

Why *would* you need a hysterectomy?

Removal of the uterus is performed to prevent, alleviate, or treat pain, pressure, bleeding, or cancer. Each reason is described in detail in the following pages.

Benign problems of the uterus and ovaries, and pain

Fibroids of the Uterus – Fibroids are round swirls of overgrown benign muscular fibers in the wall of the uterus. The only reasons to remove a uterus for fibroid growth are if it causes heavy or chronic bleeding, pain or pressure, frequent urination, blockage of the ureters (tubes that bring the urine from the kidneys) or grows during the menopause while not on hormones. Then a total hysterectomy should be done, usually through the laparoscopes.

But most fibroids DO NOT BOTHER ANYONE!!! The rule is that fibroids that do not bother anyone should be left alone. Many gynecologists have been too quick to tell a woman she needs a hysterectomy when her fibroids are not bothering her, or not bothering her very much. Each woman should be the judge for herself. Some women prefer to avoid hysterectomy because menopause is near, and their symptoms are not too significant. This is reasonable because fibroids usually shrink about 30% in early menopause. Other women grow fibroids that are huge or cause discomfort and avoid hysterectomy either because they have heard awful things about hysterectomies, or they don't choose to take the time off from their busy lives to make their life a little more comfortable. Some women feel they cannot take this amount of time for themselves or draw attention from their family to have surgery. They should honor their body and value their life experience and provide for themselves as well as they provide for their families.

Heavy bleeding can be caused by fibroids or polyps on the inner mucous lining of the uterine cavity either at the wrong times or in huge quantities, even when the fibroids are small. Uterine polyps, which are small skin tags inside the cavity, can also cause bleeding, but an ultrasound can show these as separate from the fibroids. A biopsy will need to be done to confirm that any bleeding is not due to a cancer in the endometrial cavity. When bleeding is very heavy each month, many women spend the next few weeks after the period regaining strength as they use their energy to make new blood to replace the losses. This cycle, if repeated, or is heavy, can cause anemia, severe fatigue and even depression this way. A laparoscopic hysterectomy can stop the hemorrhage, prevent anemia, and allow blood stores to replenish, restoring energy and vitality, and a life free of monthly hemorrhage.

If fertility is desired in a young woman, it is appropriate to remove smaller fibroids under the uterine lining from a hysteroscopic approach (a scope passed through the cervix up into the uterus). When fertility is not desired, then the safest, simplest single approach is to remove the uterus.

Pelvic pain or pressure can be caused by fibroids on the outside of the uterus. These can become quite large and create a mass effect in your pelvis, which you can often feel.

The larger fibroids can be felt above the pubic bone, but still may not cause symptoms of pelvic pain, bladder pressure, low back pain or frequency of urination. When the uterus can be felt below the bellybutton, many women notice pressure on their bladder or have low back pain. Laparoscopic hysterectomy is the easiest and safest procedure for them, with minimal blood loss and maximal probability of resolving the problem with one procedure.

If a younger woman has large fibroids and realistically desires to preserve her fertility, it is appropriate to laparoscopically remove the larger outer fibroids. This should be done about 8 weeks before she desires to become pregnant, so she will not prevent implantation of the pregnancy or cause pain during the pregnancy. Removal of the fibroids should be done through a horizontal incision, which is a bigger surgery because the surgeon must cut into the uterus and not sever any of the major arteries to the uterus. Blood should be donated in anticipation of this procedure, as the blood loss can be large. Dr. O'Hanlan does not perform this surgery on peri-menopausal women unless conception is the clear goal, because it entails taking on major risk for nil benefit except fertility.

Pain in the pelvis is best relieved by hysterectomy with oophorectomy.

