Original Article

Sexual Pattern of Women After Total Hysterectomy

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Abstract

Objective: To determine the etiology and sexual pattern among women underwent total abdominal hysterectomy and bilateral salpingo-oophorectomy on benign reasons in sexually active and healthy pre-menopausal women.

Methodology: This cross sectional study was done in Gynaecology and obstetrics department at Isra University Hospital Hyderabad and LUMHS. Study duration was one year from 2014 to 2015. All the women with age between 30-65 years, and who are sexually active and plan sexual activities in the course of at least 3 - 6 months following surgery were included. All the selected women underwent total abdominal hysterectomy and vaginal hysterectomy. All patients were called at OPD for follow up after every 30 days, till the six months. All the data regarding indication of hysterectomy and sexual function in the term of decreased, increased or no change in sexual satisfaction were documented on the proforma. Data analysis was done by (SPSS) version 19.

Results: Total 120 subjects were enrolled in this study. Mean age of patients was noted to be 38.5+5.3 years. In 40.5% patient's hysterectomy was done due to abnormal vaginal bleeding and in 30.50 % due to uterine fibroids. Severe endometriosis was cause in 10% and Pelvic inflammatory disease (PID) was in 18% patients. Overall 94% patients were satisfied after hysterectomy. Majority of the patients 93.33% had no effect on libido while 4.16 % patients reported decreased libido. 55.83% patients said no change in sexual desire while among 20% sexual desire was increased.

Conclusion; It was concluded that; abnormal vaginal bleeding, uterine fibroids and pelvic inflammatory disease frequent etiological factors of hysterectomy and hysterectomy not impacted on sexual pattern, almost patients were sexually satisfied.

Key words: Total hysterectomy, etiology, sexual pattern.

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Introduction

Hysterectomy is a highly common and major gynaecological operation,[1] and is most frequently achieved in females of reproductive age.[2] Most hysterectomies (60-80%) in the United States and the United Kingdom are done via abdominal incision and at least 95% of these are total rather than subtotal.[3] Above 50% of overall hysterectomies are achieved as a consequence of dysfunctional uterine bleeding associated with an extensive variety of diagnosis procedures that involve adenomyosis, endometriosis, uterine fibroids, and abnormal uterine bleeding.[4] The types of hysterectomy include total (cervix removal) and subtotal (supracervical removal of the uterus), without or with bilateral or unilateral oophorectomy.[5] Some authors debate that if the

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cervix is left intact, it lowers the risk of surgical impairment to the bladder and the adjacent nerves, and can possibly yet allow a female to experience a better longstanding sex life.[6] Data about the effect of hysterectomy on females' sexual function are unclear and inconsistent, and several practitioners do not have up-to-date awareness regarding the potential sexual outcomes of hysterectomies.[7] Females who undergo hysterectomy always remain anxious regarding the expected negative outcomes on their sexual functioning and the potential negative effects on their relationships with their partners.[8] The commonest self-reliant clinical forecaster of a lifelong and recent diagnosis of sexual malfunction of females was a lake of sexual satisfaction.[9,10, 11] The primary medical conditions resulting in sexual dysfunction of the female can be neural, vascular, anatomical and hormonal conditions.[12] The cervix and uterus can possibly be key factors in the orgasmic and sensational physiology, which is influenced by sensory stimuli from uterine, cervical, and vaginal contractions. Hysterectomy can possibly have a negative impact on this reaction system within the brain.[13] Variations rely not just on the nerves detached by the surgical procedure; however, they also rely on the genital sites that allow the female to enjoy the provoking sexual response. Clitoral sensation (by genitofemoral and pudendal nerves) must not be impaired by hysterectomy.[5] Though, the choice remains up to the females and ought to be determined by their health demands. Therefore, the purpose of this study is to determine the sexual function after Total abdominal hysterectomy and bilateral salpingo-oophorectomy on benign reasons in sexually active and healthy pre-menopausal women.

