Chapter B1

Hysterectomy

Why Not?

This chapter will give an overview of the various hysterectomy procedures – and also discuss the drawbacks of this surgery, which has become the mainstream treatment for fibroids. The question has been raised however as to whether this is still legitimate medical practice in case of fibroid disease; there are overwhelming reasons to maintain that it is not – especially where valid alternative treatment options have presented themselves.

What is written here might perhaps be offensive to some physicians, in particular gynaecologists. I do realise there are many doctors who are sincere in their care for patients. What I learned from those gynaecologists that are willing to discuss alternatives for hysterectomy, is that there are always more sides to the story. All I can do is put up the information I came across, that I think is important for women to know.

No matter what, gynaecologists are an important part of a fibroid-patient’s care. I just wish some of these doctors would listen more carefully to some of their colleagues …

Gynaecologist Dr. Stanley West: “It is time we doctors stopped disassembling healthy women. But nothing will change until more women look their doctor in the eye and calmly state their determination to remain an intact woman”
“You don’t need a Hysterectomy – it can do you more harm than good”

Strong words perhaps – coming from Dr. West, gynaecologist and author of “the Hysterectomy Hoax” – but the facts are that more than 90% of all hysterectomies are unnecessary; 50% of all patients develop complications, some of them quite serious; and the operation can have long-lasting physical, emotional and sexual consequences that may seriously undermine your health and wellbeing. Hysterectomy surgery poses unacceptable risks when used to treat conditions for which alternative treatments are available. Many gynaecologists unfortunately still have the outdated view that, as soon as the incubator role is over, the female womb is a useless, bleeding, symptom-producing, potentially cancer-bearing organ, which a woman can easily do without. It is crucial that every woman should know exactly what she is getting herself into when she is offered hysterectomy as a treatment for fibroids. These consequences will be explained in detail.

Surgical approaches to Hysterectomy – and common Complications

In public hospitals this surgery is mostly done by an apprentice, supervised by a gynaecologist. Some gynaecologists work on a private basis as well and will have you pay extra for them to do the operation themselves. Technically, hysterectomy is a fairly simple surgery to perform. Because every female body is built the same way internally, the uterus can be detached from the ligaments that support it and the blood vessels that supply it. Since it is so straightforward it should be a safe procedure. Doctor’s fact lists often indicate low complication percentages. Unfortunately however, general statistics have shown that this is far from the truth in many hospitals. An alarming fact is that one out of 1,000 hysterectomy patients will die. Given the number of hysterectomy procedures performed, of which 90% is unnecessary, this means approximately 540 unnecessary deaths a year in the States alone – one third of which happens when treating the benign condition of fibroids. Perhaps these figures are not world shocking, but when you suffer from fibroids it is important enough to know. Any unnecessary death is one to many in any case. We will also look into other effects of this surgery. If you should truly need a hysterectomy, it is important to find a good surgeon.
The Value of Hysterectomy – And Cancer

There is no doubt that there are valid and justified reasons for undergoing hysterectomy, of which cancer is the most important. Malignant tumours in the uterus are fortunately very rare. Fibroids are benign tumours and do not transform to malignant ones.

Today, some stages of cancer seem to be able to be cured without the necessity of a hysterectomy. The old rationale that hysterectomy and oophorectomy can prolong a woman’s life by preventing uterine and/or ovarian cancer is currently being drastically reconsidered.

The risk of dying of cardiovascular disease after hysterectomy is far greater than that of dying of cancer of the reproductive organs.

Often, pre-cancerous stages in the cervix or uterus are used to justify hysterectomy, while mostly these can be arrested and reversed without major surgery.

Importance of the Uterus – and Sexual Function

The uterus is far from just a disposable organ that serves no further purpose once the childbearing days are over. Apart from being an important sexual organ, the uterus is the main site for the production of some important hormones that have a protective role against cardiovascular diseases. Early menopause occurring after hysterectomy is a contributory factor for heart disease, breast cancer and other health problems.

Sexual dysfunction after hysterectomy has been widely discussed by many authorities. There is much more to it than just the emotional response of women to losing their womb; there should be no doubt that the sexual changes women report after hysterectomy - a decline in desire or even losing orgasm completely - are real and not imagined. No physician today can assure any woman that hysterectomy will not affect her sex life.

Lifelong Role of the Ovaries –

HRT, Hormonal Balance & Mood

While reproduction is the most dramatic function of the ovaries, these organs have as much to do with the maintenance of a woman’s own life as with their role in bringing other lives into the world.

The removal of the ovaries along with the uterus means instant menopause. But even after removal of only the womb, the ovaries may be impaired in their function, resulting in early menopause. Permanent ovarian failure also occurs, which is the main reason many women develop serious physical and emotional problems. Both uterus and ovaries are an important part of the neuro-endocrine system (nerves and hormones), even after menopause, and influence physical and emotional wellbeing.

The female reproductive system is by no means fully understood. Consequentially, removal of any part of this fine-tuned mechanism will result in imbalances that can only partly be remedied by hormone replacement. There are many controversies around HRT and the latest reports have a very negative outcome in regards to cardiovascular health, osteoporosis and breast cancer, and even dementia.

A woman should not need HRT at any stage of life. When necessary, there are very good natural alternatives.
**Safer Alternatives to Hysterectomy for Fibroid Management**

A patient: “I don’t think you should take everything out that makes me a woman and then put me on a bunch of drugs that make me a woman again.”

