R. CLAY BURCHELL, M.D.
Department of Obstetrics and Gynecology
Hartford Hospital
Hartford, Connecticut

HYSTERECTOMY: FUNCTIONAL VERSUS ANATOMIC INDICATIONS

Considerable confusion surrounds an issue of intense concern to women and their physicians: the indications for hysterectomy. A few years ago, the decision to perform a hysterectomy would have been decided by the physician alone based on traditional gynecologic thinking. Recently, however, women are becoming partners in the decision—a fact that, in my opinion, is positive.

When discussing medical care with a patient, the physician must take into consideration that women have now acquired increased knowledge of medicine. Numerous articles and books have been written expressly for the purpose of helping women make decisions regarding their own health care. In addition, societal and medical acceptance of such procedures as sterilization and abortion, performed on personal as well as medical indications, have strengthened the concept of partnership. It follows naturally that this principle would extend to other medical procedures, and that hysterectomy, involving as it does both emotional and medical ramifications, is the next logical operation to come under scrutiny.

Are we entering a time when the patient decides her own treatment? If so, is the physician abrogating his responsibility? If the physician does what he thinks is indicated and the patient agrees reluctantly, will he be subsequently liable under the concept of informed consent?

A transition is underway; we are moving from purely anatomic indications for hysterectomy to an approach which considers function. This has significant consequences. Since ability to function must be determined by the patient as well as the physician, the functional approach allows the woman to be a true partner in the decision. It ensures that indications for hysterectomy are flexible rather than absolute, since perception of function is obviously subjective.

Three possible functions of the uterus must be considered by the patient and her physician: reproductive, menstrual and sexual. For example, a patient may want a child or, in some instances, she may simply want the potential to reproduce. One woman may look upon menstruation as something negative, while for another, it may provide evidence of her femininity. Prior to hysterectomy,
the patient must also weigh the importance of both the direct and indirect sexual functions of the uterus. Direct function involves uterine contractions during orgasm. Indirect functions include: feeling less feminine after hysterectomy; concern about intangible sexual difficulties; or changes in the attitude of the sexual partner.

In considering function, the decision to perform a hysterectomy arises from the interaction of the patient’s wishes and the physician’s knowledge of gynecology. Each viewpoint should be considered separately. The patient explains what she wants functionally and the physician tells her what is indicated medically. The strength of the patient’s wishes is balanced against the strength of the gynecologic indications, and the final decision is usually determined by which one is stronger.

The whole process breaks down if the patient does not clearly express her feelings. Some patients are embarrassed to do so, or find it difficult to state their desires in a quantitative sense. The functional approach necessitates individualized treatment and requires increased knowledge, wisdom and sensitivity on the part of the physician.

Transition to a functional approach has evolved gradually, as the treatment of uterine myomas over the last 60 years clearly illustrates. In 1911, Kelly recommended myomectomy in younger and hysterectomy in older women. Choice of operation was correlated with age rather than desire for children. Thirty years later, in 1940, Curtis shifted emphasis slightly and advised myomectomy for women in the child-bearing period. It was noted that preservation of function by myomectomy was more dangerous than hysterectomy. In 1961, Brewer recommended hysterectomy unless further child-bearing was desired. This example, from three leading texts of various periods, demonstrates the progression of a medical procedure chosen on the basis of age alone to one based on function. No longer does the physician have a specific list of indications for hysterectomy; it is a question of balancing function against pathology.

Many physicians, particularly those who have not considered the concept in detail, may feel a functional approach is too permissive. It is my opinion, supported by critical review, that this is not the case. In practice, the anatomic approach may be more permissive than a functional one. Carcinoma in situ is a case in point. Using an anatomic approach, hysterectomy is indicated. On a functional basis, a cone biopsy for treatment may be indicated depending on the extent of the lesion and the patient’s wishes. The functional approach is much more precise in requiring that the patient understand all her options; considering the reproductive, bleeding and sexual functions of her uterus as well as the physician’s advice. Other factors, peer review and inspection of medical records by the patient, for example, insures that the whole picture is understood before the operation. The functional approach is anything but permissive!

In summary, the main difference between a purely anatomic and a functional approach to pelvic surgery lies in the thinking used to make the decision. Thus, two women may have the same operation as the result of two entirely different thought processes. Making her a true partner does not signify that the patient is deciding treatment nor that the physician is abrogating his responsibility. What it does represent is a new doctor-patient relationship.

Evidence is mounting that women are less concerned about unnecessary hysterectomies as defined by others, than they are about unwanted hysterectomies as defined by themselves. Perhaps application of the functional approach can resolve the conflict between subjective desires and traditional gynecologic indications.