

# 'Hysterectomy'

RESOURCE GUIDE **2**

The Women's Center



NATIONAL WOMEN'S HEALTH NETWORK

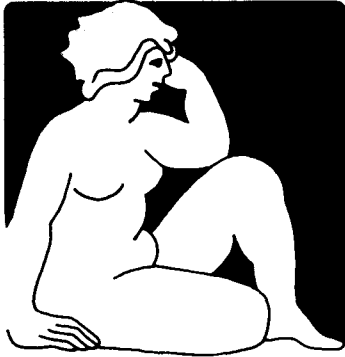
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## A Note to Our Readers



We, as women, by choice and necessity are becoming more active participants in the protection and promotion of our own health. Increasingly, we are finding that the health services we need are unavailable, inadequate, and sometimes dangerous. This year alone, hundreds of thousands of women will have unwarranted hysterectomies, mastectomies, and sterilizations. Others will be exposed to insensitive childbirth practices, while yet others will be prescribed drugs that have been linked with cancer. There are presently 14 million American women who take oral contraceptives or use intrauterine devices. The long-term effects of these drugs and devices are unknown.

To deal with many of these concerns, women need a centralized, accessible source of personal health information. As a first step, the Women's Health Clearinghouse, a project of the National Women's Health Network, compiled nine health resource guides on selected women's health issues: abortion, breast cancer, birth control, DES, hysterectomy, maternal health and childbirth, menopause, self-help, and sterilization.

This guide, along with the eight other health resource guides, has been developed from a wide selection of popular, feminist, and medical sources and has been designed to be used in a variety of ways. The directories of local women's health centers, national organizations, and resource people can be used to help organize political action and build coalitions with other health activists. The discussions of the major issues, together with the comprehensive bibliographies, can serve to increase your own personal health awareness, while the listings of libraries and information centers can facilitate your further research.

Although the material in this guide has been reviewed for technical and factual accuracy, it may not be as sensitive to your needs as we would like. Bear in mind that there is no longer any area of health care, especially concerning women, which is not without controversy. Medical experts frequently disagree. Consequently, you may find differing opinions on any one issue. In addition, health and medical information is changing so rapidly that what you read here may already have been superceded by some new development.

By sharing this information, the National Women's Health Network does not intend to give medical advice, but rather to provide information which will enable you to be an active health care decision maker.

We hope this guide will be useful to you and we welcome your comments.

### National Women's Health Network

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The Women's Center

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By Barbara Caress. Appeared in *Health-Pac Bulletin*, July-August 1977. Reprinted by permission.

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## Introduction

Our special thanks to Susanne Morgan for permission to reprint here her fine booklet, *Hysterectomy*. Thanks also to Judy Lipshutz and Norma Swenson for their help with this Guide. While most of the hysterectomy material focuses on the politics and experience of the procedure, the bibliography also includes items covering conditions which frequently lead to hysterectomy, such as pelvic inflammatory disease (PID) or estrogen drugs, as well as some of the effects and complications of surgery. For additional related information, please consult the Network's Guide #3, *Menopause*. *Breast Cancer*, Guide #1, also includes related material about surgery. Sterilization, Guide #9, may also be useful.





*At the time of being admitted as a member of the Medical Profession...  
I solemnly pledge myself to consecrate my life to the service of humanity...  
I will practice my profession with conscience and dignity...  
The health of my patient will be my first consideration...  
I will maintain by all means in my power...the honor and noble traditions of the medical profession...  
My colleagues will be my brothers...  
I will not permit consideration of religion, nationality, race, party politics, or social standing to intervene between  
my duty and my patient...  
I will maintain the utmost respect for human life...even under threat, I will not use my medical knowledge con-  
trary to the laws of humanity...*

— From the Declaration of Geneva

## Womb-Boom

**CARESS** Hysterectomy (surgical removal of the uterus) may be acceptable as a treatment for anxiety, states Dr. James Sammons, the AMA's senior staff physician. Sammons, testifying before a recent subcommittee hearing of the House Commerce Committee, advocated use of this major surgical procedure as the treatment of choice for "pregnaphobia."

Judging from available statistics, there are many American doctors who share Sammons's opinion. The National Center for Health Statistics estimated that 794,000 women underwent hysterectomies in 1976. This operation--up 15 percent in just three years--is performed at a higher rate than any other surgical procedure. Approximately 10 of every 1,000 women underwent hysterectomies in 1976. At the current rate, more than half of the women in the U.S. will have had their uteruses removed before they reach 65 years of age.

During the 1960s, the U.S. had a hysterectomy rate more than twice that of England and Wales and about four times higher than that in the rest of Europe. Rates vary in the U.S. depending on such factors as geographic location, types of insurance coverage, and numbers of obstetrician-gynecologists (Ob-gyn is a surgical specialty). Among Medicaid recipients, for example, the rates range from a low of 0.34 per 1,000 in Mississippi to highs of 12.8 in North Carolina and 24.9 per 1,000 in Nevada.

Hysterectomy has long been an accepted medical procedure for treating cancer of the cervix, uterus, and ovaries, and other serious gynecological problems, but its use as a birth control method and as a preventive measure accounts for the enormous variations in rates. (In the mid-1800s, hysterectomies were performed for symptoms ranging from "troublesomeness" and "erotic tendencies" to such problems as "eating like a ploughman" and "simple cussedness.") Dr. R.C. Wright, writing in *Obstetrics and Gynecology*, the journal of the American College of Obstetrics and Gynecology, in 1969 promoted what have come to be called "birthday hysterectomies": "The uterus has but one function: reproduction. After the last planned pregnancy the uterus becomes a useless, symptom-producing, potentially cancer-bearing organ and therefore should be removed."

### RISKS AND BENEFITS

Removing the uteri of all women at age 35--about one million a year--would prevent 34,800 cases of uterine cancer (a disease easily detected by Pap smears). This would save some 13,000 women who would otherwise have died of cancer, a gain in life expectancy for the entire group of 0.2 years. At the mortality rates for the operation (estimates range from 0.06 to 0.2 percent), some 600 to 2,000 women would have died from the operation itself and another 300,000 to 450,000 would have suffered such complications as infection, bleeding, and blood clots (complications rates run 30-45 percent). The monetary cost would be \$2.9 billion.

These figures do not reflect the psychological costs of a hysterectomy. There are many reports of women experiencing

**CARESS** depression after surgery. A 1973 English study, for example, found that one-third of the women within three years of undergoing surgery were treated for depression. Other potentially harmful side effects may result. Hysterectomy appears to affect ovarian function and if estrogen levels are thus impaired, higher rates of coronary artery disease could result. Even a one percent increase in death rates from heart disease would offset any possible gain from cancer prevention.

Outrageous as elective hysterectomy sounds for relief of anxiety, sterilization, or the general prevention of cancer, such uses were informally endorsed at the 1971 meeting of the American College of Obstetrics and Gynecology. Following debate on prophylactic hysterectomy, the assembled doctors were asked to register approval or disapproval by their applause. An audiometer registered 25 seconds of applause from those in favor of prophylactic hysterectomy and 10 seconds from those against.

Hysterectomy solely for the purpose of sterilization--hystero-sterilization--is now performed routinely in many hospitals. At the Los Angeles County-University of Southern California Medical Center, for example, the number of elective hysterectomies increased 742 percent between July 1968 and December 1970."

#### THE SASKATCHEWAN SOLUTION

In 1972 the Saskatchewan Department of Health noticed an alarming increase in the number of hysterectomies performed in the province. The number jumped 72.1 percent between 1964 and 1971 while the number of women over 15 years increased by only 7.6 percent. This rise occurred despite the presence of required second opinions for all major surgery. Obviously, most doctors simply rubber-stamped their colleagues' recommendations.

The Provincial College of Physicians and Surgeons organized a committee comprised of both medical and nonmedical personnel to study the problem. The Committee drafted a list of acceptable indications for hysterectomy (See box). According to a report by participants which appeared in the July 9, 1977 *New England Journal of Medicine*, "The so-called sterilizing, prophylactic, or birthday hysterectomy was not accepted as a justified hysterectomy when not associated with other factors, since, in our opinion, hysterectomy solely for the purpose of sterilization does not conform to good gynecological practice."

Based on these criteria, the Committee found that the number of unnecessary hysterectomies performed in five major provincial hospitals ranged from a high of 59 percent to a still unacceptable low of 17 percent. Although no penalties were invoked against doctors operating for reasons other than those listed, the Committee considered its activities very effective. By 1974, the number of unjustified hysterectomies had dropped to 7.8 percent. In those hospitals where unjustified operations were still being performed, the College of Physicians and Surgeons met with administrators and medical staffs and "recommended that unnecessary operations should cease."

The authors of the report noted in conclusion that: "It is also of interest that the start of the decline in hysterectomy rate was coincident with the publicity given to the high rate

CARESS of hysterectomies in Saskatchewan in the news media in 1972 and the announcement of the formation of the Committee." Maybe the women got smart--or the doctors got frightened.

MEDICAL INDICATIONS FOR HYSTERECTOMY

The following is the list of medical conditions the Saskatchewan Study identified as acceptable indications for hysterectomy:

- \* Malignant and premalignant lesions of the female reproductive tract
- \* Endometriosis: the appearance of uterine lining tissue in the abdominal cavity where it does not belong
- \* Adenomyosis: ingrowth of the endometrium (lining) into the uterine musculature
- \* Leiomyosis with a uterine weight of 200 grams or more (fibroid tumors)
- \* Salpingitis and oophoritis: infections, generally chronic, of the tubes and ovaries
- \* Hysterectomy associated with complications of pregnancy
- \* Benign ovarian neoplasms: tumors which are not cancerous and will not metastasize
- \* Cervical dysplasia: thought by some to be pre-malignant
- \* Hyperplasia of the endometrium: an overgrowth of the uterine lining
- \* Dysfunctional uterine bleeding: bleeding not related to normal menses
- \* Pelvic congestion syndrome: a disputed category including such symptoms as low back pain and extreme menstrual pain

EDITOR'S NOTE: Readers should be aware that there are a variety of medical and nonmedical alternatives to hysterectomy for many of these conditions. A second opinion is a wise precaution; increasingly, second-opinion programs are offered through Blue Cross or Medicaid.

