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Hysterectomy

Clinical Recommendations and Indications for Use

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Southern California Health Policy
Research Consortium

Women's Health and Hysterectomy Project

RAND
These recommendations are based on appropriateness ratings of indications for hysterectomy developed by the RAND/UCLA expert panel process. The appropriateness ratings and the literature review that accompany these recommendations are provided in two companion documents: Hysterectomy: A Review of the Literature on Indications, Effectiveness, and Risks (MR-592/2-AHCPR), and Hysterectomy: Ratings of Appropriateness (MR-592/3-AHCPR). The reader should consult these documents as necessary for background and supporting information.

The recommendations were developed as part of a project conducted by the Southern California Health Policy Research Consortium, a collaboration of the Healthcare Association of Southern California, the Los Angeles County Medical Association, the Medical Quality Commission, the American Medical Group Association, and RAND.

Members of the expert panel who produced the appropriateness ratings upon which the recommendations are based are listed below. Each panel member was nominated by his or her respective specialty society.

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<th>Name</th>
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The recommendations contained in this document were produced by a working group consisting of four members of the expert panel (Drs. Bohon, Dickerson, Ling, and Peterson). RAND researchers Steven J. Bernstein, M.D., David E. Kanouse, Ph.D., and Lucian L. Leape, M.D., assisted the working group in translating the appropriateness ratings into the recommendations contained in the document.

This document reflects the state of the scientific literature and the opinions of the panel members as of June 1993. As such, the recommendations do not reflect new evidence, new techniques, or other advances since that time. Users of the document should take account of such new information in using this document.

These recommendations have been developed for use in a quality improvement demonstration project funded by grant number R18-HS07095 from the Agency for Health Care Policy and Research, U.S. Department of Health and Human Services. The recommendations are solely the responsibility of the Southern California Health Policy Research Consortium and RAND and do not necessarily represent the official views of the Agency for Health Care Policy and Research.
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We wish to thank the following specialty societies who provided nominations from which the panelists were selected. It is important to note that these nominations do not constitute approval or endorsement of the recommendations by these societies, and none is implied.

American College of Obstetricians and Gynecologists
American Academy of Family Physicians
American College of Physicians
The Society of General Internal Medicine

We would also like to acknowledge the assistance of Stanley Zinberg, M.D., American College of Obstetricians and Gynecologists, for his help in developing these recommendations.
These recommendations were developed as a research tool to provide an authoritative guide to assist physicians in deciding whether to recommend hysterectomy for non-emergency, non-malignant disease. They apply only to that decisionmaking process and are not a suitable resource for overall management of women with the condition described.

The recommendations assume that the reader is knowledgeable about the full spectrum of gynecological disease and its management, including indications for and interpretation of diagnostic tests, and is qualified to provide pre-, intra-, and post-operative care. The recommendations also assume that patient care will be provided in an institution that has the resources to provide high-quality care.

How the Recommendations Were Developed

These recommendations represent expert judgments about the appropriateness of hysterectomy for a large number of clinical scenarios. They were developed by a working group of obstetricians/gynecologists and are based on appropriateness ratings developed through the RAND appropriateness method. This expert group judgment process includes five steps:

1. **Literature review.** A comprehensive review of the literature was carried out of the indications for hysterectomy and the effectiveness and risks associated with alternative treatments for conditions that may be treated by hysterectomy. This literature review is contained in the companion document, *Hysterectomy: A Review of the Literature on Indications, Effectiveness, and Risks* (MR-592/2-AHCPR).

2. **Derivation of indications.** A set of indications was developed that reflects how clinicians think about hysterectomy. The objective was to include all likely clinical scenarios where hysterectomy might be recommended for non-emergency, non-malignant disease, and to incorporate all of the key variables that enter into the decisionmaking process. The resulting “indications” are highly detailed, individually unique, and mutually exclusive. A total of 2,332 potential indications for hysterectomy were developed.

3. **Selection of an expert panel.** A multidisciplinary panel of nine physicians was selected from individuals nominated by the relevant specialty societies as well-recognized experts and experienced clinicians. The composition of the panel is balanced three ways. It includes physicians who perform hysterectomy and those who refer women for surgery, academicians and those in private practice, and representatives from different geographical sections of the country. There were five obstetrician/gynecologists, two internists, and two family practitioners on the panel. Four of the nine panelists were women.

4. **Rating of indications.** The indications and the literature review were then provided to the panelists, who were asked to independently rate each indication for the appropriateness of hysterectomy on a nine-point scale, where 1 = highly inappropriate and 9 = highly appropriate. An indication is “appropriate” if the benefits and positive effects outweigh the risks and negative effects by a sufficient margin that the procedure is worth doing. The ratings took place in two stages: first, independently and alone; second, independently and confidentially after face-to-face discussion.

5. **Analysis of ratings.** The median score of the nine expert ratings is used as the final rating of appropriateness. An indication for hysterectomy is considered *inappropriate* if the median panel rating
is in the 1–3 range, uncertain if it is 4–6, and appropriate if the median rating is 7–9. An indication is also considered uncertain if two or more panelists’ ratings are in the 1–3 and two or more panelists’ ratings are in the 7–9 range. The final ratings are contained in the companion document, *Hysterectomy: Ratings of Appropriateness* (MR-592/3-AHCPR).

The product of this process is a comprehensive list of indications for hysterectomy that are rated as appropriate, uncertain, or inappropriate. The ratings are detailed, specific, and comprehensive; that is, they attempt to include essentially all clinical situations (other than emergencies and cancer) in which hysterectomy is a treatment option.

Note that the ratings reflect a preponderance of expert opinion, but not necessarily a consensus. A rating of “uncertain” usually meant that the panelists found the evidence to be inadequate to make a definite judgment one way or the other; only occasionally did it reflect disagreement among the panel members.

The appropriateness ratings from the RAND process are difficult to use in clinical practice because of their detail and comprehensiveness. Further, they include every possible indication for hysterectomy as well as consideration of all diagnostic tests and alternative therapies. Accordingly, they have been simplified by grouping similar indications with equivalent ratings and by eliminating redundancy. They were then reviewed and revised by a Clinical Advisory Board consisting of four gynecologist members of the expert panel and a representative from the American College of Obstetricians and Gynecologists.

