

Hysterectomy for benign conditions

Patients and doctors will benefit from evidence based guidelines

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In contemporary clinical practice, patients should be given sufficient information about the reason for any treatment offered, the risks and benefits of the treatment, and the alternative options. For women undergoing hysterectomy, this ideal has scarcely been fulfilled. One reason for this has been the paucity of evidence on which to base counselling; the other is that gynaecologists, owing to limitations in their training, have not always been in a position to offer their patients a genuine choice of treatment options.

Hysterectomy has long been regarded as an operation performed by “hyster-happy,”¹ mostly male, surgeons. The medical historian Roy Porter counted the rising tide of hysterectomies among manifestations of the “abuse of gynaecological surgery to control women” in the 19th century.² Although campaigns against unnecessary hysterectomy have been vocal,³ this operation survived the feminist whirlwind of the mid to late 20th century and remains one of the most commonly performed operations in the world. In the United States, 600 000 hysterectomies are performed each year,⁴ or one hysterectomy every minute. In the United Kingdom, women have a one in five chance of having a hysterectomy by the age of 55.⁵

Nine of every 10 hysterectomies are performed for non-cancerous conditions. In many of these, no disease is present—and the term dysfunctional uterine bleeding is used to describe these cases. When there is disease it is commonly limited to the uterus and, in most parts of the world, is more likely than not to be a leiomyoma (uterine fibroid). Hysterectomy, usually with removal of the ovaries, may also be performed for pelvic pain. These indications are amenable to an expanding array of medical treatments—such as the levonorgestrel releasing intrauterine system—and to procedures that preserve the uterus—such as endometrial ablation and embolisation of fibroids. The uptake of these alternatives partly accounts for the fall in the number of hysterectomies performed in Europe in the past decade.⁶ Their availability also challenges the surgeon to provide more information about possible outcomes when he or she deems a hysterectomy to be necessary.

Hysterectomy rarely leads to perioperative death, but is it associated with a long term risk of death? Iversen et al tackle this question in a nested cohort study in this week's *BMJ*.⁷ One of the strengths of their study is the long duration of follow-up (mean length of more than 20 years). Women in this study who had a hysterectomy did not subsequently have, in the long term, a significantly increased risk of death—from car-

diovascular disease, cancer, or all causes—compared with women who did not have the operation.

For several reasons, care must be taken when extrapolating these findings to all women who have had a hysterectomy. Firstly, the study participants had been recruited originally into a study of oral contraception, and women in that study were known to be healthier than the general population. Secondly, 98% of the participants in the original study were white—and there is some evidence⁸ that the incidence, indications, and outcome of hysterectomy could differ between white and black women.

Major long term complications other than death, as well as perioperative and short term complications, are studied in a systematic review by Johnson et al that also appears this week.^{9 10} Because the incidence of severe morbidity complicating hysterectomy is low,¹¹ randomised trials to compare surgical approaches require large numbers and are expensive to run. It is therefore not surprising that this systematic review and meta-analysis found that data for many important long term outcome measures, including pelvic pain, bowel dysfunction, and vaginal prolapse, were either absent or underpowered.

This deficiency is unfortunate because these outcomes are probably more important to patients than, say, duration of the operation or mean blood loss. The authors conclude, on the basis of their findings, that hysterectomy should be performed vaginally rather than abdominally where possible. Compared with abdominal hysterectomy, vaginal hysterectomy was associated with women's earlier discharge from hospital and a speedier return to normal activities. Laparoscopic hysterectomy also had these advantages over abdominal hysterectomy, but it carried a higher risk of injury to the urinary tract and was more expensive and the operations lasted longer than vaginal hysterectomy.

More robust evidence on the longer term outcomes of hysterectomy is required, especially for those outcomes that are important to patients¹²—quality of life, sexual function, pelvic pain, bowel and urinary function, and vaginal prolapse. For now, Johnson et al have provided the best available evidence,⁷ and gynaecologists should adapt their practice accordingly. This is not going to be easy, as only a handful of surgeons are equally competent in performing hysterectomy by all three routes, and most gynaecologists are much more comfortable with abdominal hysterectomy than vaginal or laparoscopic hysterectomy.

We must improve training in vaginal surgery for the younger generation of gynaecologists, and our colleges

should now establish clinical guidelines for selecting the appropriate route of hysterectomy, based on the best available evidence. Such guidelines have been shown to enhance the uptake of vaginal hysterectomy.¹³

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Where next with revalidation?

Self regulation should survive, but revalidation must offer education as well as performance review

A century ago, Cornford described how a conservative faculty at Cambridge University, England, struggled to deflect the pressure to reform.¹ Some aspects of that treatise have been reprised in the *BMJ* series on the United Kingdom General Medical Council, which ends this week, as regulators take on the public's need for a mechanism to ensure that doctors provide good care for patients throughout their careers.²⁻⁸ Three themes emerge from this series and from the broader debate: revalidation is necessary; revalidation must be comprehensive; and medicine should be self regulated.

In his article, Irvine espouses the view that doctors are personally responsible for their own ability to provide good care and that they share in the collective responsibility for their colleagues.⁴ In this context, revalidation is an essential expression of professionalism and a means of establishing accountability to patients and the public.

Overwhelmingly, patients also feel that revalidation is necessary. Cain, Benjamin, and Thompson report that, in 1997, periodic retesting of doctors was an emerging issue in the United States.⁸ By 2003 a Gallup poll found that more than 80% of adults believed that it was important or very important for doctors to be re-evaluated periodically regarding their qualifications; to have high success rates for the conditions they treat most often; periodically pass a written test of medical knowledge; and to receive high ratings from their patients.⁹

Unfortunately, despite both professional obligation and patients' expectations, the performance of doctors declines over time. A recent systematic review found that, compared with their younger colleagues, older doctors and those in practice for more years had less factual knowledge; they were less likely to adhere to standards for diagnosis, screening, prevention, and treatment; and their patients had poorer outcomes.¹⁰ This review has limitations, but it remains clear that doctors who have been in practice longer are at increased risk for provid-

ing lower quality care. Professionalism, patients' expectations, and the declining performance of doctors over time converge to make revalidation a necessity.

The authors of this *BMJ* series disagreed over whether revalidation should encourage professional development or weed out those unfit to practise.^{2 3 5} As Irvine says, it needs to do both.³ If it only affirms the positive, revalidation will allow those few who are unfit to continue to practise. If it only eliminates the unfit, revalidation will permit an unabated decline in the performance of all other doctors. Both outcomes could cause harm to patients, so a revalidation programme must include both assessment and education.

Authors of the series agree that revalidation should focus on performance in practice. The assessment methods needed to support performance review are in their infancy, and much remains to be done.¹¹ At the same time, tests of knowledge and clinical skill as well as ratings by patients and peers have considerable potential as tools to screen for poor performance, given their positive associations with the quality of care.⁹ A revalidation programme should not be delayed while awaiting an ideal method, but its implementation should be accompanied by a rigorous evaluation of the assessment methods used.

In contrast, this series has been largely silent on the role of education. This may reflect doubts about the effectiveness of such education or the view that it is beyond the remit of regulators. None the less, evidence is increasing that practice based learning improves the quality of care and its inclusion is especially important given the decline in the performance of doctors over time.¹²

The specialised knowledge and skills that form the basis of a profession also make lay people largely unsuitable for regulating it. As Dauphinee argues, self regulation is the best option.⁷ However, the absence of the patients' voice in the regulation of medicine is one of the primary reasons that a robust programme of revali-

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