## FACING SURGERY? WHY NOT GET A SECOND OPINION . . .

Second opinions are a long and honored practice in the medical profession. Many physicians seek a second opinion for their patients--and for themselves--prior to ordering or undergoing surgery.

When non-emergency surgery is recommended, a patient should learn, through a second opinion, the benefits, risks, and alternatives to the recommended surgery.

The Department of Health, Education and Welfare suggests four ways to locate a specialist to give a second opinion:

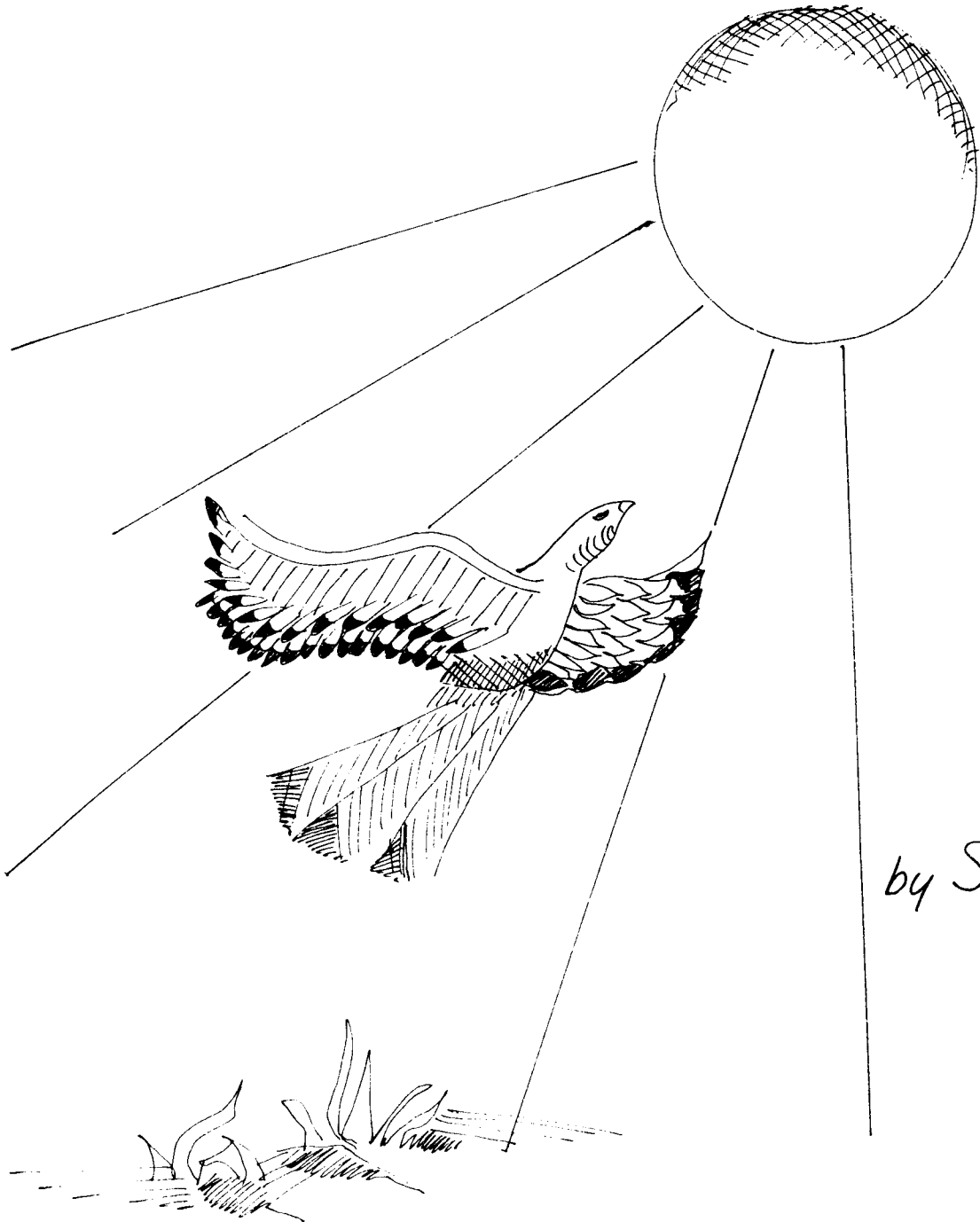
1. Ask your doctor to refer you to another doctor who is a specialist in the specific medical condition.\*
2. Call the HEW toll-free number, 800-325-6400, to locate a specialist in your community.
3. If eligible for Medicaid, contact your local welfare office to see if your state will pay for a second surgical opinion.
4. If covered by Medicare, call your local Social Security office.

Additional information can be obtained by writing Surgery, Washington, D.C. 20201.

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*\*EDITOR'S NOTE: Sometimes it is useful to consult a different specialist. Obstetrician-gynecologists, internists, radiologists, surgeons, and oncologists are all trained differently.*

# HYSTERECTOMY



*by Susanne Morgan*

# Hysterectomy: Information and Strategies

Most of us have heard of hysterectomy and probably know a number of women who have had one. Yet most of us feel we don't know very much about it. When I was 29 I was in that situation, confronted with a hysterectomy and ovariectomy when a severe pelvic infection would not clear up. I am a medical sociologist and found when I tried to learn about the experience that little information was easily available and even the professional literature did not answer many of my questions.

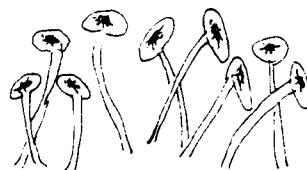
This pamphlet is the result of two years of research, talking with women and health professionals, and teaching workshops and a full course on hysterectomy. I present it to you with the gaps I see in the present research and with my questions about the attitudes and assumptions of many writers. I am working on a longer book, to go into more detail about the topics I discuss briefly here and to include the voices of many women. The major message I want you to hear is that we need to talk with each other and listen to the information we all have about the variety of our experiences.

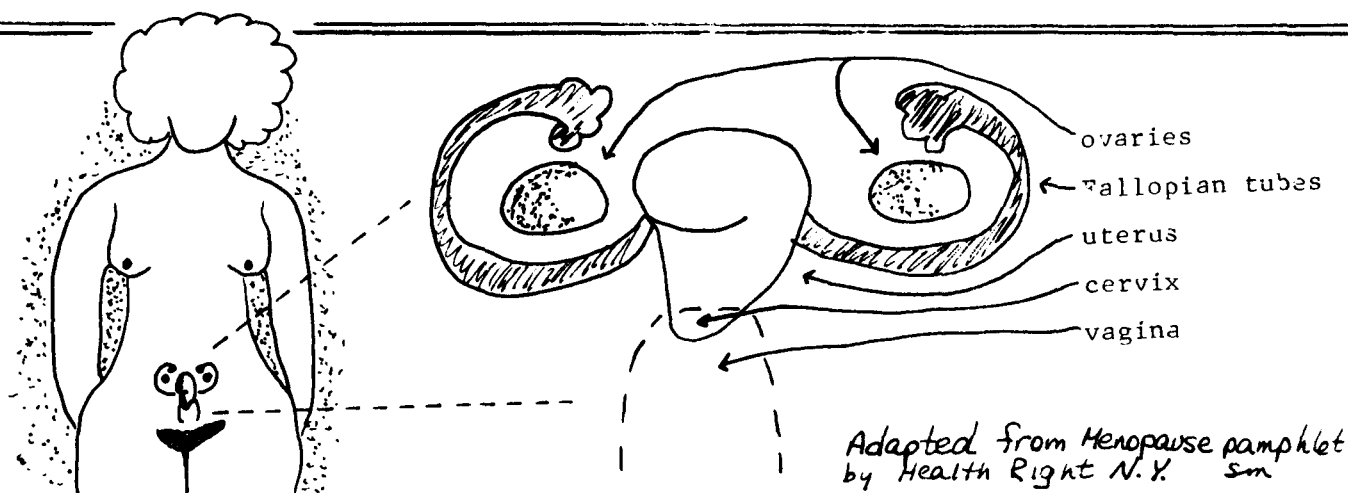
## What is hysterectomy?

The diagram on page 2 shows our pelvic structure. Our uterus, or womb, is where a baby can grow and where our menstrual flow comes from. Our vagina is the channel where a man's penis goes if we have intercourse and where our menstrual flow comes out. The cervix is the portion of the uterus which extends into the vagina. Our ovaries produce hormones which go into the blood stream, and they produce an egg more or less monthly (ovulation) between puberty and menopause except if we are pregnant or taking birth control pills. The Fallopian tubes carry the egg to the uterus. Menstruation follows unless a sperm fertilizes the egg.

So there we are. Hysterectomy is an operation to remove the uterus. Usually the cervix is removed also. After hysterectomy we will not have menstrual periods and we will not get pregnant. We will, however, still have our monthly hormonal cycles unless our ovaries are removed. We will have our vagina and can still have sex. Page 3 shows our pelvis after hysterectomy.

Sometimes there are reasons (discussed in other sections) why our ovaries should be removed also. Removing the ovaries is called ovariectomy or oophorectomy (the second term is pronounced "oh'-a-fer-ec'-to-me or oo'-fer-ec'-to-me). If our ovaries are removed the tubes are also removed. We often refer to this procedure as "total hysterectomy" but the technical term is pan hysterectomy with bilateral salpingo-oophorectomy. Pan means the uterus and cervix, salpinges or salpinx are the tubes and bilateral means both sides.





