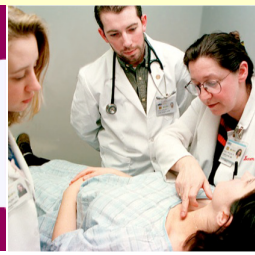
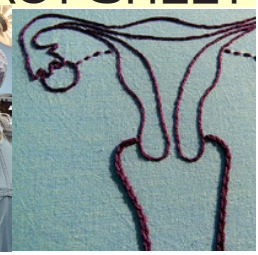
THE NATIONAL WOMEN'S HEALTH NETWORK

Hysterectomy

FACT SHEET





Background

Hysterectomy is the second most frequently performed surgical procedure (after cesarean section) for U.S. women who are of reproductive age. According to the Centers for Disease Control and Prevention (CDC), from 2006-2010, 11.7 percent of women between the ages of 40-44 had a hysterectomy.[1] Approximately 600,000 hysterectomies are performed annually in the United States, and approximately 20 million American women have had a hysterectomy.[2] By the age of 60, more than one third of all women have had a hysterectomy. The National Women's Health Network (NWHN) believes that unnecessary hysterectomies have put women at risk needlessly, and that health care providers should recognize the value of a woman's reproductive organs beyond their reproductive capacity and search for hysterectomy alternatives before resorting to life-changing operations. Quoted in the Los Angeles Times, NWHN Executive Director Cindy Pearson says, "I advise any woman who is not in a life-threatening situation to see someone else besides a surgeon to explore nonsurgical options first."

When a Hysterectomy Seems Necessary

So, when is a hysterectomy medically necessary? It may be a medically necessary procedure in the case of several life-threatening conditions:

- Invasive cancer of the uterus, cervix, vagina, fallopian tubes, and or ovaries
- Unmanageable infection
- Unmanageable bleeding
- Serious complications during childbirth, such as a rupture of the uterus

If alternative treatment options (see "Hysterectomy Alternatives" section below) are not viable and a hysterectomy is necessary, it is important to initiate open communication with your health care provider regarding the specifics of your situation. Here are some important questions (adapted from The Woman's Guide to Hysterectomy by Adelaide Haas and Susan L. Puretz) that you may want to ask your health care provider before you decide on a hysterectomy:

- What are the risks involved with this type of hysterectomy, and what is the success rate?
- How long will I be in the hospital? Can this procedure be performed on an outpatient basis?
- What type of surgery will be needed? [See below for more information about surgical options]
- How much will the operation and the follow-up care cost? Will these be covered

by my insurance? Will the care of any medical complications resulting from this operation be covered by my insurance?
- When can I expect to be fully recovered from the surgery? How will this surgery affect my sexual functioning?
- What might happen if I choose not to have surgery, or wait awhile to decide?
- How many of these surgeries have you performed? When was the most recent one?
- What type of anesthesia will be needed?
- Can someone (my partner/friend) stay with me while the surgery is being performed?
- Am I at risk for ovarian cancer and if not, is it necessary to remove my ovaries?

Types of Hysterectomy

Partial Hysterectomy : removes the body of the uterus while the cervix is left in place.

Total or Simple Hysterectomy: removes the entire uterus and cervix.

Hysterectomy with Bilateral Salpingo-Oophorectomy: removes the uterus, cervix and fallopian tubes

Radical Hysterectomy: removes the uterus, cervix, ovaries, fallopian tubes and possible upper portions of the vagina and affected lymph glands.

Hysterectomy Surgical Options

Your healthcare provider will discuss different potential surgical options for hysterectomies. You may have a hysterectomy performed as an in-patient procedure, or you may have a hysterectomy performed as an outpatient procedure. In 2008, approximately 18% of all hysterectomies were performed as a same-day outpatient surgery.iii If you and your healthcare provider decide that a hysterectomy is the best treatment option, you can read about the four different types of hysterectomies below. Most of the research literature indicates that vaginal hysterectomies have better outcomes and fewer complications, but whether you can choose this procedure is dependent on feasibility and the condition for which you are being treated.

Vaginal Hysterectomy describes a surgical procedure in which the uterus is removed through the vagina. One or both ovaries and fallopian tubes may be removed during the procedure, as well. This surgical approach avoids visible scarring and typically allows for a quicker recovery, as well as less postoperative pain and complications as compared with other types of hysterectomy. Risks associated with the vaginal approach include a slight but serious risk of shortening or damaging the vagina. Vaginal hysterectomy has also been shown to be the most cost effective form of procedure.

Laparoscopic-Assisted Vaginal Hysterectomy employs video technology to provide the surgeon with greater visibility when removing the uterus through the vagina. The laparoscopic-assisted approach entails three small external incisions: one in the navel, through which the laparoscope (small video camera) is inserted, and two others in the lower abdomen for the use of surgical instruments. This procedure may be preferred because of the rapid healing time, a less noticeable scar, and less pain, although actual surgery time is longer than the abdominal approach. Because of the longer time in the operation room and the use of extra electronic equipment, this procedure is also costlier than others Risks associated with the laparoscopic-assisted vaginal approach include a slight risk of bladder injury and urinary tract infection.

Abdominal Hysterectomy is fairly standard and remains the most common approach for removing the uterus and other reproductive organs. When performing an abdominal hysterectomy, surgeons can either use a vertical incision or a “bikini cut” incision depending on the scope of the surgery. The vertical incision cuts vertically from the navel to the pubic hair line, while the “bikini cut” is a horizontal incision made directly above the pubic hairline. The abdominal hysterectomy approach results in a longer recovery period and more noticeable external scarring but requires less specialty surgical skill.

