Original Article

Women's Experiences Following Peripartum Hysterectomy: A Qualitative Study

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Abstract

Objective: Peripartum hysterectomy is a major operation and is inevitably performed where certain indications require removal of the uterus at the time of delivery or in the immediate postpartum period. It is a traumatic birth event that affects women's physical, physiological, psychological, social, and sexual health. This study aimed to explore the lived experiences of women undergone peripartum hysterectomy.

Materials and methods: Qualitative phenomenological design was adopted to explore the lived experiences of women undergone peripartum hysterectomy. Purposive sampling technique was adopted to enroll the participants and 19 women were interviewed before saturation of responses was reached. All interviews were audio recorded and then transcribed into verbatims. Colaizzi's thematic analysis method was used to analyze the data.

Results: Based on participants' verbatims eight major themes emerged: Awareness status regarding peripartum hysterectomy; Body's response to peripartum hysterectomy; Perceived need of support; Facilitators in overcoming post-hysterectomy challenges; Relational turbulence; financial burden; Perceived psychological adaptation; Disturbed body image and low self-esteem.

Conclusion: Derived themes in the present study highlighted the multidimensional effects of peripartum hysterectomy. Peripartum hysterectomy affected physical, psychological, sexual and financial health of the women. Increased dependence and changes in the self concept are the other problems faced by peripartum hysterectomy women. Need based individualized psychological therapeutic interventions will facilitate the successful adaptation to the traumatic situation by the reinforcement of positive coping mechanisms.

Keywords: Body Image; Lived Experiences; Peripartum Hysterectomy

Introduction

Peripartum hysterectomy is a major surgical venture where certain indications require removal of uterus at the time of delivery or in the immediate postpartum period to save women's lives. Various drugs and surgical techniques have been developed to preserve the uterus but in some conditions an emergency peripartum hysterectomy is performed as final expedient in saving a woman's life (1, 2). Peripartum

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hysterectomy affects the physical, spiritual and emotional health of the women (3). Every woman come to the delivery room to experience delight and gratification that comes with mothering, none of them wants to lose their uterus. Therefore, the sudden loss of the uterus under unfortunate circumstances is traumatic and has negative emotional impact (4, 5). Loss of organ, menstruation, and fertility negatively affects women's mental health (6). After peripartum hysterectomy, during adaptive process to build resilience women use coping mechanisms like denial, faith in God or acceptance of the situation (7).

Through Medline search review of English literature on emergency peripartum hysterectomy the incidence ranged from 0.24 to 8.7 per 1000 deliveries (8). Major indications for peripartum hysterectomy were mainly previous caesarean section, placenta accrete, placenta Previa, placenta percreta, uterine atony, Abruptio Placentae, uterine rupture and uncontrolled postpartum haemorrhage (9, 10). Retrospective analysis in tertiary care institute in India reported incidence of 6.9/1000 deliveries (11).

Peripartum hysterectomy brings challenges in the life of a woman due to fear of rejection, loss of fertility and feminity. Peripartum hysterectomy affects physical, physiological, psychological, psychosocial and sexual dimensions of life. Ample quantitative literature is available but there is dearth qualitative literature that describe the adaptive mechanisms and different types of challenges and stressors experienced by females after peripartum hysterectomy. There is lack of Indian literature that describe the different aspects of life after peripartum hysterectomy from affected women's perspective. Keeping this in view the current study was planned to explore the lived experiences of women following peripartum hysterectomy.

Materials and methods

This study was approved by the Institute Ethics Committee, PGIMER, Chandigarh. Ethical clearance has been taken from Institute Ethics Committee as per Reference No: NK/7103/MSc/16.

A phenomenological study was conducted in the Obstetrics and Gynaecology OPD, PGIMER, Chandigarh, over a period of 2 years from 2020-2022. Purposive sampling technique was used to enrol subjects (women after 6 months to 3 years of peripartum hysterectomy with at least one living child) and in-depth interviews were conducted till saturation of responses. Study sample comprised of 19 subjects. An interview guide was developed after thorough literature review along with inputs from obstetricians. The interview schedule included socio-demographic, obstetrics, clinical profile of the participants and open-ended questions regarding different dimensions of life after peripartum hysterectomy. This interview guide was then pilot tested on a sample of respondents to check its comprehensibility and validity. Interview parameters were modified based on feedback and problems identified during interview. The final interview tool included specific parameters related to post hysterectomy problems. This interview tool was then utilized to collect phenomenological data from the study subjects. During in-depth interviews questions were asked from respondents and are allowed to respond in free manner. Clarifications were made whenever deemed necessary.