If our ovaries are removed our hormone level changes very suddenly and we experience "instant menopause", unless we have gone through menopause already.

### *How many women have hysterectomies?*

Hysterectomy is the most common major operation in the United States today, and the rates are increasing rapidly. The National Center for Health Statistics estimates the number performed to be 725,000 in 1975, 794,000 in 1976, and over 800,000 in 1977. Since 1968, when 545,000 hysterectomies were performed, there has been nearly a 50% increase. Dr. John Bunker of Stanford University estimates that 50% of U.S. women will have one by the age of 65; and 40% by the age of 40, if today's rates continue to grow. Perhaps 1/3-1/2 are unnecessary.

There has been publicity recently about unnecessary hysterectomies. It is important to know where these concerns come from, and how the trends in society may influence the decision we can make.

The increasing rate of hysterectomy is accompanied by some rather odd facts. Twice as many hysterectomies are done on women with health insurance as uninsured women. Many more operations are done in situations when the doctor is paid on a fee-for-service basis than when the doctor is salaried, as in a prepaid group practice or in Great Britain. The rate in some teaching hospitals has gone up several hundred percent in a short period of time. The rate varies with the part of the country and sometimes part of a state. The rate has been seen to drop dramatically in certain situations. When a health plan required all women considering a hysterectomy to have a second opinion, the number of operations performed dropped sharply.

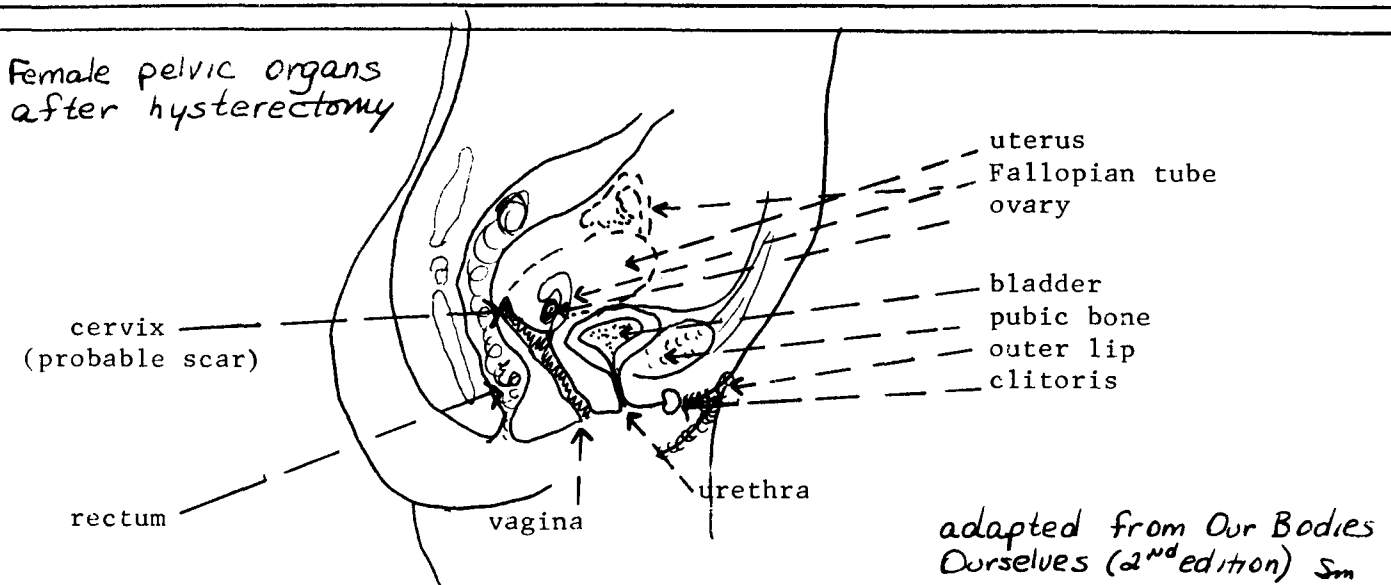
These facts make us wonder if nationally, more is influencing hysterectomy rates than just the physical condition of women. The relation of hysterectomy rate to the payment system suggests that in society as a whole there are factors influencing the rate other than pure medical opinion. This becomes even clearer when we note that U.S. hysterectomy rates are three times Britain's.

Some doctors acknowledge that their motivation is financial. One obstetrician/gynecologist was quoted in the New York Times as saying that since the birth rate is declining, "Some of us aren't making a living, so out comes a uterus or two each month to pay the rent," and others refer to a hysterectomy as "hip-pocket surgery." The needs of students are a justification for doing hysterectomies and the Washington-based Health Research Group says that "OB-GYN residents in many city hospitals have done more 'selling.'"

Other doctors defend hysterectomies for reasons other than severe illness. The vice president of the AMA, Dr. James Sammons, testified before a Congressional subcommittee on May 10, 1977 that women should be given hysterectomies if they request them "to relieve anxiety" about getting cancer or having children. And many doctors vigorously defend "elective hysterectomies" purely for the purpose of sterilization or prevention of possible future diseases.\* These doctors frequently refer to the uterus after childbearing as "a useless, bleeding, symptom-producing potentially cancer-bearing organ and therefore should be removed." Whatever the justification for this position, many people think it is insensitive and reflects an underlying sexual prejudice.

### *What's a woman to do?*

Women are beginning to challenge many areas of health care, and hysterectomy is one. We should know that however kind and genuinely interested in our welfare our doctor is, he or she is part of an environment where surgery for profit or questionable reasons is frequently



\*HEW guidelines now prohibit the use of federal funds for this purpose.

defended. We should also realize that he or she may be motivated to do more treatment than perhaps is necessary. We should make use of the resources we have: sources of information like this pamphlet, talking with other women who have had one, and going to another doctor for a second opinion.

Primarily, though, we need to make our own decision. If we know the risks and weigh the benefits, it may very well be that it is most rational for us to have a hysterectomy which is technically unnecessary. We need to be aware of the rates and the trends so we can see the larger picture, but in the end it is our own body and our own decision.

## Reasons

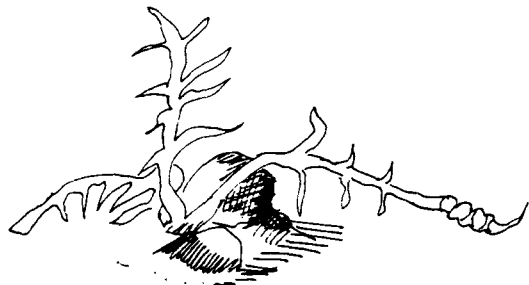
Why do women have hysterectomies? Are there other ways of treating or preventing the conditions so that a hysterectomy might be avoided? We need answers to questions like these if we are going to make rational, informed decisions about our bodies. In the following section I present very briefly some information on the common reasons (the medical term is indications) for hysterectomy. For any of you who are told you have one of these conditions, this information should be a start in learning more, from other doctors or nurses, from books and articles such as "Our Bodies, Ourselves," and from medical books. Medical books are very hard to read, and it sometimes seems they are intentionally so. But we can certainly learn more than we knew previously from reading them, especially if we read and discuss them with a friend.

## Cancer

Cancer means a tumor is malignant, that is, cells keep growing abnormally and can spread. Most hysterectomies are not done for malignant conditions, perhaps only 10 to 15% are. We can get cancer of the cervix or of the body (corpus) or lining (endometrium) of the uterus. We can also get cancer of the ovary, usually treated by hysterectomy.

Cancer is very frightening and yet malignancies can be detected and treated before they are life-threatening. Pap tests can detect early cancers, but a positive Pap test does not mean that a hysterectomy should be done. Pap tests are rated as 1 through 4 in order of severity and a Class 1 or 2 Pap smear seldom means a hysterectomy is necessary. Even Class 3 is often treated in other ways.

If cancer is suspected, biopsy or colposcopy are techniques of checking on the extent of the abnormal cells. For some pre-cancerous conditions, conization may be possible to remove only the abnormal cells.



For invasive cancer (which has spread to surrounding tissue) radiation therapy is possible but many doctors think it causes more damage than hysterectomy. If a hysterectomy is performed for cancer, it may be necessary to do a "radical hysterectomy" or "Wertheim procedure," removing the pelvic lymph nodes and ligaments and the top portion of the vagina. Although this is a very extreme procedure, the ovaries can often be left functioning and it is an effective procedure in terms of survival rates.



## *Endometriosis*

Endometriosis is extra "endometrial" tissue similar to the tissue which lines the uterus. It grows where it should not be: on the ovaries or tubes, on the ligaments holding the uterus, and other parts of the pelvic cavity. It is not cancer.

The major symptoms are painful menstruation, painful intercourse, and, often, infertility, although the exact reason is not known. Endometriosis occurs after menstruation begins and usually diminishes when the woman is not ovulating (either because she is pregnant or because she is taking hormone medication like the birth control pill.) Treatments for the disease, therefore, range from hormone medication to suppress ovulation, to surgery of the actual implants, to removal of the ovaries, which will remove the hormone stimulation and cause the implants to shrink. Endometriosis is seldom life-threatening, unless the implant ruptures as an appendix might, and the decision as to which treatment to suggest is often not clear-cut. If we are advised to have an ovariectomy (and, often, hysterectomy) due to endometriosis it is probably wise to consult a second doctor to see if hormonal medication might relieve the symptoms with less risk --even though hormones do involve risks.

