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No. 109-Hysterectomy

The following Clinical Practice Guideline has been reviewed by the Clinical Practice Gynaecology Committee and approved by Executive Committee and Council of the Society of Obstetricians and Gynaecologists of Canada.

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Key Words: Hysterectomy, uterine bleeding, fibroids, gynaecology, endometriosis

Abstract

Objective: To identify the indications for hysterectomy, preoperative assessment, and available alternatives required prior to hysterectomy.

Patient self-reported outcomes of hysterectomy have revealed high levels of patient satisfaction. These may be maximized by careful preoperative assessment and discussion of other treatment choices. In most cases hysterectomy is performed to relieve symptoms and improve quality of life. The patient's preference regarding treatment alternatives must be considered carefully.

Options: The areas of clinical practice considered in formulating this guideline are preoperative assessment including alternative treatments, choice of method for hysterectomy, and evaluation of risks and benefits. The risk-to-benefit ratio must be examined individually by the woman and her health practitioners.

Outcomes: Optimizing the decision-making process of women and their caregivers in proceeding with a hysterectomy having considered the disease process, and available alternative treatments and options, and having reviewed the risks and anticipated benefits.

Evidence: Using Medline, PubMed, and the Cochrane Database, English language articles were reviewed from 1996 to 2001 as well as the review published in the 1996 SOGC guidelines. The level of evidence has been determined using the criteria described by the Canadian Task Force on the Periodic Health Examination.

Benefits, harms, and costs: Hysterectomy is the treatment of choice for certain gynaecologic conditions. The predicted advantages must be carefully weighed against the possible risks of the surgery and other treatment alternatives. In the properly selected patient, the result from the surgery should be an improvement in the quality of life. The cost of the surgery to the health care system and to the patient must be interpreted in the context of the cost of untreated conditions. The approach selected for the hysterectomy will impact on the cost of the surgery.

Recommendations:

Benign Disease

1. **Leiomyomas:** For symptomatic fibroids, hysterectomy providesa permanent solution to menorrhagia and the pressure symptoms related to an enlarged uterus (I-A).
2. **Abnormal uterine bleeding:** Endometrial lesions must be excluded and medical alternatives should be considered as a first line of therapy (III-B).

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3. **Endometriosis:** Hysterectomy is often indicated in the presence of severe symptoms with failure of other treatments and when fertility is no longer desired (I-B).
4. **Pelvic relaxation:** A surgical solution usually includes vaginal hysterectomy, but must include pelvic supporting procedures (II-B).
5. **Pelvic pain:** A multidisciplinary approach is recommended, as there is little evidence that hysterectomy will cure chronic pelvic pain. When the pain is confined to dysmenorrhea or associated with significant pelvic disease, hysterectomy may offer relief (II-C).

Preinvasive Disease

1. Hysterectomy is usually indicated for endometrial hyperplasia with atypia (I-A).
2. Cervical intraepithelial neoplasia in itself is not an indication for hysterectomy (I-B).
3. Simple hysterectomy is an option for treatment of adenocarcinoma in situ of the cervix when invasive disease has been excluded (I-B).

Invasive Disease

I. Hysterectomy is an accepted treatment or staging procedure for endometrial carcinoma. It may play a role in the staging or treatment of cervical, epithelial ovarian, and fallopian tube carcinoma (I-A),

Acute Conditions

1. Hysterectomy is indicated for intractable postpartum hemorrhage when conservative therapy has failed to control bleeding (II-B).
2. Tubo-ovarian abscesses that are ruptured or do not respond to antibiotics may be treated with hysterectomy and bilateral salpingo-oophorectomy in selected cases (I-C).
3. Hysterectomy may be required for cases of acute menorrhagia refractory to medical or conservative surgical treatment (II-C).

Other Indications

1. Consultation with an oncologist or geneticist is recommended when considering hysterectomy and prophylactic oophorectomy for a familial history of ovarian cancer (III-C).

Surgical Approach

1. The vaginal route should be considered as a first choice for all benign indications. The laparoscopic approach should be considered when it reduces the need for a laparotomy (III-B).

Validation: Medline searches were performed in preparing this guideline with input from experts in their field across Canada. The guideline was reviewed and accepted by SOGC Council and Executive.

Sponsor: The Society of Obstetricians and Gynaecologists of Canada.