

Vault haematoma after vaginal hysterectomy

Sir,

I congratulate the authors of the article vault haematoma and febrile morbidity after vaginal hysterectomy (Vol 61(8), 2000, p. 535) in addressing a relevant clinical issue. As there is no uniform policy, haematomas are dealt with individually. Factors which could contribute to this problem are:

1. Faulty selection of cases, where we struggle to do a vaginal hysterectomy. This happens in women with an enlarged uterus with non-descent and in cases with undiagnosed pelvic adhesions. The increased blood vessels in fibroid uterus increase the risk further. These patients are better treated with an abdominal hysterectomy or laparoscopically-assisted vaginal hysterectomy (Salmanli and Maher, 1999)
2. Blood clots collected in the pelvis are usually removed at the end of abdominal hysterectomy. During vaginal hysterectomy, as the collected blood/clot is not obviously seen it tends to remain in the pelvis. This could result in increased diagnosis of vault haematomas during imaging and could cause febrile morbidity in some cases
3. The age-old method of extraperitonealising the stumps prevents blood collection in the pelvis (Parulekar, 1989)
4. Using diathermy to cut the vagina circumferentially at the start of the procedure could decrease bleeding from vaginal mucosal edges (no

studies available). Suturing the vaginal mucosal edges meticulously either with interrupted or with circumferential sutures prevents bleeding

5. At any given point of time there will be gynaecologists who are going through their learning curve and this factor cannot be eliminated completely.

Studies that look into various independent risk factors causing vault haematomas are needed.

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Post-intubation tracheal stenosis

Sir,

Drs Ahmad and Pahor (Vol 61(7), 2000, p.508) are correct to highlight tracheal stenosis as a serious complication of tracheal intubation, indeed it can be life threatening. We feel that several of the points made in their discussion merit further comment.

They describe tracheal stenosis as a consequence of prolonged intubation without clarifying how prolonged. Tracheal stenosis has been described following only 24 hours of intubation (Yang, 1995) and so any patient who has been intubated on an intensive care unit must be considered to be at risk.

The incidence of 19% quoted in their report refers to the radiological find-

ing, 1 month after extubation, of stenoses of over 10% (Stauffer et al, 1981). However, most patients do not suffer any symptoms until their trachea has narrowed to 50% of its original diameter. The incidence of symptomatic post-intubation tracheal stenosis is actually of the order of 0.1% (Bricchet et al, 1999).

Initially patients may only suffer dyspnoea on exertion and are often misdiagnosed as having asthma (Grillo and Donahue, 1996). Classical symptoms, such as stridor at rest, only occur with greater than 70% stenosis. Several authors have reported flow volume loops to be an unreliable diagnostic test and linear or computed tomography is recommended (Grillo and Donahue, 1996; Andrews and Pearson, 1973). Delay in diagnosis means that over 50% of patients present in respiratory failure (Baugnee et al, 1995) requiring urgent rigid bronchoscopy and tracheal dilatation under general anaesthesia.

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