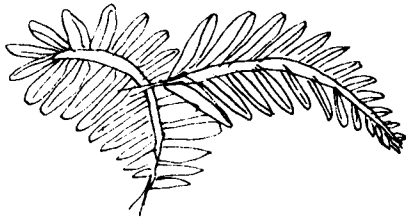
## *Pelvic inflammatory disease*

Pelvic inflammatory disease, or PID, is a bacterial infection which attacks the tubes and ovaries. It is often caused by the gonococcus bacteria but also by other bacteria and it can be intensified by an IUD. Doctors' moralistic judgements about gonorrhoea can interfere with good health care for some women. If the doctor assumes the PID is caused by gonorrhoea, he or she may be very judgemental; or if the doctor assumes the woman "could not" have gonorrhoea, appropriate diagnostic work or treatment may not be done. Before beginning antibiotics, a culture should be done to try to identify the bacteria, since after antibiotics it may be impossible to identify.



Symptoms of PID are pelvic pain, either sharp or dull discomfort. When it first begins there is often a fever, and when it is chronic there is often a low or intermittent fever. Treatment is generally antibiotics, which should be accompanied by bed rest. If the infection does not sufficiently respond to antibiotics, the infected organs must be removed, and usually this means ovaries, Fallopian tubes and the uterus. PID itself is not dangerous but if untreated then abscesses (pockets of pus) can form and if they burst the woman is in severe danger and requires an immediate hysterectomy and ovariectomy. Hysterectomies due to PID are becoming more frequent, and we should be alert to seek treatment for the symptoms, which we sometimes ignore.

## Fibroids



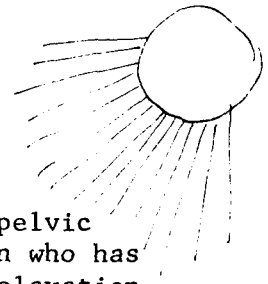
Correctly termed myomas or leiomyomas, fibroids are benign tumors in the muscle tissue in the uterus. They are common: one out of four or five women get them, and perhaps 30% of hysterectomies are for fibroids. In most cases they do not cause severe problems but if the fibroid grows very large it can press on other pelvic organs and if there is heavy bleeding the woman can become anemic. Fibroids have some relation to ovarian hormones, not sufficiently understood, and they shrink at menopause. For some reason they are more common among black women than white women.

Fibroids are a source of controversy regarding hysterectomy. Since they are not malignant, a hysterectomy for "small" fibroids may be technically unnecessary. Yet if the heavy bleeding causes a woman great distress, the hysterectomy may radically improve her life. It is likely that a diagnosis of fibroids is often misused to urge a hysterectomy that the woman really does not want or need. But it is also true that a truly informed woman may decide to have a hysterectomy to remove her fibroids. If faced with such a decision, it is important for us to get the information we need to weigh for ourselves the risks and benefits of surgery.

An alternative treatment for fibroids is myomectomy, surgical removal of the tumor itself. Sometimes it is not medically possible but if it is, the woman's uterus can be retained. This seems to be an option worth considering, yet doctors seem to offer it only if they judge the woman has not completed child bearing. That decision should be ours, and information about myomectomy should be available to all women with fibroids.



## Pelvic relaxation



Many hysterectomies, perhaps 35%, are done to correct pelvic relaxation or uterine prolapse. Usually occurring in a woman who has had several children, the condition involves weakening or relaxation of the muscles of the pelvic floor (the area around the vaginal opening) or weakening or damage of the muscles or ligaments which hold the uterus in position in the pelvic cavity. Symptoms are a feeling of heaviness, pressure when bearing down, or the sensation that her "insides are falling out." When extreme, the uterus actually does descend through the vagina, turning it "inside out". Pelvic relaxation and prolapse are more common among white women than third world women. Ligament damage usually results from obstetrical intervention.

Good care around pregnancy and childbirth and good muscle tone in future years may help prevent pelvic relaxation. We should be encouraged to keep our pelvic muscles firm by exercising the muscles used to stop the flow of urine.\* If a woman has symptoms of uterine prolapse, spending time several times a day in the knee-chest position (kneeling with chest on the floor and "bottom" in the air) can help to relieve them.

Alternatives to hysterectomy include use of a vaginal pessary and undergoing a suspension operation. A pessary is a device much like a diaphragm which is left in and holds the uterus in place. It can cause irritation and discharge but can be advisable in cases where a short time with a pessary could prevent surgery. A suspension operation lifts and reattaches the uterus.

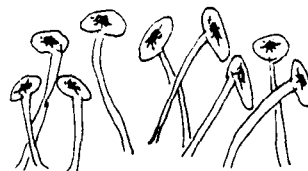
When hysterectomy is performed for pelvic relaxation or prolapse, it is usually done vaginally because there are often other conditions, technically called cystocele and rectocele, which are like hernias in the vagina and can be repaired at the same time.

## Sterilization

Although very seldom medically necessary, at least 20% of hysterectomies are for the purpose of sterilization. Sterilization itself is often controversial because women, especially poor or third world women, are sometimes pressured or misled into being sterilized. In many cities groups are organizing to combat forced sterilization.

When sterilization is a free choice, hysterectomy is often suggested instead of tubal ligation, a procedure in which the Fallopian tubes are cut or cauterized leaving menstruation the same but pregnancy essentially impossible. Tubal ligation itself has risks and is irreversible and should not be chosen by someone not fully informed of that. However, hysterectomy has a rate of complication 10 to 20 times greater

\*called the "Kegel" exercise.  
See Our Bodies Ourselves.



than that of tubal ligation and the chance of dying after hysterectomy is much greater.

Why is hysterectomy suggested instead of tubal ligation? To women, doctors say it is to prevent possible future cancer (ignoring the dangers of the hysterectomy itself.) To others, they speak of the need for students to learn the more complex procedure, as in this quote by a doctor at Boston City Hospital, "You know, a well-trained chimpanzee can do a tubal ligation ... and hysterectomy is good experience for a junior resident." The Health Research Group has studied sterilization and has said, "Once the doctor sells a woman on sterilization it is easy to move it up to a hysterectomy."

We must remember that for some women whose religious beliefs make contraception or sterilization impossible, hysterectomy can be a subterfuge and may be the most rational alternative.

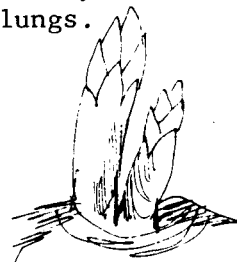
### *The procedure*



Hysterectomy involves removing the uterus and usually the cervix, tying off the blood vessels and ligaments, and stitching the upper end of the vagina closed. The vagina is never removed except in extraordinary circumstances but in some treatments for cancer it is shortened somewhat. If the tubes and ovaries remain they are secured down to the top of the vagina. The ovaries continue to produce eggs, which dissipate into the pelvic cavity.

The operation can be done abdominally, through an incision either between the navel and the pubic region, or across the top of the pubic hair. It can also be done vaginally. Abdominal hysterectomy is chosen if the ovaries are to be removed, if there is a large tumor in the uterus, or if there is disease in the pelvic cavity. Vaginal hysterectomy is generally chosen if repairs of the vagina are necessary. In situations where the choice of procedure is less clear, we may want to ask a second doctor to help evaluate the pros and cons in our particular situation. Vaginal hysterectomy has a higher rate of such complications as damage to the urinary tract but recovery time is usually shorter since the major abdominal muscles are not cut. Abdominal hysterectomy generally involves a deeper anesthetic and the hazards that brings.

Hysterectomy itself is a low-risk operation, as operations go. Yet one woman in 500 to 1,000 will die and 30 to 45% experience complications. Complications range from the relatively minor, such as a urinary tract infection while in the hospital, to damage to the urinary tract from accidental cutting of the ureter or blood clots in the lungs. Most surgical deaths are due to anesthesia.



## *Should the ovaries be removed?*

In some situations it is clear that the ovaries should be removed. If they are infected or if the disease involves them they should be removed. If a woman is clearly past the menopause then they probably should be removed; if she is younger it is less clear.

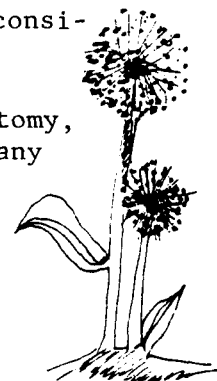
Doctors who recommend ovariectomy of pre-menopausal women point out that it prevents ovarian cancer, which, although rare and affecting mainly older women, admittedly is very dangerous. But removing the ovaries causes many more changes in a woman's system than just removing the uterus, and we need full information to weigh the costs and benefits.

Removing the ovaries of a pre-menopausal woman causes what I call "menostop," a very sudden ceasing of the hormones, estrogen and progesterone, produced by the ovaries. As our bodies adjust to the new level, we will probably have quite severe hot flashes, brief periods of extreme heat and sometimes perspiration; we might also have headaches, irritability or fatigue. As our bodies adjust to the loss of the ovaries, some changes may remain. We may have changes in body hair: less pubic hair or more facial hair. We may find a change in skin texture and our labia may shrink somewhat. We may also find changes in sexual experience. The walls of the vagina may become thinner, we may have less vaginal lubrication and it may take longer to become lubricated. Another change some researchers think is related to menopause is osteoporosis, a condition when the bones become brittle and break easily, and the back can become fused in a "dowager's hump." but it is unclear.

Ovariectomy is also called female castration. It is parallel to removing the testicles in a man and the same kind of changes occur: the person can function sexually although it often takes longer to become aroused, and other changes related to hormones occur. Male castration, removing the testicles, is called orchietomy and is very seldom done. Why is the term never used to us? I think it is because we think of castration just referring to men and it sounds extremely horrible. If our doctors said "While I am doing your hysterectomy I think I should castrate you," many of us would object or raise questions. Yet many of us are castrated perhaps unnecessarily without realizing all the implications. Avoiding the term castration makes us less suspicious of possible effects. It also makes us less aware of the contrast between our health care and that of men.