**Use of the Recommendations**

Because of the absence of outcome data for most of the indications for hysterectomy, it is not possible to base recommendations for hysterectomy on evidence from the medical literature. Further, the great variation in symptoms, anatomy, and psychosocial factors among women preclude definitive assertions that hysterectomy is or is not indicated in many situations where it might seem to be appropriate. Therefore, the primary purpose of modifying the ratings into recommendations was to identify those potential indications for hysterectomy that were clearly inappropriate except under very unusual circumstances. This represents a subset of the ratings that fell into the inappropriate category (median score of 1–3 without disagreement).

A recommendation of “inappropriate” represents the unanimous agreement of the expert panel that it is wrong to perform hysterectomy in the usual patient with the condition. Individual women may represent exceptions and require different therapy. All other women are considered “possible candidates for hysterectomy.”

The category “possible candidate for hysterectomy” is not meant to imply that hysterectomy is indicated in these women, merely that it may be a treatment option. In some cases, hysterectomy may be clearly appropriate, even necessary; in others, seldom appropriate. The full range of expert panel judgments about whether the highly detailed indications were appropriate, uncertain, or inappropriate in the average woman are found in the appropriateness ratings.

The recommendations are presented in two forms for each “chapter” of indications: guiding principles and a graphic algorithm. A chapter consists of all the specific scenarios within an accepted clinical entity, such as endometriosis. For each chapter, the guiding principles appear on the left-hand page and the corresponding algorithm appears on the right-hand page. The terms used in the recommendations are highly specific and were precisely defined by the panel. The definitions are provided with the recommendations for each chapter. The definition for one term used in many of the chapters—endometrial sample—is provided in the box below.
The recommendations are unlike other decision aids or treatment recommendations in that they focus on only one aspect of patient care: the decision to recommend hysterectomy. They are not complete algorithms for diagnosis or treatment, and, therefore, they do not provide specific recommendations for all tests or non-hysterectomy treatments. There are several reasons for this, but the most important is the absence of a clear consensus, even among experts, on the best practice for most of the conditions described here. These recommendations were developed by a group of expert physicians to enumerate the essential evaluative and treatment steps that should be taken before hysterectomy is considered.

The reader should first select the chapter that best describes the clinical condition of the woman. If additional information is needed, refer to the accompanying literature review and ratings documents: *Hysterectomy: A Review of the Literature on Indications, Effectiveness, and Risks* (MR-592/2-AHCPR) and *Hysterectomy: Ratings of Appropriateness* (MR-592/3-AHCPR).

A Cautionary Note

These recommendations represent the group judgment of a panel of experts of the appropriateness of hysterectomy for the *average* woman presenting with the specific set of clinical characteristics embraced in an individual indication. They are not the product of a rigorous risk/benefit analysis because the data for such an analysis do not exist. They cannot, therefore, be followed blindly, nor should they be considered standards of care. Rather, they are recommendations, based on evidence and experience. In individual cases there may be considerations of crucial importance to the decisions not included in the recommendation and that influence a judgment as to appropriateness for a particular woman. This should not occur often; the reason for making the recommendations as comprehensive as possible is to minimize this possibility.

*Please note that these recommendations do not address the appropriateness of hysterectomy for emergencies or malignant disease. Also, the expert panel felt that hysterectomy is inappropriate in all instances of benign disease if the woman desires to keep her uterus.*

*Finally, these recommendations do not take into account individual patient values, such as risk aversion and attitudes toward surgery. Thus, even if hysterectomy is appropriate for average (most) women with a given indication, any individual woman may appropriately opt for non-surgical therapy.*

### DEFINITION OF ENDOMETRIAL SAMPLE

Endometrial sampling is frequently recommended prior to a decision regarding whether to perform hysterectomy. In women with abnormal uterine bleeding, endometrial sampling is important to identify whether there is a specific condition leading to the bleeding (e.g., endometrial polyp, endometrial hyperplasia, endometrial carcinoma). Several methods are available to obtain endometrial tissue. These include: (1) a blind endometrial biopsy or aspiration curettage; (2) a dilation and curettage; or (3) a hysteroscopy with biopsy. A hysteroscopy with biopsy may provide the most information, inasmuch as there is direct visualization of the endometrium and the biopsy can be directed; however, the expert panel did not recommend it for all women because it is not a technique known to all obstetricians and gynecologists, it is expensive, and it requires more time on the part of both the woman and the physician. Therefore, in these recommendations, any form of endometrial sampling is considered adequate.
Prior to hysterectomy for cervical dysplasia, a woman with an abnormal pap smear should undergo cervical biopsy or conization (or LEEP or LLETZ). If the biopsy reveals CIN I, she should be followed with pap smears and a physician may elect to do conservative surgery, but no further treatment is required, and hysterectomy is inappropriate.

If the biopsy reveals CIN II, CIN III, or CIS, conservative surgery is indicated.

Women with CIN II should be followed with pap smears in 6 to 12 months after conservative surgery. If dysplasia persists or recurs, repeat treatment is indicated. Women who have recurrent dysplasia may be possible candidates for hysterectomy.

Women with CIN III or CIS may be possible candidates for hysterectomy following the trial of conservative surgery.

These recommendations assume the woman is compliant and will return for follow-up as indicated.

**DEFINITIONS**

**DEGREE OF DYSPLASIA**

The degree of dysplasia refers to that documented by the most recent cervical biopsy.

- **CIN I:** Cervical intraepithelial neoplasia I; mild dysplasia; low-grade squamous intraepithelial lesion (SIL) with cellular changes associated with human papillomavirus; low-grade SIL and mild dysplasia.
- **CIN II:** Cervical intraepithelial neoplasia II; moderate dysplasia; high-grade SIL with moderate dysplasia.
- **CIN III/CIS:** Cervical intraepithelial neoplasia III; severe dysplasia; high-grade SIL with severe dysplasia; carcinoma in situ (CIS); high-grade SIL with CIS.

**CONSERVATIVE SURGERY FOR CERVICAL DYSPLASIA**

Excision by conization or by loop electrosurgical excision procedure (LEEP), or large loop excision of the transformation zone (LLETZ) or by laser or cryotherapy procedure.
*A cone biopsy may be necessary to rule out invasive disease.

