ABSTRACT

Title – Psychosocial Problems of Women who had Undergone Hysterectomy

Hysterectomy is the removal of the uterus and, in most cases, the cervix (neck of the uterus). When ovaries and tubes are also removed along with the uterus, the procedure is known as hysterectomy and bilateral salpingo–oophorectomy. Women who undergo hysterectomy face a multitude of physical and psychosocial problems both before and after the hysterectomy. The present study explores the effects of hysterectomy on the quality of life of women in terms of its effect on the social, familial, occupational and emotional aspects.

Objectives - The objectives of the study were:

a) Literature review in order to learn about the issues involved, current state of research in the field, clarify concepts and arrive at certain hypothesis.

b) Gain first hand information from women about the post-hysterectomy changes in their life through the case study method.

Methodology – an extensive and intensive literature review was undertaken. Key informant interviews were done to get all relevant information regarding the current trends in hysterectomy related issues. Four hospitals were selected for intensive study. These were two leading government hospitals with gynaecology department in Trivandrum namely, SAT hospital and Women and Children hospital Thycaud. Cosmopolitan hospital and GG hospital were the two private hospitals included in the study. Four detailed case studies were done of women who underwent hysterectomy in order to gain an understanding of the psychosocial problems they faced. Different types of cases were chosen to make the data collected as comprehensive as possible. Cases included those women who have had hysterectomy, hysterectomy and bilateral salpingo – oophorectomy, those who opted for HRT and those who did not. Women who underwent the hysterectomy at

least five years age were chosen in order to study the differences in problems with the passage of time.

Salient findings – it was seen that all women, regardless of the circumstances that lead to the hysterectomy and the type of surgery, faced varying degrees of physical and psychosocial problems. All of them suffered hot flushes and night sweats. They also gained weight although some were able to control the weight gain through diet and exercise. Other physical distresses reported included insomnia, breathlessness, tiredness, fatigue, muscular ache, joint pain and skin problems like dryness, loss of elasticity etc.

The psychological problems included mood swings, irritability, depression, tendency to cry easily, short-tempered behaviour and lessened self-confidence.

The post-hysterectomy sexual life differed from woman to woman. Some reported improved sex life since the hysterectomy put an end to heavy bleeding and pain. Since hysterectomy resulted in sterilization, they could also enjoy sex without contraception. However, in some cases, hysterectomy resulted in loss of libido and lack of interest in sex. Physical problems like vaginal dryness, soreness etc were reported.

PSYCHOSOCIAL PROBLEMS OF WOMEN WHO HAD UNDERGONE HYSTERECTOMY

(A Pilot Study)

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Introduction

Worldwide, reproductive health of women is considered an issue of vital importance and one that has wide spread implications on health, well being and development of the entire population. The concept of total reproductive health includes care for the girl child, addressing the special needs of adolescent girls, pregnancy related care, services related to abortion and infertility, prevention and treatment of gynaecological problems and care for menopausal and post-menopausal women, among other things. Unfortunately, contraception, pregnancy and childbirth continue to remain the focus of attention of most health care providers, researchers and policy formulators. Women who fall out of the reproductive age group, especially adolescent girls and menopausal and post-menopausal women are often neglected.

There is consensus among health care providers and researchers that women who undergo hysterectomy face physical, psychological, emotional and social problems in their post-hysterectomy life. Gynaecologists have looked into the physical after-effects of hysterectomy and psychiatrists and psychologists have explored the depression and other mental health problems encountered by women after hysterectomy. However few studies have explored the effects of hysterectomy on the quality of life of women in terms of its effect on the social, familial, occupational and emotional aspects.

The research problem and its relevance

Hysterectomy is the removal of the uterus and, in most cases, the cervix (neck of the uterus). When ovaries and tubes are also removed along with the uterus, the procedure is known as hysterectomy and bilateral salpingo – oophorectomy.

Indications for a hysterectomy are the following:

1. **Benign conditions where uterus is primarily involved:**

Dysfunctional uterus bleeding (DUB): It is heavy, prolonged or frequent bleeding of uterine origin in the absence of infections, tumours, pregnancy or associated medical conditions. (I.e., menorrgagia, metrorrhagia, or polymenorrhoea). Hysterectomy is not indicated unless bleeding is recurrent, severe & unresponsive to hormonal therapy and endometrial curettage on several occasions.

Adenomyosis: In the case when the uterus is bulky and presents with menorrhagia and dysmenorrhoea total hysterectomy is done in almost all the cases.

Uterine prolapse: Symptomatic vaginal relaxation, uterine descences, and prolapse are common indications for hysterectomy.

Uterine leiomyomas: This accounts for about 30% of hysterectomies.

Obstetric problems: Uncontrolled post partum haemorrhage, uterine rupture, uterine inversion and interstitial abdominal or cervical pregnancy may require hysterectomy to prevent death from haemorrhage.

2. Benign conditions where tubes and ovaries are primarily involved:

Pelvic inflammatory disease (PID): In parous women over 35 years of age, total hysterectomy is preferred if there is fixed retro- displacement with adnexal masses or if there is persistent chronic cervitis.

Pelvic endometriosis: Patients with disseminated endometriosis cannot be treated locally and hysterectomy is required.

Ectopic pregnancy: For cervical, interstitial or abdominal pregnancy, when placenta cannot be removed without removing uterus.

3. Neoplastic diseases:

Cervical intraepithelial neoplasia: Where family is complete and/or follow check-up is not possible hysterectomy is indicated. Vaginal hysterectomy is preferred unless contraindicated by adnexal disease, uterine enlargement, or other reasons.

Early invasive cervical carcinoia: Once the carcinoma becomes invasive, hysterectomy is the treatment of choice.

Endometrial adenomatous hyperplasia, adenocarcinoma and sarcoma of uterus are indications for hysterectomy.

Ovarian and fallopian tube neoplasms: These are rare cases where hysterectomy should be preferred.

Trophoblastic disease: In high-risk cases, abdominal hysterectomy with bilateral salpingo-oophorectomy is to be followed by multi-drug therapy.

Other causes: Malignant disease of other pelvic organs, in postmenopausal cervical stenosis with recurring pyometra, recurrent hematometra and possibly endometriosis. *Hysterectomy is also used to be done as part of surgical sterilization.

TYPES OF HYSTERECTOMY:

a) According to approach

Abdominal hysterectomy: it involves detaching the uterus from the ligaments that support it and blood vessels that supply it. It is the most common approach.

Vaginal hysterectomy: the surgeon approaches the uterus through the vagina, detaches it from its supports and pulls it out. It is done with women with uterine prolapse.

Laproscopic hysterectomy: the approach can be either abdominal or vaginal assisted by a laproscope.

