Sexual dysfunction following hysterectomy

August 23, 2006 | Pelvic Pain [1], Sexual Health [2], ObGyn Compensation Survey [3], Laparoscopy [4], Hysterectomy [5], AAGL 2003 [6]
By Michael L. Moore, MD [7]

Click here for Real Player Video

Barbara Nesbitt: Hi, I am Barbara Nesbitt, I am the editor of OBGYN.net and I am here with one of our editorial advisors, Dr. Michael Moore, of Denver, Colorado. Hello, Dr. Moore.

Michael Moore, MD: Hello, Barbara.

Barbara Nesbitt: We are going to talk about sexual dysfunction in the female patient following hysterectomy and the new things that Dr. Moore has read about worldwide and what they are doing for it.

Michael Moore, MD: Thank you, Barbara. Thank you for the invitation to talk about a very important topic.

The uterus is a reproductive organ and it is part of your sexual organs as a woman, so when you have a problem that requires hysterectomy, there is going to be some potential impact on sexual functioning. A lot of information is available today in the lay literature that talks about hysterectomy and a lot of women come in having read these and they are scared to death of a hysterectomy because of all the information or, should I say misinformation that is out there about the loss of sexual function that follows hysterectomy.

The history, because I just got through doing a lecture on sexual function and hysterectomy, has enlightened me with new knowledge. I set out to gather information for this talk and much of the information that I was aware of in the early ‘90s indicated that you could anticipate a woman would have a 20% to 30% chance of sexual dysfunction following a hysterectomy and the literature attributed that to the hysterectomy itself because we know uterine contractions occur during orgasm and so, because of that, removal of the uterus was perhaps felt to affect sexual function. All the older literature, which is mostly retrospective information, was going along with that.

Now, what you have to realize from retrospective data is that they identify, say, 100 women who have had a hysterectomy in the past. Now they send those ladies a questionnaire and it might be a year, two, three years after their hysterectomy. You have got to then wait for these questionnaires to come back. Now, if you get 70 out of 100 questionnaires back, you are doing really well. But who are going to be the ladies who respond? Maybe more who are unhappy with the procedure and are not happy with the outcome. In the ‘90s, there are about eight or nine really good prospective cohort studies. Now, prospective means the information was gathered before the hysterectomy about sexual dysfunction and then sexual information was gathered six months or a year or eighteen months after the hysterectomy. It is a cohort because it is a group of women who then have the operation and we compare their questionnaire results beforehand and see their questionnaire results afterward. There is no control group and it is a very important part of scientific studies to have a control group. So that gives us some indication as to how women might do.

A very, very good study of about 150 women with 18 months of follow-up not only looked at the women’s sexual function, as well as the quality of the experience, which I think was unique to most of the studies - I think that is what drew me to this one particularly - and it looked at psychological parameters. It indicated, at least the authors drew the conclusion that the women’s sexual functioning before the hysterectomy dictated to some degree her sexual function afterward.
The majority of women who have hysterectomy notice no difference in sexual function. There is a group of women who actually find it has improved. They were starting to have pain with intercourse because of an enlarged fibroid uterus, now they can have comfortable intercourse and that does improve the quality of the experience. But some women also develop problems afterward and this represents a challenge. Who can we anticipate might develop problems afterward? Something that appears in the literature, speculated on by many authors, is the woman who does not want to have a hysterectomy at all who is the woman who has a problem.

There have been several randomized control trials looking at the effect of hysterectomy on sexual function. These are good because they have a control group, as well as the treatment group, and that becomes very important because then you can say, here’s a group of women who didn’t have a hysterectomy, had an endometrial ablation procedure, and that group is compared to a group of women who entered the study - all of these women enter the study at the same, so 200 women entered the study - 100 randomly are assigned to non- hysterectomy treatment, i.e. endometrial ablation. The other half is assigned to hysterectomy, but they all went in knowing they were going to get one or the other. They all had the same set of information and what the studies do not tell us is how many women interviewed and then once they heard all that decided not to. That’s very important because these ladies were prepared for this and, indeed, at one year and two studies that looked at non- hysterectomy treatment versus hysterectomy, the sexual functioning is the same in both groups. There was no difference in preserving the uterus and just removing the uterine lining versus removing the uterus.