**Some patients and physicians may prefer to have repeat conservative surgery for non-invasive disease (persistent/recurrent dysplasia).

Figure 1—Hysterectomy for Cervical Dysplasia
HYSTERECTOMY FOR SYMPTOMATIC ENDOMETRIOSIS

Women with symptoms from endometriosis may present with a variety of complaints, including both dysmenorrhea and noncyclic pain/discomfort (e.g., dyspareunia, defecation pain, constant pressure or fullness, bladder or bowel pressure). Because the only way to confirm a diagnosis of endometriosis is by direct visualization or biopsy, the diagnosis should be confirmed by either laparoscopy or laparotomy.

If laparoscopy reveals mild disease, hysterectomy is inappropriate even if there is major impairment, unless the woman has had a trial of hormone therapy or a trial of conservative surgery. For the woman with moderate disease, a critical factor is how impaired she is from her symptoms; if the woman has major impairment, she may be a possible candidate for hysterectomy. Women with severe disease may be possible candidates for hysterectomy.

Hysterectomy performed for endometriosis is appropriate only if it is accompanied by bilateral oophorectomy because leaving ovarian tissue may lead to continuing hormonal stimulation and continuing symptoms. Postoperatively, these women may receive replacement estrogen therapy because the level of replacement hormone usually does not stimulate endometrial implants.

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DEFINITIONS

**SEVERITY OF ENDOMETRIOSIS**

On the basis of the most recent laparoscopy or laparotomy

**MILD:** Mild or minimal disease; stage 1 or 2 of the American Fertility Society classification (AFS score ≤ 15); or no documentation.

**MODERATE:** Moderate disease; stage 3 of the American Fertility Society classification (AFS score 16–40).

**SEVERE:** Severe disease; complete obliteration of posterior cul de sac; bilateral deep ovarian lesions of ≥ 1 cm or dense adhesions of the ovary and/or fallopian tube causing more than 2/3 enclosure of the fimbriated end of the tube; stage 4 of the American Fertility Society classification (AFS score > 40).

(See Appendix for a copy of the American Fertility Society Classification of Endometriosis.)

---

**MAJOR IMPAIRMENT CAUSED BY ENDOMETRIOSIS**

During the last 3 months the woman has had a significant worsening in level of activity caused by endometriosis symptoms or the symptoms continue to have a significant negative effect on the woman’s functional ability.

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**TRIAL OF HORMONE THERAPY FOR ENDOMETRIOSIS**

A trial of oral contraceptive pills (OCPs), progestins, danazol, or gonadotropin releasing hormone (GnRH) agonists.

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**TRIAL OF OCPs OR PROGESTINS**

OCPs or progestins for at least 3 consecutive months within the last 2 years. This category includes women for whom use of OCPs is contraindicated (e.g., because of potential side effects). Contraindications may include smoking; morbid obesity; a history of breast cancer, hypertension, migraine headaches, deep venous thrombosis, pulmonary embolism or hypercoagulable state; or if the woman has had a prior trial of OCPs or progestins for any reason in the past and refuses the medication.

---

**TRIAL OF DANAZOL OR GONADOTROPIN RELEASING HORMONE (GnRH) AGONISTS**

Danazol or gonadotropin releasing hormone (GnRH) agonists (with or without a trial of OCPs or progestins) for at least 3 consecutive months within the last 2 years. The category includes women for whom use of gonadotropin releasing hormone (GnRH) agonists is contraindicated (e.g., because of potential side effects) or because the woman refuses medication.

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**CONSERVATIVE SURGERY FOR ENDOMETRIOSIS**

Any procedure performed during laparoscopy or laparotomy within the last 5 years to remove or ablate endometrial implants and lyse adhesions.
Figure 2—Hysterectomy for Symptomatic Endometriosis
Premenopausal women with abnormal bleeding of unknown etiology may be possible candidates for hysterectomy if the bleeding is a continuing problem that results in significant anemia or major impairment and is not controlled by hormone therapy.

If the woman is currently bleeding, the severity of the bleeding should be evaluated by measuring the hemoglobin or hematocrit. For women who are not anemic (i.e., hematocrit ≥ 30) and are without major impairment, hysterectomy for abnormal uterine bleeding of unknown etiology is inappropriate.

Prior to considering hysterectomy, women with abnormal uterine bleeding who have significant anemia or major impairment from bleeding should undergo endometrial sampling to rule out a treatable condition or neoplasm (e.g., endometrial hyperplasia or endometrial carcinoma).

If the sample shows only normal endometrial tissue, a trial of hormone therapy is indicated. Following the trial of hormone therapy, a woman may be considered a possible candidate for hysterectomy. She may choose hysterectomy because the hormone therapy failed to control her bleeding or, if bleeding was controlled, she may prefer hysterectomy to long-term hormone therapy.

**DEFINITIONS**

**CURRENTLY BLEEDING**
Bleeding is an active problem when the recommendation for hysterectomy is made and has been present ≥ 2 months.

**SIGNIFICANT ANEMIA**
On the basis of the most recent hematocrit (Hct) or hemoglobin (Hgb), a woman has significant anemia if the Hct is less than 30% or the Hgb is less than 10 g/dl or there is a drop in Hct of ≥ 6% (or a drop in Hgb of ≥ 2 g/dl) in the last 6 months AND the woman has received treatment with iron for 3 months or blood transfusions.

**MAJOR IMPAIRMENT CAUSED BY ABNORMAL UTERINE BLEEDING**
During the last 3 months the woman has had a significant worsening in level of activity caused by abnormal bleeding or the bleeding is continuing to have a significant negative effect on the woman’s functional ability.

**TRIAL OF HORMONE THERAPY**
At least 3 consecutive months of oral contraceptive pills (OCPs) or estrogens or progestins or danazol or gonadotropin releasing hormone (GnRH) agonists since the bleeding problem began and within the last 2 years. This category includes women for whom use of OCPs is contraindicated (e.g., because of potential side effects).

