

# HYSTERECTOMY FOR MENORRHAGIA

## An audit at Furness General Hospital

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### INTRODUCTION

Heavy menstrual bleeding (menorrhagia) is a common problem that has a major impact on a woman's quality of life and is associated with significant utilisation of health care resources.<sup>(1)</sup>

In the early 1990s, it was estimated that at least 60% of women presenting with menorrhagia went on to have a hysterectomy in the United Kingdom. This was the only treatment offered. Half of these women were found to have a normal uterus.<sup>(2,3)</sup> Since the 1990s, the number of hysterectomies has been decreasing rapidly. This is mainly due to the introduction of other treatment options such as the Mirena system and endometrial resection/ablation.

Hysterectomy is a definitive treatment for menorrhagia with high patient satisfaction. However, this needs to be balanced against the risk of serious morbidity.<sup>(4)</sup>

The aim of this paper is to present an audit of patients who underwent hysterectomy because of heavy menstrual bleeding over a three-year period.

### AUDIT STANDARDS

1. All patients with heavy periods should have full investigation, including ultrasound scan and hysteroscopy, unless opting for hysterectomy without trial of other treatment.
2. All patients with dysfunctional bleeding should be offered alternative treatment to hysterectomy.

### METHODS

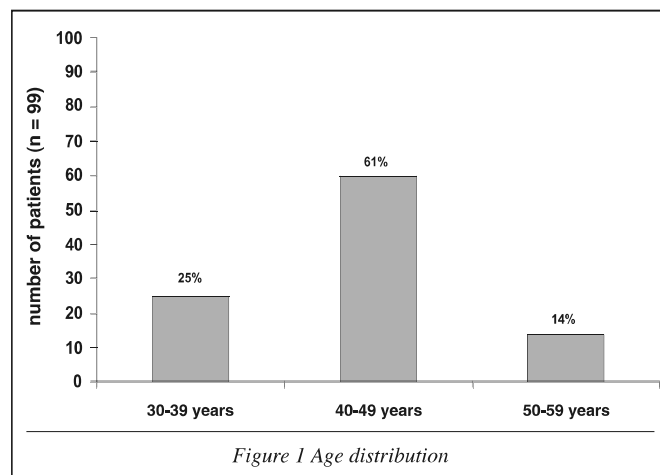
A retrospective casenote review was carried out by one consultant team for all hysterectomies, excluding women with malignancies, ovarian pathology, or utero-vaginal prolapse, over a three-year period (January 2003 to December 2005). Details of investigations, medical treatment, endometrial ablation and other procedures were recorded with a view to evaluate the compliance of clinical practice to published guidelines.<sup>(2,3)</sup>

#### Summary

Casenotes examined	149
Menorrhagia as <b>primary</b> indication for hysterectomy	99 (66.4%)
Patients with gynaecological pathology associated with menorrhagia	60 (40.3%)

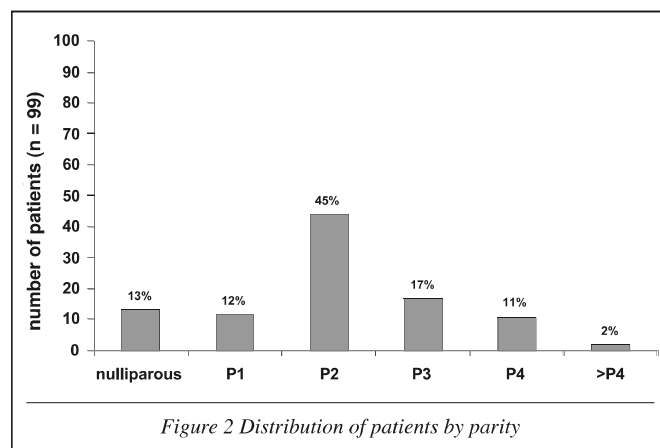
### RESULTS

A total of 99 of the 149 women (66.4%) underwent a hysterectomy exclusively for menorrhagia during the study period. The majority of the patients (61%) were in the age group 40-49 years (see figure 1). There were only 25% and 14% of the patients below 40 and above 50 years of age respectively.



Sixty-seven percent of the patients in our study were offered alternative treatment prior to hysterectomy. Out of this group, 62% were offered Mirena intra-uterine system (IUS), 36% had medical treatment and 35% opted for endometrial resection/ablation. The majority of patients (73%) were offered one type of alternative treatment while 18% and 9% of the patients were offered two and three types of alternative treatment respectively.

Seventy-three percent of patients had ultrasound scan as part of their investigations.



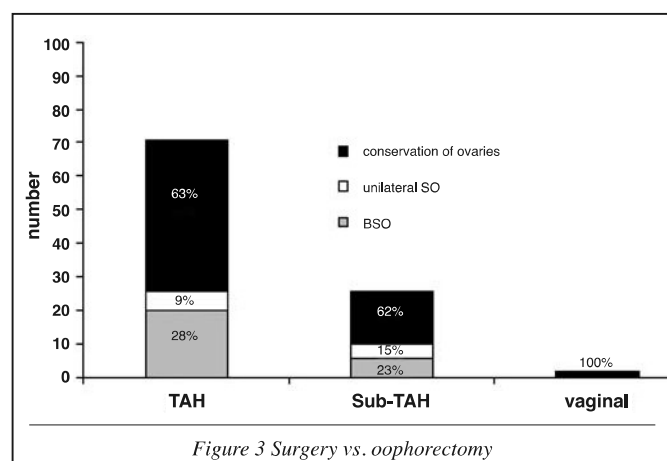
Patients' requests to have a hysterectomy, despite detailed explanation of the risks involved, were noticed in 42.4% of the cases. The number of hysterectomies carried out, due to failure of alternative treatments offered to patients before hysterectomy, was 14 (14.1%). However, menorrhagia was associated with other conditions warranting a hysterectomy in 60 (60.6%) patients. These are presented in table 1.

