

A Retrospective Analysis of Spectrum of Gynecological Morbidities and their Management in Geriatric Women: A Tertiary Care Center Study

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ABSTRACT

Objective: The study was done to determine the magnitude of gynecological morbidities in geriatric population and their management in a tertiary care center.

Materials and methods: It is a retrospective observational study of female patients aged 60 years and above admitted in Department of Obstetrics and Gynecology, Sarojini Naidu Medical College, Agra, India, over a period of 3 years from January 2015 to December 2017.

Results: In our study 484 patients were aged 60 years or above among total gynecological admission of 1,299 in 3 years duration. The most common gynecological disorder was genital tract malignancies (37.39%) followed by pelvic organ prolapse (28.93%). Of the total gynecological malignancies, cervical carcinoma was most common (83.98%). Urinary incontinence was seen in 8.06% patients; 124 patients presented with benign conditions like endometrial hyperplasia, endometrial polyp, fibroid, pyometra with endometritis, and benign adnexal masses. Total 136/140 patients with uterovaginal (UV) prolapse were managed surgically. Among 39 cases of stress urinary incontinence (SUI), 19 were managed conservatively and 20 were managed surgically [transobturator tape (TOT), tension-free vaginal-obturator tape (TVT-O)].

Conclusion: Genital malignancy and UV prolapse were the major gynecological problem in elderly women. As the size of geriatric population is increasing, approaches like geriatric friendly camps and geriatric clinics should be made so as to bring geriatric women in regular health care system for early detection and management of their hidden problems.

Keywords: Genital tract malignancy, Geriatric population, Gynecological morbidities, Uterovaginal prolapse.

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INTRODUCTION

Geriatric gynecology deals with gynecological pathologies seen in postmenopausal women aged 65 years and above. Life expectancy of India is 61 years as compared with 72 to 82 years in developed countries. Thus, the cut-off of 65 years may not be appropriate in Indian scenario and therefore, a lower cut-off of greater than 60 years is used.¹ The average life expectancy in India is 68 years.²

The Indian society which was pyramidal till the 20th century has become rectangular today, and morbidity related to geriatric gynecology problems is on the rise.³ In India, the number of people aged more than 60 years has grown from 5.4% in 1951 to 8.4% in 2011 and is projected to become 12.4% by 2026.⁴

In geriatric population, women experience vasomotor, urogenital, psychosomatic, psychological symptoms, and sexual dysfunction, and these urogenital changes make them prone to gynecological morbidities. The major gynecological problems in such women are genital prolapse, post-menopausal bleeding, malignancy, vulvovaginal inflammation, and urinary bladder dysfunction.⁵

The risk of gynecological tumor is highest in geriatric women with risk of developing cancer uteri being two fold, carcinoma ovaries (three fold), carcinoma cervix (10% increased risk).⁶

The unique features of geriatric women illness are chronicity and heterogeneity of the disease, its greater severity and slow or sometimes no recovery. Hence, the present study was conducted to assess the various types of gynecological problems faced by women aged 60 years and above with an aim to emphasize the need for promoting screening program for early detection and treatment of cancers and to establish geriatric units to meet the special need of this subset of population.

MATERIALS AND METHODS

It is a retrospective observational study of female patients aged 60 years and above admitted in the Department of

Obstetrics and Gynecology, Sarojini Naidu Medical College Agra over a period of 3 years from January 2015 to December 2017. Data were collected and 484 patients were aged 60 years or above among the total gynecological admission of 1299. Age distribution, spectrum of gynecological disorder, and their management were noted and analyzed.

RESULTS

In our study, 484 patients were aged 60 years or above among total gynecological admission of 1299 in a 3-year duration. Out of 484 patients, 277 (57.33%) were between 60 and 65 years of age, 190 (39.26%) were between the ages of 65 and 70 years, 12 (2.48%) of them were between 70 and 75 years of age, and only 5 (1.03%) were above 75 years (Table 1). The maximum age of patient was 79 years who presented with UV prolapse.