Even with removal of the cervix, because there is a lot about supracervical surgery these days: keep the cervix preserve sexual function. Two randomized control trials, one to two years of follow-up, again, no differences in sexual function if you keep the cervix or you take it. Now there was a small group of women who did develop deep pain with intercourse if their cervix is removed compared to the women who did not. So there may be some effect in terms of pain if you remove the cervix. Unfortunately, we do not have 20 year data and that may become very important, but I think it is really important for a woman who recognizes inside when she hears that “H” word come out that she really take the “how does it feel” approach because not every woman wants a hysterectomy to take care of their problems.

A 45-year-old patient came to see me just the day before I came to AAGL. She had never had children but she said, I do not plan on having children. She had a couple fibroids and when she got the report back over the phone that is when she first heard it. She really felt inside that this was not good and she had the courage to sit down with her doctor and say, this is not for me, I do not want a hysterectomy to take care of this problem. Unfortunately, the doctor had presumed that because she was over 40, did not plan on having children, that that would be the best thing for her. On the other hand, as we sat down and talked and she shared that with me, it did not make me feel good that I always approach patients with never presuming that. With fibroid tumors especially, there are three really good treatments. One is hysterectomy, and if it can be done laparoscopically even better because there is less pain and a much faster recovery. There is also the ability to do laparoscopic myomectomy, so you can remove the fibroids instead of removing the uterus and for a woman over 45, she is liable not to have any other intervention and can go to menopause and not have anything else done and her goals have been met: she did not have a hysterectomy, she has not had an adverse effect on her, whether it is psychological function, urinary function, bowel function, sexual function.

The type of woman who accepts hysterectomy, as a good procedure will do well, but the woman who does not accept that premise will not do well. She is going to have problems because she is going to blame it on that hysterectomy she did not want. The third option we offer women who do not want to have a period, but they are sick and tired of the heavy bleeding and they do not want a hysterectomy. There, we can combine a technique where we can remove the fibroids and the uterine lining - this can all be done laparoscopically and the woman will go home the day of her surgery. Our average patient is back at work in ten to fourteen days and they are sexually active again in approximately three weeks, on average. These laparoscopic surgeries work very, very well to cut down on pain in recovery.
A properly counseled woman should be told, yes, there could be a change in sexual function, but if the doctor explores her sexuality with her and prepares her for that and discusses the alternatives to hysterectomy that are appropriate for her, then that woman will guide the doctor to what procedure is right for her because she will not allow herself to undergo a procedure that psychologically attacks her defense mechanisms. So I always discuss three alternatives when women have fibroids. Now with endometriosis, pelvic pain, sometimes non-hysterectomy alternatives are not good choices. For pelvic prolapse, we know you do not have to have a hysterectomy to have your prolapse corrected, so always discuss keeping your uterus if you want to and I let the woman make her choice. Some women, they are ready for it, they find it is a good operation; they do not have certain feelings about it. Other women do and you have got to respect a woman’s feelings, just like I would want someone to respect my feelings.

Barbara Nesbitt: Now, I had a hysterectomy years ago and I have not had any problems, it was abdominal and I was extremely fortunate and also had a really good GYN who did it. So what you are saying is that if a woman is a little nervous or reticent prior to having it done, she is probably more apt to not be completely happy afterward.

Michael Moore, MD: I always think so.

Barbara Nesbitt: Everything is not explained and she is not comfortable with the whole thing, she might be more apt to be one that is unhappy post-surgery.

Michael Moore, MD: Unless that woman can voice that concern to the physician, just say ‘I don’t want that.’

Barbara Nesbitt: When do I say this, obviously prior to the procedure? This is new for women, younger women are probably better at it, I am not sure, but a lot of women feel that they should not be questioning their physicians.

Michael Moore, MD: Oh, yes.

