SEXUALLY SPEAKING: Sexuality and Hysterectomy: Finding the Right Words Responding to patients' concerns about the potential effects of surgery.

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Article Content

Hysterectomy is the second most frequent operation (after cesarean section) performed on adult American women; it's been estimated that one-third of them undergo the procedure by age 60. 1 Patient education often focuses on immediate pre- and postoperative concerns, with little information given about sexual consequences, despite the fact that the uterus is a sexual organ and plays a role in both arousal and orgasm.

My reviews of the literature on sexuality after hysterectomy indicate that many studies contain methodologic flaws, such as vague measures of sexual function and satisfaction. 2 Sexuality is rarely formally assessed or documented as part of clinical care for hysterectomy patients, 2 and few nursing studies have addressed sexuality in this population. 3

Nurses should be able to talk with patients before and after surgery, not only about the nature of the surgery and plans for recovery, but also about possible long-term consequences. Women often have questions, concerns, or perceptions about sexual functioning that they don't know how to talk about or are hesitant to discuss. The July *Sexually Speaking* column ("Do Ask, Do Tell") addressed the barriers that keep nurses from initiating such conversations with patients. Nurses can also prepare themselves to present evidence-based information about sexuality and hysterectomy and offers strategies for opening a discussion.

THE NEED FOR INFORMATION

Older research suggests that until fairly recently, sexuality was rarely or never discussed with women undergoing hysterectomy. A 1984 literature review by Drummond and Field stated that "many women lack [basic] anatomical and physiological knowledge" about the female reproductive system and the effects of hysterectomy, including its possible effects on sexual response and libido. 4 The authors cited two nursing studies that found that providing patient education before and after surgery resulted in fewer postoperative sexual problems, but acknowledged that determining which modes were most effective would require more research.

In the early 1980s, Neefus and Taylor surveyed women who had undergone successful hysterectomy and found that 20% of respondents reported

receiving no information about potential sexual problems. 5 However, more recent research indicates that most women feel they're given sufficient information about the surgery, and its likely and possible effects, by their physicians. 6, 7 (At this writing, no studies have investigated the role of nurses and other health care providers in this regard.)

Many women also receive information from non-health care sources. A study by Ewert and colleagues found that women who reported getting information about hysterectomy from newspapers generally viewed the surgery unfavorably. 6 No studies have evaluated how well information acquired through the Internet meets hysterectomy patients' needs.

EVIDENCE OF THE EFFECTS

There is abundant evidence in the medical literature supporting favorable sexual outcomes from hysterectomy, 8-12 although how it affects some aspects of sexuality (in particular, libido and the quality of sexual experience) remains somewhat unclear.

In a prospective study of 1,101 women who had undergone hysterectomy, Rhodes and colleagues found that more women reported having intercourse "[with]in the last month" at one and two years after surgery (77.6% and 76.7%, respectively) than so reported before surgery (70.5%). 12 Rates of dyspareunia also dropped, from 18.6% before surgery to 4.3% and 3.6% at one and two years after surgery, respectively. Dragisic and Milad surveyed 75 women before hysterectomy and again at six months after surgery (93% completed the postoperative follow-up). 8 The women were five times less likely to report dyspareunia after surgery than they were before, although libidinal and orgasmic frequency and strength did not change significantly.

A study by Gutl and colleagues of women who had undergone hysterectomy found significant improvements in libido and the frequency and quality of intercourse at three and 24 months after surgery, compared with before. 9 Findings from the sole nursing study to address sexuality after hysterectomy also indicate improved sexual functioning (including increased libido and decreased pain during intercourse) after surgery. 13

While most women who have hysterectomies appear to suffer few adverse sexual effects, it should be noted that in almost all the studies, preoperative measures of sexual function were obtained when women were highly symptomatic; their symptoms included pain, bleeding, and reduced or absent libido. It stands to reason that removal of the source of the symptoms is likely to result in improved sexual function.

Type of surgery.

It's been theorized that radical hysterectomy (removal of the uterus, upper vagina, and parametrium) would result in greater adverse sexual effects than would less invasive surgery. Some research appears to support this. For example, one study found that women who had undergone radical hysterectomy showed a more disturbed vaginal blood flow response during sexual arousal than did women who had undergone simple total hysterectomy (removal of the uterus and cervix); the researchers hypothesized that this "might be related to a denervation of the vagina which increases with increasing radicality of surgery." 14 Another study found that women who underwent radical hysterectomy reported more adverse sexual effects, including dyspareunia, loss of sexual interest, and difficulty with lubrication and orgasm, than did age-matched control subjects. 15

Two recent studies found no significant differences in the effects of total and subtotal hysterectomy (removal of the uterus only, not the cervix) on sexual functioning. 16, 17 Roussis and colleagues looked at sexual responsiveness in 126 women who had undergone various types of hysterectomy (48% had undergone total abdominal hysterectomy; 34%, vaginal hysterectomy; and 17%, supracervical hysterectomy). They found that most respondents reported *no* significant reduction of libido and that the "type of hysterectomy that was performed did not appear to affect the attitudes of the respondents." 16 Zobbe and colleagues considered results from both a randomized trial and an observational study regarding the effects of total abdominal and subtotal abdominal hysterectomy. 17 They found that both types of hysterectomy significantly reduced dyspareunia without adversely affecting libido or other areas of sexual function.