Table 1: Age distribution of elderly women

| Age (years) | Number (n = 484) | Percent |
|-------------|------------------|---------|
| 60–65 | 277 | 57.23 |
| 65–70 | 190 | 39.26 |
| 70–75 | 12 | 2.48 |
| >75 | 5 | 1.03 |

Table 2: Gynecological disorders in elderly women

| Disease | Number | Percent |
|---|--------|---------|
| UV prolapse (n = 140) 28.93% | 19 | 3.93 |
| UV prolapse with cystocele | 109 | 22.52 |
| UV prolapse with cystocele and rectocele | 06 | 1.24 |
| UV prolapse with cystocele and enterocele | 06 | 1.24 |
| Vault prolapse | 06 | 1.24 |
| Malignancies (n = 181) 37.39% | 152 | 31.40 |
| Cervical carcinoma | 10 | 2.07 |
| Endometrial carcinoma | 18 | 3.72 |
| Ovarian carcinoma | 1 | 0.20 |
| Vulval carcinoma | 39 | 8.06 |
| Urinary incontinence | 39 | 8.06 |
| Other benign conditions (n = 124) 25.63% | 58 | 11.98 |
| Endometrial hyperplasia | 24 | 4.96 |
| Endometrial polyp | 13 | 2.7 |
| Fibroid | 14 | 2.9 |
| Pyometra with endometritis | 15 | 3.09 |
| Benign adnexal masses | 15 | 3.09 |

Table 2 shows the spectrum of gynecological disorders in elderly women. The most common gynecological disorder was genital tract malignancies (37.39%) followed by pelvic organ prolapse (28.93%). Of the total gynecological malignancies, cervical carcinoma was most common (83.98%) followed by ovarian carcinoma (9.9%), endometrial carcinoma (5.53%), and vulval carcinoma (0.5%).

Out of 140 patients of UV prolapse, 19 patients had UV prolapse with cystocele, 109 patients had UV prolapse with cystocele and rectocele, 6 patients had UV prolapse with cystocele and enterocele, and rest 6 patients had vault prolapse.

A total of 124 patients presented with benign conditions like endometrial hyperplasia (58 patients), endometrial polyp (24 patients), fibroid (13 patients), pyometra with endometritis (14 patients), and benign adnexal masses (15 patients). Remaining 39 patients had SUI.

Table 3 shows management done in patients with UV prolapse. Out of 19 patients of UV prolapse with cystocele, 4 patients were not fit for surgery because of the presence of other comorbidities like diabetes mellitus and hypertension, and in them, pessary was inserted. And in rest 15 patients, Ward Mayo's operation was done. All 109 patients with UV prolapse with cystocele and rectocele underwent Ward Mayo's operation. In 6 patients of UV prolapse with enterocele, Ward Mayo's operation with culdoplasty was done and abdominal sacrocolpopexy was done in patients with vault prolapse.

Table 4 shows that out of 152 patients with carcinoma cervix, in 16 patients, Wertheim's Hysterectomy was done and 140 patients reported with advanced-stage disease were referred to the radiotherapy department. Out of these, 41 patients were lost to follow-up and in 95 patients, radiation therapy was given.

Ten out of 18 patients with carcinoma ovary underwent total abdominal hysterectomy with bilateral salpingo-oophorectomy and in 4 patients total abdominal hysterectomy with bilateral salpingo-oophorectomy with infracolic omentectomy was done; 4 patients were sent for chemotherapy.

Ten patients reported with carcinoma endometrium and in all of them, total abdominal hysterectomy with bilateral salpingo-oophorectomy was done. Only one patient had carcinoma vulva in which vulvectomy was done.

Table 3: Management of UV prolapse

| UV prolapse | No. (n = 140) | Management | | | |
|---|---------------|------------|-----------------------|--|--------------------------|
| | | Pessary | Ward Mayo's operation | Ward Mayo's operation with culdoplasty | Abdominal sacrocolpopexy |
| UV prolapse with cystocele | 19 | 04 | 15 | – | – |
| UV prolapse with cystocele and rectocele | 109 | – | 109 | – | – |
| UV prolapse with cystocele and enterocele | 6 | – | – | 06 | – |
| Vault prolapse | 6 | – | – | – | 6 |

Table 4: Management in gynecological malignancies

| Type of malignancy | No. (n = 181) | Management | | | | Radiotherapy/ chemotherapy |
|--------------------|---------------|-------------------------|--------------|--|------------|----------------------------|
| | | Wertheim's hysterectomy | TAH with BSO | TAH with BSO with infracolic omentectomy | Vulvectomy | |
| Ca cervix | 152 | 16 | – | – | – | 95 |
| Ca ovary | 18 | – | 10 | 4 | – | 4 |
| Ca endometrium | 10 | – | 10 | – | – | – |
| Ca vulva | 1 | – | – | – | – | 1 |