Keeping your female organs intact whenever possible may prevent a host of health problems, not only because you preserve your parts, and restore their natural balance, but because the ‘cure’ for the side effects may be worse than the original problem. Uterine Fibroid Embolisation (UFE) is in most cases a good alternative to hysterectomy for treating fibroids; it is less invasive, carries less risk, and restores the uterus to its normal function. Women should not be made to feel inadequate or disturbed for questioning the necessity of hysterectomy; they need the support of their gynaecologist.

It is indeed necessary for women to stand up for what they want, to be given a chance to base their decision on all available information, and to have the courage to look their doctor in the eye and calmly state their determination to remain an intact woman.

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**In the News**

Panic on cards as HRT tied to cancer.
“You don’t need a Hysterectomy – it can do you more harm than good”

Strong words perhaps – coming from Dr. West, gynaecologist and author of “the Hysterectomy Hoax” – but the facts are that more than 90% of all hysterectomies are unnecessary; 50% of all patients develop complications, some of them quite serious; and the operation can have long-lasting physical, emotional and sexual consequences that may seriously undermine your health and wellbeing. Hysterectomy surgery poses unacceptable risks when used to treat conditions for which alternative treatments are available.

Many gynaecologists unfortunately still have the outdated view that, as soon as the incubator role is over, the female womb is a useless, bleeding, symptom-producing, potentially cancer-bearing organ, which she can easily do without. It is crucial that every woman should know exactly what she is getting herself into when she is offered hysterectomy as a treatment for fibroids.

These consequences will be explained in detail.

Hysterectomy as a treatment for fibroids

It is a sad fact that more than 90% of all hysterectomies are unnecessary; only 10% of hysterectomies are performed for cancer, the only legitimate reason for removing the female reproductive organs. Each year, 600,000 hysterectomies are performed in the United States, while of those only 5,000 would be truly necessary. In Europe, where medicine is socialised in several countries and the profit motive plays a lesser role, the total number is ‘only’ 85,000 to 100,000. In the States 6 out of every 10 women will have had a hysterectomy by the time they turn 60, while in Australia it is estimated that this will be at least 4 out of 10. More than a third of hysterectomies are performed for uterine fibroids, in Australia this was 21% around 2000. Women in certain regions of Australia seem to be at a higher risk of losing their uterus; 36% more hysterectomies are performed in the Hunter region near Newcastle, NSW.

It seems that the hysterectomy option coincides more with the particular inclinations and surgical abilities of local gynaecologists than with medical imperatives.

An outspoken critic of the unwarranted enthusiasm for hysterectomy amongst his colleagues, Dr. Stanley West, states that the operation can have long-lasting physical, emotional and sexual consequences that may seriously undermine a woman’s health and wellbeing. He is supported by a growing number of other physicians. In 1994, he wrote of attending a seminar on medical economics in the States. The topic dealt with how obstetricians and gynaecologists should care for women in order to maximise their fee. The highest fee they can generate comes from hysterectomy and these doctors were educated how to carefully ‘cultivate’ their patients so the culmination of their years of care would be a hysterectomy. These doctors do a great deal of surgery and earn higher incomes than many physicians, surgeons or medical practitioners. A large proportion of them earn more than half a million (US dollars) annually.

Luckily, there are also sincere physicians who do care and give patients a choice.

Hysterectomy surgery poses unacceptable risks when used to treat conditions for which alternative treatments are available. Most female problems are in fact benign conditions. Uterine fibroids are the most common indication for hysterectomy. They can make your life miserable while untreated, but will not kill you. No man would agree to have his sexual and reproductive organs removed for anything short of a life-threatening illness. And no doctor would dare to suggest this to a man. Then why should women accept it?

It is crucial that every woman should know exactly what she is getting herself into when she is offered hysterectomy as a treatment for fibroids. Consequences are mostly downplayed by the majority of gynaecologists, many of whom unfortunately have the outdated view that, as soon as the incubator role is over, the female womb is a useless, bleeding, symptom-producing, potentially cancer-bearing organ, which a woman can easily do without.
Quality of life can in the majority of cases be improved in other ways. Unless cancer is positively identified, a woman should not consent to surgery just like that. Your uterus and ovaries should not be willingly sacrificed except for the purpose of saving life. Not only doctors, but women themselves should be aware that it is impossible to pluck out an organ and disturb the body’s balance without paying a price.

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**Surgical approaches to Hysterectomy – and common Complications**

In public hospitals this surgery is mostly done by an apprentice, supervised by a gynaecologist. Some gynaecologists work on a private basis as well and will have you pay extra for them to do the operation themselves. Technically, hysterectomy is a fairly simple surgery to perform. Because every female body is built the same way internally, the uterus can be detached from the ligaments that support it and the blood vessels that supply it. Since it is so straightforward it should be a safe procedure. Doctor’s fact lists often indicate low complication percentages. Unfortunately however, general statistics have shown that this is far from the truth in many hospitals. An alarming fact is that one out of 1,000 hysterectomy patients will die. Given the number of hysterectomy procedures performed, of which 90% is unnecessary, this means approximately 340 unnecessary deaths a year in the States alone – one third of which happens when treating the benign condition of fibroids. Perhaps these figures are not world shocking, but when you suffer from fibroids it is important enough to know. Any unnecessary death is one to many in any case. We will also look into other effects of this surgery. If you should truly need a hysterectomy, it is important to find a good surgeon.

