
Quality of life after hysterectomy at tertiary care hospital in upper Egypt

Laila Ezzat and Mohamed Salah
Obstetrics and gynecology
department, Aswan University,
Aswan, Egypt

Abstract

Background: Hysterectomy is the most common major gynaecological surgery often performed for benign lesions. Many studies have reported adverse psychosocial outcomes post-hysterectomy. This study is to evaluate psychological wellbeing, and quality of life in patients undergoing hysterectomy for non-malignant conditions, in comparison with patients undergoing surgery other than hysterectomy.

Methods: A comparative study was conducted on 90 consecutive out-patients who underwent hysterectomy for non-malignant indications at least 6 months ago. The comparison group comprised of 45 consecutive out-patients who underwent gynaecological surgery other than hysterectomy at least 6 months ago formed the comparison group. The study participants were evaluated on Psychological General Wellbeing Index (PGWBI), and Women's Quality of Life Questionnaire (WOMQOL).

Results: No statistically significant difference on socio-demographic characteristics such as patient age, marital status, social and education levels. There were no significant differences in the study groups on scores of PGWBI, and WOMQOL. Both the study groups had good marital adjustment and majority reported no depression and anxiety.

Conclusion: There is no major psychiatric morbidity, decline in marital adjustment and quality of life after hysterectomy for benign conditions among women at Aswan university hospital in upper Egypt.

Keywords: Hysterectomy, complications, Psychological well-being and Quality of life.

INTRODUCTION

Hysterectomy is the removal of uterus and it is the commonest major surgical procedure performed in gynaecology.(1)

It is the second most common operative procedure performed on women in world after lower segment caesarean section(LSCS). Its incidence varies between 6.1 to 8.6 per 1000 female. (2)

Hysterectomy for benign gynaecological lesions are usually undertaken to improve the quality of life (QOL) of affected females. (3)(4)

The rate of hysterectomy vary with geographic area, patient expectations, training and practice patterns of local gynaecological surgeons.(5)

Corresponding author:

Laila Ezzat
mobile: +201117234776
E-mail address: lailaezzat972000@
gmail.com

Although hysterectomy is the definitive management for many conditions, it is not risk free. It is associated with risk of iatrogenic premature menopause, surgical and anaesthetic risks. (5)

Hysterectomy is theorized to cause depression because of the perceived loss of feminine self-image, strength, and self-esteem, as well as feelings of deformation, mutilation, and the mourning of the loss of fertility. (6)

The uterus symbolizes femininity, fertility, sexuality, strength, vitality, youth, attractiveness, competency, regulation of body processes, and control of the life rhythm. (7)

Anticipatory guidance regarding decreased libido, physical changes, loss and grief reactions, and the possible complications of surgery can affect sexual functioning, marital adjustment, and consequently, QOL after removal of uterus. (8)

The positive outcomes of hysterectomy include decreases in chronic pelvic pain (CPP) and pain during intercourse, as well as the elimination of dysmenorrhea and dysfunctional uterine bleeding (DUB). (9)

However, hysterectomy may sometimes result in new symptoms related to pain, sexual dysfunction, and psychological distress, as well as in long-term adverse effects related to ovarian failure (OF). (7)

Some researchers have reported adverse sequelae of hysterectomy such as depression, psychosis, anxiety and psychosomatic disturbances. (10)(11)

On the contrary, few prospective studies concluded that hysterectomy does not lead to psychiatric disorders. Hence the need for this study.

METHODS

This comparative study was conducted in the Departments of Obstetrics and Gynaecology, Aswan University hospital, Aswan, Egypt between August 2017 and August 2018. A written informed consent was obtained from all the study participants. The study group comprised of 90 consecutive adult out-patients who underwent abdominal or vaginal hysterectomy at least 6 months ago.

The comparison group consisted of 45 out-patients who have undergone gynaecological surgery except hysterectomy 6 months ago.

The socio-demographic and clinical data such as age, marital status, domicile, education level, nature of gynaecological disorder, indication for hysterectomy and other surgery was recorded on a specific proforma designed for the study. The following tool were used.