TAH with BSO: Total abdominal hysterectomy with bilateral salpingo-oophorectomy

Table 5: Management for SUI

| Management | Number (n = 39) |
|--------------------|-----------------|
| Medical management | 19 |
| TOT | 15 |
| TVT-O | 05 |

In 58 patients of endometrial hyperplasia, dilatation and curettage with biopsy was done and among these, 51 patients' histopathological report shows atypical changes for which total abdominal hysterectomy with bilateral salpingo-oophorectomy was done; 24 patients of endometrial polyp had undergone dilatation and curettage with biopsy and in the same sitting, polypectomy was done in 6 patients and in rest 18 patients, total abdominal hysterectomy with bilateral salpingo-oophorectomy was done; 14 patients had pyometra with endometritis and in 10 patients, total abdominal hysterectomy with bilateral salpingo-oophorectomy was done. In all patients (15) with benign adnexal masses, total abdominal hysterectomy with bilateral salpingo-oophorectomy was done. Out of 13 patients of fibroid uterus, in 12 patients, total abdominal hysterectomy with bilateral salpingo-oophorectomy was done, and one patient was managed conservatively (Table 5).

Out of 39 patients who presented with SUI, maximum patients (19) were managed conservatively with darifenacin, bladder drill, and pelvic floor exercises. In 20 patients, TOT sling procedure was done and in rest 15 patients TVT-O sling procedure was done (Table 6).

DISCUSSION

In our study, 57.23% were in the age group of 60 to 65 years. This indicates that majority of geriatrics problems are in the age group of 60 to 65 years. This is consistent with the study done by Dey et al³ in which 45.56% patients admitted in ward were in the age group 60 to 65 years.

In our study, the most common gynecological disorder was genital tract malignancies (37.39%) followed by UV prolapse (28.93%) as the second most common. Studies have shown that there is significant increase in incidence of cancer after 65 years of age. In the Western world, endometrial cancer was the commonest genital malignancy followed by ovarian cancer.⁷ This was in

Table 6: Management for other benign conditions

| Other benign conditions | No. (n = 124) | Management | | |
|----------------------------|---------------|------------|-------------------|--------------|
| | | D&C biopsy | Pyometra drainage | TAH with BSO |
| Endometrial hyperplasia | 58 | 58 | – | 51 |
| Endometrial polyp | 24 | 24 | – | 18 |
| Pyometra with endometritis | 14 | – | 14 | 10 |
| Benign adnexal masses | 15 | – | – | 15 |
| Fibroid | 13 | – | – | 12 |

D&C: Dilatation and curettage; TAH with BSO: Total abdominal hysterectomy with bilateral salpingo-oophorectomy

contrast to our study where cervical carcinoma was the most common (83.98%) followed by ovarian carcinoma (9.9%), endometrial carcinoma (5.53%), and vulval carcinoma (0.5%) (Table 2).

Uterovaginal prolapse is another major health issue in geriatric women because of deficiency of estrogen in post-menopausal women. Oslen et al⁸ showed in their study that the age-specific incidence of genital prolapse increased with advancing age and most patients were older, post-menopausal, parous, and overweight.

Urinary incontinence was seen in 8.06% patients and maximum were managed conservatively and 15 of them were managed by TOT and five with TVT-O; it seems that TOT has become the new gold standard for the treatment of SUI in recent times.

Out of 152 patients with cervical cancer, only 16 patients could be operated because of advanced stage of disease. This is consistent with the study done by Ying Gao et al⁹ where radiotherapy was the most frequent treatment given to geriatric patients in cancer cervix.

CONCLUSION

Postmenopausal women have a considerable magnitude of gynecological morbidities. Approaches, such as geriatric-friendly camps and opportunistic screening among women with chronic morbidities can be considered complementary approaches to cover the hidden gynecological morbidities. Public awareness and education can also play a major role in reducing morbidities associated with this subset of population.

As the population of geriatric women is increasing with time, it is our responsibility that we should pay more attention and seriousness toward this stratum and efforts should be made like running a separate geriatric clinic could be a great help to these elderly women.

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