**Hysterectomy and Oophorectomy**

Hysterectomy is the removal of a vital female organ, the uterus. Often the cervix – the neck of the womb – is removed along with the uterus; this is called a ‘total hysterectomy’. A ‘subtotal hysterectomy’ is when the cervix is left in place. When the ovaries and fallopian tubes are also removed, this is called a ‘hysterectomy and bilateral salpingo–oophorectomy’.

Almost half of all hysterectomy operations involve the removal of one or both ovaries, and more than half of those women are pre-menopausal. For these women it will mean instant menopause. US statistics say that more than 75% of hysterectomies are done on women in their reproductive years; between the ages of 20 and 49.

Hysterectomy is a major surgery, done in a hospital under general anaesthesia. In the immediate post-operative period, an intravenous drip will be needed as well as pain relief. A catheter to empty the bladder will usually be inserted for the first day or so. Hospitalisation will depend on the type of surgery and may range from 2 to 7 days. It is important not to have intercourse for 6 weeks after surgery.

Patients are told that it will take anywhere from 6 weeks to 3 months to recover. However, most women say recovery takes almost a year, and some spend many more years tinkering with their hormones in an attempt to feel normal again. This may happen even if the ovaries are not removed, especially when a hormone imbalance is already present – as is the case with fibroids.
POSITION OF FEMALE REPRODUCTIVE ORGANS IN RELATION TO OTHER PELVIC ORGANS
Three surgical approaches

**Abdominal Hysterectomy**
This is the most common procedure for women with fibroids, since the uterus is usually enlarged and too big to remove through the vagina. Removal of the womb (and/or ovaries) is done through a 20-cm / 8-inch incision across the lower abdomen. This may be just above the pubic hairline, crossways like a Caesarean Section, or sometimes up and down in the middle below the navel.
Complications do not need to happen as long as surgeons do their job in a meticulous way. But pitfalls include adhesions, injury to the bowel, bladder, ureter, post-operative bleeding, and wound dehiscence.
Abdominal hysterectomy has the longest recovery time of all, which is three months minimum.

**Vaginal Hysterectomy**
The uterus is approached, detached and pulled out through the vagina. The wound is sutured internally using a minute stitching gun. There are no cuts in the abdomen.
For most women with symptomatic fibroids this is not an option when the uterus is enlarged.
This procedure is regarded as less dangerous than abdominal surgery, but presents its own set of risks like fever and infection, bladder injury, and adhesions.
Hospital stay and recovery time are shorter than with abdominal surgery.

**Laparoscopic-assisted vaginal Hysterectomy**
With assistance of a laparoscope – a viewing device that is inserted via a tiny abdominal incision near the belly button – the procedure is completed through the vagina, with the aid of other small surgical instruments (between 5 and 12 mm in diameter) that are inserted through 2 or 3 additional small incisions in the abdomen.
As with a ‘normal’ vaginal procedure, this option is generally unsuitable for women with enlarged wombs. Some surgeons claim to be proficient enough in this technique to also perform this surgery in these cases – although there is always a chance of conversion to open abdominal surgery.
The big advantages that have made this option very popular over abdominal surgery, are a shorter hospital stay – only one or two days – less pain, and more rapid recuperation.
But apart from that, complications that may occur are the same – and can pose an even bigger risk when surgeons with inadequate training attempt this procedure.

Complications

**Adhesions**
Tissue surfaces can stick together and develop internal scars after surgery. Any type of internal bleeding can lead to adhesions because of the sticky component that blood contains. The organs most likely to adhere to the uterus are the bladder and bowel, but there is always a danger other adhesions will develop. The surgeon may not find and suture all bleeding surfaces. Even during the surgery these may lead to damage to the tissues surrounding the uterus being removed. But also years after surgery these may result in an intestinal obstruction and/or sometimes complicate any further surgery.

**Bowel injury**
If the bowel is accidentally cut, clamped or sutured during surgery, the intestinal contents can spill into the abdominal cavity, causing infection of the peritoneum, which is the cellophane-like sac that surrounds the abdominal organs. Peritonitis can be quite serious and even fatal if not checked. Chronic problems with bowel function may result.

**Bladder injury**
If the bladder is injured this can be easily corrected during surgery. If not recognised, there will be a risk of peritonitis. If the injury results in a fistula, connecting the bladder and vagina, urine will leak uncontrollably into the vagina. Repair can only be performed in additional surgery.
Injury to ureter
This tube connecting the kidney to the bladder, is located next to the cervix and can be damaged easily. If the ureter is nicked, sewn or kinked during surgery, the outflow of urine from the kidney to the bladder will be blocked and can lead to kidney damage. Corrective surgery will then be needed.

Postoperative bleeding
Potentially fatal haemorrhaging may result from a surgeon’s failure to secure the major artery. This may require a blood transfusion. Some surgeons offer the choice to store your own blood before surgery, provided you are not anaemic. If you are, it of course lowers the threshold for needing transfusion. Sometimes a vaginal suture line will infect after surgery and cause bleeding, which may be heavy. Oozing blood will cause adhesions to form and additional surgery may be needed to secure the artery.