Vaginal hysterectomy is prefered whenever possible. Complications following abdominal hysterectomy are 70% higher than that following vaginal hysterectomy. In the CREST study (collaborative review of sterilization), overall complication rate with abdominal hysterectomy was reported as 42.8/100 cases while it was 24.5/100 for vaginal hysterectomies. Similarly, the mortality risk for hysterectomy has been quoted as 17-50/10,000 cases for abdominal; hysterectomy and 13-26/10,000 cases for vaginal hysterectomy (current concepts in treatment of fibroids).

b) According to organs removed

Total abdominal hysterectomy (TAH): It is the removal of the uterus and cervix through an incision in the lower abdomen. The fallopian tubes and ovaries are not removed.

Total abdominal hysterectomy with bilateral salpingo-oophorectomy (TAH-BSO): It is the removal of the ovaries and fallopian tubes along with the uterus and cervix through an incision in the lower abdomen.

Subtotal hysterectomy (supracervical hysterectomy): It is the removal of the uterus only and not the cervix.

Pelvic repair: This surgery may be done through the abdomen or vagina to improve muscle and fibrous tissue support for the bladder and/or rectum. The uterus as well as the fallopian tubes and ovaries may be removed at the time of repair.

COMPLICATIONS OF HYSTERECTOMY:

- Infection
- Haemorrhage
- Complications of general anaesthesia
- Urinary or bowel problems
- Vaginal problems such as prolonged healing time or shortening of vagina

- Premature menopause (even if the ovaries are left in place)
- Sexual problems such a loss of desire and reduction in orgasm
- Pelvic pain
- Depression
- Thromboembolism
- Pulmonary problems

PHYSICAL IMPACT OF HYSTERECTOMY

Weight gain—weight gain is not an inevitable result of hysterectomy. It may occur owing to lack of exercise and/or over-eating because of boredom during the recovery phase. Weight can be controlled by diet at this time just as at any other.

Constipation—this may occur at first owing to lack of muscle tone, and is preferably controlled by eating high fibre foods. In some cases the doctor may prescribe a laxative.

Urinary symptoms—slight leaking of urine may occur at first owing to lack of muscle tone. This will be improved by carrying out the exercises already taught by the physiotherapist or learned as postnatal exercises. Discomfort or burning on passing urine may indicate cystitis and the doctor should be consulted for treatment, which will rapidly relieve the problem.

Tiredness—this will occur at first to a sometimes surprising degree, but gradually improves as one becomes stronger. Despite feeling tired, difficulty may be experienced temporarily in sleeping. The problem will go away as normal routines are re-established.

Abdominal pain—this and other aches and pains, for example backache, may be experienced during the early days at home until strength is regained. The doctor should be consulted in the unlikely event of more severe pain.

Vaginal bleeding—this should diminish and become brownish rather than bright red in colour before ceasing altogether. Occasionally a tiny amount of bright blood may be noticed, indicating that a catgut stitch has come away. Any heavy, prolonged, bright red loss should be reported to the doctor.

Hot flushes—Some women experience a few hot flushes during their early convalescence owing to disturbance of the organs during operation. If these persist or worry the patient, she should talk to her doctor, who may be able to prescribe some tablets to help over this stage.

Sexual intercourse—as with other activities, this may be resumed when the patient feels ready, and according to the surgeon's instructions. There may be slight soreness the first couple of times, but this will soon disappear. A few women feel drier than before and this may cause soreness. In this case a simple lubricant such as KY jelly may be used.

Tearfulness or depression—the patient should discuss it with her doctor, who may think it appropriate to give some treatment to help over this period.

ALTERNATIVES TO HYSTERECTOMY:

As many as 30% to 40% of all hysterectomies performed may be unnecessary; for certain problems, alternative procedures may be better (Ammer, 1989; BWHC, 1992). However there is a lack of agreement about what is necessary. The quality of women's life before and after surgery and the risks and benefits of having or not having to procedures need to be considered before judging whether a hysterectomy is necessary (Easterday, Grimes, & Riggs, 1983). Women need to know that there may be alternatives to hysterectomy, and they should consider getting a second opinion before making a decision to have surgery.

Depending on the clinical presentation of individual patient, gynaecologists may choose options including NSAIDs, hormonal agents such as oestrogen, progestines, androgens, danazol, GnRH, agonists, antiprogestines, antibiotics and

drainage of pelvic abscess, necessary for support and restorative pelvic surgery like uterine suspension, vaginal reconstruction for anatomical defects, laser, cautery and conization for cervical displasia, pelvic floor strengthening exercises and pharmaceutical treatment for urinary incontinence, myomectomy, myoma coagulaton, cystectomy, oopherectomy, for benign tumors, hysterectomy for uterine polyps or submucous fibroids. More conservative surgical procedures such as endometrial resection and ablation, laproscopic procedures, dilation and curettage must be considered.

A hysterectomy is a major event in a woman's life. It will result in instant menopause and the woman will experience all the physiological changes of menopause after undergoing hysterectomy. She will no longer menstruate and will not be able to bear children. Other physical discomforts associated with hysterectomy are hot flushes, night sweats, difficulty in sleeping, fatigue and dryness of vagina, among other things. Many women also become irritable and suffer from mood swings as a result of the hormone withdrawal. Younger women often find it difficult to cope with such changes and sometimes go into depression. Hormone replacement therapy is given to avoid all menopausal features, like, hot flushes, vaginal discomfort, osteoporosis, and cardio vascular disease, to patients whose ovaries are also removed.

Many women fear about their change in attitude towards sexual life as a result of loss of desire for sexual activity and their ability to achieve orgasm. Such an effect can result following any surgery for some duration. Sexually active life can be restarted within four to six weeks of surgery. Probably, no difference is noticed during intercourse after hysterectomy.

In 2001, one thousand six hundred and forty five hysterectomies were done in Sree Avitom thirunal (SAT) hospital, which is the chief government hospital for women and children in Thiruvananthapuram. In the Women and Children government hospital in Thycaud, 325 hysterectomies were performed in the same year. SAT

hospital reported 1547 hysterectomies in the year 2002, while W&C hospital, Thycaud reported 276 hysterectomies. In 2001, the private hospitals, Cosmopolitan and GG hospital reported 234 hysterectomies and 218 hysterectomies respectively.

Table no: 1

Age wise distribution of hysterectomies done in SAT hospital in 2001 and 2002

Age	2001	2002
Below 30	17 (1%)	15 (1%)
30-39	316 (19%)	388 (25%)
40-49	809 (50%)	778 (51%)
50-59	332 (20%)	267 (17%)
60 and above	171 (10%)	99 (6%)

According to the available statistics from SAT hospital for the year 2001 and 2002, (table no: 1) when we break up these hysterectomies age wise, we find that more than 50 percent of the hysterectomies was done in women aged between 41 and 50. Women aged between 31 and 40 accounted for 20-25 percent of hysterectomies. Women below the age of 30 were one percent and those aged above 60 came to 6-10 percent. In more than 60 percent of the cases the reason for performing the hysterectomy was fibroid uterus. Dysfunctional Uterine Bleeding (DUB), ovarian tumours, and genital prolapse were the other leading indicators.

