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Editorial

Hysterectomy – a life-saving as well as a life-enhancing operation?

John Studd

London PMS and Menopause Clinic, London, UK

Correspondence: Professor John Studd, London PMS and Menopause Clinic, 46 Wimpole Street, London W1G8SD, UK.
Email: harley@studd.co.uk

Hysterectomy with or without oophorectomy continues to receive a bad press in lay magazines as well as professional journals[1] when the facts belie such a judgement.[2,3] Hardly an article fails to inform the public that the operation commonly results in depression, loss of libido, anxiety and marital problems when in most cases and virtually all studies the opposite is true. It is clearly understood that the surgery should be performed competently for the appropriate indications of distressing cyclical symptoms of bleeding, pelvic pain, depression, PMS and fatigue possibly with co-existent fibroids, PID or endometriosis. These women who may only have had a few good days a month should have their life transformed by the surgery with appropriate hormone replacement. Frequently, their one regret is that it was not performed years earlier. With correct selection, the life-enhancing effect is no longer debatable but the life-saving claim is less accepted but equally logical.

Between 3% and 4% of women per year, about 5000, in the UK die of cancer of the ovary, cervix or endometrium including a small number with sarcoma. There will be the rare occurrence of ovarian/peritoneal tumours after oophorectomy but that does not diminish the argument if it is indeed valid. Endometrial cancer is becoming more common due to increasing age and obesity, ovarian cancer is increasing slightly and an increase in cervical cancer is occurring particularly in the less well-screened immigrant population.

There is of course a mortality associated with the surgery usually calculated as one in 3000 but if the 3–4% figure is correct, the mortality of not doing the operation is about one in 35 although these deaths will occur later in life. Such a comparison expressed in this way may be deeply shocking and to many an unacceptable and unpalatable deduction. But it is hard to refute. This is not to suggest a stampede out to perform prophylactic hysterectomies and oophorectomies in asymptomatic women with no complaints and who have a natural desire to keep their organs, but it is a plea that the many women who suffer distressful gynaecological symptoms for most of the month are given the chance of curative surgery, which is not seen as a treatment of last resort after years of failed medical and hysteroscopic treatment.

However, the key to this discussion is the benefits or risks of long-term hormone replacement in these premenopausal women. Much media attention was given to the meta-analysis showing that hysterectomy and bilateral oophorectomy was associated with more heart attacks, more strokes and a shorter life-expectancy.[4] The dangers of a premature menopause on the cardiovascular system have been known for about half a century, but still it is possible to read such publications reporting the effect of an early surgical menopause with no women receiving replacement estrogens. This is unsatisfactory clinical practice. Such data should not be used to form any opinion about the merits of surgery although it speaks volumes about unacceptable after care. It should be clear that a surgeon should not remove the ovaries in a premenopausal woman without prescribing appropriate replacement therapy otherwise the operation is as incomplete as a hysterectomy with the gynaecologist omitting to close-up the wound. Such treatment must be seen as palpably substandard. But even so there are commentators who miss the point that the cause of any increased long-term morbidity of this surgery is a failure to replace the missing hormones.

HRT like any effective treatment has side-effects but the serious problems appear to be a result of the progestogen component, which is not necessary after a hysterectomy. The estrogen-only arm of the WHI study showed a 28% decrease in breast cancer (0.43–1.07), a 42% decrease in heart attacks (0.3–1.03) and a 27% decrease in mortality (0.47–1.13) in women who stated HRT under the age of 60.[5] These apparent considerable benefits were not significant but what sort of conspiracy or incompetence led to the premature closure of this study at this point. That should be a topic for a future editorial.

The profession and the public should reconsider their hostility to a well-performed hysterectomy for appropriate indications followed by safe HRT. The operation performed in women with severe menstrual, emotional symptoms can be life changing and should not be delayed on doctrinaire grounds. It is also clear that removal of the ovaries in premenopausal women must, unless there are

very good reasons to the contrary, be supported by replacement estradiol and often testosterone because ovarian androgens have been lost. This was stressed many years ago and nothing has changed.[6]

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