Aspects of Sexual Medicine

Sexual Life after Gynaecological Operations—I

A. G. AMIAS

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Introduction

Gynaecological operations have social, cultural, and psychological overtones far beyond their immediate and precise physical effects. Such factors have to be recognized by all concerned, not least by the patient herself and by her family. Unless informed and sympathetic advice is available both before and after the event even the most minor procedure, well intentioned for a diagnostic or therapeutic purpose, may be blamed for a variety of subsequent ills including sexual difficulty.

Some gynaecological procedures, especially major operations, may be followed by specific sexual problems due either to a loss of ovarian function or to an alteration in the anatomy of the genital tract. In studying and attempting to treat such difficulties it is important to bear in mind the deeper implications that a gynaecological disorder may hold for a woman anxious about her continuing sexual role. Both the disease and its proposed eradication may appear equally threatening, though the reluctance of many women to discuss sexual matters with their doctor may leave such fears unspoken. If the patient is encouraged to voice her anxieties at an early stage much future stress can be avoided, and the doctor will also have an opportunity of gauging the significance of sexual factors in her medical history. In some cases postoperative sexual problems are a continuation of those existing beforehand.

Hysterectomy

Removal of the uterus alone, either abdominally or vaginally, need entail only temporary restriction of sexual activity. After the initial recovery period of about six weeks coitus may be cautiously resumed. Initially even the most intrepid couple will be apprehensive. The abdomen may feel easily bruised and it may take three or four months before normal coital pressure can be enjoyed rather than merely tolerated. Owing to temporary shrinkage the vagina may at first seem narrow and shortened even though no vaginal epithelium has been lost. Postoperative sepsis may exacerbate this tendency and may mean a longer delay before regular coitus can be resumed without discomfort. Sensitive advice should be offered so that the patient and her husband are not discouraged. An explanation that time has to elapse before the vagina resumes its original supple state will reassure the couple, and unless there is still active pelvic inflammation they should not be dissuaded from continuing sexual activity. Coitus will help the tissues to stretch

and the lifting of medical restrictions will provide an important psychological boost. Rather than the usual dismissal after the six-weeks postoperative visit many patients will appreciate being given a specific appointment to be seen again about a month later, and beyond if necessary, to discuss any continuing difficulties, especially when the postoperative course has not been entirely smooth.

In the long term, far from hysterectomy marking a stage in the running down of sexual function, removal of the uterus should result in an increase in sexual activity and enjoyment. Many patients undergoing hysterectomy will have suffered for a great length of time from troublesome menstruation, whether by the duration or quantity of bleeding, by premenstrual tension or depression, by periodic pain, or by the constant wearing down process of a life dominated by the vagaries of uterine malfunction. A further problem may have been the physical distortion of the abdomen and sometimes of the vagina by a gradually enlarging pelvic mass. In younger women hysterectomy may provide an additional relief in eliminating finally the nagging fear of conception.

CONTINUING MALADJUSTMENT

Removal of these disabilities will generally produce the expected gratifying results both in the patient's physical wellbeing and also in the restoration and improvement in her sexual life. Where maladjustment persists the cause should be sought elsewhere than in the operation itself. It is likely, for example, that a patient with severe menstrual disturbance will have reduced her sexual activity over a period of months or years to a degree she may not have realized. She may also suffer from depression either secondary to her gynaecological problem or as a primary illness with menstrual side effects. Such factors are bound to influence the results of operation. A belief that all will be instantaneously well after removal of the uterus is certain to be disappointed. If either partner is impatient it should be explained that a gradual lowering of the rate of coitus over a long period is unlikely to be replaced by a sudden surge of activity in the wake of a major operation. It is worth pointing out that the time required for a complete readjustment has to be measured in months rather than weeks.

In each case the age of a patient has to be borne in mind. Hysterectomy is commonly performed at a time in life when there may be a natural reduction in sexual drive unrelated to the operation. This will suit many couples perfectly well and should not be hindered. In other cases hysterectomy may appear to aggravate an existing age disparity and a complaint of coital difficulty may reflect the anxiety of a woman to retain the affections of her more sexually active husband. A more complex problem is provided by the patient in whom the gynaecological condition has been used as an excuse for denying sexual contact to the husband over a long period and for whom any operation on the genital tract has continued to provide "a convenient escape route from matrimonial obligations which have become

boring or distasteful".¹ Such cases require psychiatric rather than gynaecological attention.

Hysterectomy is generally recognized to be one of the most successful procedures in the entire surgical compass; it is also one of the most maligned. Erroneous notions about the effects of the operation are fostered by opinionated and ill-informed comment in the lay press. Many women are thus convinced, before consulting any doctor, that hysterectomy with or without oophorectomy inevitably leads to a host of undesirable side effects, including premature senility and an irreversible cessation of sexual activity. Fear of operation may result in delay in seeking advice, sometimes with serious consequences. Though many misapprehensions can be corrected by careful and sympathetic explanation, patients are notably reluctant to part with ideas gleaned from non-medical sources in favour of informed opinion however skilfully expressed. There is no doubt that some of the poor results of hysterectomy can be directly attributed to the harmful effects of newspaper medicine.