Infection and fever
Infections can be urinary, or in the abdominal or vaginal cuts. They are usually prevented by the administration of prophylactic (preventative) antibiotics at the start of surgery, but a small number of patients develop infection anyway and need further antibiotic treatment. The highest risk is represented with vaginal hysterectomy, because of exposure to bacteria.

Deep vein thrombosis
Blood clots in the veins of the legs or pelvis may lead to clots spreading to the lungs, called pulmonary embolus. This is serious and potentially fatal. Women who smoke, are overweight, or have varicose veins are at greater risk of this complication. In high-risk cases, injections of heparin (a blood-thinning agent) is often used. Early movement after surgery is helpful in preventing clots, but this is harder in case of an abdominal hysterectomy.

Longer-term complications

Pelvic problems
Frequently, hysterectomy leads to prolapse or sagging into the newly created cavity in the abdomen of some internal organs, such as a dropped bladder or rectum (respectively involving the anterior and posterior vaginal wall). This may cause symptoms such as difficulties in urination or defecation, infection, and difficulty in penetration during intercourse. These conditions may be severe enough to require surgical correction. Also reported are additional urinary symptoms such as leakage or increase in frequency, occurring in 20-30% of women after hysterectomy.

Another development is that the hipbones tend to widen, causing problems in the pelvic area, the back, legs and feet.

Furthermore, disturbance of sensation may be experienced in the area of the scar; this may never feel completely as it did before. And loss of tactile sensation from the waist to the mid-thigh region may happen as a result from nerves being severed.

Post-hysterectomy syndrome
This is the name for a range of symptoms following hysterectomy. Some, but not all, may be attributed to after-effects and difficulties in recovering from a major operation.

Symptoms may include depression, headaches, dizziness, joint pain, nervousness, irritability, insomnia, post-operative fatigue, skin problems, difficult or painful sexual intercourse, and a variety of other symptoms that could be related to hormone imbalance, such as hot flushes, heart palpitations and night sweats. In case of removal of the ovaries, these hormone-related symptoms will be dramatic and immediate. But even after just removal of the womb, one has to consider that hormonal imbalances already existed if fibroids developed – and it will be hard to restore balance as the ovaries will possibly be more or less impaired in their function.

Add to that the frequent occurrence of early menopause and the change in sexual pleasure that may occur, and one has a scenario for post-hysterectomy syndrome as a serious consequence. Depression can range from mild and short lived to chronic, and the incidence is 50-70%. There are psychological as well as biochemical reasons for depression:
A hysterectomy is a very final decision, closing a chapter in a woman’s life – whether she has a wish to have further children or not. Also, effects on the neuro-endocrine system (nerves and hormones), which are responsible for the sense of emotional wellbeing, can be far-reaching. All this will be explained further.

**Early menopause**

Even when the ovaries are spared, menopause may occur 2 to 4 years earlier than normal. Why this happens and what the consequences are will be explained in paragraph ‘The Lifelong Role of the Ovaries’.

**Changes in sexual function**

These will be discussed in full in paragraph ‘Importance of the Uterus’.

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**The Value of Hysterectomy – And Cancer**

*There is no doubt that there are valid and justified reasons for undergoing hysterectomy, of which cancer is the most important. Malignant tumours in the uterus are fortunately very rare. Fibroids are benign tumours and do not transform to malignant ones. Today, some stages of cancer seem to be able to be cured without the necessity of a hysterectomy. The old rationale that hysterectomy and oophorectomy can prolong a woman’s life by preventing uterine and/or ovarian cancer is currently being drastically reconsidered. The risk of dying of cardiovascular disease after hysterectomy is far greater than that of dying of cancer of the reproductive organs. Often, pre-cancerous stages in the cervix or uterus are used to justify hysterectomy, while mostly these can be arrested and reversed without major surgery.*

**When hysterectomy is the best option**

There are valid and justified reasons for undergoing hysterectomy and many women who have been suffering from chronic, painful and sometimes life-threatening conditions have indeed benefited immensely from surgery. In those suffering from cancer of the reproductive organs, hysterectomy has saved many lives.

In the management of fibroids, hysterectomy may play a role as a second line treatment in the rare case where other procedures or surgery have failed or are in some way not suitable, or when dealing with additional genital tract problems such as prolapse. Other examples are some forms of Endometriosis.

**Pre-cancerous stages**

Yet, pre-cancerous stages in the cervix or uterus – like hyperplasia of the endometrium – are often used to justify hysterectomy. However, the vast majority of these changes can be arrested and reversed before becoming cancerous – and without major surgery. So a woman should not allow herself to be talked into surgery for fear of developing endometrial or cervical cancer at a later stage.

Although the risk for developing cancer in women with a family pre-disposition may be a bit higher, the old rationale that hysterectomy and oophorectomy can prolong a woman’s life by preventing uterine and/or ovarian cancer is currently being drastically reconsidered.
Fibroids are never malignant

If malignancy is present, this is thought to have been so in the first place; uterine fibroids are benign, non-cancerous growths and do not transform to malignant ones. Cancerous tumours in the uterus – or leiomyosarcoma – are fortunately very rare. Deep fibroid biopsy is now generally felt to be unnecessary; malignancy can be easily missed in a biopsy and results are usually unrevealing – even in the presence of malignancy. There are additional tests for cancer, some of which give a reasonable indication – while others (like a blood test for CA–125) are not very reliable, but nonetheless are still used by some physicians. (Read more in A2).

