Journal of Advanced Medical and Dental Sciences Research

@Society of Scientific Research and Studies

Journal home page:www.jamdsr.com doi:10.21276/jamdsr Index Copernicus value [ICV] =82.06

(e) ISSN Online: 2321-9599; (p) ISSN Print: 2348-6805

Original Research

Assessment of outcomes after hysterectomy with and without oophorectomy

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ABSTRACT:
Background: One of the most common surgical procedures is a hysterectomy. By the time they are 60 years old, 25% of women in the US get a hysterectomy. The present study was conducted to assess outcomes after hysterectomy with and without oophorectomy. **Materials & Methods:** 70 women were divided into 2 groups of 35 each. Group I included women who underwent hysterectomy with conservation of at least 1 ovary and group II included women who underwent hysterectomy and bilateral oophorectomy. All women in group II were offered estrogen replacement therapy following surgery. Parameters such as BMI, type of hysterectomy, reasons for hysterectomy, and outcome was recorded. **Results:** BMI (Kg/m2) was <19 seen in 2 and 6, 19-26 in 15 and 13 and >26 in 18 and 16 patients in group I and II respectively. Type of hysterectomy was abdominal in 5 and 14, vaginal in 17 and 5, subtotal in 2 and 3, laparoscopic in 4 and 5 and unilateral oophorectomy in 2 and 3 patients in group I and II respectively. Reasons for hysterectomy was heavy menstrual bleeding in 27 and 24, pelvic pain in 2 and 4, fibroids in 1 and 3, dysmenorrhoea in 3 and 1 and uterovaginal prolapse in 2 and 3 patients in group I and II respectively. The difference was significant (P< 0.05). Post- hysterectomy abdominal pain was seen in 32% and 47%, pelvic pain in 20% and 34%, hot flushes in 31% and 47%, vaginal dryness in 27% and 36%, CES-D score >16 in 26% and 48%, sexually activein 86% and 72%, sex >2/months in 80% and 67%, urinary frequency in 25% and 31%, nocturiain 22%and 40%, urge incontinence in 33% and 45%, stress incontinence in 24% and 38%, difficulty urinating in 6% and 14%, sensation of residual urine in 7% and 13%, constipation in 24% and 21%, diarrhea in 25% and 30%, alternating bowel habit in 14% and 13% and bloating in 40% and 49% in group I and group II patients respectively. The difference was significant (P< 0.05). **Conclusion:** Although some women complaint of the loss of fertility, satisfaction is high after having a hysterectomy with or without an oophorectomy.
Keywords: estrogen, fibroids, hysterectomy

Received: 11 September, 2019 Accepted: 26 September, 2019 Published: 17 October, 2019

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This article may be cited as: Bhukya P, Mothilal G. Assessment of outcomes after hysterectomy with and without oophorectomy. J Adv Med Dent Scie Res 2019;7(10):264-267.

INTRODUCTION

One of the most common surgical procedures is a hysterectomy. By the time they are 60 years old, 25% of women in the US get a hysterectomy.The widespread practice of hysterectomy in healthy women has sparked debates over the procedure's benefits.[1] Long-term prospectively gathered data following a hysterectomy are rarely documented, despite several reports indicating that the procedure has excellent effects. The relief from monthly menstruation discomfort and the end of abnormal uterine bleeding are the more evident benefits. Other problems that have been reported to improve include endometriosis-related pelvic pain, fibroids-related pressure feelings, incontinence, sexual function, depression, and anxiety. Hysterectomy satisfaction ratings are usually high.[2]

Nevertheless, after a hysterectomy, not all women report feeling better, and a tiny percentage of women go on to develop new symptoms. A decrease in sexual functioning as well as the emergence of new lower gastrointestinal and urinary problems have been linked to hysterectomy.[3]Long recuperation periods, weight gain, altered self-image, loss of reproductive

ability, social and domestic disturbances, and wound discomfort lasting up to a year following surgery are among the issues.[4] There is debate regarding the function of oophorectomy in conjunction with hysterectomy. Clinical guidelines for prophylactic oophorectomy have been established, and this treatment is frequently performed on premenopausal women. Women with endometriosis, pelvic discomfort, and premenstrual symptoms had better results when oophorectomy is performed concurrently with a hysterectomy.[5] Concerns over the danger of ovarian cancer may lead older premenopausal women to decide to have an oophorectomy. Nonetheless, there are worries that oophorectomy can actually cause new health issues, and a recently released decision analysis indicates that there is no increase in the long-term survival of women who get oophorectomy.[6]The present study was conducted to assess outcomes after hysterectomy with and without oophorectomy.

MATERIALS & METHODS

The study was carried out on 70 women. All gave their written consent to participate in the study.

