Mona maghraby

بسم اللّه الرحمن الرحيم

مركز الشبكات وتكنولوجيا المعلومات

قسم التوثيق الإلكتروني

Mona maghraby

جامعة عين شمس

التوثيق الإلكتروني والميكروفيلم

قسم

نقسم باللّه العظيم أن المادة التي تم توثيقها وتسجيلها

علي هذه الأقراص المدمجة قد أعدت دون أية تغيرات

Mona maghraby

بعض الوثائق الأصلية تالفة
وبالرسالة صفحات لم ترد بالأصل

COMPARATIVE STUDY OF POST OPERATIVE CARE FOLLOWING ABDOMINAL AND VAGINAL HYSTERECTOMY

Thesis Proposal
Submitted for partial Fullfilment of the Master Degree of obstetrics and Gynecologic Nursing

By

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(symptomatology scale) .

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INTRODUCTION

It has been reported that woman who undergo hysterectomies usually have emotional, physiological and social concerns (Higgin, 1991). Among these concerns is the fear experienced, a result of the false belief that this type of surgery threatens their femininity and their ability to remain adequate wives and mothers. In addition, the loss of the uterus may produce a sense of incompleteness and lead to distortion of the self-concept of the patient (Halm, 1991).

Hysterectomy operation may also create social concerns usually related to women's relationship with their husbands other family members and their society groups. It apparent that a women who experience hysterectomy may have physiological, psychological and social health problems that require adjustments (Webb, 1993).

Hysterectomy are carried out by two routes abdominal or vaginal hysterectomy.

Abdominal hysterectomy is the commonest procedure may be subtotal, when the body of the uterus is removed, or total when both body and cervix are removed. (Lewis, 1991).

Abdominal hysterectomy is performed three times more frequently than vaginal hysterectomy (David et al., 1993). it preferred

route in situations of a large pelvic mass, pelvic infection, malignancy, adnexal pathology, or evidence of extensive adhesive disease.

Vaginal hysterectomy route for hysterectomy is easiest form of hysterectomies to perform, when the uterus is movable or prolapsed or not. In addition, hospitalization can be shortened (Kjerulff, 1992). The patient often may be home by the second or third postoperative day, more comfortable upon obese patient and nulligravida patient.

The vaginal rout is preferred over the abdominal route because it is associated with fewer complications, an easier and shorter convalescence, and lack of a visible scar (Pratt, 1990).

Review of Literature

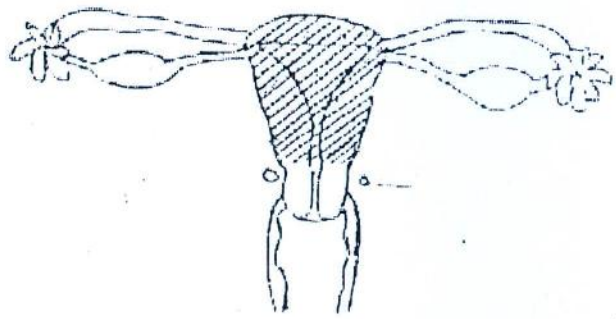
bleeding, endometriosis, nonmalignant growth in the uterus, cervical and adnexal problem of pelvic relaxation and prolapse, and irreparable injury to the uterus (Suzanne, 2000).

Total abdominal hysterectomy plus salpingo-oophorectomy (Fig. 2-c) :

This operation the uterus is removed with fallopian tubes and ovaries is indicated in the following conditions, advanced non malignant disease of the tubes and ovaries such as chronic sepsis or endometriosis, malignant disease of the ovaries, tubes and broad ligament and benign condition of the uterus in postmenopausal patient (Suzanne, 2000).

Radical hysterectomy (wertheim's hysterectomy) (Fig. 2-D):

Radical hysterectomy includes removal of the uterus, both tubes and ovaries, the parametrium and paracolpos, the upper third of the vagina and the pelvic lymph nodes including the common iliac nodes. (Lewis, 1991).