Methodology

This cross sectional study was performed in Gynaecology and obstetrics department, at Isra University Hospital Hyderabad. With one year of duration from 2014 to 2015. Total of 120 women were selected for analysis. All the women with age between 30-65 years, and who are sexually active and plan sexual activities in the course of at least 3 - 6 months following the surgical procedure were included in the study. All the women under 18 years and above 50 years, without being sure regarding sexual activity following operation and who disagreed to take part in the study were excluded from the study. A detailed medical history and clinical examination was done. All the routine laboratory investigation and ultrasound were carried out as per the hospital protocol. All the selected women underwent total abdominal hysterectomy and vaginal hysterectomy with BSO. All patients were called at OPD for follow up after every 30 days, till the six months. All the data regarding the indication of hysterectomy and sexual function in the term of decreased, increased or no changes in sexual satisfaction were documented on the proforma. After the collection of data, the analysis will be conducted by using Statistical Package for Social Science (SPSS) software, Version 19.

Results

Total of 120 patients were included in this study. Mean age of the patients was 38.5±5.3 years. In 40.5% patient's hysterectomy was done due to abnormal vaginal bleeding and in 30.50 % due to uterine fibroids. Severe endometriosis was cause in 10% and Pelvic inflammatory disease (PID) was in 18% patients. Results showed in Figure 1.

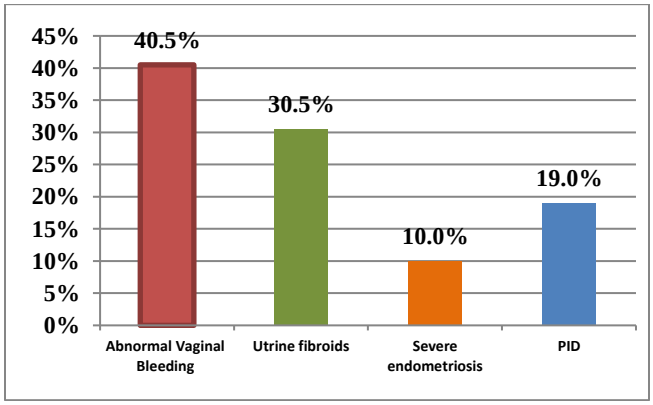

Figure:1. Indications of Hysterectomy (n=126)

Overall 94% patients were satisfied after hysterectomy while 6% were not. Figure 2

In our study, the majority of the patients 112(93.33%) had no effect on libido while 5 (4.16 %) patients reported decreased libido. 67(55.83%) patients reported no change in Sexual desire while in 24(20%) sexual desire was increased. In 64(53.33%)

Table I: Sexual Function after Total Hysterectomy (n=120)				
Sexual function	**After Hysterectomy (n=120)**			
	Decrease	**No any effect**	**Improve**	**P- value**
libido	5/(4.1%)	112/(93.33%)	3/(2.3%)	
Sexual desire	20/(16.66%)	67/(55.83%)	24/(20%)	
Dyspareunia	00	64/(53.33%)	56/(46.66%)	
Orgasm	22/(18.33%)	84/(70%)	14/(%)	0.015
Frequency of coitus	44/(36.66%)	21/(17.5%)	55/(45.83%)	
vaginismus	10/(8.33%)	105/(%)	5/(4.1%)	

patients no effect was found on dyspareunia, while in 56(6.66%) dyspareunia was improved. In 84(70%) patients no effect was found on orgasm, while in 22(18.33%) it was decreased. Frequency of coitus was improved in 55 (45.83%) patients while in 44 (36.66 %) it was decreased. 105(87.5 %) found no effect on vaginismus. Table I

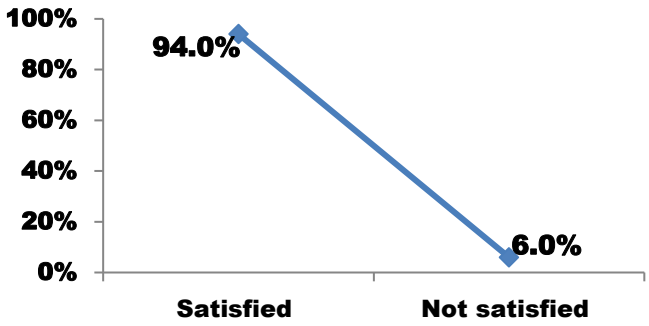

Figure 2. Overall sexual satisfaction after hysterectomy (n=126)