Data such as name, age, gender etc. was recorded. They were divided into 2 groups of 35 each. Group I included women who underwent hysterectomy with conservation of at least 1 ovary and group II included women who underwent hysterectomy and bilateral oophorectomy. All women in group II were offered estrogen replacement therapy following surgery. Parameters such as BMI, type of hysterectomy, reasons for hysterectomy, and outcome was recorded. Results thus obtained were subjected to statistical analysis. P value < 0.05 was considered significant.

RESULTS

Table I Distribution of patients

Groups	Group I	Group II
Method	hysterectomy with conservation	hysterectomy and bilateral oophorectomy
Number	35	35

Table I shows that group I included women who underwent hysterectomy with conservation of at least 1 ovary and group II included women who underwent hysterectomy and bilateral oophorectomy.

Table II Assessment of parameters

Parameters	Variables	Group I	Group II	P value
BMI (Kg/m^2)	<19	2	6	0.72
	19-26	15	13	
	>26	18	16	
Type of hysterectomy	Abdominal	5	14	0.01
	Vaginal	17	5	
	Subtotal	2	3	
	Laparoscopic	4	5	
	Unilateral oophorectomy	2	3	
Reasons for hysterectomy	Heavy menstrual bleeding	27	24	0.01
	Pelvic pain	2	4	
	Fibroids	1	3	
	Dysmenorrhoea	3	1	
	Uterovaginal prolapse	2	3	

Table II, graph I shows that BMI (Kg/m2) was <19 seen in 2 and 6, 19-26 in 15 and 13 and >26 in 18 and 16patients in group I and II respectively. Type of hysterectomy was abdominal in 5 and 14, vaginal in 17 and 5, subtotal in 2 and 3, laparoscopic in 4 and 5 and unilateral oophorectomy in 2 and 3 patients in group I and II respectively. Reasons for hysterectomy was heavy menstrual bleeding in 27 and 24, pelvic pain in 2 and 4, fibroids in 1 and 3, dysmenorrhoea in 3 and 1 and uterovaginal prolapse in 2 and 3patients in group I and II respectively. The difference was significant (P< 0.05).

Graph I Assessment of parameters

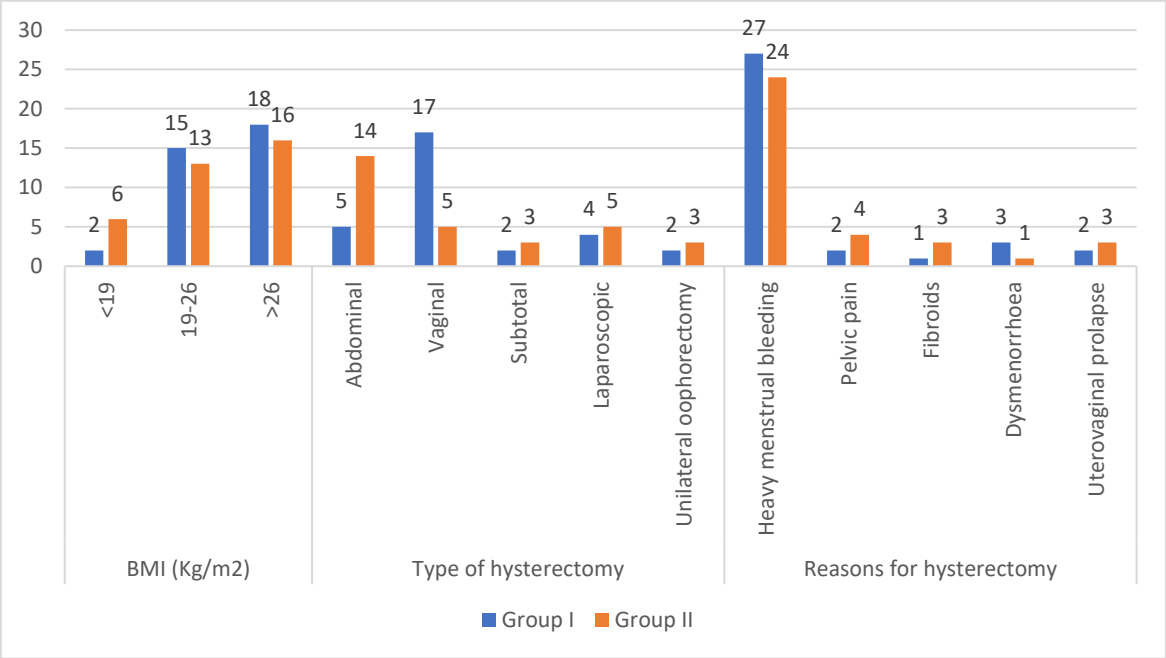

Table III Clinical symptoms, depression scores, and sexual function post- hysterectomy

