and percentages, while continuous variables were summarized as mean±standard deviation or median with interquartile range, depending on distribution. Associations between sociodemographic factors and surgical route were assessed using Chi-square or Fisher's exact test as appropriate. A *p* value of <0.05 was considered statistically significant.

Ethical considerations

The study was conducted following approval from the institutional ethics committee. Ethics committee approval number: MGIMS/IEC/OBGY/73/2026. As this was a clinical audit based on retrospective record review, patient confidentiality was maintained by anonymizing all data prior to analysis. No direct patient identifiers were included in the study database.

RESULTS

Sociodemographic profile of study participants

The majority of women undergoing hysterectomy belonged to the 40-50-year age group [132 (66.0%)], followed by women aged above 60 years [24 (12.0%)]. Most participants had middle-school education [70 (35.0%)], while 64 (32.0%) were illiterate. The study population was predominantly multiparous, with P2L2 parity observed in 152 (76.0%) women. Tubal ligation had been previously performed in 150 (75.0%) participants. A large majority of patients were rural residents [182 (91.0%)], and 178 (89.0%) had availed government health schemes for surgical care. Regarding menopausal status, 78 (39.0%) were perimenopausal, followed by 66 (33.0%) premenopausal and 54 (27.0%) postmenopausal women (Table 1).

Clinical presentation and indications for hysterectomy

Abnormal uterine bleeding due to fibroid was the most common presenting symptom [110 (40.1%)], followed by endometriosis [44 (16.1%)], fibroid-related pressure symptoms [42 (15.3%)], and uterovaginal prolapse [36 (13.1%)]. Other less common presentations included postmenopausal bleeding [12 (4.4%)] and lump in abdomen [8 (2.9%)]. Malignancy-related indications included carcinoma endometrium [8 (2.9%)], carcinoma ovary [6 (2.2%)], carcinoma cervix [4 (1.5%)], and endometrial hyperplasia [4 (1.5%)] (Figure 1).

Table 1: Sociodemographic characteristics of women undergoing hysterectomy (n=200).

Variables	Category	Frequency	Percent
Age (in years)	30-40	22	11.0
	40-50	132	66.0
	50-60	22	11.0
	Above 60	24	12.0
Education	Illiterate	64	32.0
	Middle school	70	35.0
	High school	66	33.0
Parity	P0L0	6	3.0
	P1L1	2	1.0
	P2L2	152	76.0
	P3L3	24	12.0
	P4L4	14	7.0
	P5L5	2	1.0
Tubal ligation	Done	150	75.0
	Not done	50	25.0
Address	Rural	182	91.0
	Urban	18	9.0
Government scheme	Availed	178	89.0
	Not availed	22	11.0
Menopausal status	Premenopausal	66	33.0
	Perimenopausal	78	39.0
	Postmenopausal	54	27.0

Table 2: Surgical characteristics and histopathological findings (n=200).

Variables	Category	Frequency	Percent
Type of hysterectomy	Abdominal hysterectomy	132	66.0
	Vaginal hysterectomy	38	19.0
	Total laparoscopic hysterectomy	16	8.0
	Laparoscopic assisted vaginal hysterectomy	14	7.0
Oophorectomy	Done	98	49.0
	Not done	102	51.0
Uterus size	Below 12 weeks	106	53.0
	12 weeks	44	22.0
	14 weeks	20	10.0
	18 weeks	14	7.0
	>20 weeks	12	6.0
Histopathology	Leiomyoma	98	41.5
	Adenomyosis	54	22.9
	Normal findings	58	24.6
	Malignancy	20	8.5
	Endometriosis	2	0.8
	Endometrial hyperplasia	2	0.8

Surgical characteristics and histopathological findings

Abdominal hysterectomy was the most frequently performed procedure [132 (66.0%)], followed by vaginal hysterectomy [38 (19.0%)], total laparoscopic hysterectomy [16 (8.0%)], and laparoscopic-assisted vaginal hysterectomy [14 (7.0%)]. Oophorectomy was performed in 98 (49.0%) cases. More than half of the patients had uterine size below 12 weeks [106 (53.0%)],

followed by 12 weeks [44 (22.0%)], 14 weeks [20 (10.0%)], 18 weeks [14 (7.0%)], and >20 weeks [12 (6.0%)]. Histopathological examination revealed leiomyoma as the most common diagnosis [98 (41.5%)], followed by adenomyosis [54 (22.9%)]. Normal findings were observed in 58 (24.6%) cases, while malignancy was noted in 20 (8.5%) cases. Endometriosis and endometrial hyperplasia were each reported in 2 (0.8%) cases (Table 2).

