PUBLICATION 19

[19]	[**Tonato Bagnan JA (1)**, Lokossou MSHS, Sanni Imorou R, …]	[Hysterectomy consequences on sexuality in northern Benin]	[Gynecology & Obstetrics; 7 – 12]	[pp 1-3]	[2017]

ISSN: 2161-0932

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Research Article: Gynecol Obstet 2017, 7: 458

DOI: 10.4172/2161-0932.1000458

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Research Article Open Access

Hysterectomy Consequences on Sexuality in Northern Benin

Tonato Bagnan JA[1], Lokossou MSHS[1], Sanni Imorou R[2], Aboubakar M[1], Obossou AAA[2*], Tchegnonsi Tognon F[2], Djidonou A[2], Sanni Ibrahima S[2], Lokossou A[1] and Perrin RX[1]

[1]*Mother-Child Department, Faculty of Health Sciences, University of Abomey-Calavi Cotonou, Benin*

[2]*Mother-Child Department, Faculty of Health Sciences, University of Parakou, Benin*

[*]**Corresponding author**: Obossou Awadé Afoukou Achille, Mother-Child Department, Faculty of Health Sciences, University of Parakou, Benin, Tel: 00229 95 85 32 79; E-mail: awadefr2000@yahoo.fr

Recieved date: November 03, 2017; **Accepted date**: December 05, 2017; **Published date**: December 12, 2017

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Abstract

Introduction: Hysterectomy is one of the most performed medical interventions on women. Its impact on women's sexual life has been poorly addressed in the sub-region.

Objective: To study the impact of hysterectomy on sexuality.

Patients and methods: This was an observational and prospective cross-sectional study conducted on 72 women who underwent hysterectomy in theUniversity and Departmental Hospital Borgou Alibori(CHUD-B/A) Gynecology and Obstetrics Department in Parakou, Benin, with a 5-year follow-up from January 2009 to December 2014. The Female Sexual Function Index (FSFI) scale was used as a data collection tool to assess sex life.

Results: At the end of the study, the average age of women with hysterectomy was 43.7 years with extremes ages ranging from 26 to 64 years. Symptomatic uterine myoma was the first indication of hysterectomy (48.6%), abdominal (81.9%) and total (76.4%). Respondents were relieved by the intervention in (91.7%) but hysterectomy deteriorated sexual life in 34.7% cases with a decrease in sexual desire in 95.8% of cases. Excitations challenges and lubrication were 84.7% and 80.6%. Orgasm and sexual satisfaction were not significantly affected.

Conclusion: Hysterectomy relieves women who have had surgery, but its repercussions on sexual life must be taken into account.

Keywords: Hysterectomy; Psychology; Sexuality

Introduction

Sexuality is conditioned by many cultural, religious, physical, emotional, marital and socio-economic factors. Hysterectomy, a necessary therapeutic option in certain situations, is accompanied by significant urinary, gastrointestinal and sexual morbidity by nerve fiber lesions with a psychological and sexual impact, given the role and the symbolic burden of uterus in procreation [1,2]. In recent decades, the role of the uterus and cervix remains controversial in sexual and orgasmic function. Master and Johnson in 1966 [3], then Crépault [4] in 1989 described two orgasms: clitoral and vaginal with uterine movements. For others, orgasm involves the pelvic floor and the anterior wall of the vagina. More recently, it would be a complex neuro-psycho-physiological process that activates the autonomic nervous system involving a true anatomo-functional entity connecting the vagina, the clitoris urethra and the anus.

Sexuality has a certain degree of subjectivity making it difficult to evaluate. In clinical practice, the use of the Female Sexual Function Index (FSFI) scale has been validated for the investigation of clinical sexual dysfunction [5,6]. The evaluation of the postoperative psychological state can be done using the Patient Health Questionnaire for depression and anxiety (PHQ-4) scale [7]. Few studies in the sub-regions have addressed these issues, hence the value of our study.

Patients and Method

This study was an observational and prospective cross-sectional study undertaken over a 6-month period from February 15, 2015 to August 16, 2015. It focused on a comprehensive sample of 72 women who had a hysterectomy in the Gynecology and Gynecology Department of CHUD-B/A at Parakou in Benin from January 2009 to December 2014.

Inclusion criteria: All patients who had undergone a hysterectomy for a gynecological or obstetric pathology, with a complete medical file and who gave their consent. Those who did not agree to participate in the study, did not have a telephone contacts and those whose records were unusable were not included in the data analysis. The data were collected directly from the patients using the questionnaire. The Female Sexual Function Index (FSFI) scale was used to assess sexual life.

The score is rated from 1.2 to 36. Sexual function is considered good when the score is ≥ 26.55. For each dimension, the score is good when it is ≥ 4. Medical records were used for additional information. The data were analyzed and processed using the Epi Info software version 3.5.1 The chi-square test was used, and the difference was judged statistically significant for a $p \leq 0.05$.

