Hysterectomy and Medical Misogyny

Hysterectomy in 2024 ...

In Australia, Hysterectomy rates have dramatically declined over the past few decades. There are a number of contributing factors to this.

For women with heavy menstrual bleeding, less invasive procedures such as a Mirena IUD or an Endometrial ablation, where the lining of the uterus is removed, have seen a significant contribution in decline in hysterectomy rates. For women who have only heavy menstrual bleeding, these procedures may have very high satisfaction rates and very good outcomes, with minimal downtime.

However, these procedures rarely provide satisfactory relief for women with significant dysmenorrhoea (painful periods) or persistent pelvic pain. Persistent Pelvic Pain (PPP) means that the pain in the pelvis is felt most days and lasts longer than six months. Dysmenorrhoea or PPP can cause significant distress and impact on your ability to look after yourself and others such as your children or other dependants. It can impact relationships, sleep, mood and impact your ability to maintain employment.

Often dysmenorrhoea or PPP is caused by Endometriosis, and more commonly by a condition called Adenomyosis. Many people are familiar with the term endometriosis, which affects 1 in 9 women in Australia. Endometriosis is where the lining of the uterus grows outside of the uterus, most commonly in the pelvis, and causes bleeding, scarring and distortion of anatomy. Adenomyosis, is where the endometrial tissue grows into the muscle of uterus over time. The endometrial tissue within the uterus, also bleeds and causes inflammation, which causes pain. This may be particularly worse around the time of the period but can progress so there is pain present persistently.

When pelvic related pain becomes so severe, the definitive treatment is a hysterectomy. It distresses me with how many women I see, that have been told by another doctor, that they are too young to have a hysterectomy, or that they may change their mind and decide to have more children, even when they are very sure they have finished their family. Almost even worse is when either a female or woman or person who does not identify as female, who does not wish to have children is told that she can not have a hysterectomy.

Another situation I have encountered is women who had it implied to them that a hysterectomy is an extreme option. For women living in debilitating pain, and their symptoms are impacting on their quality of life, it does not seem extreme to me at all.

However, you may be a woman where your menstrual symptoms burden your life to a more significant extent. Particularly for those women with endometriosis, adenomyosis, and or persistent pelvic pain, a hysterectomy may give definitive relief of symptoms. For these women, it can be life changing where they do not need to live with severe menstrual symptoms, and look after themselves, their families and maintain employment without concern regarding menstrual symptoms.

In addition, for women with large fibroids or women who suffer from pelvic floor prolapse, a hysterectomy may be the only surgical option available.

Denying a woman a hysterectomy, whom has been adequately counselled and understands her decision is the **epitome of medical misogyny** at its worst.

For a woman who has severe menstrual symptoms and or pain, a hysterectomy is a logical and reasonable decision. For a person that does not suffer these symptoms, and particularly for health professionals, but we need to try better in this space. This is less common in private practice as doctors often develop a close and

personal relationship with their patients and have a greater insight into the impact that their patients' symptoms have on their life.

Many hysterectomies these days can be completed laparoscopically, with keyhole surgery. This means a significant reduction in post operative pain, less complications, and sooner recovery to normal activities. Most patients would only need to spend one night in hospital and then recover at home.

The complication rate from a straightforward hysterectomy rate is overall low. That said complications can still occur, and having a surgeon that is competent, safe, and careful is especially important.

The decision to have a hysterectomy, should rarely be made in one consultation. From my perspective, I find it useful to see a patient for the first time, take their history and build a relationship, give all the available options and recommendations to suit. It is often helpful for a patient to then take this information and consider it for however long it takes for them to confidently make their decision. For some patients that are particularly anxious or not sure, it can be useful to see them for further consultations, often with a partner or a support person, to go through any questions or concerns.

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2024

"Having a hysterectomy with Dr Brooke was the best decision I have ever made. I have suffered with terrible periods my entire life and then just constant pain. I had three laparoscopies and finished my family, but I kept being told that I was that I was too young, and I might change my mind. Dr Brooke was the first doctor who listened to what I was saying, and it has changed my life".