Influences of Different Hysterectomy Techniques on Patients' Postoperative Sexual Function and Quality of Life

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DOI: 10.1111/jsm.12623

ABSTRACT

Introduction. Hysterectomy ranks among the most frequently performed gynecological surgical procedures. At the time of operation, the majority of patients are premenopausal and sexually active. Hence, detailed counseling about the effects of hysterectomy on postoperative sexuality and quality of life can be regarded as an integral part of preoperative counseling. However, available data on these subjects are limited and contradictory.
Aim. The aim of this study was to assess quality of life and sexuality following three common hysterectomy procedures—total laparoscopic hysterectomy (TLH), supracervical laparoscopic hysterectomy (SLH), and vaginal hysterectomy (VH)—in premenopausal patients using the European Quality of Life Five-Dimension Scale (EQ-5D) and Female Sexual Function Index (FSFI).
Main Outcome Measures. Preoperative and postoperative EQ-5D and FSFI scores were compared using the Wilcoxon signed-rank test. Kruskal–Wallis analysis and Mann–Whitney *U*-test with post hoc Bonferroni correction were used to assess differences among the three subgroups.
Methods. All premenopausal patients who underwent TLH, SLH, or VH without adnexectomy due to benign uterine disorders between April 2011 and June 2013 at the Department of Gynaecology and Obstetrics of Saarland University Hospital were enrolled in this observational cohort study. Sexuality and quality of life status were assessed preoperatively and 6 months postoperatively using two standardized validated questionnaires: the FSFI, a multidimensional, self-reported instrument for the assessment of female sexual function, and the EQ-5D, a standardized, validated instrument to measure an individual's health status.
Results. Of 402 eligible patients, 237 completed the study. Patient characteristics and preoperative FSFI and EQ-5D scores did not differ among the three hysterectomy subgroups. Postoperative FSFI and EQ-5D scores were significantly higher ($P \leq 0.01$) than preoperative scores for all procedures but did not differ among the groups.
Conclusions. In this cohort of premenopausal women, hysterectomy without adnexectomy performed due to benign uterine pathologies had significant positive effects on postoperative sexual function and quality of life, regardless of the surgical technique used. **Radosa JC, Meyberg-Solomayer G, Kastl C, Radosa CG, Mavrova R, Gräber S, Baum S, and Radosa MP. Influences of different hysterectomy techniques on patients' postoperative sexual function and quality of life. J Sex Med 2014;11:2342–2350.**

Key Words. Hysterectomy; Laparoscopy; Sexuality; Quality of Life; Sexual Function; Gynaecology

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Introduction

Hysterectomy is one of the most frequently performed gynecological surgical procedures [1]. Nearly 150,000 hysterectomies are conducted annually in Germany [2], 85% of which are elective interventions due to benign uterine pathologies [3,4]. At the time of operation, the majority of patients are aged 40–49 years, and one-third are aged 50–59 years [5]. In these mostly premenopausal [6], sexually active [7] patients, postoperative quality of life and sexual function may be regarded as pivotal surrogate parameters used to evaluate and to compare the outcomes of hysterectomy procedures performed due to benign uterine disorders.

Recently, sexual function and quality of life following hysterectomy have become a focus of research. For instance, previous study groups have attempted to further elucidate sexual function and quality of life in patients undergoing radical hysterectomy for cervical cancer [8,9] and in the context of female-to-male transsexual surgery [10]. However, the selection of valid and reproducible methods of assessing these target variables constitutes a major challenge. Both parameters are readily biased by factors related to the surgical approach used for hysterectomy and/or concurrent surgical procedures. For instance, Ayoubi and colleagues [11,12] suggested that laparotomy procedures were associated with long-term impairment of quality of life due to increased postoperative pain levels and delayed resumption of normal activities of daily life in comparison with a laparoscopic approach. Unilateral or bilateral adnexectomy performed concurrently with hysterectomy was found to significantly reduce postoperative libido in premenopausal patients [13]. Differences in the age compositions of study populations also limit the ability to generalize posthysterectomy quality of life and sexual function findings, as both parameters have been shown to be negatively impacted by menopause [14].

Possibly due to these challenges, the reported impacts of hysterectomy for the treatment of benign uterine disorders on sexual function and postoperative quality of life have been remarkably heterogeneous. For example, authors evaluating the effects of hysterectomy on sexual function in the past decade have variously reported postoperative improvement, no impact, or reduced libido [11,15,16]. The recent introduction of validated questionnaires for the assessment of quality of life, such as the European Quality of Life Five-Dimension Scale (EQ-5D), and sexual function, such as the Female Sexual Function Index (FSFI), has facilitated the standardized and reproducible evaluation of these parameters.

The aim of this study was to assess quality of life and sexuality after three commonly performed hysterectomy procedures (total laparoscopic hysterectomy [TLH], supracervical laparoscopic hysterectomy [SLH], and vaginal hysterectomy [VH]) in premenopausal patients in a valid and reproducible manner by using the EQ-5D and FSFI questionnaires.

Materials and Methods

Study Design and Patients

All patients who underwent TLH, SLH, or VH due to benign uterine disorders between April 2011 and June 2013 at the Department of Gynaecology and Obstetrics, Saarland University Hospital, Homburg, Germany, were enrolled in this observational cohort study. The following inclusion criteria were applied: premenopausal state at the time of surgery, assessed according to World Health Organization (WHO) criteria [17]; hysterectomy indicated for a benign gynecological condition and performed without concurrent unilateral or bilateral adnexectomy; and American Society of Anesthesiologists physical status classification of I or II, assessed preoperatively by the anesthesiological faculty of our hospital. Exclusion criteria were refusal to participate in the study, severe (Clavien–Dindo grade IV or V) [18] perioperative complication with need for intraoperative conversion to laparotomy or abandonment of the intended surgical procedure, second- to fourth-degree uterine descensus requiring surgical prolapse repair, and intraoperatively diagnosed adnexal pathology requiring subsequent unilateral or bilateral oophorectomy. The hospital's ethics board approved the study protocol.

Procedures

Since 2009, TLH has been the standard hysterectomy technique used at our hospital in cases of benign uterine disorders. We offer SLH as an alternative for women who desire partial preservation of the uterus and have histories of normal cervical cancer screening (Papanicolaou test and colposcopy) results. VH is usually offered to multiparous women presenting with grade I or II uterogenital prolapse to allow for additional surgical prolapse repair by anterior and/or posterior

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