Data analysis was done in two parts. In part A, data on sociodemographic, obstetrics, and clinical characteristics of the participants were analyzed by using descriptive statistics. In part B, the recorded interviews were transcribed into verbatims, and Colaizzi's phenomenological method was followed for analysis of qualitative data. It included exploration of lived experiences of women undergone peripartum hysterectomy, familiarization with data by reading participants' statements, identifying relevant and significant statements related to phenomenon, identifying and formulating relevant meanings related to phenomenon, clustering themes from identified meanings, writing exhaustive description of phenomenon incorporating all themes generated, developing fundamental structure of phenomenon by condensing description of phenomenon and verification of fundamental structure from participants for knowing whether it captures their experiences based on feedback was done.

Results

Mean age of the participants was 30.4 years and all were married. Less than half (42.2%) of the participants were graduates and majority of the participants (94.7%) were homemaker. More than half (63.2%) of the participants were from urban habitat and 36.8% participants belonged to social class III (Table 1). All the participants had antenatal checkup (ANC) registration either with government (84.2%) or private (15.8%) agency.

Table 1: Socio-demographic profile of the participants

Characteristics	n (%)
Age (in years)	
20-30	12 (63.2)
30-40	6 (31.6)
40-50	1 (05.3)
Marital Status	
Married	19 (100)
Educational Status	
Below matric	6 (31.6)
Matric and 12th	5 (26.4)
Graduate	8 (42.2)
Occupational Status	
Professional	1 (05.3)
Homemaker/unemployed	18 (94.7)
Religion	
Hindu	12 (63.2)
Sikh	4 (21.1)
Muslim	3 (15.8)
Type of family	
Joint	14 (73.7)
Nuclear	5 (26.3)
Per capita income (Rs./month)	
7533 and above	5 (26.3)
3766-7532	3 (15.8)
2260-3765	7 (36.8)
1130-2259	3 (15.8)
1129 and below	1 (05.3)
Social class (BG Prasad's social classification for the year 2020)	
I	5 (26.3)
II	3 (15.8)
III	7 (36.8)
IV	3 (15.8)
V	1 (05.3)
Habitat	
Urban	12 (63.2)
Rural	6 (31.6)
Semi-Urban	1(05.3)

Majority of the participants were multigravida and multiparous (89.5%) and (84.2%) respectively. Majority of the participants (84.2%) had previous caesarean section and 31.6% of participants had history of abortion (Table 2).

Majority (84.2%) of the participants delivered at tertiary care health facility (PGIMER, Chandigarh) were in high-risk group and had C-section. Abnormal implantation of placenta was the major risk factor. Majority of the participants (89.5%) had hysterectomy at the time of delivery. Peripartum hysterectomy was done in same number of participants (15.8%) due to placenta previa, placenta accreta, and primary PPH whereas in 31.6% participants placenta previa with accrete was the indication. Febrile morbidity, urinary tract infection and wound infection were the postoperative complications 55.5%, 33.3% and 11.1% respectively. (Table 3).

Table 2: Past obstetric profile of participants

Parameters	n (%)
ANC Registration	
Government	16 (84.2)
Private	3 (15.8)
ANC follow up	
PGIMER, Chandigarh	5 (26.3)
Government Hospital	8 (42.1)
Private Hospital	6 (31.6)
Gravida	
Primigravida	2 (10.5)
Multigravida	17 (89.5)
Parity	
Primiparous	2 (10.5)
Multiparous	16 (84.2)
Grand multiparous	1 (05.3)
Previous caesarean section	16 (84.2)
Indications for previous C-section (n=16)	
Previous caesarean section	6 (37.5)
Fetal distress	3 (18.8)
Failed induction	2 (12.5)
Other (oligohydramnios, pre-eclampsia, breech presentation, fetal macrosomia)	5 (31.2)
Previous abortion	6 (31.6)

Colaizzi's phenomenological data analyzing procedure was applied to analyze the information. Eight themes and twenty subthemes were generated (Figure 1).

Discussion

In the current study, mean age of participants was 30.4 years, which was almost same as reported in a study from southern part of India i.e. 31.7 years (12). All the current study participants were married and majority (84.2%) of the them were multiparous which is supported by the results of a study done in a tertiary care center in India (13).

