

What is already known on this topic

Outcomes of screening mammography include benefits (reduced risk of death from breast cancer) and harms (physical and psychological adverse effects from screening and follow-up tests and detection of inconsequential disease)

Current information about screening mammography fails to meet women's needs for full and balanced information about these benefits and harms

What this study adds

This model of screening mammography presents quantitative information about the outcomes of screening in a form suitable to inform decisions about screening

It provides information about cumulative benefits and harms over the same time frame (10 years) for women aged 40, 50, 60, and 70 years who are considering screening

is only a small chance of benefit but the stakes are high. Some women will be happy to choose the gamble even though they may experience anxiety, inconvenience, and physical adverse effects; other women will not. Clinicians may be able to use this information to support discussions with women about these possibilities and to support their patients in making a choice that is consistent with their own circumstances and values and preferences. As well as providing information for women aged 50-69 years, it may be useful for clinicians' discussions with patients in "out of target" age groups by making explicit the possible risks and benefits of a decision to be screened. We have incorporated these estimates into decision aids that are currently being tested in Australia. These methods can be applied to different populations and other screening contexts. The effect of such information on decision quality and

screening participation is currently unknown but can be tested.

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Trends in number of hysterectomies performed in England for menorrhagia: examination of health episode statistics, 1989 to 2002-3

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Twenty years ago 60% of patients with menorrhagia who were referred to a gynaecologist had a hysterectomy as treatment.¹ Endometrial ablation was first described in the United Kingdom in 1989 and is a viable surgical alternative to hysterectomy.² The levonorgestrel intrauterine system (Mirena, Schering Health) is highly effective in reducing menstrual bleeding and has been shown to reduce the numbers of patients proceeding to hysterectomy.³ It would be expected therefore that the numbers of hysterectomies would be falling. Nearly half of women referred to

secondary care with menorrhagia, however, express a preference for hysterectomy,⁴ and it should be recognised that hysterectomy remains an excellent treatment for menstrual problems and brings high levels of patient satisfaction. We aimed to observe trends in the number of hysterectomies performed for menorrhagia in England.

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Methods and results

We examined NHS hospital episode statistics compiled from data submitted by over 300 NHS trusts in England for the years 1989-90 to 2002-3. The figures for 2001-2 and 2002-3 have not been adjusted to account for shortfalls in the number of records submitted.

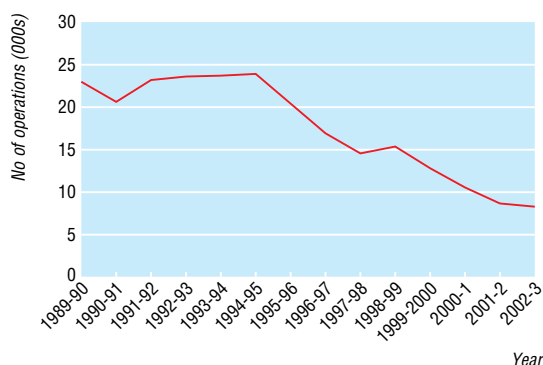
No single international classification of diseases (ICD) code exists for menorrhagia, so data included several codes, from both the ninth and tenth revisions (ICD-9: 626.2, 626.8, and 627.0; and ICD-10: N92.0, N92.1, N92.4, N92.5, and N92.6). Operation codes for hysterectomy are Q07, Q08. We used the codes Q17 and Q16 combined with Y114 (microwave endometrial ablation) and Y118 (thermal balloon ablation) to determine the number of endometrial ablations. We analysed data for patients aged 20 to 60 years.

From 1989-90 to 1994-5 an average of 23 056 hysterectomies a year were performed for menorrhagia in the NHS in England. Since 1995-6 there has been a sustained and substantial fall in this number (figure). In 2002-3, 8332 hysterectomies and 4921 endometrial ablations were performed, representing a reduction of 64% in the number of hysterectomies and a reduction of 43% (13 253 *v* 23 284) in the total number of operations for menorrhagia compared with 1989-90.

Comment

The number of hysterectomies for menorrhagia in England has fallen substantially to just over one third (36%) of the number of a decade ago. The fall in hysterectomies is not due to endometrial ablation alone as nearly 10 000 fewer operations are being performed a year.

Active education of good management of menorrhagia and promotion of effective medical management in primary care halves the number of referrals to secondary care but doubles the risk of surgery of those referred,⁵ suggesting a neutral effect on hysterectomy. The fall cannot be attributed to more operations being performed in the private sector as hysterectomy numbers are falling similarly in that sector (David Horwell, personal communication).



Number of hysterectomies for menorrhagia from 1989-90 to 2002-3 in NHS trusts in England

What is already known on this topic

Hysterectomy is a common and effective management for heavy periods

New technologies, including endometrial ablation and the levonorgestrel intrauterine system, have the potential to reduce the number of hysterectomies

What this study adds

The number of hysterectomies performed for heavy periods is only a third that of a decade ago

Although not licensed for treating menorrhagia until January 2001, Mirena has been used as a contraceptive method since May 1995, which coincides with the start of the fall in hysterectomies. The hypothesis is that Mirena is already in widespread use and having a considerable impact on the number of hysterectomies being performed. The epidemiology of Mirena for the management of menorrhagia in primary care remains to be elucidated and should be answered by the ECLIPSE study (International Standard Randomised Controlled Trial Number 86566246 (www.controlled-trials.com/isrctn)). Care should be taken with this interpretation as the use of Mirena for the management of menorrhagia is a relatively new development, and as over half of patients who have a Mirena inserted in randomised studies go on to have a hysterectomy⁴ we may yet see an increase in surgery over the next three or four years.

Being aware of this very substantial fall in hysterectomies is important and may be helpful in counselling patients before referral. The data also suggest that hysterectomy is no longer the usual management for menorrhagia in secondary care and have great implications for the future surgical training of gynaecologists.

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