Contraindications may include smoking; morbid obesity; a history of breast cancer, hypertension, migraine headaches, deep venous thrombosis, pulmonary embolism, or hypercoagulable state; or if the woman has had a prior trial of OCPs/progestins for any reason in the past and refuses the medication.

If the woman was taking hormone therapy when the bleeding problem began, then the hormone therapy must have been stopped or modified for a period of at least 3 consecutive months within the last 2 years.
Figure 3—Hysterectomy for Premenopausal Abnormal Uterine Bleeding of Unknown Etiology
HYSTERECTOMY FOR POSTMENOPAUSAL ABNORMAL UTERINE BLEEDING OF UNKNOWN ETIOLOGY

Postmenopausal women with abnormal uterine bleeding may be possible candidates for hysterectomy if the bleeding is persistent or recurrent and they have had a trial of hormone therapy.

Postmenopausal women with abnormal uterine bleeding should undergo endometrial sampling to rule out a treatable condition or neoplasm.

If no abnormalities are found (other than atrophic changes of the endometrium), hysterectomy is inappropriate unless the woman has persistent or recurrent bleeding and has had a trial of hormone therapy. If she is already on hormone replacement therapy, an adjustment of her hormonal therapy should be carried out (e.g., changing the dosage, type, or frequency of the medication). Following the trial of hormone therapy or an adjustment of hormone therapy, a woman may be considered a possible candidate for hysterectomy. She may choose hysterectomy because the hormone therapy failed to control her bleeding or, if bleeding was controlled, she may prefer hysterectomy to long-term hormone therapy.

**DEFINITIONS**

**POSTMENOPAUSAL**
One year or more since the last menstrual period or follicle stimulating hormone level > 40 mIU/ml AND estradiol level < 40 pg/ml. If the woman is being cycled on hormones, a statement by the physician that the woman is postmenopausal.

**TRIAL OF HORMONE THERAPY**
At least 3 consecutive months of oral contraceptive pills (OCPs) or estrogens or progestins or danazol or gonadotropin releasing hormone (GnRH) agonists since the bleeding problem began and within the last 2 years. This category includes women for whom use of OCPs is contraindicated (e.g., because of potential side effects).

Contraindications may include smoking; morbid obesity; a history of breast cancer, hypertension, migraine headaches, deep venous thrombosis, pulmonary embolism, or hypercoagulable state; or if the woman has had a prior trial of the agent for any reason in the past and refuses the medication.

**HORMONE THERAPY ADJUSTMENT**
If the woman was taking hormone therapy when the bleeding problem began, then the hormone therapy must have been stopped or modified for a period of at least 3 consecutive months within the last 2 years.

**PERSISTENT OR RECURRENT BLEEDING**
More than one episode of bleeding.
Figure 4—Hysterectomy for Postmenopausal Abnormal Uterine Bleeding of Unknown Etiology
Hysterectomy for Premenopausal Women with Leiomyomata and Abnormal Uterine Bleeding Without Pain

Premenopausal women with leiomyomata and abnormal uterine bleeding without pain may be possible candidates for hysterectomy if they have significant anemia or major impairment.

The severity of the bleeding should be evaluated by measuring their hemoglobin/hematocrit. For women who are not anemic (i.e., hematocrit ≥ 30) and are without major impairment, hysterectomy for leiomyomata and bleeding is inappropriate.

A woman who does have significant anemia or major impairment should undergo endometrial sampling to identify any pathologic condition. If the findings on endometrial sampling are normal, a trial of hormone therapy may be indicated, after which she may be a possible candidate for hysterectomy.

**DEFINITIONS**

**Currently Bleeding**

Bleeding is an active problem when the recommendation for hysterectomy is made and has been present ≥ 2 months.

**Significant Anemia**

On the basis of the most recent hematocrit (Hct) or hemoglobin (Hgb), a woman has significant anemia if the Hct is less than 30% or the Hgb is less than 10 g/dl or there is a drop in Hct of ≥ 6% (or a drop in Hgb of ≥ 2 g/dl) in the last 6 months **AND** the woman has received treatment with iron for 3 months or blood transfusions.

**Major Impairment Caused by Abnormal Uterine Bleeding**

During the last 3 months the woman has had a significant worsening in level of activity caused by abnormal bleeding or the bleeding is continuing to have a significant negative effect on the woman's functional ability.

**Trial of Hormone Therapy**

At least 3 consecutive months of oral contraceptive pills (OCPs) or estrogens or progestins or danazol or gonadotropin releasing hormone (GnRH) agonists since the bleeding problem began and within the last 2 years. This category includes women for whom use of OCPs is contraindicated (e.g., because of potential side effects).

Contraindications may include smoking; morbid obesity; a history of breast cancer, hypertension, migraine headaches, deep venous thrombosis, pulmonary embolism, or hypercoagulable state; or if the woman has had a prior trial of OCPs/progestins for any reason in the past and refuses the medication.

If the woman was taking hormone therapy when the bleeding problem began, then the hormone therapy must have been stopped or modified for a period of at least 3 consecutive months within the last 2 years.
Figure 5—Hysterectomy for Premenopausal Women with Leiomyomata and Abnormal Uterine Bleeding Without Pain
Women with pain caused by leiomyomata should first undergo a trial of medical therapy with either pain medications or hormonal agents. Those whose symptoms persist should then undergo further evaluation to rule out other possible causes of their symptoms prior to considering hysterectomy.

If the woman’s uterine size is 14 weeks or smaller, a laparoscopic evaluation for other possible causes of pain is indicated (e.g., endometriosis in women with cyclic pain and nongynecological causes in those with noncyclical pain). If the laparoscopic evaluation does not reveal any pathologic condition and the pain is cyclic, the woman may be a possible candidate for hysterectomy. If the pain is noncyclical, then the woman should undergo a nongynecological evaluation to identify other possible causes of her pain and, if no other causes are found, the woman may be a possible candidate for hysterectomy.

If the woman’s uterine size is greater than 14 weeks, laparoscopic evaluation may be helpful, but it is not always possible to perform this procedure. If such a woman’s pain is cyclic (e.g., dysmenorrhea), she may be a possible candidate for hysterectomy without further evaluation. If her pain is noncyclical, she should undergo an evaluation for possible nongynecological causes of her pain. If no other cause is found, she may be a possible candidate for hysterectomy.