In the present study indications for peripartum hysterectomy were placenta previa with accrete, placenta accrete, placenta previa and primary PPH. These observations support the notion of previous researchers studying the disclosure on emergency peripartum hysterectomy where almost same indications for peripartum hysterectomy i.e., placenta accreta (38.2%), placenta previa (32.3%), placenta

percreta (12.9%), uterine atony (3.2%), abruptio placenta (3.2%), broad ligament hematoma (3.2%), uterine rupture (3.2%) and uncontrolled postpartum haemorrhage (3.2%) were reported (9).

Table 3: Peripartum hysterectomy associated clinical profile of participants

Peripartum hysterectomy profile parameters	n (%)
ANC Registration	
In PGIMER, Chandigarh	16 (84.2)
Not in PGIMER, Chandigarh	3 (15.8)
Delivery done in	
PGIMER, Chandigarh	16 (84.2)
Other Government hospital	2 (10.5)
Private hospital	1 (05.3)
Period of gestation in present pregnancy	
Preterm (<37 weeks)	13 (68.4)
Term (37-40 weeks)	6 (31.6)
Mode of delivery:	
Normal Vaginal delivery	2 (10.5)
Caesarean section	17 (89.5)
Indications for current C-section (n=17)	
Abnormal implantation of placenta	15 (88.2)
Other (NPOL)	2 (11.8)
Time of hysterectomy	
At the time of delivery	17 (89.5)
Within 24 hours of delivery	2 (10.5)
Approach for hysterectomy	
Abdominal	19 (100.0)
Type of hysterectomy	
Total hysterectomy	13 (68.4)
Subtotal hysterectomy	6 (31.6)
Risk factors of hysterectomy	
Abnormal implantation of placenta	15 (78.9)
Other (cervical tear, PPH)	4 (21.1)
Indications of hysterectomy	
Placenta accreta	3 (15.8)
Placenta increta	2 (10.5)
Placenta percreta	2 (10.5)
Placenta previa	3 (15.8)
Placenta previa with accreta	6 (31.6)
Primary PPH	3 (15.8)
Postoperative complications	
Yes	9 (47.4)
No	10 (52.6)
Postoperative complications (n=9)	
Febrile morbidity	5 (55.5)
Urinary tract infections	3 (33.3)
Wound infection	1 (11.1)
High risk pregnancy due to (n=16)	
Gestational diabetes mellitus	2 (12.5)
Pre-eclampsia	1 (6.3)
Anaemia	2 (12.5)
Other (abnormal implantation of placenta)	11 (68.7)

As per the current study findings incidence of peripartum hysterectomy was high among women with previous history of cesarean section this was a familiar observation when compared to the research studies where majority of women with previous caesarean section had peripartum hysterectomy (8, 14).

In current investigation 68.4% participants had total hysterectomy and 31.6% participants had subtotal hysterectomy. Similar trend was reflected in a research study where majority of the participants had total hysterectomy (9). Febrile morbidity, wound infection and urinary tract infection are the post-operative complications presented in the study participants which were same as reported in the literature (15).

Awareness status regarding peripartum hysterectomy

In the present study, 21% of the participants had prior information about hysterectomy as one participant stated "*I knew even earlier that it would happen, my ultrasound findings revealed that there are 99% chances that I had to undergo hysterectomy".* In case of high-risk pregnancies when informed consent is taken then peripartum hysterectomy as one of the life-saving procedure is explained but for emergency indications like PPH and shock it becomes difficult. As 15.7% of the participants had no idea that they are undergoing peripartum hysterectomy. As one participant verbalized, "*My condition was not good and I became unconscious when they took me to the operation theater after that I don't know what happened with me".* Current study findings commensurate with literature where it was concluded that in elective hysterectomy group awareness regarding hysterectomy was present but lacked in emergency hysterectomy group (16).