Results

General description of the population

Between January 2009 and December 2014, 289 hysterectomies were performed; 199 files found; 114 with reachable addresses; 96 files met the inclusion criteria; 24 patients were non-consenting, i.e. a participation rate of 75%.

Characteristics of patients

The patients had a mean age of 43.7 ± 8.8 years with extremes of 26 to 64 years, of Christian religion (59.7%); married (87.5%) and lived in a monogamous relationship (53.6%). The average parity was 4.3 ± 2.3 with extremes ranging from 1 to 12. The average number of live children was 3.7 ± 2.1 with extremes ranging from 0 to 12. Three patients showed signs of psychiatric history 3/72 (4.2%) with acute delirious flushing and an attack type anxiety disorders.

Operative indications

Table 1 shows the indications and operative procedures performed.

The approach was abdominal in 81.9% of cases (Table 2).

	Count (N=72)	Percentage in %
Myoma symptomatic	35	48.6
Hemorrhage of uterine delivery / rupture	15	20.8
Cervical cancer	5	6.9
Chronic pelvic pain	5	6.9
Genital prolapse	4	5.6
Polyps delivered by the cervix	3	4.2
Endometrial cancer	3	4.2
Synechia	2	2.8

Table 1: Distribution of patients according to indication and operative procedure.

	Count (N=72)	Percentage in %
Total hysterectomy / abdominal		
Subtotal hysterectomy / abdominal	16	22.2
Total hysterectomy / vaginal route	13	18.0
Associated gestures		
None	45	62.5
Adnexectomy	23	31.9
Prolapse cure	3	4.2
Ganglionic cleaning	1	1.4

Table 2: Distribution of patients according to the approach and the gesture.

Sexual function

Sexual function and all dimensions of female sexuality were globally impaired with an average FSFI score of 14.41 ± 9.03. Table 3 shows the distribution of patients by sexual function.

Discussion

Hysterectomy is a fairly common indication with a frequency of 4% in the region of Kandi in Benin in 2009 [8]. In the United States, according to BROWN et al. [9], more than 600,000 women undergo this operation each year and it is estimated that by the age of 65, at least one in three American women will have had a hysterectomy. In our study, 59 hysterectomies were performed predominantly by the abdominal route (81.9%) with the main indications being symptomatic myomas (48.6%) and hemostasis hysterectomies (20.8%). Dossou et al. [8] found in Benin 44% hysterectomies for genital prolapse, 37.4% for uterine myoma and 9.3% for obstetric emergencies and the vaginal approach was 61.33%.

Sexual quality of life

In our study, sexual function was globally impaired with an average FSFI score of 14.41 ± 9.03. All areas of sexuality were affected with scores ≤ 4. Same observation made by Aerts [10] and Rodriguez et al.

[11]. The latter noted in a population of 100 hysterectomized patients, an FSFI score of 19.4 ± 3.6 with scores of 3.2 ± 0.9 (Desire); 3.2 ± 0.9 (excitation); 3.1 ± 0.6 (lubrication), 3.1 ± 0.7 (orgasm); 3.5 ± 1.1 (satisfaction) and 3.2 ± 1.2 (dyspareunia). Some authors report differences in sexual function depending on the approach and whether or not the cervix is preserved. Ellstrom et al. [12] reported that women who underwent subtotal hysterectomy had a significantly greater positive change in orgasm frequency and sexual pleasure than women with hysterectomy. As for Berlit et al. [13], no difference was noted.

	Evaluation parameters				
Sexual function	**Good**	**Bad**			Score
	n	%	n	%	FSFI Average
Desire	3	4,2	69	95.8	2.98 ± 0.9
Excitation	11	15,3	61	84.7	2.12 ± 1.88
Lubrication	14	19,4	58	80.6	2.13 ± 1.95
Orgasm	12	16,7	60	83.3	1.95 ± 1.88
Satisfaction	20	27,8	52	72.2	2.88 ± 1.89
Eupareunia	18	25,0	54	75	2.36 ± 2.20
FSFI	3	4,2	69	95.8	14.41 ± 9.03

Table 3: Distribution of patients by sexual function (FSFI score).

The difficulty to have an orgasm seems to be more pronounced in our series. Several authors have discussed the decline of ovarian hormones and psychological factors such as depression and body image as responsible for the decline in libido. Indeed, the hysterectomized patients who undergo an adnexectomy, have a surgical menopause. Even the hysterectomy with preservation of the appendices evolves towards an ovarian insufficiency leading to an earlier menopause.

Conclusion

Hysterectomy relieves women who have had surgery, but its repercussions on sexual life are important and deserve psychological preventive measures in order to ensure complete patient satisfaction.

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