If our ovaries are removed before menopause, we are generally given estrogen replacement therapy. I discuss these drugs in another section but the risks of estrogen should be added to the other changes in considering ovariectomy.

We need this information about negative changes after ovariectomy, so we can make more informed choices. We also need to know that many of us are castrated and in fact we get along just fine. We do not



become eunuchs, our health remains as good as or better than before, and we rationally deal with the estrogen dilemma. In other sections I share some information about ways we can help our bodies adjust to the loss of our ovaries.

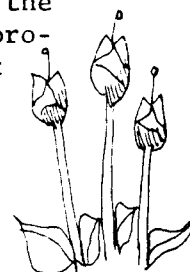
## *The hospitalization \**

A typical hospitalization for hysterectomy is something like this. The woman is usually admitted the night before, and a thorough history is taken and a general physical done. Special attention is paid to a history of allergies or heart or lung problems, which could complicate the anesthesia. Sometimes special X-Rays are done, of kidney or bowel, and sometimes a clotting study if the woman has a history of heavy bleeding. Most of this work should be done before hospitalization.

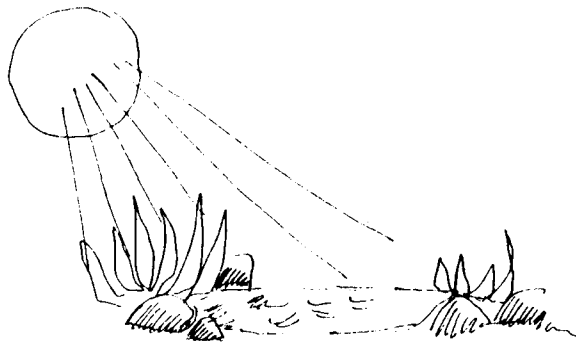
Before the surgery the woman signs consent forms for the surgery and also the anesthesia. The law requires that she understand the procedure before signing consent forms, but in fact we often don't. Sometimes consent forms include permission for any of many procedures which could be done. They leave it up to the surgeon to decide how much should be removed. Undoubtedly this kind of blanket permission is sometimes used to talk women into giving permission for procedures they do not need. We may feel we want to know the results of a diagnostic procedure before a hysterectomy is done even if the surgeon thinks it is necessary. It is also true however that general anesthesia is very dangerous and it does not make sense to unnecessarily have two operations if we can trust the doctor to make the decisions we would want. Some women ask to see the consent forms before going to the hospital, to think about what they say; others have a friend accompany them so they can talk it over on the spot. It is important to know that signing consent forms does not sign away your right to sue if you find later that you were misinformed.

During the first evening, the nurse records the new patient's vital signs (temperature, blood pressure and pulse), puts any valuables into safe-keeping, and asks if she needs a special diet. Later the nursing staff carry out the doctor's orders about how often to monitor vital signs, any special diet or medication, and preparation for the surgery. Being "prepped" includes a shower and then a very thorough shave of all the area to be exposed during surgery. This is to keep the area sterile. A douche is also often prescribed, and generally an enema. The intestines slow down during anesthesia and if they are full the woman will be very uncomfortable after the operation. A mild sleeping pill is usually prescribed "on request" and the woman is encouraged to take it to counteract being in a new, disturbing environment. Experienced patients sometimes bring a pillow from home to help sleep better!

The anesthesiologist is a doctor who administers and monitors the anesthesia used. This is a complicated job and the anesthesia is probably more dangerous than the surgery itself. The anesthesiologist usually interviews the patient before surgery, explaining what will happen and checking on problems which may affect the anesthesia.



\*Hospitals vary; doctors vary; and each woman's experience is unique.

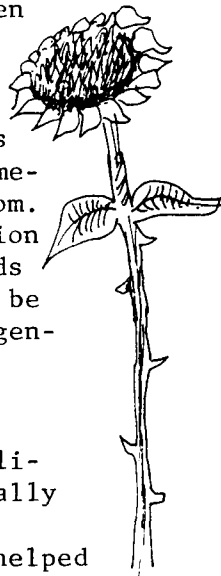


Sometimes the woman is offered a choice between a general anesthetic and a regional, usually an epidural, anesthetic. In a general anesthetic the woman is put to sleep and in an epidural a fluid is introduced into her spine which removes sensation from the lower half of her body. The epidural may be somewhat safer but sometimes is followed by severe headaches. The anesthesiologist orders the pre-operative medication (for anxiety) for the following morning and asks her to sign a consent form for the anesthesia. This pre-operative medication may cause headaches.

In the morning the woman will not have breakfast and will be given the pre-operative medication which will probably make her drowsy. She is transferred to the pre-induction room, in many hospitals in her own bed. Intravenous medication (IV) is started and she is transferred to the operating table and put to sleep (if she has a general). She is scrubbed well several times by the rigorously scrubbed team and the operation begins. She is attached to monitors, for the anesthesiologist, of her breathing, heart, relaxation, and oxygen. During the surgery she has a tube in her throat (and may have a sore throat the next day). Fewer monitors are necessary if she has an epidural. She may be given antibiotics to prevent possible infection.

After the operation she is wheeled to the recovery room where a special nursing team care for her, taking her vital signs as often as appropriate. Usually she wakes up briefly and goes back to sleep immediately. When her condition is stabilized she is returned to her room. She usually has a catheter in her urethra because her urinary function will be slowed down. For the first day or so after surgery the fluids she takes in and eliminates are measured, so any internal damage can be noticed. The catheter is usually removed after the first day. She generally has pain medication and nausea medication ordered to be given every few hours if requested.

After the operation a number of steps are taken to prevent complications. Walking is stressed very early. This is difficult, especially after an abdominal hysterectomy with a general anesthetic, but it is important to stimulate breathing and circulation. She also will be helped to cough, holding a pillow over her abdomen to reduce the pain. This is very difficult but very important. Additional breathing exercises are often suggested, such as blowing fluid from one bottle to another. These exercises are to prevent atelectasis, a condition in which the lungs do not expand fully, which can lead to pneumonia. Walking and other leg-flexing exercises in the bed are to help prevent thrombophlebitis, (blood clots which form in the legs and can travel and lodge in heart or lungs.) Thrombophlebitis is especially likely among women who are older, heavy, or on hormones and it can range from uncomfortable to life-threatening.



Hospital personnel always listen to the woman's abdomen for bowel sounds, and hearing bowel sounds guides them in allowing her to have fluids and solid foods progressively. The bowel is very sluggish during the anesthetic and as it begins to become active the woman can experience severe gas pains.

Usually the IV is taken off in the second day and she can have fluids, and in the third or fourth day solid foods. Some hospitals now recommend that a woman goes home the fifth day after an uncomplicated surgery; others wait until the seventh or eighth. At home, she is told not to climb stairs much or drive for two weeks because her strength is diminished and because the anesthetic may still slow her reactions. After abdominal hysterectomy she will also be told not to lift heavy objects for two or more weeks. She is usually sent home with pain medication to take as needed.

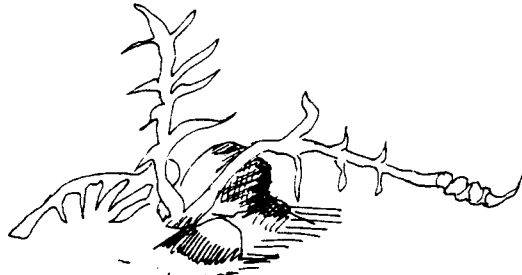
These restrictions are inconsistent with the home responsibilities many women have and yet hospital staff seldom check on what arrangements we are able to make for our own care and care of our family. A woman going in for a hysterectomy should try to arrange assistance during the convalescence and not assume that the physician knows she has small children who need lifting, stairs to be climbed, etc.

At home, she will have vaginal bleeding which will gradually taper off. She may pass clots or have periods of heavier bleeding, but such events should be reported by telephone to her nurse or doctor to double-check. She should also report any fever, new pain, or odorous or excessive vaginal discharge. All are likely signs of infection.

She will probably be told to avoid "sex" for 4 to 6 weeks. It is often unclear whether she is to avoid all sexual activity or just intercourse. What about masturbation? What about sex with women? What about sex without intercourse? Intercourse is avoided because of bumping the stitches at the top of the vagina and possible introduction of infection, but health workers seem unclear about whether orgasm is harmful. It may cause bleeding since the vagina contracts on orgasm, but that is probably not dangerous. Doctors need to learn more about our sexuality to be able to answer questions like this appropriately.

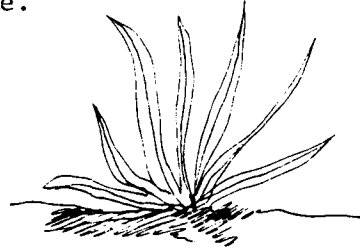
Weepiness and depression after hysterectomy is very common, both in the first few days and later. It seems similar to post-partum depression, and usually does not last long. We need support if we do feel weepy to do the very natural grieving which is necessary after any loss of a loved one or body part. Some women are depressed much longer.

Hot flashes are also very common after hysterectomy, even if the ovaries are preserved. It is not known exactly why this happens, but it is possible that the blood supply to the ovaries is disturbed during the operation.



Recovery times vary greatly and one woman's experience may be quite different from another's. In one large study, the average was to return to regular household activities in 4 to 6 weeks, and it ranged up to 9 weeks, especially for women over 36. It was common to have unexpected severe fatigue in the first few days and some women found they had to stay mostly in bed for a week. In another study it was not uncommon for women to say they did not feel really back to normal for a full year, while a contrasting control group undergoing comparable operations had a much shorter recovery time.

## Complications

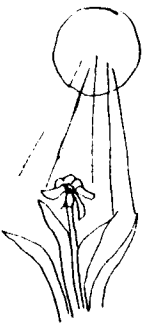


The chances are that a woman will experience no major complications after her surgery. The fear of complications should not keep us from having an operation which is truly advisable. But knowledge of possible complications and after-effects can help us weigh risks and benefits of the surgery and also report symptoms more promptly and firmly.