Table no: 2

Indicators for the hysterectomies in SAT hospital in 2001 and 2002

Indicators	2001	2002
Fibroid uterus	941 (58%)	987 (65%)
Dysfunctional uterine bleeding	112 (7%)	61 (4%)
Endometriosis	41 (2%)	29 (2%)
Ovarian tumours	206 (12%)	161 (10%)
Genital prolapse	280 (17%)	255 (16%)
Others	74 (4%)	54 (3%)

Proper pre and post hysterectomy counselling can help women to cope with the procedure and its after effects better. At present most of the hospitals in Kerala do not offer such counselling services. In order to be of help to the patients, the basis of such services should be an understanding of how hysterectomy affects the life of those who undergo it. Hence it becomes important that systematic research should be undertaken to gather data regarding not only the physical impact of hysterectomy but also its psychosocial effects.

Few studies have looked into the psychosocial aspects of hysterectomy, especially the changes in the quality of life brought about by the operation. The present study aims to explore the physical, psychological and social changes brought about by hysterectomy in young working women.

Objectives of the study

The main objective of the study is to find out the psycho-social problems faced by women who underwent hysterectomy. The pilot study had two objectives;

a) The Primary objective of the study was to do a literature review on the issues involved in Hysterectomy, which would clarify the concepts provide details on the current statues of research, and help in arriving at certain hypothesis.

b) The study also gathered first hand information from women about the post-hysterectomy changes in their life through the case study method.

Research methodology

a) Literature review – Books, articles and research studies dealing with the topic of hysterectomy were referred. For this the Medical College library, British Council library, libraries of non-governmental agencies, the Internet etc were made use of.

b) Tools of data collection- the main source of data was, four in-depth case studies of women who had undergone hysterectomy. Key informant interviews were conducted with gynaecologists working in both government and private hospitals. In addition, secondary data was collected from the gynaecology departments of SAT hospital, Women and Children Hospital Thycaud, Cosmopolitan hospital and GG hospital regarding the number of hysterectomies performed, the nature of hysterectomy, the case history of these patients etc.

Sampling design

Two government hospitals and two private hospitals were chosen to conduct the pilot study. The unit of study was woman under the age of 45 who had undergone hysterectomy at least four years back. The time lag was introduced to collect data regarding the changing nature of problems that women face in the post-hysterectomy period. From these hospitals one case each was identified for detailed case study using random sampling method.

Review of literature

The emotional stability of a patient can greatly influence the course of an illness. Women who undergo hysterectomy are characterized by so many features like children are growing and leaving home, producing ‘empty nest syndrome’, child rearing and home making roles gradually decline in importance. Women may

begin to fear waning physical and sexual attractiveness as they approach the menopause. Hysterectomy may add further to those feelings of damaged self-esteem (Rose, A.M.)

Some authors, especially those of the psychoanalytical school, attribute to the uterus, unique, symbolic importance central to feeling feminine and attractive. They suggest that loss of the uterus may deal a blow to self-esteem, and that at this juncture in their lives many women may suddenly want another child as evidence that they are still fertile. More recent views point out that women do not usually want to start bringing up another baby during their fourth decade, although many may dread the changes heralded by hysterectomy or the menopause. Because they have been little preparation and do not know what to expect. (Rose, L., The Menopause book).

Women who cope best with these changes are those who can replace their maternal role with fulfilling work outside the home and those who receives adequate social support, especially from their husband. (Dinah Gould, BSc, SRN; recovery from hysterectomy)

Lessening of sexual satisfaction after hysterectomy is a concern in medical literature. Loss of libido or sexual desire is reported, as well as diminished pleasure from intercourse. This might be a consequence of depression or a contributing factor in brining depression about. Again, hormonal disturbance is cited as an influence but the causal mechanism is not clear. Lowered estrogen levels might cause less vaginal lubrication, with dryness & soreness interfering with desire and satisfaction (Cooper.W). libido, however, is influenced principally by psychological factors and androgen levels rather than estrogen and progesterone (Oakley, A)

Various researches have contradicted these reports of impaired sex life after hysterectomy. Coppen et al used follicle stimulating hormone and luteinising hormone measurements in a study of women up to three years after hysterectomy

and found no evidence of hormone disturbance after operation and no decrease in sexual activity and satisfaction.

Richards described a post hysterectomy syndrome in which symptoms include depressed mood, hot flushes, urinary problems, fatigue, headaches, dizziness, and insomnia.

References to classes and support programs for hysterectomy patients were scarce. Hamilton and Kelly described an educational program with classes taught by staff nurses during the patient's hospitalization. Keith reported the positive outcomes of a post hysterectomy discussion group led by a nurse and a social worker, but Kieth also concluded that a presurgery group meeting was needed to alleviate some of the women's anxieties and misconceptions. Philips compared the responses of women who received one-to-one presurgical instruction by the physician with the responses of those who attended a presurgical class taught by a registered nurse. He concluded that the women who had not had the class experience had more unanswered questions and hypothesized that "group discussions with women facing the same surgery may further reduce anxiety to the level where learning can be more effective."

According to Christine Webb, a counseling approach is adopted and the contents were planned in 4 sessions. A friendly approach should be adopted, with a smile, some eye contact, a display of sympathetic interest, careful listening, adopting the client's terminology and conventions and generally meeting her on her own ground (Bridge & MacLeod)

Session I: Explanation of the operation: showing a simple diagram: explanation that the uterus and cervix have been removed, but tat the ovaries were left and therefore the 'change of life' will not begin. The only effect will be the end of 'periods' and no longer being able to have children. Feelings of femininity or 'being a woman' will not change, nor will feelings and sensations in relation to sexual intercourse.

Session II: Guide to controlling one's own recovery: emphasis that each woman is an individual and will have a unique recovery. Avoidance of adverse comparisons with other women advised. Tiredness or what one feels like doing are guides for resuming activities. When one feels ready to try a new activity, do so gently at first. If all goes well, carry on and increase this activity. If, however, it seems too much and one feels over-tired, this is a sign that one needs to wait a little longer before trying again. In this way, activities will be gradually increased until they reach normal levels again.

Session III: Ventilation of patient's feelings about having a hysterectomy: all women were asked, " How do you feel in yourself about having had a hysterectomy?"

Session IV: Effects of hysterectomy

ROLE OF OVARY AFTER HYSTERECTOMY:

Ovaries preserved at hysterectomy are a boon, provided they serve the intended function. In 34% of women, ovarian failure occurs within two years of the hysterectomy and in 54% within 4 years as compared to those who attained natural menopause (Siddl. N, Sarrel P, Whitehead M). After hysterectomy, there is an immediate reduction in ovarian blood flow due to ligation of the adnexal branches of the ovarian vessel (Janson & Janson). Histological study of ovarian biopsy obtained one year post- hysterectomy showed a significant (87%) reduction in the primordial follicles although serum oestradiol and progesterone levels remain unchanged at this time (Li TC & Saravelos). The ovaries in postmenopausal women show marked stromal hyperplasia and secrete large amounts of androstenedione, estrone and dehydroepiandosterone suggesting that there could be an endocrine role for the postmenopausal ovary in relation to its contribution of androgen to plasma pool of estrogen through extragonadal conversion.