The Women's Quality of Life questionnaire (WOMQOL): Quality of life is a multi-dimensional construct and defined subjectively. The WOMQOL was developed as part of a community-based study of women's health, including mental health through the menstrual cycle with no known pathology. (12)

A generic conceptualization of QOL was used in the construction of the measure that weighted health and no health factors to ensure the representation of the life experiences of a broad range of women in the community-based Women Wellness study. The participants were asked to answer "yes", "no" or "not applicable" to the 40 questions in the WOMQOL based on how they have felt in the last week of their life.

The Psychological General Well-being Index (PGWI) contains 22 questions, covering the six subscales anxiety, depressed mood, positive well-being, general health, vitality and self-control (13)

The validity and reliability of this instrument are well documented, and it has previously been used to compare patient groups and to determine the effect of an intervention on the patient's sense of subjective well-being. (14)

Results

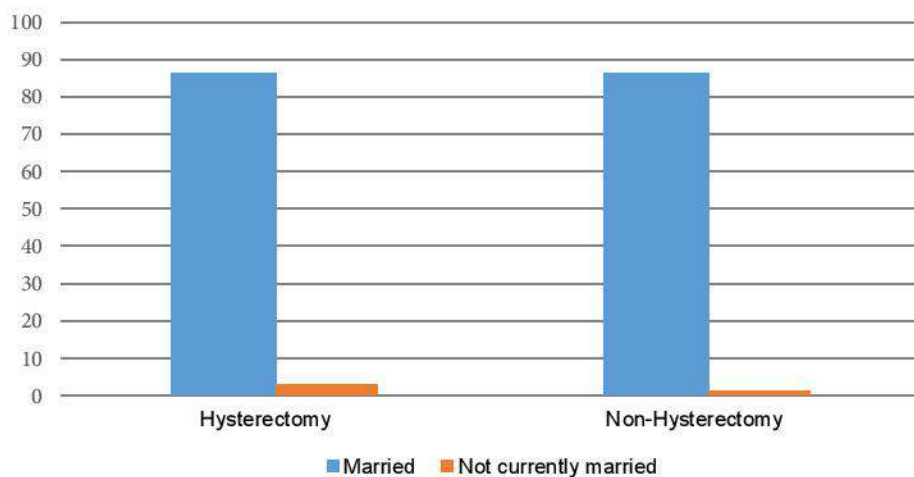
In our results the hysterectomy group and non-hysterectomy comparison group were not statistically significant different on socio-demographic characteristics such as patient age, marital status, social and education levels

Table 1: Patient age

Item	Hysterectomy	Non-hysterectomy
Mean±SD (years)	45.5±11.5	44±9
<35 years	6(6.66%)	9(25.71%)
35-49 years	76(84.44%)	24(68.57%)
≥50 years	8 (8.88%)	2(5.71%)

Table 2: Patient marital status

Item	Hysterectomy	Incidence	Non-hysterectomy	Incidence
Married	87	(96.66%)	44	(97.77%)
Not currently married	3	(3.33%)	1	(2.22%)



This table and chart show that the patient marital status among hysterectomy group were 87 patients married with incidence 96.66% and 3 patients not currently married with incidence 3.33%. But non-hysterectomy group were 44 patients married with incidence 97.77% and 1 patients not currently married with incidence 2.22%.

Table 3: Patient domicile

Item	Hysterectomy	Incidence	Non-hysterectomy	Incidence
Urban	68	(75.55%)	33	(73.33%)
Rural	22	(24.44%)	12	(26.66%)

Table 4: Patient education

Item	Hysterectomy	Incidence	Non-hysterectomy	Incidence
Primary-Highschool	73	(81.11%)	37	(82.22%)
College	17	(18.88%)	8	(17.77%)

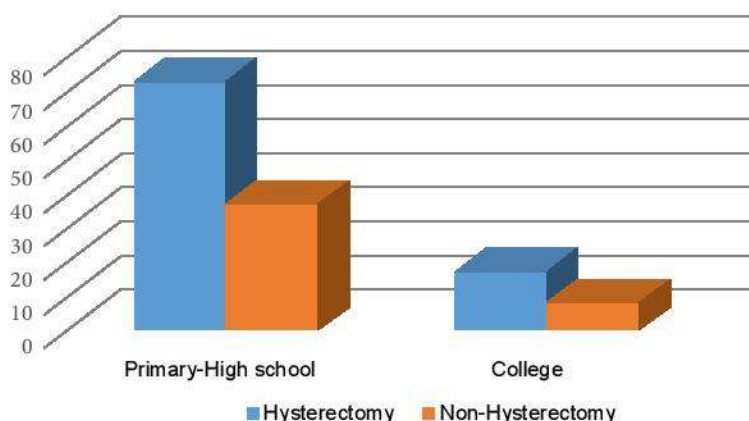


Table 5: Mean scores of the two groups on study measures.