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**DEFINITIONS**

**PAIN CAUSED BY LEIOMYOMATA**
Includes either dysmenorrhea or noncyclical pain/discomfort (e.g., dyspareunia, constant pressure or fullness, bladder or bowel pressure).

**MEDICAL THERAPY FOR LEIOMYOMATA AND PAIN**
Since the pain began and within the last 2 years, the woman has received a trial of pain medication or a trial of hormone therapy.

**TRIAL OF PAIN MEDICATION**
Any pain medication (e.g., nonsteroidal anti-inflammatory drugs [NSAIDs], aspirin, or acetaminophen) taken daily when pain was a problem for at least 3 months within the last 2 years, OR use of these medications is contraindicated (e.g., because of allergies or potential side effects).

**OR**

**TRIAL OF HORMONE THERAPY**
At least 3 consecutive months of oral contraceptive pills (OCPs) or estrogens or progestins or danazol or gonadotropin releasing hormone (GnRH) agonists since the problem began and within the last 2 years. This category includes women for whom use of OCPs is contraindicated (e.g., because of potential side effects).

Contraindications may include smoking; morbid obesity; a history of breast cancer, hypertension, migraine headaches, deep venous thrombosis, pulmonary embolism, or hypercoagulable state; or if the woman has had a prior trial of OCPs/progestins for any reason in the past and refuses the medication.

**NONGYNECOLOGICAL EVALUATION**
Since the pain or discomfort began, the woman underwent one or more of the following:
1) A formal consult with another physician, including an internist, gynecologist, urologist, gastroenterologist, or family physician, OR
2) One of the following procedures: barium enema, flexible sigmoidoscopy, colonoscopy, intravenous urogram, or cystourethroscopy, OR
3) A visit to any mental health specialist (psychiatrist, psychologist, Master’s level mental health professional) or a pain clinic for this problem.
Figure 6—Hysterectomy for Premenopausal Women with Leiomyomata and Pelvic Pain But Without Abnormal Uterine Bleeding
Premenopausal women with leiomyomata and abnormal uterine bleeding and pain may be possible candidates for hysterectomy if evaluations for both symptoms reveal no other causes and their symptoms persist after a trial of medical therapy.

The severity of the bleeding should be evaluated by measuring their hemoglobin/hematocrit. Women who have significant anemia or major impairment (from either bleeding or pain), should undergo endometrial sampling to rule out a treatable condition or neoplasm. If the findings on sampling are normal, laparoscopy or laparotomy should be done to rule out other causes of their pain. (Laparoscopy may not be possible in women with a uterine size of greater than 14 weeks.)

If these evaluations are negative, a trial of medical therapy is indicated, after which the women may be possible candidates for hysterectomy.

**DEFINITIONS**

**PAIN CAUSED BY LEIOMYOMATA**
Includes either dysmenorrhea or noncyclic pain/discomfort (e.g., dyspareunia, constant pressure or fullness, bladder or bowel pressure).

**SIGNIFICANT ANEMIA**
On the basis of the most recent hematocrit (Hct) or hemoglobin (Hgb), a woman has significant anemia if the Hct is less than 30% or the Hgb is less than 10 g/dl or there is a drop in Hct of ≥ 6% (or a drop in Hgb of ≥ 2 g/dl) in the last 6 months **AND** the woman has received treatment with iron for 3 months or blood transfusions.

**MAJOR IMPAIRMENT CAUSED BY ABNORMAL UTERINE BLEEDING AND/OR PAIN**
During the last 3 months the woman has had a significant worsening in level of activity caused by abnormal bleeding or pain **OR** the bleeding and/or pain continue to have a significant negative effect on the woman’s functional ability.

**MEDICAL THERAPY FOR PAIN AND/OR BLEEDING**
Since the pain began and within the last 2 years, the woman has received a trial of pain medication or a trial of hormone therapy.

**TRIAL OF PAIN MEDICATION**
Any pain medication (e.g., nonsteroidal anti-inflammatory drugs [NSAIDs], aspirin, or acetaminophen) taken daily when pain was a problem for at least 3 months within the last 2 years, **OR** use of these medications is contraindicated (e.g., because of allergies or potential side effects).

**OR**

**TRIAL OF HORMONE THERAPY**
At least 3 consecutive months of oral contraceptive pills (OCPs) or estrogens or progestins or danazol or gonadotropin releasing hormone (GnRH) agonists since the bleeding problem began and within the last 2 years. This category includes women for whom use of OCPs is contraindicated (e.g., because of potential side effects).

Contraindications may include smoking; morbid obesity; a history of breast cancer, hypertension, migraine headaches, deep venous thrombosis, pulmonary embolism, or hypercoagulable state; or if the women has had a prior trial of OCPs/progestins for any reason in the past and refuses the medication.

If the woman was taking hormone therapy when the bleeding problem began, then hormone therapy must have been stopped or modified for a period of at least 3 consecutive months within the last 2 years.
Was the Hct/Hgb obtained?

Yes

No

INAPPROPRIATE

Was an endometrial sample obtained?

Yes

No

INAPPROPRIATE

Did the endometrial sample show pathology?

Yes

No

Go to Chapter 6*

Is the size of the uterus more than 14 weeks?

Yes

Possible candidate for hysterectomy

No

Has the woman had a laparoscopy or laparotomy?

Yes

No

INAPPROPRIATE

Did it show pathology?

Yes

No

Go to another chapter

Has the woman had a trial of medical therapy for pain and/or bleeding?

Yes

No

INAPPROPRIATE

Possible candidate for hysterectomy

*All women who are being considered for hysterectomy and who are currently experiencing abnormal uterine bleeding should have endometrial sampling performed to rule out neoplasm.

Figure 7—Hysterectomy for Premenopausal Women with Leiomyomata and Both Abnormal Uterine Bleeding and Pain
HYSTERECTOMY FOR POSTMENOPAUSAL WOMEN WITH LEIMYOMATA

Postmenopausal women with leiomyomata who have had significant growth of the uterus (defined as an increase in size equal to six weeks gestational size or more) within the past 12 months may be possible candidates for hysterectomy.