Any kind of surgical intervention or treatment will bring with it anxiety for most women. It often brigs fear of death or disability. In addition to the fears and concerns related to undergoing any kind of treatment, treatment to the reproductive organs involves unique issues because the role these organs play in a women's sexuality adds significance to them. Any treatment, which may later on remove these organs, is seen as a threat to a woman's femininity, and many women are concerned that the treatment will disrupt their sexual functioning. In some instances this may be true, but many concerns are unfounded and can be relieved with adequate intervention. (Miss Rutter, senior nurse tutor, Chelsea hospital for women, London; inter menstrual bleeding)

OOPHERECTOMY AT HYSTERECTOMY:

Removal of ovaries, which are normal at the time of surgery, is called ooperectomy. Abdominal hysterectomy is usually performed either with or without oopherectomy. Ovarian preservation depends on women's age, her family, medical history, attitude towards prophylactic oopherectomy and future complications of hormone replacement therapy. (Zalel Y, Lurie S, Beyth Y, Goldberger S, Tepper R). The dilemma over whether to remove or conserve ovaries at the time of hysterectomy has been debated, with varying degrees of passion, over more than 100 years. Removing apparently normal ovaries at the time of hysterectomy may have a number of advantages. It may eliminate the possibility of subsequent ovarian malignancy, residual ovarian syndrome, benign ovarian cysts and abolish ovarian cycle syndrome in women with premenstrual syndrome. (Studd J)

Oopherectomy can be prophylactic or therapeutic. Prophylactic oopherctomy is the procedure where the removal of normal looking ovaries is done for future benefit of preventing long-term morbidity and mortality, especially ovarian cancer. It is found those elective oopherectomy rates between 50 and 66% in women 40-64 years of age undergoing hysterectomy (Dicker. RC., Scally. MJ, Greenspan. JR., Layde. PM., Ory. HW, Maze. JM). In USA one in 70 women develop ovarian

cancer in her lifetime and between 4% and 14% of these women will have had antecedental hysterectomies in which ovaries were retained (Sightler SE, Boike GM, Estape RE, Averette HE).

Hysterectomy is the commonest gynecological surgery performed. Decision to remove the ovaries or not depends on the age of patient, menopause, and high risk factors and on patient's decision. A proper counseling plays a very important role in deciding knowing the implication. Removal of one ovary does not protect or decrease the incidence of ovarian cancer. If ovarian pathology is found at hysterectomy after 40 years of age bilateral oopherectomy is indicated.

Prophylactic oopherectomy should be considered for women who are at risk of inherited ovarian cancer. HRT should be avoided to these women to avoid increased risks of osteoporosis and cardiovascular problems. (Rani Reddy, KKS Reddy; oopherectomy at hysterectomy; journal; dept of radiotherapy, Jawaharlal institute of postgraduate medical education and research, pondicherry)

Why Would a Woman Resist Hysterectomy?

In the United States 550,000 hysterectomies are performed each year. In the vast majority of these cases the indications for surgery are benign, non life-threatening conditions. Only 10% of hysterectomies are performed for cancer.

The common rationale for advising hysterectomy and oophorectomy (removal of the uterus and the ovaries) is as follows: the role of the uterus is that of an "incubator," to carry babies into this world. Once the incubator role is over, be it because of a woman's age or her lack of desire for more children, the uterus is a nuisance. The uterus may bleed, cause pain, prolapse, and/or develop cancer. At this point, hysterectomy is an advantage to a woman's well being and longevity. Regarding the ovaries, it is commonly felt that after age 40 ovarian function (hormone production) is approaching its end, and since the ovaries can develop cancer it is only logical to remove the ovaries as well during hysterectomy. The

resulting absence of ovarian estrogen, it is proposed, can be easily overcome with estrogen replacement therapy.

Is this attitude supported by scientific evidence and recent research? An increasing number of women, as well as many physicians, believe strongly that it is not. The uterus has many roles, not just that of an incubator. Consequently, hysterectomy may be followed by negative consequences, which may significantly impact, on the quality of a woman's life. First, let us consider the old rationale that hysterectomy and oophorectomy can prolong a woman's life by preventing uterine and/or ovarian cancer. The lifetime probability that a 50 year-old woman will die of uterine cancer (including cervical cancer) is 0.5%, for ovarian cancer this probability is 0.8%. In contrast, the same woman's risk of dying of cardiovascular (heart and blood vessels) disease is 33%. It has been shown that hysterectomy (even without oophorectomy) during a woman's reproductive years increases the risk (triple the risk according to some studies) of heart attack during the remaining reproductive years. If the ovaries are removed as well, the risk of developing heart disease and osteoporosis is further increased. In addition, it has been shown that after hysterectomy, even without oophorectomy, women tend to enter menopause earlier, by as much as 4 years on the average according to one study. Estrogen produced by the ovaries reduces the risk of osteoporosis and possibly the risk of heart disease. Estrogen may also help to maintain cognitive and sexual function. Theoretically then, hormone replacement therapy after hysterectomy and oophorectomy could counter the negative effects of estrogen deficiency. However, a recent study reports a slight increase in the risk of heart disease, thromboembolic disease, and breast cancer in women on combined estrogen-progesterone (Prempro) replacement therapy which has made the decision regarding whether to use hormone replacement therapy more difficult, requiring individual consideration of risk versus benefit and quality of life issues. Even prior to this latest study it had been shown that only about 50-60% of women for whom

hormone replacement therapy was prescribed were still taking the medication after 12 months. Overall, only 10% of menopausal women in the U.S. are taking hormone replacement therapy. Given these facts, there is a compelling argument for avoiding unnecessary hysterectomy whenever possible. It is clear that optimal health is maintained by uterine and ovarian preservation, except when cancer is already present or there is a family predilection for cancer (Michael E. Toaff, MD, MSc)

Recent studies show that the symptoms of surgical menopause (sudden onset of menopause after removal of the ovaries) are more severe and prolonged compared to symptoms during natural menopause (when ovarian function gradually diminishes). The aging ovaries continue to produce certain amounts of estrogen and androgens for at least ten years after the start of menopause. Androgen deficiency affects bone loss, libido, muscular and fat distribution, the sense of well being, energy, and appetite. Preservation of the ovarian production of estrogen and androgen, albeit reduced compared to the reproductive years, may contribute significantly to a woman's health. This is another rationale for preserving the genital organs even after menses have ceased.

Other long-term adverse effects of hysterectomy have been reported. Some studies, although not all, report that new urinary symptoms such as frequency, urgency, and incontinence occur in 30% of woman after hysterectomy. This may be the inevitable result of bladder denervation (surgically cutting off the nerve supply to the bladder) during hysterectomy. Also, slow propulsion constipation develops in about a third of women after hysterectomy, even without the presence of rectocele. Frequently, hysterectomy leads to sagging of some internal genital organs such as the anterior vaginal wall (dropped bladder or cystocele) and posterior vaginal wall (rectocele). These conditions may cause symptoms such as difficulties in urination, stress urinary incontinence or constipation, difficulty in

penetration during intercourse, and vaginal infection. These conditions may be severe enough to require surgical correction.