Item	Group	N	Mean	Std. Deviation
WOMQOL	Hysterectomy	90	34.44	5.538
	Non-hysterectomy	45	34.70	5.335

Table 6: Mean scores of the two groups on study measures

Item	Group	N	Mean	Std. Deviation
PGWBI	Hysterectomy	90	84.79	14.224
	Non-hysterectomy	45	85.72	10.264

As regard The Women's Quality of Life questionnaire (WOMQOL) in hysterectomy group the mean was 34.44 and Std. Deviation was 5.538 , but in the non-hysterectomy group the mean was 34.70 and Std. Deviation was 5.335.

As regard The Psychological General Well-being Index (PGWI) in hysterectomy group the mean was 84.79 and Std. Deviation was 14.224 . but in the non-hysterectomy group the mean was 85.72 and Std. Deviation was 10.264.

The mean scores of the study groups on measures of (WOMQOL) and (PGWI) there were no significant differences in the study groups on these measures.

DISCUSSION

Hysterectomy for benign gynaecological lesion are usually undertaken to improve the quality of life of affected females. (3)(4)

The rate of hysterectomy vary with geographic area, patient expectations, and training and practice patterns of local gynaecological surgeons. (5)

The positive outcomes of hysterectomy include decreases in chronic pelvic pain (CPP) and dyspareunia, as well as the elimination of dysmenorrhea and dysfunctional uterine bleeding (DUB).(9)

However, hysterectomy may sometimes result in new symptoms related to pain, sexual dysfunction, and psychological distress, as well as in long-term adverse effects related to ovarian failure (OF).(7)

In the current study we aimed to evaluate prevalence of, psychological well-being and QOL in women post-hysterectomy in

comparison to women undergoing gynaecological surgery other than hysterectomy at a tertiary care centre.

Earlier studies have reported higher prevalence of psychiatric morbidity post-hysterectomy.(15)(16)(17)(18)

In the current study The a minority of patients after hysterectomy have depression and anxiety, but Snaith reported prevalence of depression following hysterectomy to be around 20 %.(19) and Ackner found that Psychiatric complaints were found in 30% of women post hysterectomy.(8)

The findings of the present study are in agreement with previous researchers who found no significant increase in depressive disorders after hysterectomy.(20)

Present study found most women having good quality of life which is inconsistent with the observations of earlier studies. (21)(22)

Hysterectomy is effective in reducing dyspareunia and pelvic pain which may translate into better sexual functioning, and consequently better marital adjustment and quality of life.

Recent prospective studies have determined that none negative effects resulted from hysterectomy overall, and some authors have even found positive effects of hysterectomy on the psychosocial and sexual well-being of women.(23)

CONCLUSION

This study suggests that there is no major psychiatric morbidity, decline in marital adjustment and quality of life after hysterectomy for benign conditions among women at Aswan university hospital.

RECOMENDATION

Future multi-centric research on the peculiar socio-cultural implications, use of larger sample size and effect of hysterectomy will be a significant addition to the available evidence in Egypt.

ACKNOWLEDGMENTS

Authors would like to acknowledge to all doctors and staff of Department of Obstetrics and Gynecology, Aswan University Hospital for their sincere support and help.