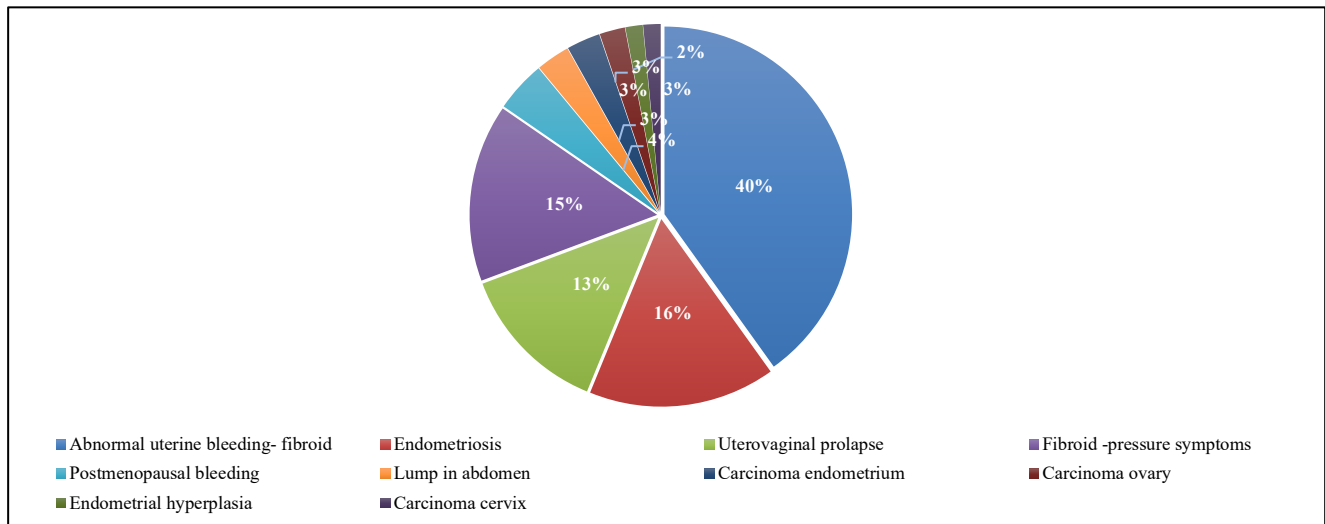


Figure 1: Clinical presentation among women undergoing hysterectomy.

Conservative management prior to hysterectomy

Conservative medical management was received by 98 (49.0%) women, while 102 (51.0%) underwent surgery without prior conservative treatment. Among those who received treatment, 62 (31.0%) had a duration of less than six months, while 36 (18.0%) received treatment for more

than six months. The most commonly used conservative treatments included dilatation and curettage [52 (28.6%)], tranexamic acid therapy [46 (25.3%)], hormonal pills [26 (14.3%)], and levonorgestrel intrauterine system (Mirena) [26 (14.3%)]. Expectant management was observed in 24 (13.2%) cases, while NSAIDs and myomectomy were used in 4 (2.2%) cases each (Table 3).

Table 3: Conservative management practices prior to hysterectomy (n=200).

Variables	Category	Frequency	Percent
Conservative management	Received	98	49.0
	Not received	102	51.0
Duration of treatment	<6 months	62	31.0
	>6 months	36	18.0
Type of treatment	Dilation and curettage	52	28.6
	Tranexamic acid	46	25.3
	Hormonal pills	26	14.3
	Mirena	26	14.3
	Expectant management	24	13.2
	NSAIDs	4	2.2
	Myomectomy	4	2.2

Reasons for not receiving conservative management

Among women who did not receive conservative treatment, the most common reasons included inability to attend follow-up visits [38 (15.7%)], uterovaginal descent requiring surgery [28 (11.6%)], financial constraints [20 (8.3%)], and treatment not being offered [20 (8.3%)]. Other factors included malignancy [16 (6.6%)], myths or unwillingness for treatment [14 (5.8%)], lack of awareness [4 (1.6%)], and non-compliance [2 (0.8%)] or presence of a large mass [2 (0.8%)]. The association between these factors and lack of conservative management remained statistically significant ($p < 0.001$) (Table 4).

Determinants of conservative management

A statistically significant association was observed between haemoglobin level and receipt of conservative management ($p = 0.003$). Women presenting with abnormal uterine bleeding were significantly more likely to receive conservative management compared with those presenting with uterovaginal prolapse or malignancy ($p < 0.001$). Additionally, education level ($p = 0.002$) and uterine size ($p = 0.003$) demonstrated statistically significant associations with receipt of conservative management. These findings indicate that both clinical presentation and socioeconomic factors influenced treatment decisions.

Table 4: Reasons for not receiving conservative management (n=200).

Reasons	Frequency	Percentage
Cannot follow up	38	15.7
Cost	20	8.3
Myths/unwilling for treatment	14	5.8
Huge mass	2	0.8
Malignancy	16	6.6
Non compliant	2	0.8
Not aware of conservative management	4	1.6
Not offered	20	8.3
Uterovaginal descent-surgery recommended	28	11.6

DISCUSSION

The present study provides important insights into the demographic profile, clinical characteristics, and underlying drivers influencing hysterectomy in a predominantly rural population. Most women were aged 40-50 years (66.0%), multiparous (76.0%), and from rural backgrounds (91.0%), consistent with populations reported to have a higher likelihood of undergoing hysterectomy. Socio-demographic determinants appeared to play a crucial role in influencing treatment pathways. Previous studies, including that by Apantaku et al, have shown that lower educational attainment is associated with increased likelihood of hysterectomy, with women having less than a college degree demonstrating higher odds compared to more educated counterparts. Our study similarly observed an association between education and type of hysterectomy ($p=0.02$), indicating that lower educational status may influence both treatment decisions and surgical approach. The predominance of rural residence in our cohort contrasts with high-income settings, where urban populations and minimally invasive approaches are more common, highlighting disparities in access and health-seeking behaviour.¹³ Limited health literacy, misconceptions regarding medical therapy, and lack of awareness about alternative treatments may further contribute to preference for definitive surgical management in such settings.