Infection, of the incision area or of the bladder, is not uncommon and generally treated by antibiotics. Hemorrhage is much less common, as is accidental cutting of the rectum, bladder, or ureter. Any anesthesia carries major risks, of allergic reactions or heart or lung complications, and it is important to cooperate with the health team in the history taking and post-operative exercises to help prevent problems. Nerve trauma sometimes occurs and leads to leg weakness.

Hormone levels may be affected, at least temporarily, by hysterectomy even if the ovaries are left in. This could be the reason many women have hot flashes and unusual fatigue after this particular operation.

Urinary problems after hysterectomy are very common and range in severity from minor to serious. They can be due to infection of the bladder from the catheter, trauma or damage to the bladder or ureter or urethra, or accidental cutting of the urinary organs. Note in the diagram how close together the organs are.



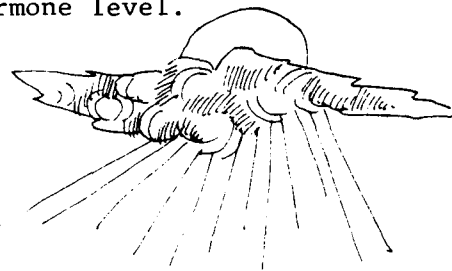
After surgery some women develop adhesions, internal scar tissue which forms bands which can bind various pelvic structures together. Adhesions are more common after surgery involving infection. They can range from unnoticeable, to causing some occasional pain if they bind, for example, the end of the vagina to part of the bowel, to very serious if they eventually obstruct the bowel.

Some studies indicate that many women gain weight after hysterectomy. It is unclear whether this is due to metabolic changes, psychological

distress, social expectations, or a combination. If a woman is concerned about gaining weight she should try to consider if in fact it is rational for her to try to avoid it. We have such strong societal messages telling us to be very thin it is hard to be clear about whether a weight gain is a problem. But we should be aware that others have gained weight after hysterectomy.

Excessive tiredness has been reported in some studies comparing women after hysterectomy to similar groups of women after other operations. If the ovaries were left in, women reported less tiredness, although still 12% had to quit work and 25% could do the same work but were more tired. We should be prepared to seek support if we experience excessive fatigue.

If the ovaries are removed, additional problems can occur. Ovariectomy brings about "premature menopause" and the effects of low estrogen can be troublesome. The sections on ovariectomy, sexuality, and alternatives to estrogen replacement therapy contain more information, but a woman considering ovariectomy should know that if she has not already finished menopause she will probably notice major changes, which diminish as her body adjusts to the new hormone level.



## *Psychological research on hysterectomy*

How will a woman react to a hysterectomy? That is a hard question to answer by looking at the published research. Some studies, asking short questions ("Have you been happy since your hysterectomy?") find that women generally say they are fine. Other studies, doing in-depth interviews, find that hysterectomy has a great symbolic importance to many women. The first kind of study is often done by gynecologists soon after the operation and the second kind of approach is taken by psychoanalytically trained (such as "Freudian") psychiatrists. It seems to me that both are correct: hysterectomy does have an important symbolic significance to most of us at some level, and most of us adjust to it well. We need new research which thoroughly describes our experiences from our own perspective.

In the meantime, we do have some information about emotional "sequellae" (after-effects) of hysterectomy. Women are probably more likely to become depressed after hysterectomy than after other similar operations (although some authors disagree.) For some women there may be a "sleeper effect" and they may become depressed in the second year following surgery. How many women become depressed? How severely? Different studies give different answers, but it is probably true that perhaps more than half of us having hysterectomy will have a short period of weepiness and that less than 5% will become depressed enough to be hospitalized. It is probably

also true that if we have had a tendency to become depressed at times of stress we will be more likely to become depressed after hysterectomy.

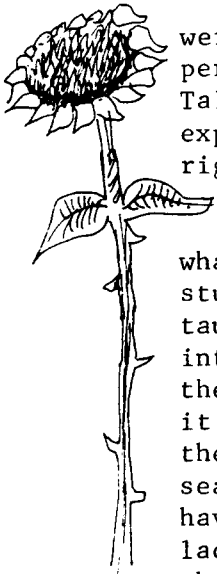
As I read the research, it seems very likely that there are physiological reasons, as yet unexplained, why depression may follow hysterectomy. We need to know there is a chance we will become depressed, so that if we do have those feelings we can seek out appropriate support. It is easy for many of us to convince ourselves that any problems are due to our inability to cope and that we don't deserve help. Surgeons also vary in recognizing women's depression.

How do women feel about their loss of fertility? About not menstruating? Again, it is hard to know from the published research, since the researchers often do not question traditional ideas of femininity. It does seem, though, that childbearing is an important issue for us, and that most of us have mixed feelings: relief about not having contraceptive worries, and twinges of feeling that we are in some way not like other women. For those of us who have never had the children we wanted, grief and anger are very natural feelings.

Most of us are glad to have no more periods, especially if they were painful or very heavy. But we also have many feelings that our periods are natural and that in some way it is odd not to have them. Talking with other women who have had hysterectomies can help us to express these feelings and know that we're still women and still all right.

How do men react to hysterectomy? Very little is written, but what is mentioned is that some men have very strong reactions. Several studies discuss women whose mates leave after their hysterectomy, taunt them with being "half a woman" or "neutered" or refuse to have intercourse with them. These are the exceptions and most husbands treat their wives tenderly after hysterectomy. If good research were done, it might very likely show that most men have significant feelings about the operation itself and its effect on the women they love. Such research is needed, partly to further explain the reactions that women have. It is often assumed that any problems she has are due to her own lack of adjustment, without considering the man's actions. Also, men whose partners are undergoing hysterectomy need support themselves.

What if a woman suspects or discovers that her hysterectomy was unnecessary? The recent publicity about hysterectomy rates puts many of us in that position. Anger and grief are normal reactions to that kind of feeling, and we need ways to express and act on our anger. We also need to know that we made the most rational choice in the situation we faced. Most of us had very real problems and hysterectomy was the solution which seemed best. We must not blame ourselves for the medical profession's tendency to operate rather than investigate other



kinds of treatment. We must not blame ourselves if we think we are not the ideal, assertive consumer. Getting medical care in this society puts all of us in a position of subservience and it is very hard to act powerfully from that position. Some of us may actually seek out hysterectomy even when doctors advise against it. If we find ourselves or someone we know in that situation, we need support in identifying the problems we do have, but we do not need to be blamed for the tendency to seek medical help for many different problems. In many ways the medical establishment encourages all of us to do that.



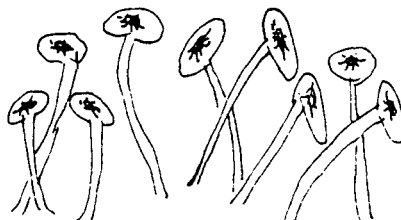
## *Sexuality*

I have three things to say about sexuality after hysterectomy or castration. One, there are changes. Two, the changes may or may not cause problems. Three, we can surmount the problems we may have and deserve the help we need in doing it.

The uterus is part of our sexual system and removing it causes changes. Denying this (which most writers for the public do) is insulting to us and reflects the assumption that our sexuality is just being able to have intercourse, being able to function for a man.

I read Masters and Johnson's description of women's sexual response cycle and noticed that the uterus is involved in each stage. They describe four stages: excitement, plateau, orgasm, and resolution. During the beginning stages, blood rushes to the pelvic area, the uterus is elevated and increases in size, and the vagina balloons. After hysterectomy there is less pelvic tissue to become engorged and the extra sensation of the uterus elevating and expanding is not there. The vagina may be unable to balloon in the same way as previously. During orgasm, the uterus contracts and studies show that the more severe orgasms are associated with stronger contractions. This suggests that after hysterectomy orgasms may not reach the same physiological intensity as before. Also, having less pelvic tissue may mean less sensation of arousal and less likelihood of multiple orgasms. These changes may be totally unnoticed, or the relief the hysterectomy brings may far outweigh any smaller changes.

In addition to these changes, some complications of the surgery can affect sexual feelings. Urinary tract infection or injury can cause pain with intercourse. Adhesions can cause pain with orgasm or intercourse if they bind the vagina to another part. Some women have more gas after abdominal surgery, and some have a greater tendency to



vaginal infections. Neither of these will prevent sexual activity but either can create problems. Also, some surgeons unwittingly stitch the vagina at the end rather than in the top, where the cervix was. This leaves scar tissue where a penis would hit it during intercourse, causing considerable pain.

If the ovaries are removed then the levels of estrogen and progesterone drop markedly. The most noticeable effect of reduced estrogen level is a reduction in vaginal lubrication and an increase in the time it takes to become lubricated. Since lubrication is the first indication of sexual arousal for a woman, similar to erection for a man, a sudden change in arousal time can be very hard to adjust to, whatever our sexual activity.

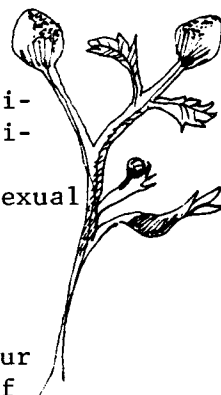
Low estrogen level can cause the lining of the vagina to become thinner rather than thick and corrugated, and this with reduced lubrication can make intercourse painful and can also lead to bladder irritation. Also, Masters and Johnson say that there is generally less intensity in the physiological phases of a post-menopausal woman's sexual cycle. Taking estrogen drugs may help moderate these changes but many women still notice them.

After ovariectomy, there are no monthly hormonal cycles and our body is generally in the hormonal state most like that just before our period. There is some evidence that ovariectomy reduces the level of the hormone which affects libido, or sex drive.