Discussion

The influence of the hysterectomy on sexual function is the challenging issue. There is no strong evidence of sexual dysfunction resulting from blood supply and local nerve, or by alteration, in the anatomical associations.[14] Surgical hysterectomy is correlated with no modification or even an enhancement in sexual functions, mainly in females on hormonal therapy. Therefore, overall, hysterectomy makes improvement in sexual function, irrespective of surgical technique or cervix removal. This is possible because of the symptoms enhancement that has an earlier negative impact on sexual functions. Several studies have proposed that after hysterectomy sexual functioning is a key concern of patients, however nurses, doctors, and other healthcare experts are unwilling to discuss sexual problems.[15]

In our study, 0ver all 94% patients were satisfied after hysterectomy while 6% were not. However, In comparison to our results, other reports reveal that patients reported dissatisfaction after hysterectomy in terms of sexual dysfunction.[16] One study shows that 20% to 30% of females who experience a hysterectomy report worsening in a certain aspect of their sexual function.[17] A study grounded on the literature review established that, while the majority of females appear to undergo significant enhancement in sexual functioning following the hysterectomy, particularly 10% to 22% of females underwent a deterioration in sexual function after surgery.[18] A precise reason underlying the likely sexual malfunction following hysterectomy is obesity.[19,20] It is assumed that upper vaginal neural support is correlated to lubrication and orgasm and that several nerves in the pelvis carry out their function via a structure termed as uterovaginal plexus.

Historically the uterus is a controller and regulator of vital physiological functions, a source of vitality and energy, a sexual organ, and a sustainer of attractiveness and youth. Females are worried that hysterectomy can possibly affect their sexual fitness or their sexual charm. Hysterectomy, as reported by many studies, has several adverse plus advantageous effects on sexual fitness. Because hysterectomy disturbs the anatomical relationships of the pelvic organs and local nerve supply, it is believed that the functionality of these organs can possibly be adversely affected.

In our study, the majority of the patients, i.e. 93.33 % had no effect on libido while 4.16 % patients reported decreased libido. 55.83% patients reported no variation in Sexual desire while in 20 % sexual desire was increased. This may be due to the reason that their disease like PID, endometriosis, chronic pelvic pain was cured which was causing dyspareunia. In 53.33% patients, no effect was found on dyspareunia, while in 56(46.66%) dyspareunia was improved. In 70% patients, no effect was found on orgasm, while in 18.33% it was decreased. Frequency of coitus was improved in

45.83% patients while in 36.66% it was decreased. 87.5% found no effect on vaginismus. In comparison to our study, Study conducted by Goktas SB et al [21] reported that female sexual malfunction has been noticed to increase following a hysterectomy. In surgical menopause, bilateral oophorectomy leads to a considerable deterioration in the levels of testosterone. Androgens are believed to be essential for libido, sexual arousal, pleasure, contribute to clitoral and vaginal function in the course of genital sexual stimulation.[22] Hence, drastically declining levels of androgen following premenopausal bilateral oophorectomy can possibly result I reduced orgasm and sexual libido. Same results are found in the study conducted by Kim DH et al [23] who reported that more than two-thirds of females underwent either no variation or enhancement in sexual function and they found no statistically significant differences in variations in libido, rate of orgasm, rate of coitus, and degree of orgasm.

Roovers JP et al[24] also reported that sexual fitness increases following vaginal hysterectomy and total abdominal hysterectomy in their study. Danesh M et al[25] reported that most women who were sexually active before surgery experienced the same or better sexual functioning after surgery. Lonnée-Hoffmann R et al[14] reported that hysterectomy for benign disease has beneficial effects on sexual function. Xiao M et al[26] reported that RH can highly impair the sexual function among females.

A few experimental studies revealed that hysterectomy resulted in vaginal sensory loss, without influencing sexual function. Ultimately, the belief that uterus is essential for sexual function could raise the hysterectomy associated anxiety and lead to worsening of sexual function after the surgery.[27] In contrast, many fresh reviews reported that in short and longstanding, hysterectomies done to diminish symptoms associated to benign somatic conditions have advantageous impacts on sexual function and quality of life in general, despite the applied surgical procedure and whether the cervix is removed or not.[28,29]

Conclusion

It was concluded that abnormal vaginal bleeding, uterine fibroids and pelvic inflammatory disease frequent etiological factors of hysterectomy and hysterectomy not impacted on a sexual pattern, because almost patients were sexually satisfied after hysterectomy. Appropriate tools should be developed to assess the sexual function and body image perception among females and must be discussed with females regarding their sex life.

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