

What's New in Gynaecology?



Sydney Women's Endosurgery Centre

An Update for General Practitioners

Sydney Women's Endosurgery Centre www.swec.com.au

Hysterectomy: Myths and Facts

Dr David Rosen

According to Government statistics^{1,2} an average of 43,500 hysterectomies were performed in Australian Private and Public hospital settings in 2008-9 and 2009-10, the most recent years for which figures are available for public hospitals, thus making hysterectomy a very widespread and common procedure. Yet despite this prevalence, there remains a great deal of misleading information regarding this commonly performed operation and a number of misconceptions that our patients often have;

MYTH: Hysterectomy causes menopause

FACT: This is perhaps the most common erroneous belief that exists in the non-medical community. As clinicians, we are often faced with shock or even outright anger when "hysterectomy" is mentioned as a suitable option for management of certain gynaecological conditions (see box). "I don't want to get all shriveled up" is a direct and oft heard quotation from patients! The fact of the matter is that hysterectomy involves the removal of the uterus(+/- cervix) only—the ovaries, the source of oestrogen (and progesterone) in the premenopausal woman, remain intact. The hysterectomy does NOT cause immediate menopause. The currently available evidence³ from a study of 900 women (roughly half post-hysterectomy, half controls) at Duke University found the age of onset of menopause to be brought forward by anywhere up to 2 years earlier in the post-surgical group. It was not stated what form of hysterectomy they had nor whether this finding was due to the disruption in distal blood supply (from the uterus) or the underlying disease that prompted the need for hysterectomy (eg. Endometriosis). At SWEC we are mounting a study of the same issue post-laparoscopic hysterectomy to determine if the minimally invasive approach shows any difference.

Table 1:

Indications for Hysterectomy

1. Menorrhagia
2. Dysmenorrhea esp. Endometriosis
3. Metromenorrhagia (irregularly frequent and heavy bleeding)
4. Fibroids/ pressure symptoms on bowel/bladder
5. Prolapse
6. Contraception (rarely a primary indication but often combined as a benefit with other indications)
7. Malignancy
8. Prophylactic hysterectomy to allow oestrogen only therapy in the post-menopausal woman
9. Combinations of the above factors

MYTH: The uterus is too big for a laparoscopic hysterectomy

FACT: This is a relative concept and depends largely on the skill of the individual surgeon. What may be too big for one gynaecologist is routine for surgeons who are used to dealing with larger uteri. In general, the ability to remove a uterus laparoscopically without the need for a laparotomy incision depends upon the ability to safely manage the vascular supply to the uterus (uterine and ovarian vessels) and the morcellation required to remove the large specimen from the body. With these skills, uteri anywhere from 400g up to 3kg have been laparoscopically removed!

...continued over

MYTH: Hysterectomy requires 6 weeks recovery with minimal activity

FACT: The idea of minimally invasive surgery (Laparoscopic/Robotic and vaginal hysterectomy) is a rapid return to normal activity. Average post-operative stay after Total laparoscopic hysterectomy at SWEC is 2.1 days with return to work or normal activity after 21 days. Furthermore the enhanced view afforded by the laparoscope combined with surgical expertise has allowed a low rate of complications. No surgery is without risk and at a tertiary referral centre, cases are often at the more difficult end of the spectrum, however our data indicates a major complication rate of under 1%. This compares favourably with data from larger studies comparing abdominal hysterectomy (6.2% major complication rate), vaginal hysterectomy (9.5%) and laparoscopic hysterectomy (11.1%).⁴

MYTH: Hysterectomy is my only option

FACT: Of course this is untrue. All options should be and are explored. First & foremost, hysterectomy is NEVER an option if one is uncertain of whether ones family is complete. Secondly, some patients may pose such an anaesthetic risk that all options should be explored before resort to hysterectomy. Nonetheless for many of the conditions listed above, hysterectomy provides a 100% solution. No more periods, no more pain, no risk of conception (and unless there have been previous cervical abnormalities, no further pap smears). Medical therapies are often tried with varying degrees of success, however much as no surgery is without risk, all medication has side effects and these too must be discussed.

An interesting development has been the recent debate over hysterectomy in the post-menopausal woman to allow the use of Oestrogen only replacement and thus avoid the small but documented increased risk of breast cancer in those using combined HRT (oestrogen + progesterone—necessary if the uterus remains).⁵

MYTH: After hysterectomy I will no longer get PMS

FACT: As the ovaries remain, so will menstrual “cycles” if not the end result i.e. menses. In most cases however, our patients report a significant diminution in the severity of these symptoms once the uterus is removed.