REFERENCES

1. Verma D, Singh P, Kulshrestha R. Analysis of histopathological examination of the hysterectomy specimens in a north Indian teaching institute. *Int J Res Med Sci.* 2016 Dec;4(11):4753-8.
2. AL Kadri HM, AL Burki HA, Saleh A. Short and Long term complications of Abdominal and Vaginal Hysterectomy for disease. *Saudi Med J.* 2002; 23(7):906-15.
3. Gray R. The future of hysterectomy. *BJOG.* 2005;112:1333-9.
4. Jones HW. Abdominal hysterectomy In: Rock JA, Jones HW, eds. *Te Linde's Operative Gynecology* 10th ed. Philadelphia, USA: Lippincott Williams and Wilkins; 2008: 727-743.
5. Vanithamani Sivapragasam¹, Chellammal K. Rengasamy¹, Aruna B. Patil² An audit of hysterectomies: indications, complications and clinic pathological analysis of hysterectomy specimens in a tertiary care center *Int J Reprod Contracept Obstet Gynecol.* 2018 Sep;7(9):3689-3694
6. Nathorst-Boos J, Fuchs T, von Schoultz B. Consumer's attitude to hysterectomy. The experience of 678 women. *Acta Obstet Gynecol Scand* 1992;71(3):230-4.
7. Bachmann GA. Psychosexual aspects of hysterectomy. *Womens Health Issues* 1990;1(1):41-9.
8. Kusum Lata Mathur^{1*}, Manu Sharma², Mohua Mazumdar², Shikha Talati², Sidharth Srivastav² Psychological well-being, marital adjustment and quality of life after hysterectomy: a comparative study *Int J Reprod Contracept Obstet Gynecol.* 2018 Dec;7(12):4960-4965
9. Farquhar CM, Sadler L, Harvey S, McDougall J, Yazdi G, Meuli KA. Prospective study of the short-term outcomes of hysterectomy with and without oophorectomy. *Aust NZJ Obstet Gynaecol* 2002;42(2):197-204.
10. Lambden MP, Bellamy G, Ogburn-Russell L, Preece CK, Moore S, Pepin T, et al. Women's sense of well-being before and after hysterectomy. *J Obstet Gynecol Neonatal Nurs* 1997;26(5):540-8.
11. Ryan MM. Hysterectomy: social and psychosexual aspects. *Baillieres Clin Obstet Gynaecol.* 1997;11(1):23-36.
12. Gehlert S, Chang CH, Bock RD, Hartlage SA. The WOMQOL instrument measured quality of life in women of reproductive age with no known pathology. *J Clin Epidemiol.* 2006;59(5):525-33
13. Dupuy H. The Psychological General Well-Being (PGWB) Index. In: Wenger NK, Mattson ME, Furber CD, Elinson J, eds. *Assessment of quality of life in clinical trials of cardiovascular therapies.* New York: LeJacq Publishing Inc, 1984:170-83.
14. Kluivers KB, Johnson NP, Chien P, Vierhout ME, Bongers M, Mol BW. Comparison of laparoscopic and abdominal hysterectomy in terms of quality of life: a systematic review. *Europe J Obstet Gynecol Reproduct Biol.* 2008;136(1):3-8.
15. Vyas JN, Rathore RS, Sharma P, Singhal AK. A study of psychiatric aspects of hysterectomy. *Indian J Psychia.* 1989;31(1):839.
16. Subramaniam D, Subramaniam SK, Charles SX, Verghese A. Psychiatric aspects of hysterectomy. *Indian J Psychia.* 1982;24(1):75.
17. El-Toukhy TA, Hefni M, Davies A, Mahadevan S. The effect of different types of hysterectomy on urinary and sexual functions: A prospective study. *J Obstet Gynaecol.* 2004;24(4):420-5.
18. Gath D, Cooper P, Day A. Hysterectomy and psychiatric disorder, I: levels of psychiatric disorder before and after hysterectomy. *Br J Psychiatry* 1982;140(4):335-42.
19. Snaith RP. The hospital anxiety and depression scale. *Health Quality Life Outcomes* 2003;1(1):29.
20. Bhatia MS, Kaur N, Goyal U. Psychiatric reactions in hysterectomy. *Indian J Psychia.* 1990;32(1):52-6.
21. Richards DH. A post-hysterectomy syndrome. *The Lancet.* 1974;304(7887):983-5.
22. Flory N, Bissonnette F, Binik YM. Psychosocial effects of hysterectomy: literature review. *J Psychosom Res.* 2005;59(3):117-29.