Parameters	Group I	Group II	P value
Abdominal pain	32%	47%	0.05
Pelvic pain	20%	34%	0.01
Hot flushes	31%	47%	0.02
Vaginal dryness	27%	36%	0.05
CES-D score >16	26%	48%	0.01
Sexually active	86%	72%	0.12
Sex >2/month	80%	67%	0.05
Urinary frequency	25%	31%	0.81
Nocturia	22%	40%	0.01
Urge incontinence	33%	45%	0.03
Stress incontinence	24%	38%	0.05
Difficulty urinating	6%	14%	0.05
Sensation of residual urine	7%	13%	0.04
Constipation	24%	21%	0.12
Diarrhea	25%	30%	0.35
Alternating bowel habit	14%	13%	0.83
Bloating	40%	49%	0.54

Table III shows that post- hysterectomy abdominal pain was seen in 32% and 47%, pelvic pain in 20% and 34%, hot flushes in 31% and 47%, vaginal dryness in 27% and 36%, CES-D score >16 in 26% and 48%, sexually active in 86% and 72%, sex >2/months in 80% and 67%, urinary frequency in 25% and 31%, nocturia in 22% and 40%, urge incontinence in 33% and 45%, stress incontinence in 24% and 38%, difficulty urinating in 6% and 14%, sensation of residual urine in 7% and 13%, constipation in 24% and 21%, diarrhea in 25% and 30%, alternating bowel habit in 14% and 13% and bloating in 40% and 49% in group I and group II patients respectively. The difference was significant (P< 0.05).

DISCUSSION

Hysterectomy has been implicated in the development of many symptoms, including changes in urinary, lower gastrointestinal, and sexual function.[7] Symptoms have been attributed to direct damage to tissues at surgery, adhesion formation, nerve injury, and, in the case of sexual function, loss of the cervix and uterus and its potential effect on orgasm.[8,9] Psychosocial effects also have been described, such as depression and loss of self-image or feminine identity. However, many earlier reports assessed symptoms only after hysterectomy, and their conclusions should be interpreted with caution because of selection and recall biases.[10,11]The present study was conducted to assess outcomes after hysterectomy with and without oophorectomy.

We found that BMI (Kg/m2) was <19 seen in 2 and 6, 19-26 in 15 and 13 and >26 in 18 and 16 patients in group I and II respectively. Type of hysterectomy was abdominal in 5 and 14, vaginal in 17 and 5, subtotal in 2 and 3, laparoscopic in 4 and 5 and unilateral oophorectomy in 2 and 3 patients in group I and II respectively. Reasons for hysterectomy was heavy menstrual bleeding in 27 and 24, pelvic pain in 2 and 4, fibroids in 1 and 3, dysmenorrhoea in 3 and 1 and uterovaginal prolapse in 2 and 3 patients in group I and II respectively. Farquhar CM et al[12]determined the outcomes of hysterectomy with and without conservation of the ovaries. Data were collected prospectively for 3 years from 257 women undergoing hysterectomy (group 1) and 57 women undergoing hysterectomy with oophorectomy (group 2). Pelvic pain, abdominal pain, and depression scores were reduced in the 3 years after hysterectomy. Twenty-one percent of the women in group 1 and 43% in group 2 regretted the loss of fertility 3 years after hysterectomy. Satisfaction with the operation was greater than 90% after 3 years in both groups. New symptoms of pelvic pain were infrequent in groups 1 (3%) and 2 (5%).

We found that post- hysterectomy abdominal pain was seen in 32% and 47%, pelvic pain in 20%and 34%, hot flushes in 31% and 47%, vaginal dryness in 27% and 36%, CES-D score >16 in 26% and 48%, sexually active in 86% and 72%, sex >2/months in 80% and 67%, urinary frequency in 25% and 31%, nocturiain 22%and 40%, urge incontinence in 33% and 45%, stress incontinence in 24% and 38%, difficulty urinating in 6% and 14%, sensation of residual urine in 7% and 13%, constipation in 24% and 21%, diarrhea in 25% and 30%, alternating bowel habit in 14% and 13% and bloating in 40% and 49% in group I and group II patients respectively. Weber AMet al[13]compared urinary, lower gastrointestinal, and sexual function and to describe patients' expectations and satisfaction before and after hysterectomy.Forty-three women completed questionnaires before and about 1 year after abdominal hysterectomy for benign gynecologic conditions. Symptoms related to urinary, lower gastrointestinal, and sexual function and satisfaction with treatment were assessed. There were no statistically significant changes in urinary or bowel symptoms before and after hysterectomy, with preoperative symptoms resolving in some women after surgery and developing in others. Sexual function including orgasmic ability did not change in the 34 sexually active women. The level of satisfaction with treatment was very high.

The shortcoming of the study is small sample size.

CONCLUSION

Authors found that although some women complaint of the loss of fertility, satisfaction is high after having a hysterectomy with or without an oophorectomy.

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