Associated problems	Number of patients (n = 60)	(%)
Menorrhagia and uterine fibroids	35	35.4
Menorrhagia and pelvic pain	16	9.1
Menorrhagia and endometriosis	8	8.1
Menorrhagia and anaemia	1	1

*Table 1 Conditions associated with menorrhagia in women who underwent a hysterectomy*

Hysterectomy was carried out by a consultant in 68% of the cases and the rest were carried out by middle-grade gynaecologists. Total abdominal hysterectomy (TAH) was performed in 72%, subtotal hysterectomy in 26%, while vaginal hysterectomy was carried out in only 2% of the cases.

Both ovaries were conserved in 63% of the cases. Unilateral salpingo-oophorectomy (SO) was carried out in 12%, while bilateral salpingo-oophorectomy (BSO) in 25% (see figure 3).



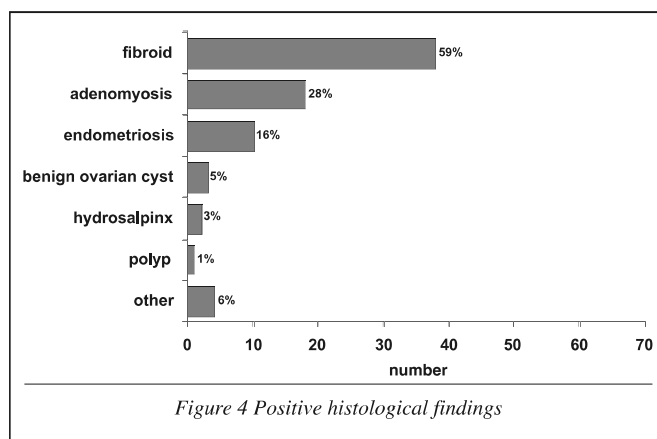
Complication rate for hysterectomy was 14.1%. Details of different types of complications are shown in table 2.

Type of complications	Number of patients (n = 14)	(%)
Infection	7	7.1
Wound haematoma	3	3
Vault granulation tissue	2	2
Wound drainage & repeat closure	1	1
Pelvic pain	1	1

*Table 2 Complications of hysterectomy*

Histological examination revealed that 65% of hysterectomy specimens showed a variety of positive findings (see figure 4).

The histology, of 58% of the 42 patients who had hysterectomy carried out at their request, showed no abnormality. On the other hand, 62% of the 25 patients who had hysterectomy due to failure of endometrial resection had positive histological findings.



## DISCUSSION

Hysterectomy is an effective procedure but its widespread use should be balanced against its potential for mortality and morbidity. Morbidity in our study was relatively minor.

Only one of the 99 women had a haemoglobin below 10 g/dl preoperatively and required blood transfusion. This reinforces the fact that women may perceive their menstrual loss to be heavier than it actually is.

There was a high level of compliance in patients' counselling before hysterectomy. Nearly 67% of women received some form of alternative treatment. Subtotal hysterectomy was carried out only at patient request or in the presence of extensive pelvic adhesions due to conditions such as pelvic infection, endometriosis or previous pelvic surgery.

Patient choice is essential before considering any form of treatment. Many women refuse conservative treatment in hospital as they may have had years of medical treatment in primary care before referral. However, in view of the high percentage of normal histology among women who underwent a hysterectomy at their request, greater emphasis on patient education, by means of information leaflets and counselling, may help in improving the implementation of the Royal College of Obstetricians and Gynaecologists guidelines. A structured-care pathway with early hospital referral can help to improve the uptake of more conservative treatment.<sup>(5)</sup>

Second-generation endometrial ablation techniques, such as thermal balloon endometrial ablation and microwave endometrial ablation, have been introduced with the aim of providing simpler, quicker and effective treatment options for menorrhagia. These techniques are less operator dependent than the first-generation techniques, but they rely heavily on the devices themselves to ensure safety and efficacy. This should encourage gynaecologists to offer it as an alternative treatment for the management of patients with menorrhagia, resulting in further reduction in the number of patients undergoing hysterectomy.

## ACKNOWLEDGEMENTS

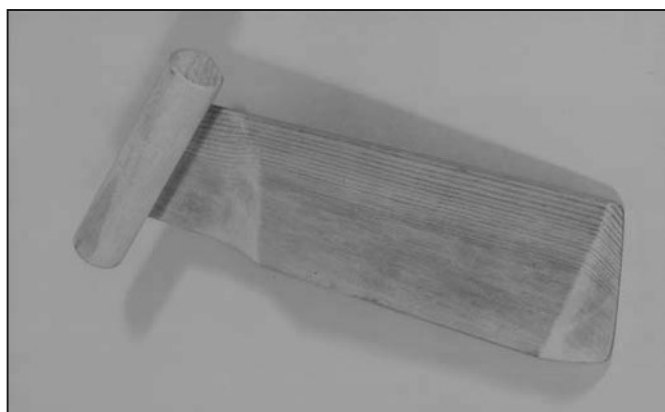
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