Subtotal Hysterectomy

Hysterectomy without removal of the cervix is an obsolete procedure acceptable only in cases of unusual technical difficulty. Contrary to earlier assumptions, direct intravaginal observation has shown that the cervix makes no contribution to vaginal lubrication during coitus.² Women who have had a total hysterectomy experience the full cycle of sexual response with no impairment of physical satisfaction.

Oophorectomy and Radical Hysterectomy

Excision of both ovaries with or without removal of the uterus is likely to produce the expected results of sudden surgical castration. Apart from the adverse effects on sexual activity the withdrawal of oestrogen in the premenopausal woman has widespread systemic consequences. This has led to a sensible conservatism in the treatment of ovaries at the time of hysterectomy for benign conditions. There are, none the less, circumstances in which removal of ovaries becomes unavoidable even in the absence of malignant disease. These may be for reasons of technical difficulty or because the condition itself requires removal of the adnexae as an essential part of treatment. Bilateral oophorectomy is the rule during operations for uterine cancer and in most cases of ovarian malignancy.

The response to oophorectomy is variable. Deviation may be due to continuing production of oestrogen from residual fragments of ovarian tissue or from an extragenital source in the adrenal glands. The degree of oestrogen lack may be judged by assay of pituitary gonadotrophins and of oestrogen excretion and serial examination of vaginal cells. Even where little or no oestrogen can be detected the result of oophorectomy may not prove as dire as expected, and, surprisingly, younger patients may have fewer symptoms than women of menopausal age. Nevertheless, the effects on sexual activity can be severe owing to a combination of loss of libido—in itself partly psychological—and a reduction in lubrication and sensation in the lower genital tract.

OESTROGEN REPLACEMENT

Replacement therapy should be considered for all patients

under 50 who are shown by their symptoms or on assay to lack adequate oestrogen. Patients over 50 may require treatment on symptomatic grounds, though there is no convincing argument for continuing replacement beyond the age of the physiological menopause. A daily oral regimen is more effective than oestrogen implant or depot preparations, which tend to be absorbed unevenly. Dosage is usually a matter of trial and error. Therapy may be started with ethinyl oestradiol 10-30 µg daily and the dose increased in accordance with the patient's response. A dose of more than 50 µg daily should be avoided in view of the known risks of thromboembolism. A local oestrogen cream may be useful both as a specific coital lubricant and for its added endocrine effect, though a simple water-soluble jelly may suffice.

Carcinoma of the Uterus

Apart from the direct results of ovarian ablation the treatment of uterine cancer either surgically or by irradiation has profound effects on sexual activity. Wertheim's hysterectomy is a major undertaking with a considerable morbidity, necessitating a long period of physical and mental rehabilitation. The operation entails removal of the upper one-third of the vagina, and post-operative fibrosis may result in considerable reduction in the functional length of the cavity. The resumption of regular coitus will gradually stretch the vagina to its original size, but the associated stresses on the patient and her partner should not be underestimated. Too early a resumption of sexual activity has caused disruption of the vaginal vault,³ but too long a delay will increase the effects of fibrosis and slow down the process of readjustment. In most cases three months is an optimum waiting time.

Fear may be as significant in causing coital difficulty as the anatomical changes after operation or irradiation.³ Anxiety that coitus was the cause of the disease and that its resumption might lead to spread or recurrence can produce serious loss of libido on both sides—notably greater after radiotherapy. To this may be added the psychological effects of a long period of inability to work and on the man's part the fear of becoming infected with his wife's disease.⁴

Radiotherapy interferes much more with vaginal function than does radical surgery. The phenomena of lubrication and of lengthening and expansion of the vagina during sexual activity are never possible after a full course of radiotherapy, which produces serious distortion of the lower genital tract in over 80% of cases.⁵ The inferior functional results of irradiation would indicate a preference for surgery rather than radiotherapy in the treatment of early carcinoma of the cervix in younger patients. Williams's operation for vaginal atresia⁶ may be beneficial in restoring some coital function in cases of irreversible contracture of the vaginal lumen (see Part II of this article).

While the total eradication of the disease has to be the prime consideration in all cases of pelvic malignancy, an understanding of the likely functional effects will help both the doctor and patient in choosing between alternative forms of treatment and in facing the considerable problems of readjustment. Though it may not be possible to avoid the anatomical effects of radical treatment, there is no doubt that the reduction of fear, anxiety, and guilt by explanation and sympathy will do much to mitigate the consequences.

(The concluding part of this article together with the references will appear next week.)