Emotional health may also be affected by hysterectomy. The uterus has great psychological significance for some women, more so in certain cultures. Although many women have no emotional difficulties after surgery, hysterectomy may be followed by problems such as depression, anxiety, and sexual dysfunction. The issue of sexual function after hysterectomy is complex. Some women feel that by losing their uterus they have lost their womanhood. They may feel that their partner no longer desires them leading to loss of libido. One physical consequence, which may result from hysterectomy, and may directly affect sexual function, is shortening of the vagina resulting in pain during deep penetration. The most important effect of hysterectomy on sexual function may be on orgasm. For some women, "deep" orgasm involves rhythmic uterine contractions. Following hysterectomy this important component is lacking and such women complain of a dramatic decline in the quality of their orgasm. For women whose orgasmic pleasure does not depend on uterine contractions, hysterectomy may not lead to a decline in the quality of their sexual response. In fact, many women report that hysterectomy led to an improved sexual life, especially when hysterectomy eliminated major medical problems such as bleeding, pain, and/or prolapse of the uterus. In other women, fear of an unwanted pregnancy always had a negative effect on sexual function and elimination of this fear by hysterectomy has enhanced pleasure.

Finally, many women are strongly opposed, in principle, to the removal of any organ, genital or otherwise, unless absolutely necessary.

In this discussion the drawbacks of hysterectomy have been summarized. As women have informed themselves regarding these issues many have resisted hysterectomy until they are convinced that it is absolutely necessary for their well-being. After 30+ years in the practice of obstetrics and gynaecology it remains my

firm belief that a woman has the right to decide the fate of her own organs. She should not be made to feel inadequate or disturbed for questioning the necessity of hysterectomy. In fact, I believe that it is the obligation of the physician to present to each women all of her treatment options in detail, giving the pros and cons of each. I believe a physician should do so honestly, even if that particular physician is not capable of providing some of the treatment options and referral to another physician may be required. If after such an honest discussion, the patient elects not to have a hysterectomy, it is the obligation of the physician to support her in her decision, even when it means referral to another expert.

Depression and psychiatric problems was reported in many studies of post-hysterectomy women [Salter (1985), Steiner and Aleksandrowicz (1970) Baker (1968)] The susceptibility was found to be more for women who already suffered from depression, those aged below 40, and who had low educational levels. Those women who had misunderstandings or misconceptions about the surgery and its outcome were also more likely to suffer from psychosexual problems in the post-hysterectomy phase. The same was the case with women who believed that the uterus played a significant role in their self-concept/ sexual functioning. It was also observed that hysterectomy caused more stress and depression then other comparable surgeries. [Barker, 1968; Drummond and Field, 1984; Green 1973; Roeske, 1978; Humphries, 1980; Lalinec-Michaud and Engelsmann, 1984; Salter, 1985]

Different researchers have proposed various reasons for the onset of depression. One argument is that women's self concept of femininity is undermined by the loss of the uterus which in turn leads to depression [Raphael, 1978]. Another argument is that depression is brought about by the hormone changes in the body following hysterectomy. [Richards (1973), Richards (1974)]

A few researchers have found evidence of cases where women were less depressed after the hysterectomy than they were before the operation. It was reported that

heavy, prolonged and irregular bleeding led to depression that lifted once the symptoms were relieved through hysterectomy. These studies also found that hysterectomy did not affect the libido or the sexual satisfaction of those who underwent hysterectomy. [Patterson and Craig (1963), Gath (1980), Coppen, Bishop et al (1981)]

A 1975 study by Cooper reported loss of libido, diminished pleasure during sex and problems like dryness of vagina and soreness in post-hysterectomy women. This has been explained in terms of postoperative pain due to vaginal shrinkage, decreased lubrication leading to painful intercourse and lack of interest in recreational sex (as against sex for procreation), especially among women who associate sex with the reproductive function. (Drummond and Field, 1984)

Studies have failed to establish whether or not hysterectomy causes sexual dysfunction. While some studies have reported 10 to 40 percent of women reporting sexual problems, many studies report either no change or an improvement in sexual functioning (Bachmann, 1990). The improvement in sexual functioning may be due to absence of fear of pregnancy and absence of pain that was present before the hysterectomy.

FINDINGS OF THE PILOT STUDY

Case no: 1

Anna is 45 years old schoolteacher. She had a postgraduate degree and a B.Ed. She has a 22 year old daughter and a twenty-year-old son. Her husband is a retired government employee. Anna had suffered from no major illnesses all her life. She led a relatively sedentary life with little or no exercise other than the daily household cooking and housekeeping. Anna ate a moderately healthy diet that included vegetables, fish and fruits and red meat and fats in moderation. She was slightly overweight and suffered from mild blood pressure but was other wise healthy.

Anna's family described her a good wife and mother. She enjoyed cooking and gardening and was also good at interior decoration. She had a good academic record and was happy and satisfied about working as a schoolteacher. Her fellow teachers described her as a good teacher who had good rapport with her students and her colleagues. Anna's husband described her as a practical, levelheaded person not given to emotional outbursts or anger. She was close to her widowed mother and her only sister and was in good terms with her husband's relatives.

Both Anna and her husband described their pre-operative sex life as happy and satisfying. But once Anna started getting irregular, frequent and heavy periods, their sex life suffered. Anna derived no pleasure from the sexual act since she was plagued by backache and stomach cramps even when she was not menstruating. Her husband was unhappy with the state of things and urged her to see a doctor.

Anna's problems started at the age of 36 with heavy and prolonged periods accompanied by severe backache and stomach cramps. She did not consult a gynaecologist for at least a year after the onset of these symptoms. During this time, her periods started becoming very irregular and frequent and lasted for ten days and more. Anna decided to consult a doctor since the illness was interfering with her daily life.

Anna was advised to have a total hysterectomy and bilateral salpingo – oophorectomy since she was suspected of having cancerous cysts in her ovaries. This diagnosis was conformed during the operation and hence her uterus was removed along with both her ovaries. After the operation she was given the option of Hormone Replacement Therapy (HRT) but she declined it since she was told by many people that it is more harmful than beneficial in the long run.

After the operation, Anna was happy to be relived of her symptoms like heavy bleeding and irregular periods. But she said that the backache continued to be problematic. In addition, she also started having pain in the leg and arm joints. Anna was of the opinion that her general health status had deteriorated after the

hysterectomy. She complained of weight gain, hot flushes, irritability, frequent urinary infections and other minor ailments. The complaints were most severe during the one year following the operation. After that, her weight stabilized although it did not revert back to the pre-operative status. The frequency and intensity of the hot flushes too declined. At present, Anna describes the hot flushes as bearable.

The urinary tract infections were serious enough to go to a doctor and he prescribed an estrogen-based cream that helped in eliminating the infection. Anna also suffered from dryness of the vagina that resulted in painful intercourse and lessened pleasure during sex.