When next, the woman is told the only way to really rule out the chance for malignancy is a hysterectomy, she is cleverly scared into surgery. Naturally, doctors always have to consider the possibility of the worst and should warn their patients, but patients are mostly not really in a position to weigh the consequences. They have to rely on what doctors tell them and advise them. This sometimes goes against their gut feeling; making a choice from that position can be pretty hard. It requires a lot of courage to think for yourself, and some education to be able to make the right decision. Finding a doctor who is willing to openly discuss these things and support their patients to make the right choice – even if this means the woman chooses a different treatment than the one the physician has to offer – is a rare thing. It is to be hoped this will change for the better in the future.

With good follow-up after uterine-saving treatment of fibroids, there is hardly any risk of inadvertently missing a possible malignancy. Apart from the risks that accompany major surgery; compare the chance for a woman around menopausal age to die of uterine and cervical cancer, or ovarian cancer – which is respectively 0.5% and 0.8% – with the 33% risk of dying of cardiovascular disease after hysterectomy or oophorectomy, irrespective of using hormone replacement. This high risk may be further increased when surgery is performed during a woman’s reproductive years.

Ovary transplanted to arm

New developments in genital tract cancer treatment keep on happening: Some stages of cancer seem to be able to be cured without the necessity of a hysterectomy. But if surgery is inevitable, other techniques can be developed to minimise the risk to further compromise health and healing. A good example of a more holistic approach happened in 2002, when gynaecologists and vascular surgeons in the Netherlands successfully transplanted a specially prepared ovary to the upper arm of a woman suffering from cancer, who needed a hysterectomy followed by radiation therapy. Because the radiation would be harmful to the ovary, the decision was made to move it and connect it to a vessel and artery in the upper arm. After some time the ovary started to produce hormones, preventing immediate menopause. It was the first time such an operation had been performed in the Netherlands, and shows what can be done in order to maintain the best possible hormonal balance – which will prevent further after-effects and will have its reflection on the patient’s entire wellbeing.
Importance of the Uterus — and Sexual Function

The uterus is far from just a disposable organ that serves no further purpose once the childbearing days are over. Apart from being an important sexual organ, the uterus is the main site for the production of some important hormones that have a protective role against cardiovascular diseases. Early menopause occurring after hysterectomy is a contributory factor for heart disease, breast cancer and other health problems. Sexual dysfunction after hysterectomy has been widely discussed by many authorities. There is much more to it than just the emotional response of women to losing their womb; there should be no doubt that the sexual changes women report after hysterectomy - a decline in desire or even losing orgasm completely - are real and not imagined. No physician today can assure any woman that hysterectomy will not affect her sex life.

A disposable organ?

Once the childbearing days are over, the uterus still has its role to fulfil; it is not just a disposable organ. Apart from being an important sexual organ, the uterus is the main site for the production of prostacyclin. This hormone protects women from heart disease and unwanted blood clotting, and cannot be synthetically manufactured in a laboratory. So the removal of the uterus ensures its production will cease forever. This explains why the risk for heart disease is reported to increase threefold in women who have had a hysterectomy in their reproductive years. When subsequently menopause may start earlier than normal after a hysterectomy because the ovaries cease to function properly, the risk for cardiovascular disease remains high. These facts are often downplayed by many gynaecologists.

Sexual function after hysterectomy

This is a rather complex issue; there are a number of factors that may be responsible for the occurrence of sexual dysfunction after removal of the womb:

As a result from the surgery, some of the nerves connected to the uterus are severed that also supply parts of the abdomen, clitoris and upper thigh. This can lead to a loss of tactile sensation from the waist to the mid-thigh region. Also, shortening of the vagina may result from hysterectomy, causing pain during deep penetration.

An important result may be the effect on orgasm. It is now more commonly known that the cervix plays a role in sexual pleasure and orgasm, but the role of the uterus is less known.

A direct nerve connection exists between not only the clitoris and uterus, but also the nipples - something we can all be aware of as women. The uterus is part of the complex neuro-endocrine system (nerves and hormones), which involves the limbic or 'emotional' brain centre responsible for regulating hormonal balance and our entire wellbeing. One of its functions is a beautiful 'healing mechanism' that nature has provided for the uterus after childbirth; when breastfeeding, nerves carry information from the nipples to the uterus, stimulating recovery of the reproductive organs to prepare the womb again for conception, and making the mother receptive again for sexual activities.

Whereas a man needs direct stimulation of the top of the penis to reach a climax, a woman has more than one way to induce orgasm. Women's experience of orgasm is more varied because of this, but in the build up to a deep internal orgasm, the vagina, clitoris and nipples are in fact 'only' the initiators of sexual excitement; uterine contractions are the end point of this excitement.

The groundbreaking research by Masters and Johnson on human sexuality revealed that the accelerating pitch of sexual excitement prompts the uterus to contract and rise out of the vagina. Other researchers have shown that internally induced orgasm occurs when the penis presses hard and repetitively
against the cervix, causing movement of the uterus and its supports. 'Deep orgasm' involves the rhythmic contraction of both cervix and uterus, and this is why some women complain of a dramatic decline in the quality of their orgasm after hysterectomy. Individual follow-up reports from gynaecologists about this, say that in spite of these negative studies, patients tell them that sex is 'the same' or 'no different' after hysterectomy. One can wonder however how it was before surgery for those women - likely their sexual function was already impaired because of the symptoms of fibroids and related causes. After all, dealing with symptomatic fibroids is not exactly libido enhancing, may cause painful intercourse, and may alter blood supply to the reproductive parts and thereby related sexual pleasure. And because blood flow does not exactly improve after removal of an important organ in this whole system, the situation may indeed remain 'the same' . . . or worsen.