The clinical profile of patients in the present study was characterized predominantly by benign gynecological conditions, with abnormal uterine bleeding due to fibroid (40.1%) and uterovaginal prolapse (13.1%) being the most common indications. These findings reflect the significant burden of symptomatic benign conditions in this age group and their role in driving surgical intervention. Symptom profile showed a significant association with the type of hysterectomy performed ($p=0.002$). Evidence from a US cohort indicates that women with heavy or prolonged bleeding have a markedly increased risk of hysterectomy, supporting the role of symptom burden in determining surgical management.¹⁴ While these findings are

consistent with existing literature, they suggest that although clinical factors influence the mode of surgery, the decision to proceed to surgery itself may also be influenced by non-clinical factors.

With respect to surgical characteristics, abdominal hysterectomy (66.0%) was the most commonly performed procedure, and the use of minimally invasive techniques remained limited (15.0%). This pattern reflects not only clinical considerations such as uterine size but also constraints related to infrastructure, availability of expertise, and healthcare access. Histopathological findings were comparable with previous reports, with leiomyoma (41.5%) and adenomyosis (22.9%) being the most common diagnoses.¹⁵ However, the presence of normal histology in 24.6% of cases raises concerns regarding the appropriateness of surgical indications, suggesting that clinical decision-making may not always be optimally aligned with underlying pathology.

A key finding of the present study is the substantial underutilization and inadequacy of conservative management prior to hysterectomy. More than half of the women (51.0%) underwent surgery without prior medical therapy, and among those who received treatment, the duration was often less than six months (31.0%), indicating an insufficient trial. These findings are consistent with reports from other settings, including a Canadian study where 59.7% of women underwent hysterectomy without prior conservative intervention.¹⁶ Multiple factors contributed to this pattern. Inability to follow up (15.7%), likely due to long travel distances, poor transport, and loss of daily wages, emerged as a major barrier. Financial constraints (8.3%) also played a significant role, as repeated consultations and long-term therapy impose ongoing costs. Additionally, conservative management was not offered in a considerable proportion of cases (8.3%), indicating potential gaps at the provider level.

The preference for surgical management appears to be further reinforced by systemic and economic factors. Government-funded health schemes often cover hysterectomy as a one-time intervention, whereas conservative treatments such as hormonal therapy or levonorgestrel intrauterine systems require out-of-pocket expenditure and lack structured financial support. This creates an imbalance where surgical management is effectively incentivized over medical therapy. Consequently, patients may perceive hysterectomy as a more practical and cost-effective option. Cultural beliefs also contribute, with hysterectomy often viewed as a definitive cure for symptoms such as abnormal uterine bleeding, particularly when these affect quality of life.

The reasons identified for not receiving conservative management- including inability to attend follow-up, financial limitations, lack of awareness (1.6%), and provider-related factors- highlight the complex interplay between patient-level and system-level barriers. Clinical

indications such as malignancy (6.6%) and uterovaginal descent (11.6%) also necessitated direct surgical intervention in some cases. Provider-related considerations, including concerns regarding patient compliance, anticipated loss to follow-up, and limited availability of minimally invasive techniques, may further influence early surgical decision-making. The absence of standardized protocols mandating adequate trial of conservative therapy may also contribute to variability in practice.

These findings indicate that the high rate of hysterectomy in rural women is driven by a combination of clinical, socio-economic, and system-level factors rather than clinical necessity alone. The low uptake and inadequate duration of conservative management reflect gaps in counselling, accessibility, and financial coverage. Strengthening awareness of non-surgical options, integrating conservative management into government schemes, and ensuring adequate trials of medical therapy are essential to reduce potentially avoidable hysterectomies. Improving access to minimally invasive techniques and strengthening clinical governance through audits may further support evidence-based decision-making.

The study has certain limitations, including its retrospective design, potential selection bias due to referral patterns, and lack of long-term follow-up. Despite these limitations, it provides valuable real-world insights into determinants of hysterectomy in rural settings. Future research should focus on patient perspectives, provider behaviour, and system-level interventions to promote rational and patient-centred gynecological care.

CONCLUSION

This study highlights key clinical and sociodemographic factors influencing hysterectomy among rural women and reveals significant gaps in the provision and adequacy of conservative management prior to surgery. Limited trial of medical therapy and delayed presentation often contributed to surgical intervention. Strengthening early diagnosis, improving awareness of non-surgical options, and ensuring appropriate conservative treatment could help reduce potentially avoidable hysterectomies and promote more rational gynecological care.

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