If there has been no growth in uterine size, hysterectomy is inappropriate for postmenopausal women with leiomyomata if they are asymptomatic.

Women who do have symptoms may be possible candidates for hysterectomy after their symptoms have been evaluated for other causes. Women with pain symptoms should undergo an additional evaluation of their pain prior to considering hysterectomy, while those with bleeding symptoms should have an endometrial sample obtained to rule out a treatable condition or neoplasm. Hysterectomy is inappropriate if these studies have not been done.

DEFINITIONS

POSTMENOPAUSAL
One year or more since the last menstrual period or follicle stimulating hormone level > 40 mIU/ml AND estradiol level < 40 pg/ml. If the woman is being cycled on hormones, a statement by the physician that the woman is postmenopausal.

SYMPTOMS
- **PAIN:** Constant pressure or fullness, bladder or bowel pressure, dyspareunia.
- **CURRENTLY BLEEDING:** Bleeding is an active problem when the recommendation for hysterectomy is made and has been present ≥ 2 months.

ADDITIONAL EVALUATION
Since the pain or discomfort began, the woman underwent one or more of the following:

1) A formal consult with another physician, including an internist, gynecologist, urologist, gastroenterologist, or family physician, **OR**
2) One of the following procedures: barium enema, flexible sigmoidoscopy, colonoscopy, intravenous urogram, cystourethrogram, abdominal ultrasound, abdominal CT, or abdominal MRI, **OR**
3) A visit to any mental health specialist (psychiatrist, psychologist, Master’s level mental health professional) or a pain clinic for this problem.
Has there been significant recent growth of the uterus?

Yes → Possible candidate for hysterectomy

No

Does the woman have symptoms?

No → INAPPROPRIATE

Yes

Pain

Currently bleeding

Has the woman had an additional evaluation?

No → INAPPROPRIATE

Yes → Possible candidate for hysterectomy

Was an endometrial sample obtained?

No → INAPPROPRIATE

Yes → Possible candidate for hysterectomy

Figure 8—Hysterectomy for Postmenopausal Women with Leiomyomata
HYSTERECTOMY FOR PELVIC PAIN AND ADHESIONS

Women with pelvic pain and adhesions may be possible candidates for hysterectomy only if they have evidence by laparoscopy or laparotomy of chronic pelvic inflammatory disease (PID) or other adhesive disease (excluding endometriosis), and they must have major impairment from the pain. Hysterectomy should be considered only after a trial of pain medication.

Women who have severe disease with major impairment after a trial of pain medications may be possible candidates for hysterectomy. Women with mild or moderate disease may be possible candidates for hysterectomy if they have major impairment after a trial of pain medications and have undergone an evaluation for a nongynecological source of their symptoms and have failed a trial of conservative surgery.

**DEFINITIONS**

**EXTENT OF PELVIC ADHESIONS**
- **MILD:** Not meeting the criteria for either moderate or severe.
- **MODERATE:** Tubal occlusion; obliteration of the tubal fimbriae; hydrosalpinx.
- **SEVERE:** Obliteration of posterior cul de sac; tubal-ovarian complex.

**MAJOR IMPAIRMENT CAUSED BY PELVIC PAIN AND ADHESIONS**
During the last 3 months the woman has had a significant worsening in level of activity caused by pain or the pain continues to have a significant negative effect on the woman’s functional ability.

**TRIAL OF PAIN MEDICATION**
Any pain medication (e.g., nonsteroidal anti-inflammatory drugs [NSAIDs], aspirin, or acetaminophen) taken daily when pain was a problem for at least 3 months within the last 2 years, OR use of these medications is contraindicated (e.g., because of allergies or potential side effects).

**NONGYNECOLOGICAL EVALUATION**
Since the pain or discomfort began, the woman underwent one or more of the following:
1) A formal consult with another physician, including an internist, gynecologist, urologist, gastroenterologist, or family physician, OR
2) One of the following procedures: barium enema, flexible sigmoidoscopy, colonoscopy, intravenous urogram, or cystourethroscopy, OR
3) A visit to any mental health specialist (psychiatrist, psychologist, Master’s level mental health professional) or a pain clinic for this problem.

**CONSERVATIVE SURGERY FOR PELVIC PAIN**
Any procedure performed during laparoscopy or laparotomy within the past 5 years to lyse adhesions or remove a pelvic abscess.
Figure 9—Hysterectomy for Pelvic Pain and Adhesions
Chapter Ten

HYSTERECTOMY FOR DYSENORRHEA

Women with dysmenorrhea may be possible candidates for hysterectomy if the pain has been present for at least 6 months and causes major impairment and they have had a trial of medical therapy and have undergone laparoscopy or laparotomy to rule out other treatable disease (e.g., endometriosis).

A trial of medical therapy with both nonsteroidal anti-inflammatory drugs (NSAIDs) and hormones is indicated prior to considering hysterectomy. Hysterectomy for dysmenorrhea is inappropriate if laparoscopy has not been performed and if a trial of medical therapy has not been given.

DEFINITIONS

DYSENORRHEA
Cyclic pain or discomfort associated with menses; excludes midcycle or ovulatory pain. Does not include women with pain caused by fibroids, adhesions, endometriosis, or chronic noncyclic pelvic pain.

MAJOR IMPAIRMENT CAUSED BY DYSENORRHEA
During the last 3 months the woman has had a significant worsening in level of activity caused by pain or the pain continues to have a significant negative effect on the woman’s functional ability.

MEDICAL THERAPY FOR DYSENORRHEA
Since the pain began and within the last 2 years, the woman has received a course of nonsteroidal anti-inflammatory drugs (NSAIDs) and hormone therapy.

COURSE OF NSAIDS
At least 3 months of NSAIDs daily when pain was a problem OR use of these medications is contraindicated (e.g., because of allergies or potential side effects).

AND

HORMONE THERAPY FOR DYSENORRHEA
Oral contraceptive pills (OCPs) or Depo-Provera for at least 3 consecutive months. This category includes women for whom use of OCPs is contraindicated (e.g., because of potential side effects).

Contraindications may include smoking; morbid obesity; a history of breast cancer, hypertension, migraine headaches, deep venous thrombosis, pulmonary embolism, or hypercoagulable state; or if the woman has had a prior trial of OCPs/progestins for any reason in the past and refuses the medication.
Has the pain been present for more than 6 months? 