MYTH: Hysterectomy will affect my orgasm (or bowel/bladder function)

FACT: In general, this is completely untrue. Data from a number of prospective trials⁶ indicates no difference in sexual function pre or post hysterectomy. Specifically claims of a loss of “uterine” orgasm seem specious in that female orgasm involves a combination of autonomic and central nerve stimulation to the skeletal muscles of the pelvic floor and diaphragm as well as possibly smooth muscle in the walls of the vagina and anus. There is no evidence that “uterine” contraction adds to the depth or sensation of orgasm. Indeed uterine contractions, usually associated with menstruation or labour, are rarely reported as pleasurable events. Nonetheless it may be that some women regard this combination of sensations as part of

their sexual experience and that may be affected if the uterus no longer exists. By contrast, the freedom from heavy, lengthy or painful periods may enhance libido and therefore sexuality in many women. In post-operative sexual questionnaires we collect from our patients at SWEC no difference has been documented.

Pelvic surgery however may have an effect on bowel and bladder function. Once again, in individual cases especially those with extensive endometriosis or large uteri it is plausible that the autonomic plexi of nerves within the pelvis are damaged and this may occasionally result in alteration to visceral function, usually only temporary such as constipation or reduced bladder sensation, which recovers over 16 months. Search of the medical literature indicate wildly conflicting evidence supporting or refuting these claims. Because every woman is different and thus every operation different, huge numbers are required for any surgical study to draw meaningful conclusions when small differences are involved.

MYTH: You cannot have a laparoscopic hysterectomy if you have had Caesarean sections

FACT: Not only is this false but the complete opposite is true—not only can you have a keyhole procedure if you have had previous Caesarean sections, you should. Previous abdominal surgery can cause adhesions of the bladder to the cervix or bowel adhesions within the abdominal cavity either to the abdominal walls or the tubes and ovaries. Laparoscopy once again affords magnified and proximate views of altered anatomical structures allowing more precision in dissection. In terms of previous Caesarean sections, they are often quoted as a reason not to have a vaginal hysterectomy (the rationale being that the scarring obscures the surgical planes between cervix and bladder making inadvertent perforation more likely) in favour of an abdominal approach. Our aim is to give women the opportunity to have keyhole rather than open surgery.

The same holds true for overweight and obese patients, those who have had abdominoplasty (tummy tucks) and umbilical hernias repairs—none of these are contraindications or indeed even pose a risk for laparoscopic surgery. Obviously we have a bias, but we are not alone. In 2010 the American Association of Gynecological Laparoscopists released the following position statement⁷:

“ Conclusion

It is the position of the AAGL that most hysterectomies for benign disease should be performed either vaginally or laparoscopically and that continued efforts should be taken to facilitate these approaches. Surgeons without the requisite training and skills required for the safe performance of VH or LH should enlist the aid of colleagues who do or should refer patients requiring hysterectomy to such individuals for their surgical care. ”

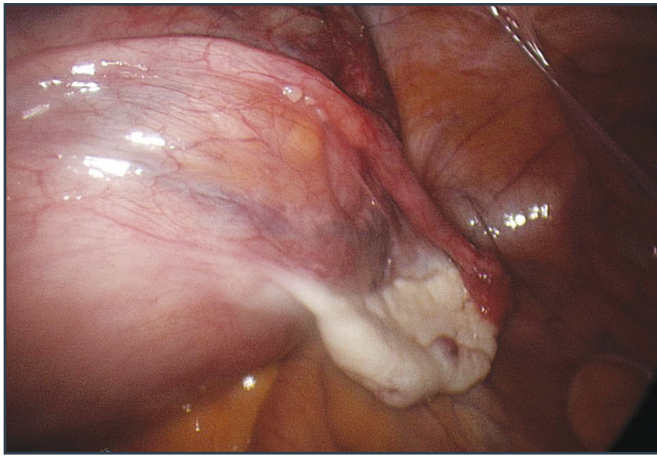


Fig 1.
Uterine fundus,
right tube and
ovary at laparo-
scopy prior to
laparoscopic
hysterectomy.
The uterus
weighed 1.5kg!