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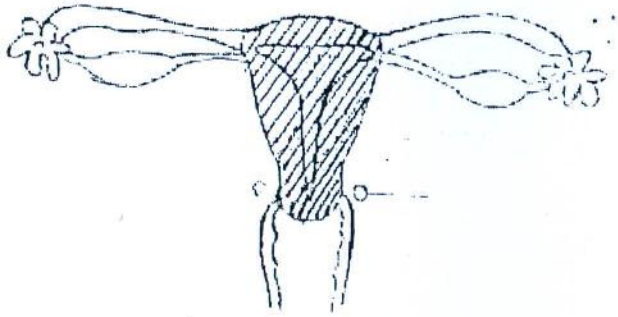
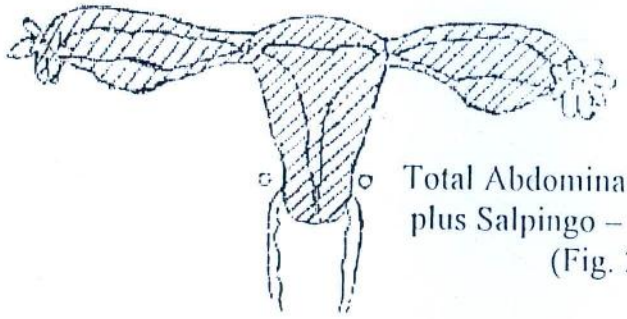
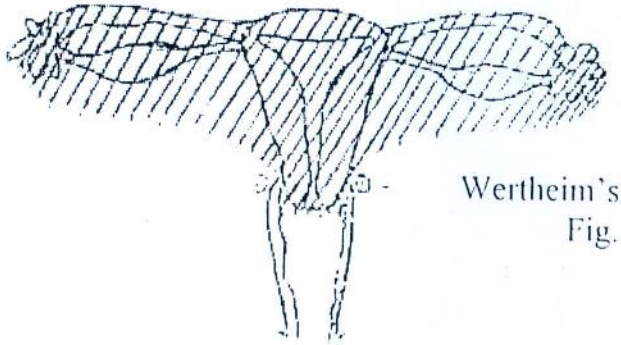


-lysterectomy
B)



Total Abdominal Hysterectomy
plus Salpingo – oophorectomy
(Fig. 2-C)



Wertheim's hysterectomy
Fig. (2-D)

ROUTE OR TECHNIQUE

OF HYSTERECTOMY

Hysterectomy may be performed by either the abdominal or vaginal route :

A) Vaginal hysterectomy is highly suitable when the indication for surgery is vaginal relaxation or it may also be used when the uterus is being removed because of small myomata (Tumors of the uterine muscle) or recurrent uterine bleeding due to endocrine imbalance. The major advantages of this procedure are that it can be done quickly, requires relatively light anesthesia, and has minimal postoperative discomfort.

Specific care of the vaginal hysterectomy, the nurse must ensure that the patient has sufficient pads to change often it must be for the first 48 hours after operation. Specific vulval care will depend on the vaginal discharge present and whether or not there are any perineal sutures.

B) Abdominal hysterectomy, on the other hand, is usually associated with a slower and more prolonged recovery and, therefore, with greater cost. It is especially suited for those conditions associated with decreased uterine mobility. Pelvic adhesions and scarring and for gynecologic malignancy.

As regard specific care of abdominal wound follows the general principles of wound healing and wound management some wound are left exposed others are dressed daily and there are usually remove drain after 48 hours to prevent haematoma formation.

COMPLICATION OF HYSTERECTOMY

Postoperative complication significantly increases surgical morbidity rates, lengthens hospital stay and increases costs of care, and in rare cases is a major factor in patient death. Women undergoing pelvic surgery are especially at risk for hemorrhagic or infectious complication that may occur immediately after surgery or may not develop for days to weeks after the operation (Norman and Gant, 1993).

HEMORRHAGE:

Bleeding complication has been found to accompany with 1-3% of all hysterectomy (Reiter et al., 1992, Andersen et al., 1993). Hemorrhage can be divided into three major categories:

a) Intraoperative hemorrhage: Occurs when a patient require a blood transfusion or loss more than 1000 ml. of blood during the operation (Harris, 1995).

b) Early postoperative hemorrhage in which bleeding occurr in the immediate 24-hour postoperative period is usually caused by inadequate hemostasis during surgery. Vaginal bleeding may be controlled with a vaginal pack or a vaginal suture. If it is not controlled so abdominal laparotomy to allow ligation of the vessel bleeding. (Gitsch et al., 1991).