Body's response to peripartum hysterectomy

Just more than half of the participants expressed decreased physical strength and annoying physical symptoms after peripartum hysterectomy as one participant expressed *"Before surgery, I was able to do work and climb the stairs easily but now my body does not feel like same, I get tired so easily".* Another participant expressed "*Bending down for longer duration makes me feel like something is falling and I feel pain in my back and groin".*

Annoying emotional symptoms were expressed by 31.5% of the participants. As one participant shared, "*I just get very angry when someone says something and I can't bear it if someone says anything about me or my daughter, or even if I think about that (hysterectomy) I don't feel good and get very angry".*

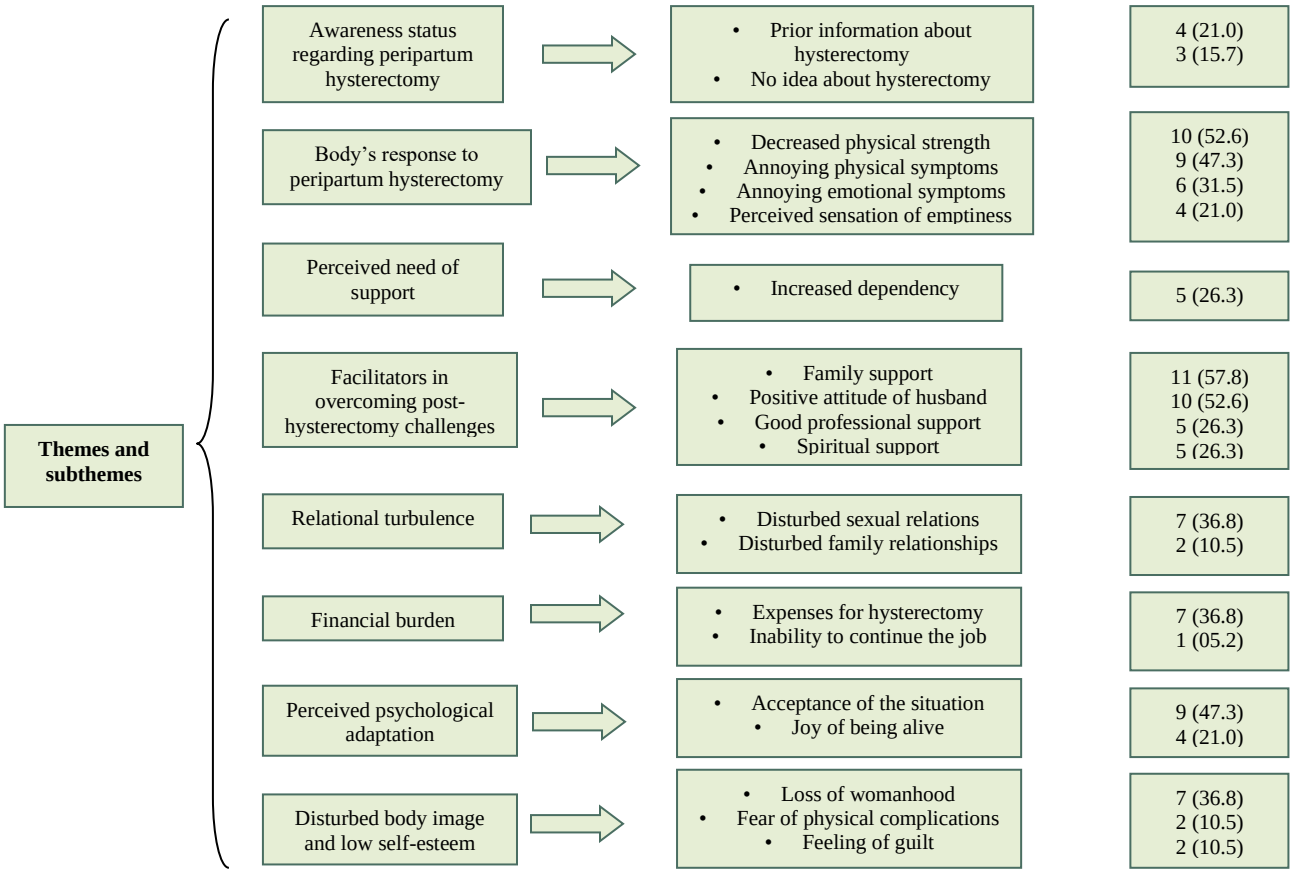

Figure 1: Themes and subthemes' frequency distribution based on participants' responses

Some participants (21%) experienced perceived sensation of emptiness in the abdomen, "*It feels like the entire place has become empty as before there was no problem at all but after hysterectomy it feels like there is nothing".* Above findings are in accordance with one study results where women reported decreased social functioning and increase in postoperative fatigue, bodily pain after peripartum hysterectomy (16).

Perceived need of support

Current study participants (26.3%) experienced perceived need of support as reflected from verbatim, *"In the beginning, I could not even take bath by myself, my family members used to help me. My husband used to make me stand and take for a walk, at that time I needed help".* Need of assistance is also reflected through a study finding where participants took almost four months to resume normal day to day activities (16).