Pain before or during periods - Pain can be caused by large fibroids, endometriosis of the uterus, or adhesions. Endometriosis is the tissue that is identical to endometrial lining tissue, located in extra-uterine locations. It usually grows thick and bleeds each month just like the endometrial cavity lining, only it hurts much more to have this tissue bleeding and sloughing monthly in the wrong locations. Monthly pain in the pelvis just before and during the period is common and likely due to endometriosis if it cannot be alleviated by Naprosyn (Alleve). Always try Naprosyn for gynecologic pain before seeing the doctor, as surgery can be avoided this way. When Naprosyn does not alleviate the pain, and the pain is causing a woman to miss work or simply feel awful, she should consider how long she will keep having the pain without any surgery: usually until menopause, usually age 51. If this sounds like too long, then consider the surgery.

When endometriosis is suspected as the cause of monthly pain, then it is advisable to remove not just the uterus, but also the ovaries, because they can easily stimulate new growth of endometriosis with the high levels of estrogen that the ovaries secrete. When the ovaries are left in there is a 50% chance of relief from pelvic pain. When the ovaries are removed, the relief from pelvic pain is over 90% likely.

If fertility is desired and endometriosis is suspected based on the pain profile, then laparoscopic removal of endometriosis is reasonable with conservation of the ovaries. Preserving the ovaries is essential if fertility is desired, but it also allows the endometriosis to re-grow over the next year or so, with recurrence of pain and need for repeat surgery in about 50-75%. This is due to two reasons: first, the ovaries put out much more estrogen than HRT involves, stimulating re-growth, and secondly, the ovaries often harbor microscopic or deep nests of endometriosis that progress and cause more pain or ovarian masses and need for repeat surgery. Unless fertility is the clear goal, the

most effective surgery for painful periods and pelvic pain in general must include removal of the ovaries.

In addition, the most effective surgery for pain in the pelvis or severe monthly cramps must involve removal of the uterus. As a woman ages past 40, the uterine lining can begin grow *inside the muscular wall of the uterus* (adenomyosis) and cause pain either all month long or in cycles. This is called adenomyosis, and it is commonly diagnosed in the mid to late 40's. This pain does not respond well to Naprosyn, making laparoscopic hysterectomy/oophorectomy a welcome choice for relief of pain.

Pain during sex. Painful sexual activity involving deep thrusting into the vagina is usually caused by endometriosis, adenomyosis or, possibly adhesions from a prior surgery. If Naprosyn doesn't relieve pain during sexual activity, then an anatomic cause is suspected and surgery can relieve this pain with reasonable effectiveness.

Infection of the uterus, tubes or ovaries. Because pelvic infections are frequently recurrent and occasionally associated with malignant changes, surgery to remove the uterus, tubes and ovaries is standard, especially if fertility is completed.

Quality of life: do you deserve it? Hysterectomy causes short-term morbidity, but appears to increase average life expectancy slightly among peri-menopausal women and is cost-saving. Medical outcomes and economic consequences favor the hysterectomy over trying to preserve the uterus as medical remedies are most often unsuccessful, and ultimately the surgery needs to be done. Research on women undergoing hysterectomy shows that 78% are symptom free after their operation, and another 14% have reduced symptoms, while 8% have new symptoms. Fully 95% report that they were pleased with their HRT or it exceeded expectations 5% reported not liking their HRT because for some it contained testosterone. Physical well-being was improved in 80% and unchanged in 15% and worse in 4.6%. 32% noted less depression than before the surgery, while 65% had no depression, and 4% became more depressed. Overall, 3% were dissatisfied. Satisfaction was associated with understanding the need for the surgery, a positive outlook, removal of the ovaries, taking HRT for at least the short-term, complete symptom relief, a quick recovery, improved physical well-being, and the absence of depression. (Khastgir et al, Am J Ob/Gyn, 2000) **In another study, at 12 and 24 months after their hysterectomy 95.8% and 96.0%, respectively, reported that the hysterectomy had completely or mostly resolved the problems or symptoms they had before surgery; 93.3% and 93.7%, respectively, reported that the results were better than or about what they expected; 85.3% and 81.6%, respectively, reported that their health was better than before the hysterectomy; and 87.9% and 93.1%, respectively, reported being totally recovered.**

After reviewing your symptoms that have led you to review this document, it is only you who can decide whether your life could be significantly improved by eliminating the gynecologic problems that brought you to this point. If your problems do not impact the quality of your life, then there is no benefit to surgery. If you have significant room for

improvement, then make the decision to create a new life for yourself. You definitely deserve it.