The hysterectomy also brought about several psychological changes in Anna. She reported that she was a lot more irritable after the operation. In the six months following the operation, Anna suffered from mood swings and mild depression. Minor things would make her cry and depressed. The mood swings and depression got better after a couple of years but she said that the irritability remained.

Both Anna and her colleagues felt that she had less patience with her students in the post-operative phase. High level of noise in the class made her lose her temper and deal with the students harshly. Although she still enjoyed teaching, she got tired more quickly and had to withdraw from many of the extracurricular activities (running the science club, organizing science festivals. for example) she was involved with in the school.

Her family also noted the irritability, the anger and mood swings. The daughter was more sympathetic than the son and helped Anna get through the worse days of her post-operative recovery. Her husband said that it took him some time to adjust to the behavioural changes in his wife. He found it hard to deal with the mood swings, especially her depressive phase. Since Anna was unable to give him a satisfactory explanation for her behaviour, he was often impatient and angry with

her. However, once the depression improved, the family put up with the irritability and at present they report that it is no longer a pressing problem.

The hysterectomy affected Anna's sexual life very adversely. She reported loss of libido and significant decease in interest in having sex. After the hysterectomy, she suffered from dryness of the vagina and painful intercourse. The couple tried lubricants and creams that combated the dryness but did not result in better sex as far as Anna was concerned. She said that she felt frigid and had no interest in sex. Combined with this was the physical pain she had in terms of backache, joint pains and muscle aches. Since she was getting tired more easily, she had less energy and felt too fatigued to enjoy intimacy.

Apart from seeking treatment for the urinary tract infections and consulting an orthopaedic doctor in relation to her backache and joint pains, Anna never sought treatment for any of the other problems that she faced after hysterectomy. In spite of her husband's insistence, she had refused to consult a doctor regarding her sexual problems. She had strong inhibitions regarding discussing the matter with a doctor. Even with the passage of several years, the sexual problems have persisted. The couple said that they have reached a 'compromise' in matters related to sex, but it was clear that the husband was unhappy about their post-hysterectomy sex life since there was marked decrease in the frequency and the involvement of the wife in sexual intimacy.

Anna believes that Hormone Replacement Therapy is harmful in the long run and refuses to consider it. The gynaecologist who performed the hysterectomy had offered that option but had not given her much information on HRT. Anna's friends and acquaintances had told her that HRT was harmful and had advised her not to opt for it.

Case no: 2

Nirmala is 42 years old and is working as administrative assistant in a private company. She has a post-graduate degree. She is married to an engineer and have two sons aged 21 and 18 respectively. She had no major illness in the past. She follows a vegetarian diet and maintains ideal body weight.

Before the hysterectomy, Nirmala was described as a quiet and happy woman. She had a small circle of friends with whom she was close and they used to meet at regular intervals. Nirmala and her husband shared a warm relationship and they described themselves as being good friends rather than being the strictly traditional husband and wife. Both of them were happy and content in the relationship. Their sex life was also satisfactory. They enjoyed travelling, watching films, and spending time together as a family. As a mother, Nirmala was not authoritarian or distant. Her sons found her to be a doting mother who took an interest in their studies; sports activities and both the children were close to their mother. At work, Nirmala was seen as a punctual and dedicated person who was cordial and she got along with her co-workers well.

Nirmala had a hysterectomy and bilateral salpingo – oophorectomy 6 years ago at the age of 36. She had irregular and frequent periods with heavy bleeding. She was diagnosed with fibroid growth in her uterus but the gynaecologist advised against hysterectomy taking into consideration her young age. She was given medicines and painkillers and was asked to wait for a year before opting for surgery.

In that one year period, Nirmala continued to have frequent periods (once in ten days or less) along with heavy bleeding. At the end of one year, investigations revealed that along with fibroids she had developed cysts in her ovaries that were growing bigger with the passage of time. The doctor advised her to have a total hysterectomy since there was a possibility that the cysts might be cancerous. Nirmala had cysts in only one of her ovaries but both ovaries were removed as a precautionary measure.

After the hysterectomy, the doctor decided not to put Nirmala on hormone therapy since she had a medical condition that could grow worse under HRT. Nirmala's aunt who was a gynaecologist also advised her against taking HRT.

In the post-hysterectomy phase, Nirmala put on a lot of weight and this resulted in joint pains and difficulty in doing household work. She also had hot flushes, which she found unbearable. She became very irritable, short tempered and withdrawn. She was quick to lose her temper with her husband and children. Her sons found her behaviour puzzling but her father told them that it was all part of her recovery from the hysterectomy. Her job performance was not affected since her job was of clerical nature that did not warrant much interaction with other people.

With the passing of time, Nirmala's problems lessened in intensity. She brought down her weight by eating a sensible diet and regular exercise. The hot flushes became less frequent and less intense as time elapsed. Although some of the irritability and mood swings persisted it was no longer uncontrollable nor were they problematic.

Nirmala's husband was very supportive through all these stages. When Nirmala was suspected of the likelihood of getting cancer, he insisted on her undergoing the hysterectomy at the earliest. He stood by her while she was going through the behavioural changes that were induced by the hysterectomy. He reassured her that he felt no difference during sexual intercourse after she had undergone the hysterectomy. Nirmala suffered from dryness of the vagina after the operation that made sexual intercourse painful. She consulted a gynaecologist who prescribed a gel for her and once she started using the gel, the dryness disappeared. The couple described their post-hysterectomy sex life as happy and normal.

Nirmala said that she had no problem accepting the hysterectomy. She was suffering from severe bleeding and pain for more than a year and hence wanted to put an end to it. She knew that the hysterectomy was inevitable and was mentally prepared for it. She reported feeling no sense of loss at the removal of her uterus.

She did not perceive it as a “loss of femininity”. She said that the operation had no effect on her looks, youth, nor on her life in general. The rapid weight gain and the mood swings were the only problems which worried her. She said that for a period following her operation she used to lose control over her temper totally.

Nirmala was not given much information regarding the post-hysterectomy changes that were likely to occur. Hence, the emotional turbulence, short temper and other emotional problems were unexpected for both Nirmala and her family. Nirmala was lucky to have an aunt who was also a gynaecologist. From her the family got the necessary information on the physical and psychological changes that happen after the hysterectomy. This knowledge helped Nirmala’s husband to deal with her problems with compassion and empathy, which in turn helped Nirmala a lot during her recovery period.

Case no: 3

Ambika is a 40-year-old bank clerk who is married to an accountant. She holds bachelors’ degrees in botany and education. She has two children a son and a daughter. The son is 20 years old and the daughter is seventeen.

Ambika was very much concerned about her health. She went into homeopathy and naturopathy. She was a strict vegetarian who exercised daily and did yoga. She was a loner who did not move easily with other people or make friends quickly. Ambika herself said that she was an introvert who was short tempered and moody. As a wife she fulfilled the role in the traditional sense. Her husband was ten years older than she was and she held him in respect and awe. She was not comfortable sharing her feelings, emotions or problems with him. She had problems dealing with her teenage daughter and was closer to her son. In the bank where she worked she had only a single close friend. Her colleagues described her as aloof and withdrawn.

