GAC GUIDELINES ADVISORY COMMITTEE

Summary of Recommended Guideline

Hysterectomy Procedure

Lefebvre G, Allaire C, Jeffrey J, Vilos G, Arneja J, Birch C, et al. SOGC clinical guidelines. Hysterectomy. Journal of Obstetrics & Gynecology Canada: JOGC. 2002 Jan;24(1):37-61; quiz 74-6

Rating (out of 4):

Scope

This guideline summary is intended for gynaecologists.

Clinical Question

What are the indications for hysterectomy? What is an appropriate preoperative assessment and what are the available alternatives required prior to hysterectomy?

Background

Hysterectomy is the most frequently performed major surgical procedure in gynaecology. Within each province, the rate fluctuates significantly by region. No relationship has been established between these differences and patient outcomes or satisfaction. In 1999-2000, the proportion of vaginal hysterectomy had increased to 32 percent of all hysterectomies in Canada. While choice of approach for the surgery is discussed in this document, ultimately it remains a decision for the individual surgeon in concert with his or her patient. This guideline summary presents considerations involved in the decision-making process of choosing hysterectomy or alternative therapies for each of the more common indications.

Considerations

- Hysterectomy is the treatment of choice for certain gynaecologic conditions. The predicted advantage must be carefully weighed against the possible risks of the surgery and other treatment alternatives.
- The cost of the surgery to the health care system and to the patient must be interpreted in the context of the cost of untreated conditions. The approach selected for the hysterectomy will impact on the cost of the surgery.

Recommendations

Surgical Approach

- The vaginal route should be considered as a first choice for all benign indications. The laparoscopic approach should be considered when it reduces the need for a laparotomy. (III-B)

Benign Disease

- Leiomyomas: For symptomatic fibroids, hysterectomy provides a permanent solution to menorrhagia and the pressure symptoms related to an enlarged uterus. (I-A)
- Abnormal uterine bleeding: Endometrial lesions must be excluded and medical alternatives should be considered as a first line therapy. (III-B)
- Endometriosis: Hysterectomy is often indicated in the presence of severe symptoms with failure of other treatments and when fertility is no longer desired. (I-B)
- Pelvic relaxation: A surgical solution usually includes vaginal hysterectomy, but must include pelvic supporting procedures. (II-B)
- Pelvic pain: A multidisciplinary approach is recommended, as there is little evidence that hysterectomy will cure chronic pelvic pain. When the pain is confined to dysmenorrhea or associated with significant pelvic disease, hysterectomy may offer relief. (II-C)

Preinvasive Disease

- Hysterectomy is usually indicated for endometrial hyperplasia with atypia. (I-A)
- Cervical intraepithelial neoplasia in itself is not an indication for hysterectomy. (I-B)
- Simple hysterectomy is an option for treatment of adenocarcinoma *in situ* of the cervix when invasive disease has been excluded. (I-B)

Invasive Disease

- Hysterectomy is an accepted treatment or staging procedure for endometrial carcinoma. It may play a role in the staging or treatment of cervical, epithelial ovarian, and fallopian tube carcinoma. (I-A)

Acute Conditions

- Hysterectomy is indicated for intractable postpartum hemorrhage when conservative therapy has failed to control bleeding. (II-B)
- Tubo-ovarian abscesses that are ruptured or do not respond to antibiotics may be treated with hysterectomy and bilateral salpingo-oophorectomy in selected cases. (I-C)
- Hysterectomy may be required for cases of acute menorrhagia refractory to medical or conservative surgical treatment. (II-C)

TABLE I QUALITY OF EVIDENCE ASSESSMENT	CLASSIFICATION OF RECOMMENDATIONS
The quality of evidence reported in these guidelines has been described using the Evaluation of Evidence criteria outlined in the Report of the Canadian Task Force on the Periodic Health Exam. I: Evidence obtained from at least one properly random-ized controlled trial. II-1: Evidence from well-designed controlled trials without randomization. II-2: Evidence from well-designed cohort (prospective or retrospective) or case-control studies, preferably from more than one centre or research group. II-3: Evidence obtained from comparisons between times or places with or without the intervention. Dramatic results in uncontrolled experiments (such as the results	Recommendations included in these guidelines have been adapt-ed from the ranking method described in the Classification of Recommendations found in the Report of the Canadian Task Force on the Periodic Health Exam. A. There is good evidence to support the recommendation that the condition be specifically considered in a periodic health examination. B. There is fair evidence to support the recommendation that the condition be specifically considered in a periodic health examination. C. There is poor evidence regarding the inclusion or exclusion of the condition in a periodic health examination, but recommendations may be made on other grounds. D. There is fair evidence to support the recommendation

of treatment with penicillin in the 1940s) could also be included in this category. III: Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees.	that the condition not be considered in a periodic health examination. E. There is good evidence to support the recommendation that the condition be excluded from consideration in a periodic health examination.

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Ontario Guidelines Advisory Committee
500 University Ave., Suite 650,
Toronto, ON M5G 1V7
Telephone: 1-888-512-8173
Fax: 416-971-2462
Email: contact@gacguidelines.ca