Yes → Has the women had a trial of medical therapy for dysmenorrhea? 

No → INAPPROPRIATE 
Yes → Does the women have major impairment? 

No → INAPPROPRIATE 
Yes → Has the women had a laparoscopy or laparotomy? 

No → INAPPROPRIATE 
Yes → Did it show pathology? 

Yes → Go to another chapter 
No → Possible candidate for hysterectomy

Figure 10—Hysterectomy for Dysmenorrhea
Chapter Eleven

HYSTERECTOMY FOR CHRONIC NONCYCLIC PELVIC PAIN

Women with chronic noncyclic pelvic pain may be possible candidates for hysterectomy if the pain has been present for at least 6 months and causes major impairment, and they have had a trial of pain medications and have undergone laparoscopy or laparotomy to rule out other treatable disease. Because of the difficulty in being sure that the pain is related to the uterus, prior to considering hysterectomy, these women should have been evaluated for both nongynecological and psychological causes of pain.

DEFINITIONS

CHRONIC NONCYCLIC PELVIC PAIN
Noncyclic pelvic pain without evidence of organic disease, such as adhesions, endometriosis, fibroids, or pelvic relaxation. Includes any type or severity of pain or discomfort other than dysmenorrhea (e.g., constant pressure or fullness, dyspareunia, ovulatory or midcycle pain, bladder or bowel pressure). Includes women with the combination of dysmenorrhea and chronic noncyclic pelvic pain.

MAJOR IMPAIRMENT CAUSED BY PELVIC PAIN
During the last 3 months the woman has had a significant worsening in level of activity caused by pain or the pain continues to have a significant negative effect on the woman’s functional ability.

PSYCHOLOGICAL EVALUATION
Visit to any mental health specialist (psychiatrist, psychologist, Master’s level mental health professional) or a pain clinic within the last year for this problem.

TRIAL OF PAIN MEDICATION
Any pain medication (e.g., nonsteroidal anti-inflammatory drugs [NSAIDs], aspirin, or acetaminophen) taken daily when pain was a problem for at least 3 months within the last 2 years, OR use of these medications is contraindicated (e.g., because of allergies or potential side effects).

NONGYNECOLOGICAL EVALUATION FOR NONCYCLIC PAIN
Since the pain or discomfort began, the woman underwent one or more of the following:
1) A formal consult with another physician, including an internist, gynecologist, urologist, gastroenterologist, or family physician, OR
2) One of the following procedures: barium enema, flexible sigmoidoscopy, colonoscopy, intravenous urogram, or cystourethroscopy.
Figure 11—Hysterectomy for Chronic Noncyclic Pelvic Pain
HYSTERECTOMY FOR ENDOMETRIAL HYPERPLASIA

Women with isolated endometrial hyperplasia may be possible candidates for hysterectomy depending on the pathology on biopsy. If the biopsy shows simple (cystic or glandular) hyperplasia, hysterectomy is inappropriate because there is no evidence this will progress to endometrial carcinoma.

If the biopsy shows complex (adenomatous) hyperplasia, the woman should initially undergo a trial of progestins for at least 3 months, followed by repeat biopsy. If there is no atypia, an additional trial of 3 months of progestin therapy may be indicated before considering hysterectomy, because progression of disease is less likely. Women who fail progestin therapy may be possible candidates for hysterectomy.

These recommendations assume the woman is compliant and will return for follow-up as indicated.

DEFINITIONS

PATHOLOGY
  Simple: cystic or glandular hyperplasia.
  Complex: adenomatous hyperplasia with or without atypia.

PROGESTIN THERAPY
  At least 3 months of progestins within the last 2 years since hyperplasia was diagnosed.
What is the pathology on biopsy?

- Simple hyperplasia
- Complex hyperplasia with and without atypia

Has the woman had a trial of progestin therapy?

No → INAPPROPRIATE

Yes → Possible candidate for hysterectomy

INAPPROPRIATE

Figure 12—Hysterectomy for Endometrial Hyperplasia
Chapter Thirteen

HYSTERECTOMY FOR ASYMPOTOMATIC PELVIC RELAXATION OR PELVIC RELAXATION WITH URINARY INCONTINENCE

Women with pelvic relaxation and urinary incontinence or pelvic relaxation without symptoms may be possible candidates for hysterectomy depending on the degree of prolapse.

Hysterectomy is inappropriate for women who present only with cystocele or rectocele or first-degree prolapse because it rarely relieves incontinence.

Women with second-degree prolapse may be possible candidates for hysterectomy if they have objectively confirmed (e.g., direct visualization or cystometrogram) stress incontinence and have undergone a trial of nonoperative treatment such as Kegel’s exercises or use of a pessary, because this may provide symptomatic relief without hysterectomy. If the woman prefers hysterectomy following such a nonoperative treatment, she may be considered a possible candidate. Because urinary incontinence in women with pelvic relaxation may or may not be caused by the pelvic relaxation, in the absence of confirmed stress incontinence, hysterectomy is inappropriate for women with second-degree prolapse.

Women with third- or fourth-degree prolapse may be considered possible candidates for hysterectomy, whether or not they have symptoms, because they are at risk for future complications.

DEFINITIONS

UTERINE PROLAPSE
Degree of prolapse includes descent noted with valsalva, strain, or upright position.

FIRST DEGREE: Cervix descends into the lower third of the vagina.
SECOND DEGREE: Cervix descends to the introitus or less than 1 cm beyond.
THIRD DEGREE: Cervix descends 1 cm beyond the introitus.
FOURTH DEGREE: Cervix and uterus project through the introitus.

URINARY INCONTINENCE
Involuntary urine loss causing a social or hygienic problem.

STRESS INCONTINENCE
Women with urinary incontinence should have objective confirmation of urine loss under conditions of stress by direct visualization, cystometrogram, or other urodynamic study and a urinalysis to identify other potential causes of their incontinence, such as urinary tract infection.

CYSTOCELE
Herniation of the urinary bladder into the vaginal canal.

RECTOCELE
Herniation of the rectum into the vaginal canal.

