

Hysterectomy vs non-surgical therapies: Should gynaecologists consider alternative techniques for heavy periods?

An interview with Sonia Grover

Sonia Grover is an obstetrician and gynaecologist at the Mercy Hospital for Women. She has spent her career in obstetrics and gynaecology in a mixture of clinical and research work, with a 'little bit of a bent' towards research in paediatric and adolescent gynaecology. She is also particularly interested in the non-operative treatments that are becoming more widely available to women for heavy menstrual bleeding.

'I'm interested in exploring non-surgical approaches to problems', Sonia explains. 'I'm always questioning the origins of why we do procedures. For instance, for procedures such as curettes, there are now new techniques and new evidence that allow us to often avoid doing these procedures, so why do we still keep doing curettes when the less invasive diagnostic approaches haven't been explored or used first? There are also new techniques and new evidence with regard to menorrhagia and hysterectomy. Can we justify continuing with surgery as a first option? For pelvic pain, ultrasound is so much better than 30 years ago. Today it is possible to get detailed information about anatomy and pathology – even down to detecting tiny nodules, as well as information about the tender sites and structures, and mobility of ovaries. This should allow for a more careful selection of patients who actually need to go to theatre and increased reassurance for those who may be able to avoid this. So there's a theme there that involves considering new technologies, new imaging techniques, new medications and new ways of tackling old problems in different ways.'

Sonia's interest in non-surgical treatments has gone hand in hand with studies she has undertaken or overseen in the data collection of major adverse

events (MAEs) associated with hysterectomy and endometrial ablation. One such project that she supervised was a thesis submitted by one of her students, Kai Xin Lee, for the degree of Bachelor of Medical Science in May 2002 at the Royal Women's Hospital (RWH).



Sonia Grover: 'If we can fix a problem with a simpler technique, such as one of the medical approaches, then why don't we do that first?'

The study evaluated the rates of MAEs over a ten year period (from 1990 to 2000) in the hospital and in Victoria as a whole (using the International Classification of Diseases, Versions 9 and 10). Ms Lee also reviewed 542 medical records (from 1990 to 2000) at RWH of past practices in the provision

of newer evidence-based non-surgical treatments for patients with menorrhagia. Sonia Grover and Kai Xin Lee have presented the results of the study at a number of forums, including the RANZCOG Annual Scientific Meeting in Auckland in September 2003.

'Kai Xin Lee was an incredibly hard working, enthusiastic young woman', Sonia says of her student. 'Her printed data and statistics were very thorough and very reliable. It's not until you double check with other resources that you realise the problems in the crude data – and Kai Xin's work certainly helped to clarify which codes could reliably be used for identifying significant adverse events.'

The key findings in the first section of the study indicated that over a ten year period, there was an average complication rate for major adverse events of seven per cent across the three hysterectomy procedures: abdominal hysterectomy, vaginal hysterectomy (VH) and laparoscopically assisted vaginal hysterectomy (LAVH). The highest complication rates occurred amongst LAVHs and the lowest amongst VHs.

The second section of the study indicated that in 1990, 42 per cent of patients had surgery as a first line therapy, while the remainder were tried on medical therapies. By 2000, the number of women who had first line surgery

had dropped to 23 per cent. While the decline in surgery is encouraging on the surface, Ms Lee found that 80 per cent of the cohort who underwent surgery in 2000 for heavy menstrual bleeding was believed not to have been offered the newer evidence-based effective non-surgical treatments prior to agreeing to their procedures (tranexamic acid and levonorgestrel IUS).¹ This raises the question: Would these women have agreed to a hysterectomy if they had been informed that there were other options?

THE CASE FOR AND AGAINST HYSTERECTOMY

Hysterectomy is a traditionally contentious and delicate subject. One of the arguments raised about the procedure is the subjectivity of the measurements of menstrual bleeding, that is, menorrhagia is defined as blood loss of greater than 80 millilitres (mls). However, the number of women who have a confirmed loss of greater than 80mls is estimated to be between 44 and 56 per cent, suggesting that the remainder of the women who experience losses of less than 80mls may be opting for surgical intervention when it is not absolutely necessary.²

There have also been arguments raised that tertiary educated women have lower hysterectomy rates than women who are less well educated, suggesting that better educated women are more in tune with the medical therapies that are available than their less well educated counterparts.³ Again, these arguments encourage the question: Would fewer women have hysterectomies (and therefore avoid the potential adverse events, risks for scarring or postoperative pain associated with these procedures) if they were better informed about heavy menstrual bleeding and the newer evidence-based non-surgical treatments that are available?

