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Original Article

Psychiatric morbidity after hysterectomy

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Abstract

Fifty-four women were examined 3 to 6 months after hysterectomy, with General Health Questionnaire and DSM-IV to find out the psychiatric morbidity. 38.8% women had psychiatric disorder, which is higher than general population. Depressive disorder and generalized anxiety disorder were the common psychiatric diagnosis. To minimize the psychiatric complications, it was suggested that the women should undergo counseling before and after the operation to minimize the psychiatric complications.

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Introduction

The uterus is a vital organ that plays a very special role in the women's emotional thinking. The surgical operation on the uterus is thought to be an insult to the emotional equilibrium. The

Numerous writers have reported high risks of adverse psychological reactions to hysterectomy[2]. These reactions have been described not only as depression but also as agitation and insomnia, non-specific anxiety, reduced psychosexual functioning and psychosomatic disorders[3,4,5].

Although several writers have reported adverse psychological sequelae to hysterectomy, others have reported no such effects. Patterson and Craig concluded hysterectomy is of little significance in respect to the development of mental illness[6]. Other writers drew similar conclusions also[7].

In a review of the large and conflicting literature, Meikle selected 21 studies from which inferences could reasonably be drawn. Fifteen of these reported to show that hysterectomy are followed by undesirable psychological reaction.

These discrepant findings can be explained largely in terms of research design and method. First, in nearly all studies, the patients were assessed only after hysterectomy. Hence it is not clear whether any psychiatric morbidity detected after operation was due to the operation itself superimposed on to the patient's preoperative condition Secondly, only a few studies have used standardized methods to diagnose psychiatric illness. The others have either been based on the investigator's clinical judgement, with little or no attempt to quantify data, or they have used indirect measures such as admission to mental hospitals, referral to a psychiatrist, on the psychic riling of

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medication in general practice. Thirdly, nearly all studies have used mixed gynaecological samples. e.g. patients hysterectomized for menorrhagia, prolapse, and cancer or in combination with abortion or stillbirth and with or without removal of ovaries. Thus a review of the hysterectomy literature leaves an over-riding impression that the different findings reported and their varying interpretations arise largely from aspects of design and method.

Against these perplexing results of different diversified studies, the present study was designed with an aim to determine the patterns and level of psychiatric morbidity in a series of women who had undergone hysterectomy for menorrhagia of benign origin.

Method and materials

The patients were all women who had a hysterectomy in Rajshahi Medical college Hospital over the period of January to December 2000.In this study, psychiatric and social assessment were made at interview within 3 to 6 months after hysterectomy. Standardized measure GHQ (General Health Questionnaire) [9] was used for screening. The positive cases were further interviewed. The final diagnosis was made by DSM-IV criteria[10]. Complete gynaecological examination and investigations were done to assess physical health status. Past history of psychiatric morbidity were obtained by reports of psychiatric consultations and history of psychotropic medications.

It was decided not to include a comparison group since no strict control group was attainable.

Result

Fifty-four patients were included in the study and were interviewed within 3 to 6 months after hysterectomy. The age of the 54 patients ranged from 26 to 64 years, the mean being 45.05 (SD=9.03). Fifty-one patients (94.4%) were married and living with their husbands and three patients (5.6%) were widow. Twenty-seven patients (51.8%) had more than 3 children; twelve had 3(22.2%), seven had 2(12.96%), four had 1(7.4%) and three patients had no children.

After screening with GHQ and interviewed by DSM-IV, it was found that 21(38.8%) patients had psychiatric disorders. Sixteen patients (29.62%) had organic complaints and 17(31.48%) patients had no problems (Table-I).

Among the patients having psychiatric disorders, thirty-three percent patients had been suffering from depressive disorder. (Table-II) Generalized anxiety disorder was the second common psychiatric diagnosis, followed by panic disorder, somatization disorder, somatoform pain disorder and obsessive compulsive disorder.

Anxiety was the most common symptom found, followed by diminished interest in daily life and pleasure activities. (Table-III) Other symptoms were irritability, depressed mood, loss of libido, multiple somatic complains without organic lesion, hypochondriasis, obsessive thought and suicidal idea.

Table-I Distribution of patients according to diagnosis (n=54)

Diagnosis	Number of patients	Percentage %
Psychiatric disorders	21	38.8
Organic disorders	16	29.6
No disorders	17	31.4

Table-II shows the distribution of patients according to psychiatric diagnosis. (n=21)

Psychiatric disorders	Number of patients	Percentage (%)
Depressive disorder	07	33.3
Generalized anxiety disorder	05	23.8
Panic disorder	03	14.3
Somatization disorder	03	14.3
Somatoform disorder	02	09.5
Obsessive compulsive disorder	01	04.8

Table-III Distribution of patients according to presence of psychiatric symptoms. (More than one symptom was present)

Symptoms	Number of patients	Percentage (%)
Anxiety	14	66.6
Diminished interest in daily life and pleasure activities	13	61.9
Irritability	11	52.4
Depressed mood	7	33.3
Loss of libido Multiple somatic complaints	6	28.6
Without organic lesions	5	23.8
Hypochondriasis	3	14.3
Obsessive thought	1	4.7
Suicidal thought	1	4.7

Discussion

This study was designed to find out the psychiatric morbidity after hysterectomy. The results revealed that 38.8% patients were suffering from psychiatric disorders. The level of psychiatric morbidity in this study is lower than other study done in Bangladesh.[11] But it is consistent with other studies done in western world[12,13]. This study could not reveal whether hysterectomy itself led to psychiatric morbidity or not, as this study did not measure psychiatric morbidity before hysterectomy and as per history, all the patients were psychologically unremarkable before the operation. During interview, some of the patients stated that they had taken anti-depressant medications before the operation and some of them were still taking them. One of the patients had been suffering from obsessive compulsive disorder for the last seven years. However, these findings did not measure accurately the level and patterns of pre-operative psychiatric morbidity.

The main finding in this study was that the levels of psychiatric morbidity after hysterectomy were much higher than in the general population. Ballinger found that amongst gynaecological outpatients, levels of psychiatric morbidity were much higher than they were in general population, or amongst patients attending in general practice or admitted to a medical ward[14]. This view is also supported by Martin et al, who found high levels of pre-operative psychiatric morbidity in patients awaiting hysterectomy in St Louis and concluded that post-hysterectomy symptoms must be evaluated in relation to pre-operative state[15]. The proper explanation for the excess of pre and post-operative psychiatric disorder has not been explored yet. But it is proposed that menorrhagia and emotional distress due to surgery may be causative factors. This is understandable that menorrhagia is a disagreeable and most unwanted symptom that likely to induce distress particularly in predisposed personalities.

This small study may be considered as a beginning as it could not precisely find out the cause of higher level of psychiatric morbidity, but it emphasizes that the women who will undergo hysterectomy should have psychiatric counseling before and after operation to minimize the emotional distress. Also need of a well-designed study to assess the level and patterns of psychiatric morbidity of the socially underprivileged womenfolk of Bangladesh having diversified gynecological problems is clearly felt.

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