Indeed, hysterectomy may increase sexual pleasure for some women, as it eliminates the possibility of unwanted pregnancy and symptoms related to menstruation (such as dysmenorrhea). 18 For women who experience dyspareunia caused by uterine fibroids or endometriosis, hysterectomy may result in pain relief and a return to enjoyable sexual activity.

Possible adverse consequences.

Removal of the uterus affects the anatomic structures of the pelvis, including the bowel, bladder, and nerves. Changes to the nerve supply of the upper vagina may interfere with lubrication and orgasm. 19 Mobility of the pelvic organs during intercourse, as well as the ability of the upper vagina to expand during arousal, may also be affected. 20 Many of the nerves to the pelvic area run through the uterovaginal plexus, and excision of the cervix may result in damage to this structure. Masters and Johnson observed that "many women will certainly describe cervical sexual pressure as a trigger mechanism for coital responsivity." 21 Loss of the cervix and its mucous-producing glands may decrease vaginal lubrication. The reduction of sensitive tissue from the upper vagina may also lead to decreased arousal and reduced probability of multiple orgasms. 22 For women who feel uterine

contractions during orgasm, the loss of the uterus may adversely affect the experience of orgasm. 23

TALKING WITH PATIENTS

Despite the significant anatomic changes that result from hysterectomy, the evidence suggests that most women who have the surgery regain good sexual function, often better than they had before surgery. It's important that women hear this from nurses and other health care providers, especially women who may be getting their information from sources outside of health care. However, women should also know that although the surgery will alleviate many symptoms (such as pain and bleeding) that affect sexual function, the nature and quality of their sexual response may change.

The best time to provide such information will differ among patients. Some women may need this information well before surgery, so that they can prepare for the surgery and its possible effects. Some may benefit from having this information reiterated immediately after surgery. Examples of ways to communicate this information using the PLISSIT and BETTER models are provided on page 66 and page 67.

Resources for Nurses and Patients

Do You Really Need Surgery? A Sensible Guide to Hysterectomy and Other Procedures for Women by Michele C. Moore, Caroline M. De Costa. Piscataway, NJ: Rutgers University Press, 2004

Hyster Sisters: The Hysterectomy Recovery Support Website http://www.hystersisters.com

The Woman's Guide to Hysterectomy: Explanations and Options (revised edition) by Adelaide Haas, Susan L. Puretz. Berkeley, CA: Celestial Arts, 2002

Torpy JM, et al. *JAMA* patient page: hysterectomy. *JAMA* 2004; 291(12):1526.

The PLISSIT Model of Treatment

Permission.

Give the patient permission to talk about sexual issues related to hysterectomy. This conversation may be started either pre- or postoperatively. The nurse might begin with a general comment:

* Example: "Women having a hysterectomy often have questions or concerns about sexuality. Is there anything you would like to talk about?"

Limited Information.

Provide factual information in response to a question or observation. A good time to do so may be postoperatively, before discharge.

* Example: "While many women wait to have penetrative intercourse until after the six-week postoperative visit, it's fine to kiss and cuddle. Don't worry if you find yourself becoming aroused; it's not harmful and will actually speed healing."

Specific Suggestion.

Requires a higher level of expertise on the part of the nurse, who must be able to anticipate specific sexual concerns. Best times to offer such statements are during postoperative preparation for discharge or at later postoperative checkups.

* Example: "If you find penetrative intercourse painful, you may want to try intercourse lying side by side with your partner or with you on top. This will give you more control over the depth and forcefulness of penetration and lessen the likelihood of pain."

Intensive Therapy.

Referral to a sex therapist or a specially trained counselor may be needed for more severe or chronic problems.

* Example: "It sounds to me as though the depressed mood you describe may be a factor in your recovery. There are treatments that may help, and I'd like to refer you to a specialist who can discuss them with you."

Annon J. *The behavioural treatment of sexual problems.* Honolulu, HI: Enabling Systems; 1974.

Using the BETTER Model

Bringing up the topic.

* Example: "Before you're discharged, I'd like to give you the opportunity to ask any questions you may have about sex after hysterectomy."

Explaining that sex is a vital part of life.

* Example: "Women are sometimes shy about bringing up this topic, but the nurses here are used to talking about sexuality; we find that many women do have questions about this important aspect of their lives."

Telling patients that resources will be found to address their concerns.

* Example: "I have a list of books you might be interested in. They deal with various aspects of the hysterectomy experience, and you may find them helpful."

Timing of intervention can be adjusted according to the patient's need.

* Example: "Perhaps we can talk about this after your visitors leave this evening. Or you can call the unit at any time after discharge to ask us about this and anything else that we may have missed. Your physician should also be able to answer these kinds of questions."

Education regarding sexual side effects of treatment.

* Example: "Most women report that after surgery their sex lives go back to what they were before they had symptoms. However, you may notice a difference in the experience of orgasm because the uterus, which normally contracts during orgasm, is no longer there."

Recording. Include a note in the patient's chart indicating that the subject of sexuality after hysterectomy has been discussed.

* Example: "Potential side effects related to the planned surgery were discussed. Patient was given reading material and contact information for the local women's health resource center."

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