At the age of 34, Ambika noticed that her usual five day period prolonged to seven or eight days. She was also losing large amounts of blood. She went to a gynaecologist who found that she had fibroids in her uterus. The doctor advised her to have a hysterectomy. Ambika did not want to go through a hysterectomy and decided to approach a homeopathy doctor.

The homeopathy doctor assured her that the fibroids can be cured without surgery. Ambika was given homeopathy medicines, which she took for over an year. However, her condition grew worse. Her periods now lasted for ten to twelve days. The bleeding was so heavy that she was unable to go to work and had to stay home. In addition, she also suffered from severe stomach cramps, backache and frequent fevers. Ambika's husband had to cope with her invalidity during the days she had severe and prolonged bleeding. The pain made it impossible for Ambika to get out of bed and do household work. her husband had to stay home from work and look after not only Ambika but also take care of the household duties. Since Ambika's own parents had passed away and her widowed mother-in-law was too weak and infirm, there was no one to help the couple at the time of their need. Ambika's husband urged her to get the hysterectomy done.

In the end, Ambika went back to the gynaecologist for further testing. It was discovered that her fibroids had grown bigger in the past one year. It was decided that she had to undergo immediate hysterectomy.

A hysterectomy was performed where only her uterus was removed, leaving her ovaries intact. After the operation, Ambika's chief complaint was that of hot flushes. She found the heat unbearable. She said that the hot flushes have continued unabated through all these years. Physically she suffered from no other problems. She managed not to gain any extra weight by doing regular exercise. However, after five years after the operation she developed joint pains in her legs. The doctor diagnosed a certain degree of bone degeneration that could be the

result of her hysterectomy. She was given the option of HRT but she refused it because of concerns about possible side effects.

Psychologically, Ambika said that she was always short tempered and according to her, her temperament improved after the hysterectomy. Before the operation, the pain and discomfort of her condition had made her very angry and irritable. This improved a lot after the operation. Her children noticed no marked improvement in her nature and were unable to say whether the hysterectomy influenced her post-operative behaviour pattern.

At work, Ambika's sole friend reported that Ambika had gone through a turbulent time at work, in the few months just before the hysterectomy and things got better only after nearly two years after the operation. During this time Ambika was found to be exceptionally short tempered and quarrelsome at work. The frequent absenteeism from work and the inability to maintain harmonious relationship with other co-workers created many problems in the bank for Ambika. Although many of the co-workers knew about the operation and the circumstances leading to it, most of them were unwilling to attribute her short-temper to it.

Ambika was not mentally prepared for the hysterectomy. She wanted to avoid it at any cost and it was only when she could not lead a normal life that she decided to undergo the hysterectomy. She feared that the operation would result in a loss of femininity. She felt that she will feel less of a woman without her uterus and was very depressed before the operation. She used to cry a lot in the days before the operation. But she never shared her fears and apprehensions with her husband. She said that an emotional bonding was absent between the couple.

After the operation she reported that all her fears were unfounded. She felt no difference and in retrospect she feels that her fears were all baseless. She felt that she should have undergone the operation sooner instead of dealing it for more than a year and suffering the pain and discomfort for all that time.

Although Ambika had declined to discuss her pre-hysterectomy sex life, she said that after the operation there was improvement. Before the hysterectomy, since the couple had not undergone sterilization operation, they were using condoms as a means of contraception. Ambika's husband did not enjoy sex since he had to use the condom. After the hysterectomy, the couple were happy to stop using the condom and found much pleasure in having sex without having to worry about pregnancy. Ambika reported neither lessening of libido or loss of interest in sex. She did not have physical problems like dryness of the vagina or pain during intercourse in the post-hysterectomy period.

Case no: 4

Manju is a 37 years old pediatrician. She is married to a neurosurgeon and the couple has a seven year old daughter. After completing her MBBS, Manju specialized in pediatrics and is currently working in a private hospital.

Manju was the youngest of four children and the only sister of three elder brothers. She grew up in a very loving home. Academically she was brilliant and always excelled in studies. In addition, she had a sweet disposition that endeared her to one and all. She was an extrovert who had a lot of friends. She was of robust health and ate a balanced diet. As a pediatrician she was successful and found her work challenging and rewarding. Hers was a love marriage and the couple was very close. Her husband was supportive and caring. He understood the pressures of the medical profession and did every thing possible to make both her personal life and professional life happy. The success of their relationship was also reflected in their sexual life, which they described as "everything we could wish for". Since both of them were busy doctors, each had a hectic schedule. In spite of all the work related tensions and stress, the couple were able to maintain a close and loving relationship.

At the age of 32, Manju had to undergo a hysterectomy and bilateral salpingo – oophorectomy following complications with her second pregnancy. She had a

miscarriage following tubular pregnancy and the resulting complications called for a hysterectomy. Manju opted for Hormone Replacement Therapy after the operation. She said that she had no doubts regarding the usefulness of HRT and was willing to face long-term side effects if any. She was of the opinion that the positive influence of HRT far outweighed its negative points.

After the hysterectomy, Manju went back to work once the rest period advised by her doctor was over. Initially she had some difficulties in terms of backaches and body pains but these problems disappeared after a period of time. She also had hot flushes, mood swings and mild depression. For nearly a year after the hysterectomy, Manju had difficulty dealing with heavy patient load and night shifts. However, almost all the negative symptoms she had disappeared with regular HRT.

Manju was slender all her life. She did not gain weight even at time of her first pregnancy and delivery. But after the hysterectomy, Manju had put on much weight. She has no physical discomfort due to the weight gain. But she does feel bloated and she considers herself overweight and ungainly. The weight gain seems to disturb her emotionally.

Manju's husband and her family found no significant difference in her pre and postoperative behaviour. Her husband found no change in temperament, mood or general demeanor. The hysterectomy had not affected their sex life. But the couple feels a sense of sadness at the thought of not being able to have any more children. Both husband and wife had wanted at least one more child.

She did not report any feelings of "loss of femininity" due to the removal of her uterus. Being a doctor she is unsentimental about the whole issue. Neither did she associate the hysterectomy with loss of looks, youth or vitality. She found no change in the texture of her skin or looks in general.

Manju said that since she was very young at the time of hysterectomy, everyone, especially her husband, had advised her to opt for HRT. In retrospect, in spite of some recent studies which reported increased morbidity associated with long term use of HRT, Manju feels that opting for HRT treatment was the right thing to do in her case.

Interpretation of findings and discussion

Although the four women who were interviewed for the case study were different in many respects, certain factors emerge common to all the cases. All of them suffered from various physical and psychological problems both before and after the hysterectomy. In the first three cases, severe, prolonged and irregular bleeding had interfered with the daily functioning of those women forcing them to opt for hysterectomy. The common complaints during the post-hysterectomy period were hot flushes, irritability, mood swing and weight gain. Other problems varied from person to person. In terms of sexual life, responses varied from loss of libido to increase in sexual pleasure after the operation.