On the other hand, women also reported that hysterectomy led to an improved sexual life because of elimination of major problems such as bleeding, pain or prolapse of the uterus. But this improvement also has been reported after alternative procedures to eliminate these symptoms. For other women, fear of unwanted pregnancy could have had a negative effect on sexual function, and elimination of this fear may enhance pleasure.

Given all this, there should be no doubt that sexual changes like a decline in desire, a chance in orgasm or even losing orgasm completely - that quite a number of women report after hysterectomy - are real and not imagined. No physician today can assure any woman that hysterectomy will not affect her sex life.

And we should not forget yet another function of the uterus; to some women their womb is related to her innermost sense of self, and forms the centre of her creative self. Even though we may not always be aware of these subtle feelings, women may start to first emotionally fight a hysterectomy for this reason. It is usually not given much credence by the medical profession - and often this emotional reaction is used to ridicule all objections a woman may have to losing her womb. (We will explore these issues and more in part C: Fibroids & Emotions).

Outdated views

Throughout the past century's medical history, the womb was seen by physicians as the cause for just about anything that could be wrong with a woman; overeating, painful menstruation, attempted suicide, nymphomania and masturbation were all thought to be cured by removing the uterus.

Even though it is clear nowadays that the uterus is not just an 'incubator' that is past its 'use by' date as soon as fibroids develop and it starts to bleed more than it should - unbelievably enough it is still viewed by many gynaecologists to be a troublesome, disposable organ. A large number of obstetricians and gynaecologists still reassuringly state that women who have had a hysterectomy are delighted to no longer have to plan their lives around their heavy or painful periods, and gain fresh energy because they are no longer anaemic - and that life is fuller and happier than it has been for years. This most drastic cure-all may seemingly solve a lot of your symptoms, but the many pitfalls during and long after surgery should prompt closer investigation - especially where the same happy reactions are now reported after alternative treatment like Fibroid Embolisation. . . and with far less consequences.

I believe that to cut unnecessarily into this fine-tuned mechanism, still not fully understood by medical science, can be considered a medical crime.
Lifelong Role of the Ovaries –
HRT, Hormonal Balance & Mood

While reproduction is the most dramatic function of the ovaries, these organs have as much to do with the maintenance of a woman’s own life as with their role in bringing other lives into the world.

The removal of the ovaries along with the uterus means instant menopause. But even after removal of only the womb, the ovaries may be impaired in their function, resulting in early menopause. Permanent ovarian failure also occurs, which is the main reason many women develop serious physical and emotional problems. Both uterus and ovaries are an important part of the neuro-endocrine system (nerves and hormones), even after menopause, and influence physical and emotional wellbeing.

The female reproductive system is by no means fully understood. Consequently, removal of any part of this fine-tuned mechanism will result in imbalances that can only partly be remedied by hormone replacement. There are many controversies around HRT and the latest reports have a very negative outcome in regards to cardiovascular health, osteoporosis and breast cancer, and even dementia.

A woman should not need HRT at any stage of life. When necessary, there are very good natural alternatives.

Ovarian role

The ovaries produce hormones before, during and after menopause. During the reproductive years they store and mature the eggs, but their role doesn’t stop after menopause. The theca, which is the outer covering of the ovary where the eggs grow and develop, shrinks as the woman naturally ages – but the inner stoma actually becomes active at menopause for the first time in a woman’s life.

The ovaries continue to function, working in concert with the skin, liver and body-fat in the production of hormones – thus promoting bone health and skin suppleness, and protecting against heart disease and supporting sexual functioning. So the ovaries contribute to a woman’s health and wellbeing throughout her life.

When both ovaries are removed along with the uterus, it means instant menopause. But even when the ovaries are spared, they may cease to function 2 to 4 years earlier and menopause will start prematurely.

Consequences include increased chances of osteoporosis, and cardiovascular disease. The already higher than normal chance of developing heart disease (33%) after hysterectomy, is further increased when the ovaries are removed as well – and especially when surgery is done during the reproductive years of a woman. This is reported to increase the risk by as much as three times during the remaining ‘reproductive’ years. But also after menopause this risk is higher, irrespective of using HRT – the use of which could even make things worse.

Women don’t need HRT at any stage of life –
Yes, this too can do you more harm than good. There are natural alternatives.

Early menopause; HRT; and the effect of hormones on mood

Surgically induced menopause, as a result from oophorectomy or advanced by hysterectomy, has more consequences than natural occurring menopause, with symptoms far more severe than those that accompany the natural gradual decline in hormone production.

Hormone Replacement Therapy (HRT) is the usual medical answer, but it is a disputed one.

At first, only oestrogens were replaced, with consequences of increased occurrence of breast and ovarian cancer
and cardiovascular disease. Combinations with progestogens do not represent much improvement. Women often don’t feel ‘normal’ on hormone replacement – this may relate to libido, orgasm, negative mood changes and general wellbeing.