Barbara Nesbitt: So for the women who were born in that time or think that way, we are trying to educate and that is why you are here. What should I say to you on that visit before we decide on which procedure to do? I could just say to you, doctor, I’m worried about this, I’m married or not or whatever, but I’m worried about my sex life after the procedure. Should she just not have the courage to say that or what should she say?

Michael Moore, MD: Oh, I hope she does or at least learn some more about what she is going to have. I encourage patients to go to the Internet, to seek out more information, even to get other opinions about the procedures they are considering because this is a big step and they are going to have to live with the outcome.

Two things happen: one, I think physicians go through training, they get a knee-jerk reflex that hysterectomy is the right operation for these problems. Now, some physicians are not trained to do myomectomies, they are worried about the bleeding associated with the removal of the fibroids, but not the uterus. What we know is that the proper surgical techniques result in good outcomes, quite frequently that big, bad, bloody cases are not usually the rule in well-trained hands. But if you do not have that skill set, you may not offer that to the patient and yet, if you do not offer that to the patient, then they may not do well because they might take that other option, so we always lay out the options and that way the patient does not have to be her own advocate. But a woman must be aware that there are all sorts of alternatives, she should be encouraged to look for those alternatives and look into her own heart about how she feels because this does affect your sexual organs, and it may effect your sexual functioning.

In the largest cohort study, about 1,200 women out of Maryland, they showed that about 5% to 10% who did not have sexual dysfunction problems before the hysterectomy will develop sexual dysfunctions problems. Some of those may be relational problems: the husband or boyfriend becomes a jerk after the operation; maybe he did not want her to have the hysterectomy. I have run into that before, where the man has that feeling. They feel they are no longer a woman and women
feel that way, so by using patient-specific therapy and not making the patient fit into the therapy, we will have better outcomes.

**Barbara Nesbitt:** Okay, thank you, but I just want to throw one thing because this is what I am hearing. What I am hearing is that there are possibly three options: hysterectomy, myomectomy or the ablation.

**Michael Moore, MD:** For fibroids.

**Barbara Nesbitt:** So, number one, before you even get into sexual function following a hysterectomy, a woman should ask, do you do these, all three procedures and how often have you done them? Pose those good questions and then when you are comfortable with the doctor who is going to do the procedure is qualified to do more than just one and you have made your selection that you have found a really good GYN, then you should be comfortable in sitting down and exploring post-op problems, sexual dysfunction, but she wants a good GYN that explains the alternatives.

**Michael Moore, MD:** I agree, Barbara, I think the doctor is the one who should bring this forward, not the patient, if at all possible.

**Barbara Nesbitt:** But the patient should be aware if she is hearing hysterectomy only, she should be starting to ask questions, like why and maybe because it’s your only option, but he will explain that to you and that gets a good rapport going, I think, with the patient and the physician then they can talk about the procedures that will be done and when I have a good rapport with you, then I can ask other things.

**Michael Moore, MD:** Of course.

**Barbara Nesbitt:** I think what you said is, make sure you have a physician who is trained in different types of alternatives, right?

**Michael Moore, MD:** Yes.

**Barbara Nesbitt:** I am not trying to put words in your mouth, but make sure you are happy with who will be doing the procedure and makes you comfortable in the fact that they are well qualified and then I think the woman has this wonderful opportunity to feel comfortable and not panic.

**Michael Moore, MD:** That would be the ideal situation.

**Barbara Nesbitt:** You have let them all know that there are options, they should speak up and they should be comfortable in asking their physicians just about anything they want to ask them, that is why they are going to them.

**Michael Moore, MD:** That is the case. Yet a woman should not be afraid to question the expertise of her physician because in this day and age, there has never been such a technological gap in training. Most physicians graduated before the age of modern laparoscopy, they do not feel comfortable doing laparoscopic surgery, they do not have the training and therefore they do not offer the options. They are aware of them and they should offer therapies they do not do, that is the ethics of medicine.

**Barbara Nesbitt:** Well, I thank you and I think this will help educate a lot of women before the procedure as well as after. Thank you, Doctor; it has been wonderful talking to you.

**Michael Moore, MD:** I hope so. Thank you for taking an interest in this subject.

**Barbara Nesbitt:** Thank you.