

Northwest Gynecological Oncology

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REDUCING UNNECESSARY HYSTERECTOMY RATE

Hysterectomy (surgical removal of the uterus) is the most common gynecologic surgical procedure. About two thirds of women over age fifty have had a hysterectomy. Some of them do not know exactly why. Research shows that compliance with guidelines to reduce unnecessary hysterectomies is low among gynecologists. Following are some of the more common reasons to perform a hysterectomy, including diagnostic steps used to avoid hysterectomy when it is not essential.

Malignant Growths

1. Cancer of the corpus. Highest survival with surgical staging first +/- radiation:
 - Endometrial cancer
 - Uterine stromal sarcoma (leiomyosarcoma, stromal sarcoma, MMMT)
2. Endometrial hyperplasia is only precancerous, and most often, even when severely atypical, safely regressible with Progesterone (P4) to conserve fertility. Do hysterectomy if not fertile, or if patient intolerant of P4 or if repeated endometrial biopsies show persistent disease. If P4 okay, use natural progesterone 300-400 mg daily for three months and resample the endometrium. If not regressed, can try another three months and resample. Hysterectomy if not regressed. Oophorectomy advisable here.
3. Cancer of the cervix:
 - Lesion <3mm need only cone, but hyst should be done if non-reproductive - individualize.
 - Stage IB1 vertical spread to uterus common, always radical hyst or radiation - possible in some very small cervical cancers to conserve uterus by a radical trachelectomy with node dissection.
4. Epithelial cancer of the ovary. Metastatic spread to myometrium and endometrium. Exception is stage IA, grade 1 (tumor confined to one ovary, well differentiated, Px is 95%) in reproductive aged woman, just do unilateral oophorectomy and stage thoroughly. She should have her children then later have hyst and other ovary out.
5. Germ cell cancer of the ovary in young woman: no hyst, just do unilateral oophorectomy and stage thoroughly (if dysgerminoma look hard for bilateral spread).

Benign Growths

1. Fibroids - that bother the patient because of size or location:
 - Size which causes pressure on bladder, pressure on rectum, low back pain, pain that radiates, hydroureter.
 - Location which causes pressure on bladder, pain, excessive bleeding. Reasonable to resect some myomas that cause symptoms if fertility is goal. Procedure entails more blood loss than hysterectomy, can leave mangled uterus, adhesions and pain. Surgeons prefer hysterectomy because it follows plains of dissection, less blood loss, and prevents and removes likely future problems.
2. Polyps - that cause irregular or excessive bleeding. Reasonable to resect polyps hysteroscopically. Some recurring types may require hysterectomy or if on tamoxifen for 5 years.

Functional Problems

1. Dysmenorrhea - which impacts quality of life. Trial of NSAID's and OCP's before consider surgery. If endometriosis, remove ovaries too, to reduce pain with highest probability of success.
2. Bleeding - which impacts the quality of life. First rule out a neoplastic problem: cancer, hyperplasia, fibroids, and polyps. Then, investigate whether hormones have been regulated well before consider surgery: OCP's, P4,

Structural and Anatomic Problems

1. Prolapse of the uterus - which bothers the patient; uterus droops between legs. Most successful surgery to repair includes hysterectomy with tacking the vaginal apex to the sacrum or uterosacral ligament.
2. Prolapse of the bladder - which bothers the patient; anterior vaginal wall with bladder beneath it droops into vagina, associated with pressure and incontinence frequently. First try pessary. Vaginal hysterectomy with Kelly plication effective for prolapse alone, but less effective in curing associated incontinence. Hysterectomy is part of procedure but not a must for best success. Laparoscopic Burch better if incontinence.
3. Stress urinary incontinence - which impacts the quality of life. Similar to bladder prolapse. Try pessary. Estrogen ring or cream can reduce incontinence, and urgency in about half of women. Best success if tack the vaginal walls anteriorly to pubic bone ligament (Laparoscopic Burch Procedure) to improve urethral closing pressures.
4. Prolapse of the rectum - which bothers the patient; posterior wall of vagina droops into the vagina and makes evacuation of rectum difficult. Try placing thumb into vagina and popping stool out posteriorly. Most easily treated by vaginal hysterectomy with posterior repair, but posterior repair possible and equally successful performed alone.
5. Adhesions - pulling positional pains or cramping intestinal pains.
6. Endometriosis - monthly pains. After fertility, hysterectomy/oophorectomy offer highest probability of relief.

When the Ovaries Must Be Removed

1. Family history of ovarian carcinoma - Br Ca 1 or 2 positivity, or extensive and young family history of breast and ovary carcinoma or just ovary carcinoma.
2. For relief of Premenstrual Migraines or other severe premenstrual syndromes that impact quality of life. Want to avoid systemic exposure to P4. Remove uterus so won't need P4, and ovaries to halt P4 secretion. Possible and expensive to use Lupron to halt ovarian P4 secretion, give oral/patch estrogen to ablate hot flashes, and use Progestasert IUD to keep uterine lining safe.
3. Benign ovarian pathology - endometriosis, simple ovarian cysts (.3% malignancy).

There is no need to remove the uterus from a patient with a benign cyst unless she consents, aware that hysterectomy is optional. This is very reasonable.

Ovarian cysts resolve in over 50% of cases, so repeat the sonogram in 3-4 weeks and respond to persistent findings. Simple cysts under 6-8 cm with negative Ca 125 are benign. Can leave these alone, and get yearly sono. When Ca125 is over 200, and when cysts have any solid component or septae, laparoscopic resection is advisable.

4. Suspicious ovarian morphology - complex cysts (septae, thick walls, free fluid: all raise suspicion of malignancy to >8%, solid areas raise malignancy risk to 33%). Must remove laparoscopically intact, with Oncologist available to stage.
5. Pain associated with menses can be resolved with the highest chance of success only with removal of the ovaries.
6. Breast cancer at any age. Removal can reduce new or recurrent breast cancer by as much as 50%.

Routes of Removal

1. Total abdominal hysterectomy: Incision on abdomen, any size uterus, and any parity. Stay in hospital about 4 days, full function in 5-6 weeks. Abdominal scar.
 - Standard Pfannenstiel incision: low transverse on skin and vertical separation between rectus muscles. Good for benign surgery, moderate fibroids.
 - Cherney or Malard incision: low transverse on skin and transect muscles near insertion onto pubis. Good for large fibroids, and malignancy staging.
 - Vertical midline or paramedian: Good for large fibroids, and malignancy staging.
2. Vaginal hysterectomy: Surgeon operates through the vagina, grasping the cervix and pulling it down to the outside to resect. Best only if parous (vagina stretched), smallish uterus. Hard to remove ovaries by this route sometimes, but quick recovery and no scar. Usually 2 days in hospital, 2-3 weeks to full recovery. Not for cancer because can't explore upper abdomen.
3. Laparoscopic Assisted vaginal hysterectomy: surgeon operate through the scopes to disconnect the ovaries and check upper abdomen for problems, then completes the hysterectomy operating through the vagina as above. The laparoscopic approach allows definite removal of ovaries from vaginal hysterectomy route. Must be parous because uterus

removed surgically through vagina. Usually 2 days in hospital, 2-3 weeks to full recovery. Cancer of endometrium and early ovary okay this route.

4. Total laparoscopic hysterectomy: Surgeon disconnects the ovaries and uterus operating through the scopes placed through four half inch incisions in abdomen. The tissue is delivered through the vagina after it has been disconnected. The laparoscopic approach is possible regardless of parity. Any size uterus. Hospital for 2 days, full recovery in 2-3 weeks. Cancer of endometrium and early ovary okay this route.