Facilitators in overcoming post-hysterectomy challenges

Positive attitude of husband and family support were the facilitators highlighted through verbatim, "*Husband was like whatever doctor has done is okay. The most important thing is that my life is saved".*

"*Family paid for everything and helped a lot; my family took very good care of me and my daughter because I was not able to do anything".* In literature, study participants felt the need of psychological and economical support from family members during the treatment process as compared to present study findings where participants received positive support from the husband and family members after hysterectomy (17).

Some participants (26.3%) verbalized feelings of receiving Good professional support facilitated the recovery process as evident from current study participant statement, "*Doctors and nurses all were very good here. They talked very politely and did provide care as it's to be done and I didn't face any problem there".* Role of professionals has been found very significant for comprehensive supportive care in the form of counselling (12).

Spiritual support was a facilitating agent as one

participant expressed "*We couldn't have done anything without God. God has the main role; he is the one who saved me"* and is supported by previous study findings where *participants*' trust in God acted as a facilitator in overcoming the post hysterectomy situation (18).

Relational turbulence

Among study participants, 36.8% expressed disturbed sexual relations as one participant stated, "*It is more hurtful than before, I find it (having sex) difficult and my body is unable to process that much. At that time, I feel like nothing has happened and I get agitated".* Current study findings commensurate with another study findings where post peripartum hysterectomy women felt association of loss of uterus with decreased feminine emotions and feelings and loss of childbearing (18). Some participants (10.5%) expressed disturbed family relationships "*She (mother-in-law) used to taunt me day and night and there is a lot of fight, she used to ask me be at home and tortures me too much".* In literature similar trend is reflected where women have to suffer from gender-based violence such as physical, emotional abuse, deprivation of resources, and sexual violence as they can no longer reproduce (7).

Financial burden

Participants felt economic burden in terms of less income sources and more expenditure. Additional expenses for hysterectomy were verbalized by 36.8% of participants as one participant stated, "*We don't have job and do farming and that too of vegetables. It became difficult to sell vegetables during lockdown and we faced some problems regarding money".* One participant experienced the inability to continue the job after hysterectomy, "*I used to run the parlor as my condition worsened, I left the work and all the goods were wasted and my career also with has stopped*". Current study findings were supported by a research study where post hysterectomy women were not able to perform work at the expected standards and left their work which eventually affected their financial state (16).

Perceived psychological adaptation

Psychological adaptation to a threatening situation is an inherent quality of human beings and is evident also from the verbatim given, "*There is no point in thinking about what has happened, we cannot do anything and nothing will change now".*

"*I used to feel that my life is saved that's more important. Whatever happened was good, got saved because it was a tough time".* Various types of coping mechanisms became apparent in present study which were also highlighted in the literature where women used coping strategies like faith in God or acceptance of the situation to build resilience (7).

Disturbed body image and low self-esteem

Sense of loss of womanhood because of hysterectomy was reflected by 36.8% participants as one participant expressed, "*The existence of a woman is only because of the fact that monthly periods come, since it(uterus) has been removed, I do not feel that I am the same, it seems very strange".* Similar findings were reported in the literature where most of the women considered uterus as most important organ of feminity and its absence was major blow to their identity (7).

Some participants (10.5%) expressed fear of physical complications, "*Many times, it comes to mind that because of this (hysterectomy) don't know what would happen. I am afraid that now I don't get periods and because of that, I could have problems".* In previous research also woman expressed their fear of post-hysterectomy physical symptoms and genitourinary system changes (18).

Among current study participants, 10.5% expressed the feeling of guilt after hysterectomy as one of the participants stated, "*I was feeling guilt about what has happened to me, in previous pregnancies nothing like this has happened".* One research study also identified fear and feeling of guilt associated with lack of womb as main problems after peripartum hysterectomy (12).

It is a single centre study with the availability of all advanced facilities for mother and child care. Studies can be conducted in different health care set ups to further validate the findings.

Conclusion

Present study concluded that awareness of hysterectomy depends on the nature of procedure whether it is elective or emergency. Peripartum hysterectomy patients experienced physical and emotional symptoms which interfered with their daily routine and this traumatic birth experience lowered their self-esteem and made them dependent on others. Disturbance in personal and family relations significantly affected the women's life. Individualized psychological therapeutic interventions will facilitate the process of successful adaptation post peripartum hysterectomy.

Conflict of Interests

Authors declare no conflict of interests.

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