Some women notice even much more subtle changes, such as their production of odors they had associated with sexuality, and the thinning of their labia and the lack of that indirect stimulation of their clitoris.

These have been physiological changes which might affect our sexual functioning. We need to realize that our sexual experience is a wonderful combination of physical and emotional. On the negative side, we cannot deny that many of us at some level may feel "less of a woman" after this major surgery on our sexual organs. In our society woman's worth is very tied up with her reproduction capabilities and few of us totally escape society's pressures. For those of us who relate to men, the hysterectomy may affect his feelings and his sexual functioning. Many men are frightened of hurting the woman they relate to, and others have trouble separating procreation from sexuality. We and they need information and support in communicating these feelings.

So far I have focused on the potentially negative changes, because we need to know in making an informed decision what might happen to us and because if we do notice any of these changes we need to know they may be physiologically based. For many of us, however, these changes are totally insignificant compared to the relief the hysterectomy brings. A severe pelvic infection or endometriosis, for example, can cause extreme pain from the thrusting of a penis. Orgasm itself can be very



painful if the uterus hurts when it contracts. Many women have hysterectomies for fibroid tumors, which can cause excessive bleeding, and if we prefer to avoid sexual activity during these times, hysterectomy will open many new opportunities. If the bleeding has caused fatigue or anemia, we will not notice more subtle changes because we may feel strong and healthy for the first time in years.

There are also very strong psychological benefits for many of us from hysterectomy. If contraception was a problem, we will be free to be sexual when we want to without distraction. Worry about our health undoubtedly affects our sex life, and hopefully hysterectomy relieves that concern. Our human intelligence also means that we can overcome the sexual problems which might develop. Although we are affected by physical changes, we can adjust to them and we can learn new ways to get aroused.

We should know there are some ways to help assure a happy sex life after hysterectomy. One is to develop sources of support, places where we can express our fears without judgement. If we do notice changes in lubrication, a lubricant like KY Jelly or scented oils can feel very good, especially as our clitoris is stroked, and it can help in the transition to arousal. We, our partners, or our doctors should not confuse KY Jelly with our physiological lubrication, however.

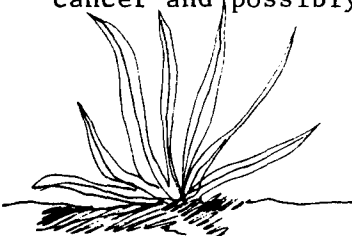
Another excellent physiotherapy is masturbation and lovemaking. Not only does it reassure us and our partner that we are all right, it also has a direct beneficial effect on our hormones and sexual tissue. The more frequently we are aroused, the more quickly we will become lubricated.



## *Estrogen replacement therapy*

This section will be of interest to women whose ovaries are removed but also to those who anticipate a "normal menopause". Conjugated equine estrogens (made from pregnant mares' urine: Premarin is the major brand) are generally prescribed to counteract the symptoms of low estrogen. They do in fact help. They reduce or eliminate hot flashes and they help prevent vaginal dryness, and as short-term medication they can help a woman through a transitional time. Many doctors, however, prescribe large doses of estrogen whether or not a woman has troublesome symptoms, and suggest she take it for very long periods.

Why is this a problem? Estrogens, taken in large doses for a long time, have been shown to be related to increased incidence of endometrial cancer and possibly also breast cancer, and it seems prudent to try to



minimize or avoid taking such dangerous drugs. Also, it may be that by taking them we "fool" our bodies into not producing additional hormones and actually become dependent on the drug.

Why are estrogens prescribed so much? One reason is the marketing efforts of Ayerst, the drug company that makes Premarin. As the evidence linking estrogens to cancer has been published, the company has sent reassuring letters to all doctors and it is probably responsible for articles about the safety of estrogens in lay and professional publications. These activities have prompted a complaint by the Health Research Group to the FDA.

Another reason estrogens are prescribed is that many women request them, convinced by Robert Wilson's book "Feminine Forever" and more recent ones such as Wendy Cooper's "No Change" that estrogens prevent aging and preserve youthfulness. Of course these claims sound attractive to us, because youth is so valued in our society. But the picture of women in these books is painfully negative. Also, independent research has shown many of the claims to be false and there is evidence much of Wilson's research was funded by the makers of Premarin.

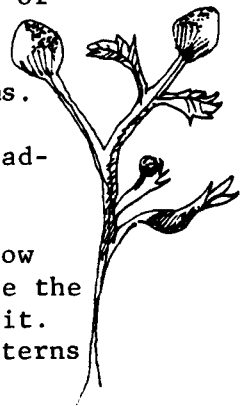
So here we have some dangerous drugs which do help our symptoms. What do we do? I suggest we calmly try to minimize the estrogen we take and also learn and share information on ways to help our body adjust to the stress of the change.

If we are taking Premarin and want to try to stop taking it, how do we do it? We can ask for a lower dose and try that, or alternate the lower and higher, or take it every other day, and gradually reduce it. We can take control of how we use the drug, and experiment with patterns and doses.

I am not presenting "alternatives to estrogen replacement therapy" because there is no simple pill we can take instead of the drug. I am suggesting ways we can become healthier because if we are healthier our bodies adjust to stress better. Also, our bodies do make estrogen, mainly in the adrenal gland, and strengthening it will help our body make more estrogen. The forthcoming book by the Los Angeles Feminist Women's Health Center presents some very exciting research in this area.

Osteoporosis, a condition of too little calcium in the bones which causes brittleness has been related by some researchers to low estrogen. Others find that calcium supplements (such as bone meal or dolomite) seem very effective in preventing osteoporosis but stress that they work only if accompanied by a healthy, high protein diet and exercise.

Exercise is also important in general health and exercise probably helps the adrenals produce more hormones. Don't forget that sexual activity is exercise also, and has a direct effect on the production of sex hormones.



Avoiding foods containing sugar, salt, refined flour and food additives will definitely help anyone because all of those foods are stresses to our body, along with coffee and alcohol. The condition of low estrogen may be very much like the condition of low blood sugar, or hypoglycemia, and keeping to a regimen of regular, high protein, low sugar meals helps some women eliminate hot flashes.

Some of us find vitamin supplements are helpful and the research of the Feminist Women's Health Center supports this. Vitamin E, the B vitamins, and Vitamin C are particularly valuable. Since even if we eat whole unprocessed foods they are grown in a way to maximize yield but minimize nutrition, it may make sense to take vitamin and mineral supplements even if we eat well. Rosetta Reitz's new book, Menopause: A Positive Approach, (Chilton; Radnor PA,) is a wonderful source of information and inspiration on nutrition and hormones.

Herbs are also potent medicines, and someone interested in herbs would find herbalists would have specific suggestions about menopausal difficulties. I am not suggesting specific amounts of vitamins or herbs because each of us should seek out, from books, other people, and our own experimentation, what is right for us. An excellent resource is Women and the Crisis in Sex Hormones (Rawson, N.Y.) by Barbara and Gideon Seaman.

Learning ways to deal with stress will also have a direct effect on our hormone level. Some of us learn meditation, biofeedback, or breathing exercises; others find counseling very helpful.

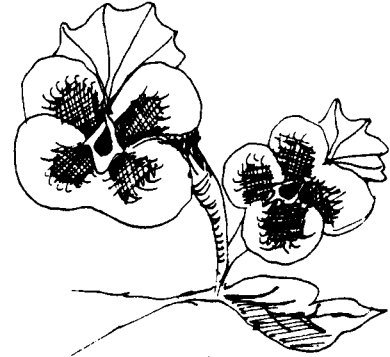
## *Strategies for helping*

What do women having hysterectomies need?

We need information. From other women's experience and from technical sources. Not advice if it comes in ways we can not use.

We need support. We need permission to express the "unacceptable" feelings: fear, anger, guilt, grief, glee, pride. We need to know our listener understands that these feelings are true but also it is true that we are fine, that we are strong and resilient. We need to be reassured that we are coping with a difficult situation and coping very well. We need permission to be pleased when we are having no problems and we need not to criticize other women who are having problems.

And as we get these things we need, we will be able to be there for other women in the same way.



Dear Sisters,

Here's my own story. I decided to use a Lippes Loop IUD after my second child was born, to stay off the Pill and avoid new sexual complications of a diaphragm. A year later I got a pelvic infection, and was sick for a year with constant pain and a low fever. I had good, conservative medical care - they would look inside, take the worst part out, and send me home to get well. But I never did.

I remember the grief I felt when I realized that I really would have to have my uterus and ovaries out. I felt helpless and angry, and guilty, too. I thought maybe if I had taken time off work I would have healed better. Now I know I did the best I could in the situation, but I sure felt bad.

The operation itself was okay for me. I knew the surgery routine by then, and was glad to finally be fever-free. I do remember a lot of pain with urination, and some heavy bleeding at home, and of course the pain of the incision, the fatigue, and the severe hot flashes, but they soon passed.

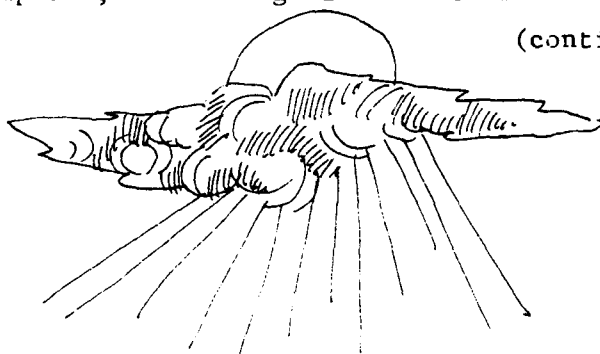
I've noticed sexual changes and I feel bitter, even though I know I am in charge of my sexuality and it certainly is better than when my uterus hurt with orgasms! I do miss the uterine contractions and that deep feeling of release, and my orgasms feel less intense. It takes longer to get turned on and I miss that sudden feeling of wetness that used to take me by surprise. I have internal scar tissue between my vagina and intestine which sometimes makes intercourse painful, especially if I have gas. My husband and I are having trouble relearning how to get me aroused, on top of each of our feelings about the surgery itself. I feel cheated, since sex was so good for me before, and I need to remind myself how powerful and sexy I really am!