Laparoscopic-Assisted Abdominal Hysterectomy requires only one incision for both the

laparoscope and the removal of the uterus. This approach is an alternative to the three-puncture laparoscopic-assisted vaginal approach; however, the laparoscopic-assisted abdominal approach is only appropriate for a supracervical hysterectomy (meaning the cervix is healthy and does not need removal). The laparoscope has the potential to be a useful tool for total and radical hysterectomies as well, however most surgeons prefer the traditional abdominal approach for these procedures.

Robotic-Assisted Laparoscopic Hysterectomy requires three to four incisions near the belly button. A laparoscope is inserted, and the surgeon performs the procedure from a remote control area. This procedure results in smaller scars, but the procedure has not been shown to have better surgical outcomes. Rates of discharge from the hospital to a nursing facility were similar to other surgical options for hysterectomies. It is also significantly more costly than the other types of hysterectomies.

Surgical and Post-Surgical Risks

Although the death rate from hysterectomy is low (less than 1 percent) surgical complications are very real and can result in any of the following: infection, hemorrhage during or following surgery and/or damage to internal organs such as the urinary tract or bowel. Patients have a 30% chance of complication (typically infection or fever) while in the hospital and a significantly lower risk of more serious complications such as hemorrhage or bladder and bowel damage depending on the individual's condition and the surgical approach taken.

Long-term Risks

Removal of the uterus and ovaries at a young age (early forties and younger) may increase the risk of a heart attack, stroke, and (even when ovaries are not removed) the chances of experiencing an earlier menopause. Hysterectomy has also been associated with urinary problems, such as increased frequency of urination, incontinence, fistula, and urinary tract infections; sexual function problems, such as decrease in sexual sensations and lack of lubrication; depression or psychological stress (stemming from feelings associated with losing reproductive organs); hormone deficiencies (which may be caused by removal of the ovaries), or a decrease in blood supply to the ovaries. There is not enough consistent evidence to know what the effects that a hysterectomy has on sexual function.

Long-term consequences

All four types of hysterectomies require the removal of the uterus. Therefore, once a woman receives a hysterectomy, she can no longer have a biological pregnancy.

Hysterectomy Alternatives

For each of the conditions listed below, you may want to talk to your physician about an approach called "watchful waiting." If your condition is not causing problematic symptoms, you may want to closely observe your symptoms without initiating active treatment. Many women are treated for conditions that do not necessarily require treatment, and the side effects of these treatments can cause more health problems than the actual condition. In many circumstances, you can carefully observe if and how the condition changes, or is, hopefully, naturally eliminated.

Fibroids

There are many treatment options for shrinking or removing uterine fibroids without removing reproductive organs. These include using anti-estrogen drugs, uterine artery embolization (UAE) laser ablation of uterine fibroids, cryosurgery, and myomectomy. For more information on fibroids, click here.

Cancer

Hysterectomy is often necessary and life preserving when invasive cancer is diagnosed; however, hysterectomy is frequently recommended when cancer is neither invasive nor life threatening. For pre-cancerous cells, there are a few options that you and your health care provider should discuss. Loop Electrosurgical Excisional Procedure (LEEP) can be used to remove pre-cancer-

ous cells, and cryosurgery can be used to treat non-cancerous growths and abnormal tissue. For early invasive cervical cancer that has not spread to other regions, a radical trachelectomy (the removal of cervix or the neck of the uterus) can be performed in lieu of a total hysterectomy.

Excessive Endometrial Lining

Endometrial ablation can be used to remove excess endometrial lining. Dilation and Curettage (D&C) can also be used to remove the lining or abnormal tissue.

Endometriosis

Operative laparoscopy is a surgical procedure that can generally be done on an outpatient basis to remove endometrial growths and adhesions. Pain medication, hormone therapy, and other conservative surgical procedures can also be used to control any discomfort associated with endometriosis.

Uterine Prolapse

According to MedlinePlus, an information service of the National Institutes of Health (NIH) a vaginal pessary (an object inserted into the vagina to hold the uterus in place) can be used as a temporary or permanent form of treatment for a prolapsed uterus (MedlinePlus). Vaginal pessaries are available in many shapes and sizes and must be individually fitted. A surgical procedure called a "suspension operation" can also be performed to lift and reattach a descended uterus, and often a fallen bladder or rectum as well. Health practitioners suggest that Kegel exercises can be a powerful prevention and treatment tool for strengthening uterine muscles and avoiding prolapse.

Removing Ovaries

Often when getting a hysterectomy, doctors might suggest removing the ovaries to prevent ovarian cancer down the road. This, however, is not always medically necessary unless you are at risk for ovarian cancer or have a family history of ovarian cancer. While removing the ovaries does eliminate the risk for ovarian cancer, it may contribute to increased risks of heart disease and death. According to Our Bodies, Ourselves, ovarian cancer accounts for 14,700 deaths per year in the United States but heart disease accounts for considerably more at 326,900 per year and strokes causing 86,900. Conserving the ovaries during a hysterectomy should be carefully considered based on personal medical history and should be discussed with a physician before opting for removal.

Contact Us

The National Women's Health Network is committed to ensuring that women have access to accurate, balanced information. For more information, email us at healthquestions@nwhn.org or call the Women's Health Voice at (202) 682-2646. Stay informed, connect with us on Facebook and Twitter.

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