Don't Discount Gynecologic Surgeries for Elderly

Risk of major procedures could be reduced by attending to group's specific perioperative needs.

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SAN FRANCISCO — Elderly women should not be denied major gynecologic surgery solely on the basis of their presumed age-based operative risk, according to Lindsay M. Mains, M.D.

In a study she presented at the annual meeting of the American College of Obstetricians and Gynecologists, Dr. Mains showed morbidity and mortality among elderly women undergoing major gynecologic surgery is high, compared with rates in younger women undergoing this surgery. But attention to specific perioperative needs of the elderly might reduce this risk, said Dr. Mains of the Ochsner Clinic Foundation in New Orleans.

Dr. Mains' study reviewed data from 110 major gynecologic surgeries on women aged 80-90 years old. All patients received preoperative medical clearance, except one who required emergent surgery.

Although half of the patients were overweight or obese, 61% had no serious medical history otherwise, and 96% had an American Society of Anesthesiologists' (ASA) score of 3 or less.

Most procedures (77%) were performed to remove cancer or a benign mass; the rest were undertaken to treat pelvic organ prolapse and/or urinary incontinence. Almost all patients (95.5%) received general endotracheal anesthesia.

An abdominal procedure was performed in 65% of patients, while 32.5% underwent laparoscopy. A total of 4.5% had a vaginal procedure.

Dr. Mains reported an intraoperative complication rate of 4% and a postoperative complication rate of 45%. Eight percent of the total study group had major life-threatening complications, including death in 3.6% of patients.

The most common postoperative complications were ileus, which occurred in 14% of patients, infection in 14% (urinary tract infection in 6%, wound infection in 5%, and death due to sepsis in 3%), cardiopulmonary events in 13%, and fever of unknown origin in 11%.

There were four fatalities—one due to myocardial infarction and three due to sepsis and intravascular coagulation.

"Our mortality rate was lower than other studies on elderly patients, which include men and women and have shown mortality rates up to 13%. This is an interesting finding and warrants further study," she said.

One of the mortalities occurred on postoperative day 10 in the only patient who had undergone emergent surgery to do intra-abdominal hemorrhage, she noted.

Dr. Mains suggested that some of the complications in the subjects might be specific to the elderly population, and attention to these issues could help in reducing risk.

For example, half of the 14% of patients who experienced postoperative ileus were readmitted for this problem.

"We could attribute the slow return of bowel function in our subjects to their general decreased mobility and increased sensitivity to narcotics. Emphasis on early ambulation and physical therapy as well as reduction in narcotic use in these patients may help reduce these complications," she said.

Similarly, a high rate of infection in this population might indicate an increased need for perioperative prophylactic antibiotics. And she speculated that because of an increased rate of pulmonary problems in these patients, greater use of incentive spirometers and bronchodilators perioperatively would likely be beneficial.

Finally, almost one-quarter of the patients received blood transfusions although only 16% had blood loss in excess of 500 cc. This may be an indication of an inability of elderly patients to compensate for perioperative blood loss, she said.

"Aggressive correction of preoperative anemia and dehydration in these patients could benefit their surgical outcome."

Dr. Mains suggested that elderly women should be advised there is a 5%-10% risk of serious morbidity associated with major gynecologic surgery in their age-group. However, with attention to the specific perioperative needs of the elderly, this risk might be further reduced.

She said that physicians consider that many elderly patients are willing to accept greater risks for smaller benefits. "The decision about a patient's operability should weigh her risks and benefits. Therefore, as physicians, we must have a clear understanding of these risks and their incidence when counseling patients," she said. ■