It was seen that even in those cases where heavy and painful bleeding led to the hysterectomy, the women undergoing the surgery had mixed feelings about it. While they accepted the hysterectomy as necessary and expressed relief from painful symptoms after the hysterectomy, they had approached surgery with various apprehensions. Such apprehensions had its origin in a) inadequate information given to the women by the doctor, and b) accounts of other people regarding what to expect after the hysterectomy. It was seen that the accounts of post-hysterectomy life passed on to women who are to undergo hysterectomy by friends, relatives and acquaintances are mostly of a negative character. Such accounts make the patients apprehensive and anxious. In addition, the information given by the health care providers to the women undergoing hysterectomy was found to be inadequate. In most cases, doctors did not discuss the post-hysterectomy problems or its treatment with these women.

A change was found in the intensity and frequency of problems during the post-hysterectomy period. All four women reported that the first 12 to 18 months after the surgery were the most difficult to cope with. This was especially true in the case of hot flushes and mood swings. With passing of time the hot flushes decreased in intensity and frequency and in some cases disappeared after four to five years. The irritability and mood swing too was reported to be controllable within a year of the hysterectomy.

It was found that there are marked differences in the cases where the ovaries are removed along with the uterus. Such women face more difficulties in terms of both physical and psychological problems. The woman who took HRT treatment after the oophorectomy reported far less severity of such problems.

Supportive behaviour from the husband was found to be of vital importance in determining the post-hysterectomy adjustment of these women. Those women who enjoyed a close and supportive relationship with their spouse were able to cope with the post-op stress better. Social support in the form of family, friends and coworkers also had a positive impact on post-hysterectomy recovery.

Conclusions and suggestions

Women who undergo hysterectomy face a multitude of physical, psychological and emotional problems both before and after the hysterectomy. The major factors contributing to these problems are lack of proper information, lack of support and counselling and fears and apprehensions born out of wrong information. Since doctors, especially gynaecologists, have a heavy work load it is both practical and beneficial to appoint qualified counsellors in the hospitals in order to interact with the hysterectomy patients and their families. The aim of such interaction should be ensuring that the patient copes better with the hysterectomy and post-hysterectomy scenario by lessening the psychosocial problems faced by the hysterectomy patients.

The physical, emotional and social problems that the hysterectomy patient faces are closely interwoven. The way in which the woman perceives her role in life greatly affects her reaction to the loss of reproductive ability. The patient who defines her role as a woman in relation to her reproductive ability must be assisted in redefining her self-concept, preferably before the hysterectomy. The patient must be assured of her intrinsic worth and dignity regardless of her reproductive ability. It is also important to explore her relationships with others. An assessment of the family structure enables to determine if a support system is available to the patient. Most patients undergoing hysterectomy require a minimum six to eight weeks to recover from the initial surgery. A return to the equal of the preoperative state may take up to one year depending on the recuperative physical and emotional powers of the woman and the support she receives.

The best way to describe some women's initial response to the announcement of impending hysterectomy is to compare the experience to the grief process as defined by Kubler-Ross. Shock & disbelief are the initial reactions to the need for removal of the uterus and subsequent loss of reproductive ability. If the surgery is an emergency, it is important to deal with the patient who may not realize the full extent and implications of the procedure. Denial often is present. An attitude of isolation and withdrawal may develop. It is important to listen to what the patient says, and then offer simple, clear, and concise explanations to questions and attempt to determine the extent of understanding available to the patient.

When a period of time from diagnosis to surgery is available to the patient, the shock and disbelief at the need for surgery often progresses to anger. This anger is directed at an intrusive procedure that will result in a loss of reproductive ability and, often, a conceptual loss of femininity. The anger may be personal and inner directed. The patient must be allowed to express the anger and hostility she feels before she can begin to cope with the actual surgery. Listening and providing support can encourage verbalization.

Depression in the patient before surgery is common. Whenever possible, the woman should be allowed time to resolve her depression and progress into an acceptance of the fact that she is to have a hysterectomy. At this point, there must be assistance to the patient in exploring the redefinition of her role in life and the implications of the surgery.

Fear of the unknown for the patient who has not experienced previous hospitalisation or surgery can be traumatic. Exploring the patient's fears and helping her to come to terms with it is important. Active listening should be a primary tool in dealing with the emotional problems of a hysterectomy patient. Non-verbal communication is also a support mechanism. Support to the patient's family is vital to the success of emotional support for the patient. If the family is strong, they will provide a needed resource to the patient.

The hospital staff, the family and significant others in the patient's life should understand what the hysterectomy patient goes through and should deal with her empathetically.

References

1. Bachmann, G. A. 1990. "Psychosexual aspects of hysterectomy" Women's Health Issues 1(1), 41-49.
2. Barker, M. G. 1968. "Psychiatric illness after hysterectomy" British Medical Journal, April 1968, 91-95.
3. Cooper, W. 1975. No Change. London: Arrow Books.
4. Coppen, A. and Bishop, M. 1981. "Hysterectomy, hormones and behaviour: A prospective study." Lancet, 1, 126-128.
5. Drummond, J. and Field, P. 1984. "Emotional and sexual sequelae following hysterectomy." Health Care for Women International, 5, 261-271.

6. Gath, D. 1980. “Psychiatric aspects of hysterectomy.” In Robins, L. , Clayton, P., Wing, J. (eds.) The Social Consequences of Psychiatric Illness. New York: Bruner-Mazel .

7. Green, R. L. Jr. 1973. “The emotional aspects of hysterectomy.” Southern Medical Journal, 66(4), 442-444.

8. Humphries, P. T. 1980. “Sexual adjustment after hysterectomy.” Health Care of Women, 2(2), 1-14.

9. Lalinec-Michaud, M. and Engelmann, F. 1984. “Depression and hysterectomy: A prospective study.” Psychosomatics, 25, 550-558

10. Lalinec-Michaud, M. and Engelmann, F. 1985. “Anxiety, fear and depression related to hysterectomy.” Canadian Journal of Psychiatry, 30(1), 44-47.

11. Patterson, R. M. and Craig, J. B. 1963. “Psychological effects of hysterectomy.” America Journal of Obstetrics and Gynaecology, 85: 1, 104-111.

12. Raphael, B. 1978. “Psychiatric aspects of hysterectomy.” In Howells, J. G. (ed.) Modern Perspectives in the Psychiatric Aspects of Surgery, London: Macmillan.

13. Richards, D. H. 1973. “Depression after hysterectomy.” Lancet, 2, 430-433.

14. Richards, D. H. 1974. “ A post-hysterectomy syndrome.” Lancet, 2, 983-985.

15. Roeske, N. C. 1978. “Hysterectomy and other gynaecological surgeries.” In M. T. Notman and C.C. Nadelson (eds.) The woman patient: Medical and psychosocial interfaces: Vol. 1. Sexual and reproductive aspects of women’s health care, 217-231, New York: Plenum.

16. Salter, J. R. 1985. “Gynaecological symptoms and psychological distress in potential hysterectomy patients.” Journal of Psychosomatic Research, 29, 155-159.