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Editorial

The Cervix at Hysterectomy

Should the cervix be removed as a routine part of hysterectomy for benign disease? This surgical conundrum has been a part of the never-ending debates in gynecology. The confusion is emphasized in the terminology used. Many gynecologists use the term subtotal with implications of a substandard or incomplete procedure, while others use the alternative supracervical with its connotations of being a superior and improved technique. The subtotal or supracervical approach has enjoyed cycles of popularity with various advantages and disadvantages being periodically highlighted by proponents and opponents alike. Some of the most influential gynecological laparoscopists have championed the cause of STH from time to time in an attempt to ease the difficulties of cervical removal at laparoscopy. There has been a swing towards the subtotal or supracervical (STH) approach in the recent years especially in some European countries. For example, in Denmark, 22% of all the hysterectomies are subtotal [1] while the ratio of STH to total abdominal hysterectomy (TAH) in Sweden is 0.56[2]. Emerging evidence and surgical trends requires us to reevaluate this issue.

Suggested reasons for removal of the cervix

Cancer in the residual cervical stump: There is a real risk of serious morbidity and mortality from cervical cancer developing in the retained cervix. This is the most feared of all complications of a retained cervix. In a Brazilian series, 3.85% of a series of 363 cases collected over 15 years had cancer developing in the cervical stump [3]. Gynecologists for much of the 20th century have been prompted by this fear to remove the cervix. It must be recognized that these rates reflect the general population rates in countries which do not have well structured cervical screening programs. There are no data about the risk of developing stump cancer in women who are appropriately screened, but it is presumed to be extremely low. Hence, the rationale of cervical removal to prevent cancer does not hold true in a population where screening facilities are in place.
Post surgical vaginal bleeding: After a STH, women may continue to have cyclical or irregular vaginal bleeding. This was seen in 11.4% of the women undergoing such a procedure and of these, 7% required a further surgery to relieve symptoms [2]. This represents additional surgical morbidity in this group of patients.
Persistence of symptoms: When surgery is performed for endometriosis or pelvic pain, about 1 in 4 women will have persistent symptoms if STH is performed [4]. This data may reflect the early experience with laparoscopic surgery with a possibility of inadequate removal of the corpus itself. But it does warn us of the possibility of cervical pathology other than cancer developing in the cervical stump.

Suggested reasons for retaining the cervix

Safer surgery: This cervix sparing approach is undoubtedly technically simpler than TAH and avoids the need for dissection through the highly vascular paravaginal cuff in close proximity to the ureter. It remains an entirely intraperitoneal procedure and avoids communication between the potentially contaminated vagina and the abdominal cavity. It has long been suggested that these direct consequences of the approach are associated with clinical benefits. The Cochrane review suggests that there is a trend towards a reduction in surgical time, blood loss and postoperative febrile morbidity in the STH group. However, there was no difference in serious morbidity rates or readmissions after either of the procedures [5].

Improved sexual, bowel and bladder function: Hysterectomy disrupts nerve plexuses and anatomical relations in the pelvis. This has the potential to affect the functions of the pelvic organs including the bladder, bowel and the pelvic floor. A trial suggesting improved sexual function with STH attracted significant media

attention in the West. However, this claim did not stand the rigors of larger and better conducted randomized trials. Also, there is no difference in bowel or bladder function after STH or TAH [6].

Conclusions

The advantages of the subtotal approach to hysterectomy are confined to the perioperative period. Likely benefits such as a faster postoperative recovery and improved short term quality of life, especially with the laparoscopic STH, should be confirmed by adequately sized randomized trials. On the other hand, there are no long-term advantages of retaining the cervix and post hysterectomy cervical cancer surveillance is mandatory. The risks of vaginal bleeding and persistent symptoms are not offset by improvements in pelvic organ or pelvic floor function. In these settings, there seems to be a strong case for TAH remaining the default hysterectomy in a country such as ours, where opportunities for cervical screening are limited.

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