The hormones used in hormone replacement do not always compensate for the missing hormones; this is thought to be because the ovaries and uterus may play a role in producing additional hormones of which medical science is as yet unaware. The female reproductive system is by no means fully understood. Fact is, when the uterus is gone and the feedback between ovaries, uterus, hypothalamus and pituitary gland ends, the ovary realises it doesn’t have any place to drop its eggs, so it stops trying.

For this reason early menopause occurs after hysterectomy.

But permanent ovarian failure may also happen and is the main reason many women develop serious physical and emotional problems. Effects on the neuro-endocrine system, which are responsible for the sense of physical and emotional wellbeing, can be far-reaching. A change in levels of the ovarian hormones oestrogen and progesterone affects levels of endorphins, the natural opiates associated with feelings of wellbeing.

The ovaries and uterus work in concert with both the pituitary gland and the hypothalamus. These play an important role in the hormonal cycle and are part of the limbic brain, which is not only responsible for hormonal balance and emotional responses but also regulates the autonomic nervous system.

Because the limbic brain is an interconnected system, all parts may influence each other; this means that emotional wellbeing as well as heart rate, intestinal peristalsis and gland activity, to name a few, can all be affected in a negative way when there is a hormonal imbalance present. This goes to show how emotional states and physical events can be influenced by each other (this process is explained in further detail in Fibroids & Emotions). Considering all this, it is hardly a wonder that more serious depression may develop when the ovaries are removed or if they cease to function.

One would be inclined to think that replacing oestrogen would be the answer, but this has never been proven. On the contrary, long-term use can reverse the effect on mood as well as present a risk for blood clots. Oestrogen’s effect on the thyroid gland and the effects on the ratios of copper and zinc in the brain, can all negatively affect stress-levels and mood, and increase the risk for stroke and heart disease. Furthermore, a lack in progesterone – even if only relative compared to oestrogen levels – contributes to depression and a decline in libido.

The stories around HRT are multitude, and confusing. The news around it is contradictory. Long-term studies have been discontinued because of the risks involved, which tells a tale in itself. The majority of short-term studies (around 5 years) show an increasing risk of breast cancer with duration of use, and a risk for stroke and venous thromboembolism continued throughout the therapy. The elevated risk of coronary heart disease seems largely to be limited to the first year. Reductions in risk of colon cancer and fractures from osteoporosis are mostly not enough reason for the use of HRT; risks must be balanced against the severity of menopausal symptoms and benefit of treatment, especially where other factors for increased risk for the side effects are present.

It is now generally felt that hormone replacement should only be used as a temporary measure to counteract severe menopausal symptoms. The good news is that there are natural alternatives. Dr. Lee explains in his book “What your doctor may not tell you about Menopause” how the answer can be found in the much larger drop in progesterone compared to oestrogen after menopause. And supplementing with natural progesterone does not have all the side effects associated with synthetic progestogens. Another benefit is that natural progesterone does not only prevent osteoporosis but also reverses it. (For more information on Natural Progesterone Cream see B6. / Also see the last paragraph: ‘In the News’).

I just hope many more women will be able to reach the menopausal stage in life in a natural way and not because of surgery – and preferably without any need for hormone supplementation.
Safer Alternatives to Hysterectomy for Fibroid Management

A patient: “I don’t think you should take everything out that makes me a woman and then put me on a bunch of drugs that make me a woman again.”

Keeping your female organs intact whenever possible may prevent a host of health problems, not only because you preserve your parts, and restore their natural balance, but because the ‘cure’ for the side effects may be worse than the original problem. Uterine Fibroid Embolisation (UFE) is in most cases a good alternative to hysterectomy for treating fibroids; it is less invasive, carries less risk, and restores the uterus to its normal function. Women should not be made to feel inadequate or disturbed for questioning the necessity of hysterectomy; they need the support of their gynaecologist.

It is indeed necessary for women to stand up for what they want, to be given a chance to base their decision on all available information, and to have the courage to look their doctor in the eye and calmly state their determination to remain an intact woman.

Many options to treat fibroids

Oral therapies and natural balancing therapies
Depending on the severity of symptoms, there is a range of less drastic therapies like medical (hormone) therapy, herbal or homoeopathic treatment, natural progesterone therapy, dietary changes and other healing modalities that support the natural balance of the body. With medical therapies often the control is only partly or transient, and the same may happen with more natural therapies, although these, if used well, may contribute in bringing about a more fundamental re-balancing in the body. Understanding the problem and regaining balance is an important step in true healing in any case. (Find extensive information in chapter B6, and in part C: Fibroids & Emotions).

All this will be supportive, but if these basic measures are not sufficiently adequate on their own where symptoms are too severe, more drastic treatment is appropriate. Also, if fertility is an issue, uterine-sparing treatment is the way to go. The two main procedures to choose from are:

The surgical approach of Myomectomy
The majority of gynaecologists state that myomectomy is a much more risky surgery compared to hysterectomy, but it is indeed the opposite in the hands of a skilled and experienced surgeon. Unfortunately they are presently few and far between. Dr.West is one of the few American based gynaecologists who are proficient in performing myomectomy. In Australia there are good gynaecologists in the Melbourne Fibroid Clinic. (See 2.4).

