Postoperative Psychosocial Impact of Hysterectomy on Women: A Systematic Review

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Abstract

Hysterectomy is a common surgery done in women's health care for both non-cancerous and cancer-related issues. Although it helps relieve physical problems, it can also impact a woman's mental health and how she feels about herself and her relationships. This review talks about the main cognitive and social effects after the surgery, such as feeling sad, changes in how she sees her body, lower self-confidence, and problems with sex. Women who are younger or have the surgery because of cancer often face more emotional difficulties. Studies show that offering mental health support before and after the surgery can help lower stress and sadness, and make the recovery process better. It's important to include mental health care in the treatment plan for a hysterectomy to improve a woman's overall quality of life and long-term health results.

Keywords: Hysterectomy, Postoperative psychosocial impact, stress and sadness, quality of life.

Introduction:

Hysterectomy, with or without removal of the ovaries, is one of the most common gynecological surgeries globally. In the United States, over 33% of women undergo this procedure by age 60, mainly due to conditions like abnormal uterine bleeding, fibroids, or other benign and malignant gynecological issues. The U.S. has the highest lifetime risk for hysterectomy among women, and around 54% of those who have the surgery also have both ovaries removed [1]. The UK performs around 100,000 hysterectomy operations annually, making it one of the most common major surgeries. It can be subtotal/supracervical (uterus removal with cervix intact) or complete (uterus and cervix removed). Despite clinical studies not having verified the advantages, subtotal hysterectomy is considered to have the potential to enhance sexual function and the pelvic floor. Traditionally, vaginal (VH) or abdominal (AH) techniques have been used to perform a hysterectomy. Although it may have a higher risk of problems, laparoscopic hysterectomy (LH) has become increasingly common recently since it requires less recovery time and shorter hospital stays than abdominal surgery. This shift towards minimally invasive techniques reflects a broader trend in surgical practices, prioritizing patient comfort and quicker recuperation. As surgical technology continues to advance, further

research may illuminate additional benefits and risks associated with these various approaches. Because vaginal hysterectomy is typically faster, less expensive, and produces results that are equivalent to those of laparoscopic procedures, it is frequently chosen among the surgical choices [2]. The NFHS-4 data show that 6% of Indian women between the ages of 30 and 49 have undergone a hysterectomy. This national average, yet, masks major regional variations across states and union territories. Andhra Pradesh has the greatest prevalence, with 16% of women in this age group having undergone a hysterectomy, which is more than twice the national norm. In accordance with the national average, Telangana comes in second with 14%, followed by Bihar with 11%, Gujarat with 8%, and Tamil Nadu with 6%. Lakshadweep reported the lowest frequency at 2%, while Dadra & Nagar Haveli has the highest at 7% among the Union Territories. The data demonstrate a distinct geographic pattern, indicating that the percentage of women having hysterectomies differs significantly by area of the nation. According to the statistics, the burden is considerably larger in some regions, especially in southern and eastern India. This indicates that one's choice to undergo a hysterectomy may be influenced by variations in healthcare availability, medical practices, customs of society, or health conditions [3].

Indications of hysterectomy [4]

1. **Uterine leiomyomas** - About 30% of hysterectomies are caused by uterine leiomyomas, or fibroids; the primary symptoms are pressure feelings, pelvic pain, and heavy bleeding. Asymptomatic fibroids rarely require surgery, unless there is a silent ureteral blockage or a suspicion of cancer.
2. **Endometriosis and Adenomyosis** - About 20% of cases are endometriosis and adenomyosis; both of these conditions are identified when symptoms (such as irregular bleeding, dysmenorrhea, and pelvic pain) do not go away with conservative or therapeutic measures.
3. **Genital prolapse** - About 15% of cases involve genital prolapse, which occurs when non-invasive and symptomatic treatments are ineffective.
4. **Chronic Pelvic Pain** – Only after thorough evaluation and failure of conservative treatments; often requires psychiatric evaluation.
5. **Endometrial hyperplasia** - Only recommended in cases of complicated or atypical hyperplasia if there is a significant risk of malignancy.
6. **Cervical Intraepithelial Neoplasia & Invasive Cancers** – Hysterectomy indicated for advanced lesions or cancer where fertility preservation is not desired.

Types of hysterectomy [5]

Based on the removal of organs and tissue, a hysterectomy can be classified into three types:

- A partial (supracervical) hysterectomy – It is the removal of the womb's primary body. The ovaries, fallopian tubes, and cervix are not removed.
- Total hysterectomy - The womb and the cervix are removed during a total (full) hysterectomy. The ovaries and fallopian tubes remain in position.
- Radical hysterectomy: During a radical hysterectomy, the womb, cervix, surrounding vaginal tissue, and portions of the supporting tissues are removed. Occasionally, the fallopian tubes, ovaries, and pelvic lymph nodes are also removed.