Will I be happy after I have a hysterectomy?

The highest probability is that you will forget that you had a hysterectomy because your uterus will no longer be a source of pain or pressure or bleeding or cancer. Because I only do hysterectomies on women who will, based on medical evidence and feminist principles, benefit from them, my patients are healthier after their surgery than they were before. Ask any of them.

Cancerous or pre-cancerous problems of the ovaries, uterus or cervix:

Cancer or pre-cancer of the uterus – When cancer grows inside the uterus, both the womb and the ovaries must be removed in their entirety because they are lymphatically connected and can allow easy spread to the other organ. The cervix cannot be left in as any type of uterine or ovarian cancer can spread to the cervix, making it Stage II rather than I. If a pre-cancer of the uterine lining is present, it is appropriate in many cases to employ one or two 3-month trials of progesterones to regress the overgrowth of the lining. This therapy is successful in about 80% of women who do not have tiny areas of early cancer reported in their uterine biopsy. If there is still precancerous overgrowth of the lining after two progesterone trials, then a laparoscopic hysterectomy will be useful in preventing the progression to a cancer later on.

Increased risk of uterine or tubal cancer – If you have an extensive family history of women developing uterine cancer, whether from obesity, or for genetic mutations (HNPCC or BRCA), removing your uterus can prevent another operation later, prevent bleeding management problems, and potentially save your life. While BRCA mutations most typically involve new cancers of the fallopian tubes and/or ovaries, reports have been published of papillary serous (ovary-like cancer) cancer of the uterus. Since uterine cancer is the most common cancer women get in their pelvis, consideration for removal, especially in the presence of other risk factors, is reasonable. One final reason, for women with tendencies to get PMS or breast cancer, is that any uterine bleeding in the perimenopause or menopause is treated with progestins (the hormonal stimulant for PMS).

Pelvic mass, infection, cancer or pre-cancer of the ovaries – A pelvic mass must be examined by both physician and ultrasonographer to determine if it is a cancer of the ovary. If the strict criteria for a benign growth are met and no worry for cancer is present, then no surgery is needed, unless the mass is huge and imposes by its size or causes pain by twisting. Many women's ultrasound picture falls into the gray area of pelvic masses – that is, their ovarian masses have one or two features of a malignancy, but appear otherwise probably benign. These tumors must be surgically investigated by removing them laparoscopically and giving the tumor tissues to the pathologist to examine under

the microscope during the surgery to see if a malignancy is present. While most are indeed benign, some are found to be malignant in the earliest stages.

If a cancer is found in an ovary, then the entire uterus and both of the ovaries must be removed, with the appendix, the lymph nodes and a fatty pad in the abdomen called the omentum because ovarian cancer likes to spread there. This is not negotiable, except for one case; unless you have a very rare, early stage of ovarian cancer that is a very mild type and you have never had any babies, and plan to. In this rare situation, the ovary can be removed and the cancer staging procedures done, but the other ovary and the uterus are left in for fertility without risk to the patient.

Pre-cancer and cancer of the cervix – Recurrent abnormal pap smears which have been fully investigated by thorough colposcopic (magnified) examination can often be treated by removal of the uterus. This reduces likelihood that the pre-cancer will return and reduces chances of either ovarian or uterine cancer. It is an optional treatment, however, and can sometimes be avoided by careful colposcopic Laser or Loop treatments, unless so many cervical treatments have already failed and there is very little cervix left. When cancer of the cervix is present, a specialized “radical” hysterectomy with a lymph node dissection is performed through the laparoscopes.