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Three Cheers for Elective Hysterectomy

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Recently, another barrage of media stories appeared bemoaning the number of hysterectomies done in the United States. Almost all experts agree that there are too many hysterectomies, but there is little agreement on which ones should not have been done.

Hysterectomy is the second (after cesarean section) most commonly performed major surgical procedure in the United States today.[1] About 650,000 American women will have hysterectomies in 1989. Thirty-seven percent of all US women will have had a hysterectomy by the time they reach age 60. The number of hysterectomies increased dramatically from 1965 to 1975, but then leveled off and decreased to the present level of about 7 per 1000 women. The highest rates occur in women aged 35 to 44 years, the age group the so called baby boomers are now entering in large numbers. Therefore, if the age-specific hysterectomy rates remain the same, the number of hysterectomies will increase to 810,000 in 1995 and 854,000 in 2005.[1]

Hysterectomy is also one of the most controversial surgical procedures. Disagreement exists, not only on appropriate indications for the procedure, but also on indications for vaginal versus abdominal routes, and for concomitant oophorectomy. Much heated debate centers on what exactly constitutes an "elective" hysterectomy. For years much criticism has been directed to gynecologists by government agencies, third-party payers, professional societies, and women's advocacy groups for doing unnecessary hysterectomies. One of the most debated issues is how to interpret the observed differences in hysterectomy rates in different regions of the country. In 1982, the Northeast had the lowest rate, slightly more than 4 per 1000, compared with more than 10 per 1000 in the South, and 7 per 1000 in the North Central and West.[2] The startling difference between the rates in the Northeast and the South has put the spotlight on southern physicians whose practices have undergone intense scrutiny. Despite many different approaches, we still do not understand the reason for these differences, although factors relating to both physicians and patients have been considered.

As a woman who lives in the South, I have a special interest in hysterectomy practices in this region. During a three-year period, 1983 to 1985, a large number of my friends, working colleagues, or their wives had hysterectomies. I was surprised that I personally knew so many women having hysterectomies and wondered if, indeed, this surgery was done much more often than necessary in Atlanta. I did an informal survey of 22 women I knew who had had hysterectomies. I tried to interview them approximately one year after the procedure. I asked them the reason for the surgery, how they felt before and one year after, and if any complications had resulted. The women ranged in age from 33 to 42. All but two had children and had completed their planned childbearing. One of the women without children had never been married, and the other was divorced. Neither had intended to have children.

For 19 of the women, the reason for the hysterectomy was heavy bleeding, often painful, either due to fibroids or endometriosis. Each detailed long histories of heavy bleeding. Sixteen of the 19 had had more than one dilation and curretage either for control of the bleeding or for diagnostic reasons. Many described pain, tiredness, exhaustion, anemia, and the need for daily iron supplements. All of the 16 described episodes of bleeding that were not controlled by tampons and sanitary napkins used together. Ten of the women described many embarrassing moments with blood stained clothing, either at work or in public. The reason for hysterectomy in the other 3 women was prolapse of the uterus in 2 and suspected endometrial cancer in the third.

Of the 22 women, all were relieved and happy that they had had hysterectomies. Many commented, "I should have done it sooner." None expressed regrets, although most were worried before surgery either about the danger or that they would lose something important. None reported decreased sexual enjoyment after hysterectomy. Many said that their sex lives were renewed because pain and bleeding were no longer present. Others reported no noticeable change in their sexual lives. One woman said that she had bought a white suit for the first time in her adult life, since she no longer had to worry about unexpected or uncontrolled bleeding.

After hearing each of the women's stories and how improved their quality of life was after hysterectomy, I accepted that the hysterectomies were justified, even though the underlying conditions (except for one) were not life threatening. I was happy that these women ultimately had the ability to control these events in their lives. I make no claim that this is a scientific study. These are a series of anecdotes from women I knew or came to know personally. I expect many would disagree with me and might have judged one or more of these hysterectomies unnecessary. I am neither a surgeon nor a gyneclogist. I do not and will not perform hysterectomies. I also do not advocate and am adamantly opposed to

unnecessary surgery.

What worries me is that some august body of physicians, politicians, third-party payers, or consumer advocates will try to enshrine their notion of what a "necessary" hysterectomy is and is not. I believe that the decision for hysterectomy should rest with a woman and her gynecologist. I don't think we need more regulation on this issue. What we need to do is educate women on the various risks, benefits, and alternatives to hysterectomy. An educated consumer will be the best regulator of the market for elective hysterectomy. Each woman contemplating elective hysterectomy should be given a consent form well in advance of the anticipated hospitalization for surgery. The consent form should include the risks of the procedure, the potential benefits, and the alternatives to hysterectomy for her particular condition. She can then balance these for herself and make an informed decision at her leisure. To deprive women of the choice of elective hysterectomy based on someone else's opinion that it is unnecessary would be a terrible setback for women trying to control their lives. Let us be wary of those who state they are trying to protect us from unscrupulous doctors doing unnecessary hysterectomies for greed motives. Who should be the judge concerning what is necessary, especially when it affects the quality of our lives? Right now it should be a woman and her doctor.

Three cheers for elective hysterectomy—but only when it is necessary of course!

References

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2. Easterday CL, Grimes DA, Riggs JA: Hysterectomy in the United States. *Obstet Gynecol* 1983;62:20