Psychosocial impact of hysterectomy on women

1) Depression

After a hysterectomy, depression is frequently cited as the most common mental health issue. The loss of femininity, reproductive ability, and bodily integrity—feelings compared to deformation or mutilation—has been mainly blamed for this. Virtues such as youth, strength, beauty, vitality, sexual identity, and life regulation have all been symbolically linked to the uterus. Regardless of whether they have children or not, women who still want children in the future are more vulnerable to postoperative depression. When Richards discovered that 70% of hysterectomy–oophorectomy patients satisfied criteria for sadness, compared to 30% in a surgical control group, and that one-third of those under 45 reported less sexual interest, he came up with the name "post hysterectomy syndrome" in the 1970s. Women who underwent oestrogen and/or androgen therapy had reduced levels in a double-blind crossover trial conducted by Sherwin et al. However, more recent evidence challenges the view that hysterectomy directly causes depression. According to recent studies, the incidence of depression following a hysterectomy is approximately 10%, particularly when the ovaries are maintained. There is no solid evidence that a hysterectomy by itself causes mental disorder. Psychosexual results following surgery seem to be more influenced by psychological issues, such as menopausal changes or previous depression or anxiety [6].

Factors Associated with Depressive Symptoms before Hysterectomy:

In a bivariate study, signs of depression before hysterectomy were associated with younger age, menstrual status, state and trait anxiety, and the intensity and interference of pain. Because of the small sample size, trait anxiety was not included in the study. According to multivariable analysis, signs of depression were more common in women under 50, those with greater levels of state anxiety, and those whose pain interfered with their day-to-day activities [7].

2) Impact on body image and self-esteem

After an abdominal hysterectomy, the scarring may be viewed as a kind of mutilation, which can result in a loss of femininity and energy as well as a negative body image. The sexual and pain results of hysterectomy are associated with these psychological problems. However, there is little empirical research on body image, femininity, or self-perception about hysterectomy. Research has indicated that post-surgical sexual dysfunction can be predicted by women's sexual self-perceptions. The results of controlled trials are conflicting; some indicate that body image is worse than in intact uteri. According to a recent comparison, abdominal hysterectomy was almost three times more likely than laparoscopic hysterectomy to result in a poor body image perception [6].

3) Sexual function after hysterectomy

Hysterectomy can be performed as a subtotal or total procedure, with the total procedure removing the cervix and the subtotal leaving it in situ. Both a subtotal and a total hysterectomy are possible; the former will remove the cervix while the latter leaves it in place. Since it is uncertain how the cervix affects genital sensation and sexual excitement, the possible consequences on sexual function are still up for debate. While a selective hysterectomy may cause less damage and preserve genital sensation, a complete hysterectomy may cause intense agony during sexual activity. It's unknown if the procedure

will improve sexual function. A hysterectomy, which removes one or both ovaries, is frequently performed together with a bilateral salpingo-oophorectomy (BSO). The production of steroid hormones, which are involved in female sexual activity, depends upon the ovaries. Reduced steroid concentrations, hypoactive sexual desire disorder, and diminished sexual pleasure and comfort are all consequences of BSO that may worsen sexual function before and after a hysterectomy [8].

Sexual function in women with preoperative pain and depression:

According to the extensive prospective study, women who experienced both depression and pelvic pain before a hysterectomy fared worse over 24 months than those who had only one or neither illness. Following surgery, the majority of women—including those who experienced both pain and depression—still demonstrated notable, substantial gains in their quality of life and sexual function. The findings confirm clinical concerns that pain and depression can influence surgical success assessments and make recovery even harder. However, it also provides reassurance that hysterectomy is safe and frequently beneficial for these complex patients [9].

Hysterectomy and mental well- being

Younger women who undergo a hysterectomy and those who receive surgery because of cancer are more likely to have worse psychological health in the years that follow. This could be brought on by the psychological effects of receiving a cancer diagnosis, the loss of reproductive function, or the emotional impact of early surgical intervention. It's possible that these women aren't getting enough psychological or emotional support to cope with and adjust to these life changes. The study highlights the need for increased awareness and targeted support for this group, suggesting that younger women who have a hysterectomy—especially for serious medical reasons—may benefit from more focused psychological care to help maintain their mental health and overall well-being in the long term [10].

According to this study, giving women psychological support both before and after a hysterectomy greatly lowers their symptoms of anxiety and depression while also improving their perception of their bodies. These support findings from previous studies and highlight the clear emotional benefits of incorporating psychological support into the treatment process. Crucially, providing this kind of care does not place financial burdens on patients or healthcare organisations, making it a practical and accessible intervention. The research suggests that starting with hospital admission, psychological therapy should be a routine component of nursing care for all women having a hysterectomy [11].

Conclusion

Hysterectomy is a common surgical procedure with significant psychological impacts, especially for younger women and those undergoing surgery for cancer. Depression, anxiety, and changes in sexual function and body image are some examples of these impacts. Nonetheless, research indicates that offering psychological assistance both before and during surgery can significantly enhance emotional health without increasing financial burden. Thus, it is crucial to incorporate mental health services into standard hysterectomy care to improve overall results and assist women during their recuperation.

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