Estrogen? I was taking Premarin and adjusted the dose by whether the hot flashes got worse. Gradually I cut it down and was taking a small dose every other day, and then, after many unsuccessful tries, I quit! Now I'm off it and get hot flashes only under stress or if I drink alcohol or eat lots of sugar. And I'm proud of myself!

Since the hysterectomy I am much happier, and am in a much better place in my life. But I still feel anger and grief and fear. My work in Re-evaluation Co-counseling has been very helpful, to give me a space to feel those feelings and not let them rule my life.

You know in a way I'm glad to be able to do this research and write this pamphlet, even though I wish it all hadn't happened!

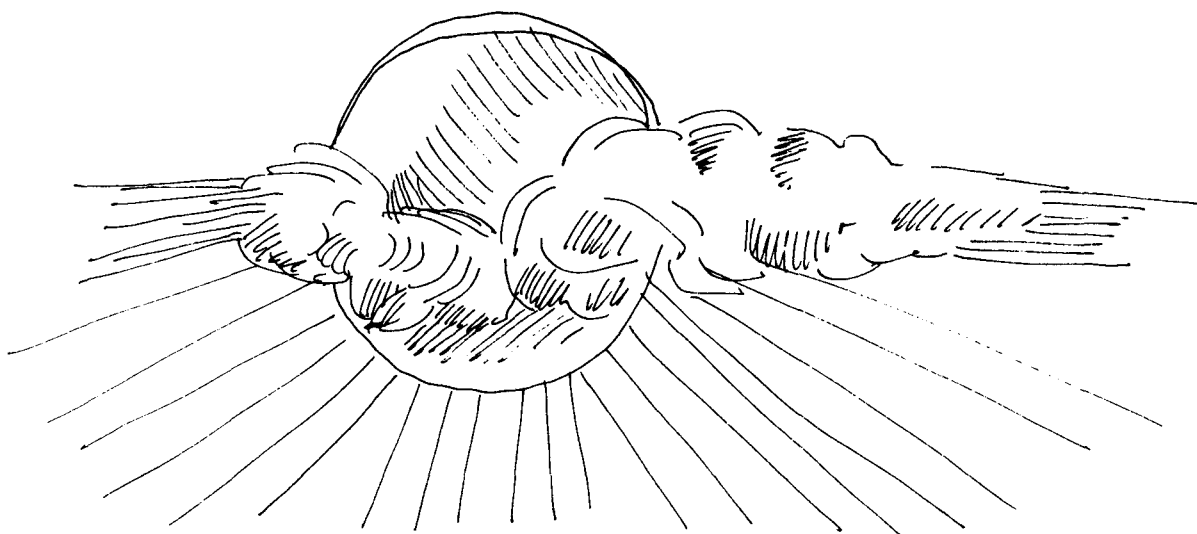
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Will you share your story with me? My next project is to expand the pamphlet into a book and I want to include as many of our voices as I can. Write and describe how you felt, what you noticed, what information you can share. If you don't want any of your story included, just say so. I will of course change names.

I look forward to hearing from you!

*Susanne Morgan*



Additional copies: \$1.00 each  
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and

**BOSTON  
WOMEN'S  
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RESOURCES

The best all-around reference is.

Our Bodies, Ourselves by the Boston Women's Health Book Collective (Simon and Schuster, 1976).

Three recent books on hysterectomy have helpful information but tend to reflect medical assumptions about topics such as psychological reactions and estrogen replacement therapy:

Hysterectomy: A Complete Up To Date Guide To Everything About It and Why It May Be Needed by Nancy Nugent (Doubleday, 1976).

What Every Woman Should Know About Hysterectomy by W. Gifford-Jones (Funk and Wagnalls, 1977).

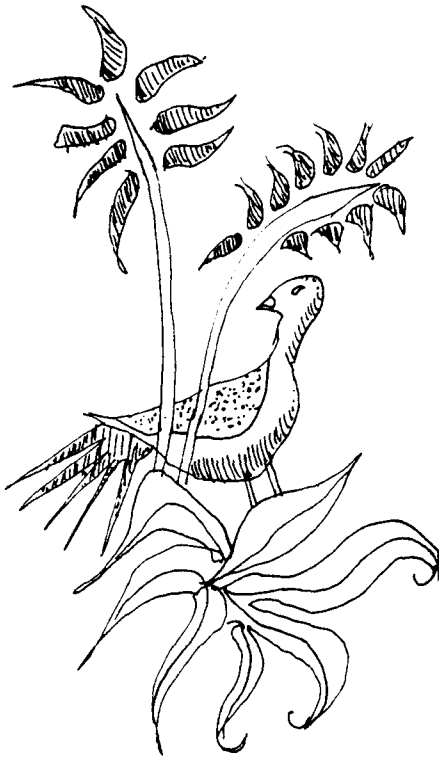
Every Woman's Guide to Hysterectomy: Taking Charge of Your Own Body by DeeDee Jameson and Roberta Schwalb (Spectrum, 1978) - by far the best of the three.

A contrasting view and a great deal of information, especially about ovariectomy and menopause, is in:

Women and the Crisis in the Sex Hormones by Barbara Seaman and Gideon Seaman (Rawson Associates, 1977; Bantam paperback, 1978).

Menopause: A Positive Approach by Rosetta Reitz (Chilton Book Co., 1978; Viking paperback forthcoming, March 1979).

Perhaps the best technical resource is the reference librarian in a medical school, university, or hospital library. The librarian can help you find books and, if the library has it, teach you to use INDEX MEDICUS to find recent articles about hysterectomy or ovariectomy.



Many people have shared their thinking and support as I have worked on this project. Among them are:

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Roy Lotz  
Barbara Mathews

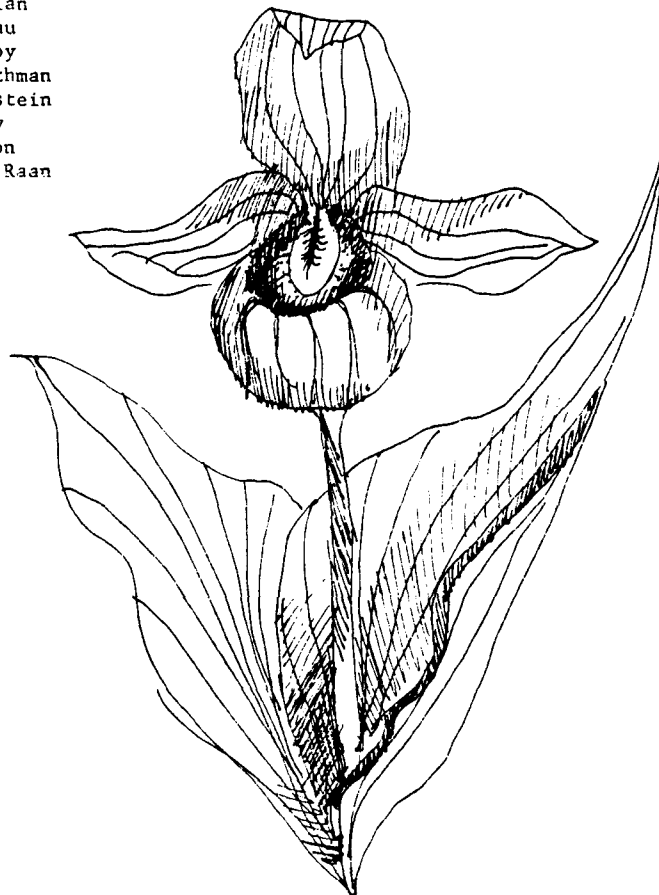
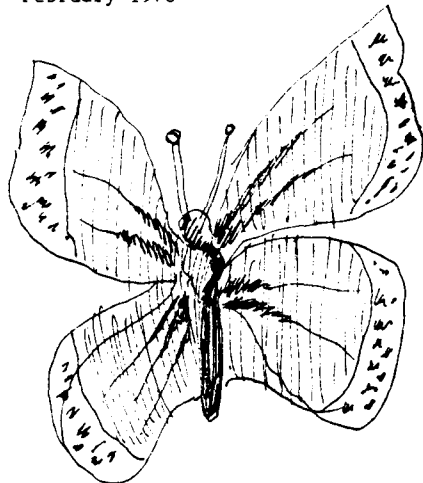
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Heleena Van Raan

The members of UCLA CED 158, Fall 1977

And the many women who have shared their experiences.

I appreciate your support.

February 1978



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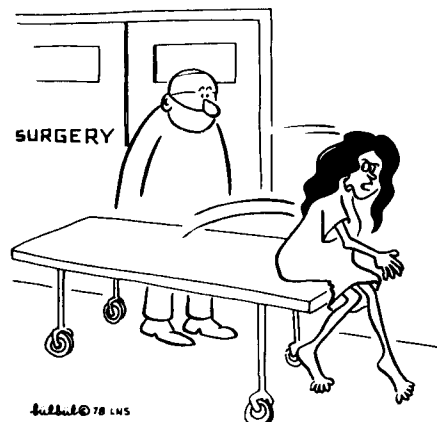
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1167-1169.



I'VE CHANGED MY MIND! I HEARD HYSTERECTOMIES  
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## Audio-Visual Materials

HYSTERECTOMY. Available from Women's History Research Center, 2325 Oak St., Berkeley, CA 94708.

## Resource People

The following is a list of National Women's Health Network members and others who are willing to share further information on hysterectomy.

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