Sonia Grover agrees that the definition of menorrhagia should be debated, but that a key determinant of a woman's referral and treatment should be her perception of her menstrual loss. 'We've known for a long while that not everyone who complains of heavy periods does in fact have heavy periods and it's an interesting question, isn't it? If it's a problem to the woman, then it's a problem. While the definition [of menorrhagia] may be greater than 80mls, if a woman's now having 60mls and she's been used to having 20mls, then for her it is a problem if it's changed. So I think we have to acknowledge that the problem is as perceived by women, although there should be an educational component in there to let them know what is normal and that there are women who have very heavy periods who in fact think it's normal because that's what they've experienced all their lives.'

She also agrees that better educated women are less likely to have a procedure than less educated women, but 'we're still not sure if that is because doctors interact differently with their patients and presume that they can cope with taking different medications or if it is because the women demand other alternatives. And do the women who are less well educated prefer first line surgery or is it that they are actually not given the options? We actually don't know the answers to that and there could be several factors in play there', she explains. 'However, it has been shown several times – at least statistically – that socioeconomic status and education levels do have an impact on hysterectomy rates.'

Sonia Grover explains that there is already an evidence base for non-surgical treatments for menorrhagia. The most relevant evidence to Australia and New Zealand is the results of a Cochrane review in February 2003 about the effectiveness of surgery versus

medical therapy for heavy menstrual bleeding. The review, which was conducted by Jane Marjoribanks, Anne Lethaby and Cindy Farquhar at the National Women's Hospital in Auckland, reported on the outcomes of 625 women who were treated for menorrhagia. One cohort (314) underwent surgery, while the other cohort (311) had medical treatment. After one year, surgical treatment was found to be more effective than levonorgestrel IUS in controlling bleeding at one year, although a smaller trial indicated that there was no significant difference in either treatment at two and three years. Statistically, there was also no difference in satisfaction rates or quality of life in either cohort at one year.⁴

The evidence abroad suggests that non-surgical treatments are taken up quite well.

'The evidence elsewhere would say that the non-surgical treatments are taken up quite well', Sonia Grover says of international studies of the medical treatment of menorrhagia. 'Work in the UK and Scandinavia has shown that two thirds of the women with Mirenas took their names off the waiting list and were still feeling comfortable two, maybe even three years down the track. My personal experience is that these options do work for many women. They're not the answer for everyone, but they do work for many women.'

CAUTIOUS RESPONSES AND CHANGING ATTITUDES

To date, the results of the Cochrane review and the New Zealand Guidelines Group's guidelines for the management of heavy menstrual bleeding, released in June 1998, have not translated into clinical practice in Australia or New Zealand. She expects that the clinical uptake of the new medications is dependent on changing attitudes.

'I do wonder if it's attitudinal', she speculates, 'that clinicians have been used to operating for a long time and they know that hysterectomy is a method that is reliable and works very well. It could be that they are reluctant to break with a pattern of management that they are used to. There is possibly also a lack of awareness about treatments. For example, what is the optimal dosage for tranexamic acid? A clinician may employ small doses and if it's not effective for the patient, then it's considered to not be worthwhile. Some gynaecologists have also been less than enthusiastic about the Mirena because you can have spotting, although many women will be quite comfortable with a markedly reduced menstrual loss, even if it's occasional spotting.'

'If it is an attitudinal factor, then I think we need to achieve a balance by asking ourselves "If we can fix it with a simpler technique, such as one of the medical approaches, then why don't we do that first?"'

Sonia says that obstetricians and gynaecologists only have to look again to the Scandinavian countries to see that the non-surgical therapies have to date been effective for some women. 'I guess we have to ask ourselves, "Why do Scandinavian women have such a low rate of hysterectomy when they clearly still have menorrhagia there?" Is it the

women tolerating and accepting it as normal or is it because they use alternative methods to manage their heavy periods? It's probably a combination of both. Clearly, in Scandinavian countries, they've been using Mirena and they've been using tranexamic acid for many years and I'm sure that those two factors are substantial in reducing the hysterectomy rate.'

It could be that clinicians are confident with a pattern of management they are used to...

Sonia is optimistic that given time, gynaecologists and their patients will become more inclined to use the non-surgical treatments as a first line therapy, but that some areas of practice will always be slower than others. 'We've looked at the number of practitioners who have put their names down for Mirena on a State by State basis when the Mirenas first became available and the percentage of clinicians in Queensland, for instance, was substantially higher than the percentage of clinicians in Victoria. However, if you speak to drug company representatives, they will tell you that Victoria is far more conservative in the uptake of new therapeutic approaches compared to Queensland and there is generally a transition from north to south.'

She believes that an information campaign about the non-surgical treatments directed at gynaecologists is only part of the solution and that institutional change will also be vital. 'The impact of educating and informing women has been demonstrated to be very powerful in work done overseas and this aspect has not been fully explored yet in Australia.'

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