The minimally invasive keyhole-surgery of Uterine Fibroid Embolisation
Most experienced gynaecological surgeons also state that embolisation can be a good alternative to hysterectomy in select patients. As you will see in the UFE chapter, it is an effective treatment and there are not many contra-indications to embolisation. But patients oftentimes have to ask specifically for embolisation treatment.

And today, more and more women are indeed opting for the least invasive procedure of UFE – and with very good results, irrespective of uterine or fibroid size, or number of fibroids. This treatment distinguishes itself by a very low risk and complication rate, and no regrowth of fibroids, contrary to myomectomy. Additional procedures or surgery are not excluded because of it, should this in the rare case be necessary – surgery will then be easier, with less blood loss.

Many physicians do not offer this treatment option because of lack of information – and perhaps there are some gynaecologists who might feel threatened by its hopeful possibilities, because they do not perform this procedure themselves. Read all about it in the UFE chapter (B2), which contains the latest study reports.
...And have your doctor read it too!

What some patients say:

I didn’t want to risk hysterectomy; when things became really unbearable I went for embolisation – and wished I had done it sooner! It gave me back my live and it was a breeze.

One woman doctor was very rude, very matter of fact about the whole thing. She said I should have a hysterectomy – “You don’t want any more children - we’ll just give you a hysterectomy.” She made it sound so simple but I know there is a hormone change when you have one and it’s not just so easy. Something inside me said, don’t have a hysterectomy. I just couldn’t envision surgery so I wanted to look further.

The hormonal issues with hysterectomy are enormous, even when the ovaries are spared. And the uterus supports all other organs. So I chose fibroid embolisation; I’m so glad I gave myself this chance; I feel ‘completely’ healed.

All treatment options have their value, provided they are used when appropriate.

**Comparisons between embolisation and myomectomy**

are discussed extensively in B3: Fibroids & Fertility.

**Other procedures**

Some other alternatives are discussed in chapter B5; like (the various types of) Endometrial Ablation, which is usually inadequate where certain types of fibroids or large fibroids are present or fertility needs to be preserved – while other alternatives methods like laser treatment have some major drawbacks.

**Real health and responsibility**

Given all the above findings, it seems rather illogical to promote hysterectomy as a treatment for fibroids and a measure to prolong a woman’s life and its quality. Research supports the opposite conclusion; optimal health is maintained by uterine and ovarian preservation, except when cancer is already present or there is a clear family predisposition for cancer.

I strongly believe, together with an increasing amount of women and physicians, that it is up to the woman herself to decide if she needs her reproductive/sex organs or not and if she wants to risk surgery. She should not be made to feel inadequate or disturbed for questioning the necessity of hysterectomy. It should be the obligation of each physician and gynaecologist to present all treatment options to women, giving the pros and cons of each. I believe a physician should do so honestly, even if that particular physician is not capable of providing some of the treatment options, and referral to another doctor may be required. Should the patient elect not to have a hysterectomy, it is the obligation of the physician to support this decision.

Perhaps the best advice comes from Dr. Stanley West:

The challenge informed women face is to persuade doctors to turn away from the panaceas of the past to the treatments of the future. Just as basic to full autonomy is control of your body and the right to make decisions about your health and health care on the basis of all available information, free from pressure, scare tactics and outdated doctor-knows-best paternalism. It is time we doctors stopped disassembling healthy women. But nothing will change until more women look their doctor in the eye and calmly state their determination to remain an intact woman.
In the News

Panic on cards as HRT tied to cancer
By Miranda Wood, Health Reporter
August 10, 2003
The Sun-Herald

Doctors are expected to be flooded with inquiries from women on hormone replacement therapy (HRT) this week after a British study found the menopause treatment doubles the risk of breast cancer. The study of 1 million women, aged between 50 and 64, showed an increase in breast cancer cases for women taking all forms of HRT. Australian Medical Association (NSW) vice president John Gullotta said he believed this latest research would create the same anxiety among women as a US study did last year. "It does cause a lot of panic unnecessarily in a lot of women," he said. "I would urge all women who are on HRT for a long period to speak to their doctor in regard to whether they still need to be on it."

National Breast Cancer Centre chief executive Professor Christine Ewan said it was too early to quantify the risk to women. She said although the study found the risk of breast cancer was higher for women on HRT for a long period, the extra risk had disappeared within a few years of stopping therapy.

The latest research from Britain's Million Women Study found women on combined oestrogen and progestogen preparations for 10 years doubled their chances of suffering breast cancer. Women on oestrogen-only therapy increased their risk by 25 per cent while the research found breast cancer patients on HRT were 22 per cent more likely to die.

The study, published in The Lancet, follows other controversial HRT reports in the past year. Last May, a US study found women taking a particular combination of hormones were twice as likely to develop dementia. American doctors halted a major clinical trial after their research showed a 26 per cent increase in breast cancer cases for women on HRT, along with a jump in heart disease, blood clots and stroke.

Note
Follow up publications about women who did go off HRT, say that for some of them the symptoms of menopause return and are too much to cope with.....so they go back on HRT, despite all the risks.
I wonder, do these women ever get told by a physician about Natural Progesterone Cream....
In any case, it's best to avoid premature menopause......and to try and reach that part of life as balanced as possible. (See chapter B6 – Complementary Therapies)
Read more in the other chapters of www.fibroidsolutions.com:

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www.fibroidsolutions.com
INFORMATION ABOUT UTERINE FIBROIDS
THAT MAKES A DIFFERENCE