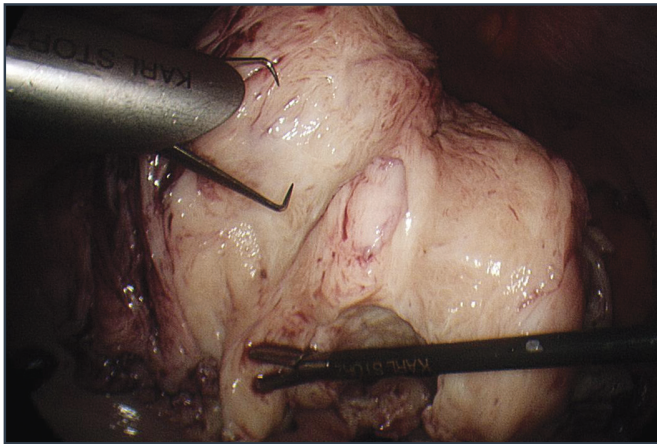


Fig 2.
Morcellation of
the same uterus
after pedicles
freed, to allow
removal from
the abdominal
cavity via the
laparoscopic
ports.

MYTH: Subtotal hysterectomy is better/worse than complete hysterectomy

FACT: Leaving the cervix can reduce the potential risk of ureteric damage at hysterectomy and may make recovery slightly quicker, especially with laparoscopic hysterectomy, because the peritoneal cavity is not exposed to the external environment. It does however mean pap smears will have to be continued, that the uterus will need to be morcellated for removal rather than passing through the colpotomy incision (vaginal opening) and can cause continued menstrual spot bleeding until the menopause. There is no evidence that sexual function is altered whether the cervix remains or is removed with the uterus.⁸

MYTH: Ovaries should/should not be removed at the time of hysterectomy

FACT: Postmenopausal ovaries produce low levels of oestrogen and androgen. Conflicting data exists but the current consensus is that ovaries are conserved in woman under 65 years.⁹ The overall risk of ovarian cancer in Australian women is 1% and prophylactic oophorectomy will reduce (but not entirely remove) these risks, however those with a family history or with concerns due to close experience in friends may outweigh these considerations. It also worth considering if there are contra-indications to the use of post-operative oestrogen replacement before oophorectomy is recommended.

Evidence is also gathering that a proportion of malignant ovarian tumours may arise from the fallopian tube and consideration to salpingectomy at the time of hysterectomy should now be given.

A Final Note

TOTAL Hysterectomy means removal of the uterus and cervix—it DOES NOT mean nor refer to the tubes and ovaries. That would be a Hysterectomy and USO or BSO—unilateral or bilateral salpingo-oophorectomy. This is perhaps the most common misconception associated with hysterectomy.

What's Coming Up at SWEC?

SWEC is delighted to announce the opening of a new service for women of the North and North Western suburbs. From May Drs Cario, Chou and Rosen have been consulting and operating at Macquarie University Private Hospital. Macquarie Private Hospital is a state of the art facility with the latest in surgical and medical technology available. Most notably, our surgeons will be able to offer Robotic surgery and we will keep you updated on any changes in the variety of robotic cases approved for rebate. At Macquarie we will be concentrating on consultations for menstrual abnormalities and difficult or challenging hysterectomy such as for large fibroids, prolapse, incontinence and endometriosis surgery as well as our usual focus on all aspects of gynaecological care.

For all appointments with our surgeons at Macquarie Private Hospital Medical Centre please call 9887 8899 or the Doctors' Rooms.

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SWEC

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Who are the Sydney Women's Endosurgery Centre (SWEC)?

SWEC is a group of Sydney Gynaecologists dedicated to excellence and innovation in minimal access surgery for women.

The associated surgeons have all trained and practiced extensively in laparoscopic surgical techniques both here and overseas and SWEC is seen around the world as a leading centre of gynaecological endoscopic surgery. Two Fellows in laparoscopic surgery are employed full time by SWEC working at St George Private and St George Public Hospitals, and visiting Fellows who spend from 1 to 2 years learning the surgical techniques we practice. Indeed our former Fellows have returned to the UK, Ireland, Saudi Arabia, Israel and India to set up endoscopic practices of their own.

SWEC Surgeons practice in private and public hospitals throughout the east, south and west of Sydney. As gynaecologists only they spend all their time involved in major gynaecological surgery including:

- Surgery for pelvic pain and endometriosis
- Removal of fibroids and difficult hysterectomy for pain or heavy menstrual bleeding
- Surgery for prolapse
- Incontinence procedures, amongst others

We strongly believe that advanced gynaecological procedures should be performed by surgeons who specialise in these cases.



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