

The residual ovary after hysterectomy

A. MANCUSO - R. D'ANNA (*) - C. DUGO (*) - R. LEONARDI

Summary: Of 118 cases of patient who had undergone abdominal hysterectomy with the preservation of one or both the ovaries, only 73 patients (62%) attended for review. Eleven had had cysts of the residual ovary. The occurrence of an asymptomatic pathology in three cases suggest that patients, for whom preservation of an ovary was considered preferable, should undergo a periodic clinical and ultrasonographic review.

Women of reproductive age having a hysterectomy because of benign disease of the uterus require the gynaecologist to decide whether to preserve or to remove the gonads during surgery.

Some clinicians consider it preferable to preserve the ovaries without taking into account the age of the patients^(1, 2); others maintain that routine removal of these organs during hysterectomy is to be preferred⁽³⁾.

Beyond the age of 40, and especially over 45 years, many are in favour of removal of the ovaries.

Those who favour oophorectomy give arguments based on epidemiological findings^(4, 5, 6) considering the possibility of residual organs developing either benign or malignant, disease, and on endocrinological assessment. It is possible that after the excision to the uterus the ovaries atrophy prematurely probably due to reduction of the blood flow^(7, 8).

Those in favour of preservation of the ovaries maintain that these organs play an

important role in steroid metabolism even after the menopause⁽⁹⁾; that no surrogate treatment can completely make up for their absence⁽¹⁰⁾ and that the development of benign and malignant disorders of the residual ovary do not appear to be overtly influenced by a preceding hysterectomy^(11, 12).

Considering all these factors, we decided to review the cases of patients who had undergone abdominal hysterectomy with preservation of one or both the ovaries in order to assess the possible insurgence of disorders.

MATERIAL AND METHODS

One hundred and eighteen patients who had been admitted to the Institute of Gynaecology in the University of Messina, between 1983 and 1988 and who had had hysterectomy with conservation of one or both ovaries, were asked to attend for evaluation of anamnestic data and echographical pattern.

Seventy three (62%) attended, including four women who had had further surgery following a problem with a residual ovary.

The age of the patients at the time of hysterectomy had been 26 to 46 years: forty-seven per cent under 40, 49 per cent between 41 and 45 and 4 per cent over 45 years.

Cattedra di Patologia Ostetrica e Ginecologica
Università degli Studi di Messina

(*) Cattedra di Clinica Ostetrica e Ginecologica
Università degli Studi di Messina

Tabel 1.

Age	Pelvic mass dimensions (mm)	Type of* surgery	Laten- cy (months)	Symp- toms	Hystolog. exami- nation
<i>Treated surgically</i>					
42	(77×70)	TAH	22	yes	Follicular cyst
27	(61×57)	TAH+ RSO	42	yes	Follicular cyst
31	(79×68)	TAH	7	yes	Follicular cyst
39	(140×85)	TAH+ RSO	6	yes	Luteal cyst
<i>Found at review</i>					
37	(147×79)	TAH+ RSO	63	yes	—
33	(77×45)	TAH+ LSO	57	yes	—
37	(75×49)	TAH+ RSO	27	yes	—
37	(59×35)	TAH	26	no	—
39	(67×34)	TAH	25	no	—
44	(68×34)	TAH	13	no	—
42	(59×48)	TAH	36	no	—

(*) TAH = Total Abdominal Hysterectomy
RSO/LSO = Right/Left Salping-ovariectomy

In 24 women both gonads had been preserved, in 21 the right ovary and in 28 the left ovary.

The interval of time between the hysterectomy and our enquiry was of 6 to 72 months.

RESULTS

Twenty-six per cent of the patients were asymptomatic, 23 per cent evidenced pelvic pain, localised or diffuse; 14 per cent had urinary problems of various kinds and 7 per cent complained of dyspareunia. In 30 per cent of symptomatic patients there was more than one symptom.

Ultrasonography showed a normal pelvis in 62 patients (85%); in 11 cases there was a pelvic mass varying between 56 and 147 mm in diameter (Tab. 1). The pelvic mass was asymptomatic in 3 patients, it was associated with pains, dyspareunia or urinary problems in 8 cases.

In these patients the time between hysterectomy and further surgery or our examination was between 6 and 63 months.

The patients who had additional surgery presented technical difficulties due to the presence of adhesions, but there were no cases of surgical damage to abdominal or pelvic organs.

Histological examination of the ovary in these patients revealed a multiloculated cyst in 3 cases and a luteal cyst complicated by haemorrhage in one.

DISCUSSION

Our study revealed the difficulties of following up all cases, and we were able to review only 62 per cent of the 118 patients who had undergone this type of surgery.

Among these the incidence of disorders of the residual ovary was 15 per cent, somewhat greater than is reported in literature, in studies where only those patients who required further surgery were reviewed (^{8, 12, 13}).

Our data also revealed that the choice of preserving one or both the gonads is not relevant to the subsequent insurgence of ovarian disorders, as the same problems occurred whether one or both ovaries were preserved.

Moreover there seemed to be no particular time of risk, during which to concentrate check-up, for the appearance of the residual ovary syndrome as cases evidenced a distribution over a wide period of time (Tab. 1).

Organic disease of the residual ovary was not always associated with subjective symptoms useful for diagnosis; in fact in three patients out of eleven, the pelvic mass was totally asymptomatic.

The possibility of an adequate follow up should be taken into account when deciding whether to preserve or to remove the ovaries during hysterectomy.

If an ovary is conserved the gynaecologist should firmly advise periodic ultrasonographic and clinical examinations.

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Address reprints requests to:

R. LEONARDI
Via Torino, Isolato W
98100 Messina (Italy)