NONOPERATIVE TREATMENT
At least 3 months of Kegel exercises or 2 weeks of vaginal pessary use since pelvic relaxation was a problem and within the last 2 years.
Figure 13—Hysterectomy for Asymptomatic Pelvic Relaxation Or Pelvic Relaxation with Urinary Incontinence
In women presenting with pelvic relaxation and with pelvic pain or discomfort, it is important to consider other sources of pelvic pain and other methods of pain relief before considering hysterectomy.

Women with cystocele or rectocele without prolapse should first have a trial of vaginal pessary use. A successful trial of a pessary is evidence that the woman’s symptoms are caused by pelvic relaxation, and hysterectomy is inappropriate for these women because alternative treatment modalities (suspension procedures) are more likely to be successful. If the pessary trial is not successful, the pelvic pain may have other causes. These women should undergo a laparoscopy or laparotomy AND a nongynecological evaluation, after which they may be possible candidates for hysterectomy.

Women with first- or second-degree uterine prolapse should first have a trial of vaginal pessary use. A successful trial of a pessary indicates that the woman’s symptoms are likely associated with the prolapse, and therefore these women may be possible candidates for hysterectomy. If symptoms are not relieved by a pessary, the pain may be from other causes, and these women should undergo a laparoscopy or laparotomy AND a nongynecological evaluation, after which they may be possible candidates for hysterectomy.

Women with third- or fourth-degree prolapse may be considered possible candidates for hysterectomy, whether or not they have symptoms, because they are at increased risk for future complications.

<table>
<thead>
<tr>
<th>DEFINITIONS</th>
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<tbody>
<tr>
<td>UTERINE PROLAPSE</td>
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<td><strong>FOURTH DEGREE:</strong> Cervix and uterus project through the introitus.</td>
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<table>
<thead>
<tr>
<th>PAIN CAUSED BY PELVIC RELAXATION</th>
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<tbody>
<tr>
<td>Includes sensation of discomfort, irritation, heaviness, or fullness within the perineum or pelvis, or dyspareunia.</td>
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<table>
<thead>
<tr>
<th>CYSTOCELE</th>
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<tr>
<td>Herniation of the urinary bladder into the vaginal canal.</td>
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<table>
<thead>
<tr>
<th>RECTOCELE</th>
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<tr>
<td>Herniation of the rectum into the vaginal canal.</td>
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<table>
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<tr>
<th>SUCCESSFUL TRIAL OF A PESSARY</th>
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<tr>
<td>A significant decrease or complete relief of symptoms with a pessary used for at least 2 weeks since the problem began and within the last 2 years.</td>
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<thead>
<tr>
<th>NONGYNECOLOGICAL EVALUATION</th>
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<td>Since the pain or discomfort began, the woman underwent one or more of the following:</td>
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<tr>
<td>1) A formal consult with another physician, including an internist, gynecologist, urologist, gastroenterologist, or family physician, OR</td>
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<tr>
<td>2) One of the following procedures: barium enema, flexible sigmoidoscopy, colonoscopy, intravenous urogram, or cystourethroscopy, OR</td>
</tr>
<tr>
<td>3) A visit to any mental health specialist (psychiatrist, psychologist, Master’s level mental health professional) or a pain clinic for this problem.</td>
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</table>
Figure 14—Hysterectomy for Pelvic Relaxation with Pain Or Discomfort
HYSTERECTOMY FOR OTHER POSSIBLE INDICATIONS

(For Nonemergency, Nonmalignant Disease)

Asymptomatic leiomyomata
Hysterectomy is inappropriate for women with leiomyomata who have neither signs nor symptoms, regardless of uterine size, age, or menopausal status. In women with large leiomyomata, it is important to assure that they are, in fact, asymptomatic, and that there is no evidence of urinary tract or bowel compression.

Benign unilateral adnexal mass
Excludes endometrioma and masses that are or might be malignant (including borderline or low malignant potential lesions) by biopsy at laparotomy or laparoscopy. Hysterectomy is inappropriate for benign unilateral adnexal masses.

Family history of ovarian carcinoma
Assumes hysterectomy is being performed in conjunction with bilateral oophorectomy. Hysterectomy is inappropriate for women with a family history of ovarian carcinoma who are less than 40 years of age. Women who are 40 years or older may be candidates for hysterectomy if there are two or more first-level family members who have had the disease OR one first-level and two second-level members.

First-level family member: mother, sister, or daughter
Second-level family member: grandmother or aunt

Cervical polyps
Hysterectomy is inappropriate treatment for cervical polyps.

Endometrial polyps
Hysterectomy is inappropriate treatment for endometrial polyps unless they have had a recurrence after 2 or more dilation and curettage procedures, in which case it may be appropriate.

For hygienic purposes in women with severe mental retardation
Women with an absence of normal mental development who are unable to maintain pelvic hygiene may be candidates for hysterectomy.

Desire for permanent sterilization
Hysterectomy is inappropriate solely for sterilization.

Fear of cancer
Hysterectomy is inappropriate solely to allay fear of cancer.

Premenstrual syndrome
Hysterectomy is inappropriate solely for premenstrual syndrome.

Asymptomatic uterine retroversion
Hysterectomy is inappropriate solely for asymptomatic uterine retroversion.

Uterine retroversion with dyspareunia
Hysterectomy is inappropriate for women with retroversion and dyspareunia UNLESS they have had a trial of pessary, in which case it may be appropriate.
**THE AMERICAN FERTILITY SOCIETY**  
**REVISED CLASSIFICATION OF ENDOMETRIOSIS**

<table>
<thead>
<tr>
<th>Patient’s Name</th>
<th>Date</th>
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<thead>
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<th>Classification</th>
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<th>Laparotomy</th>
<th>Photography</th>
<th>Recommended Treatment</th>
<th>Prognosis</th>
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**PERITONEUM**

<table>
<thead>
<tr>
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<th>&gt;3cm</th>
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<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Deep</td>
<td>2</td>
<td>4</td>
<td>6</td>
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</table>

**OVARY**

| R Superficial | 1    | 2     | 4    |
| R Deep       | 4    | 16    | 20   |
| L Superficial| 1    | 2     | 4    |
| L Deep       | 4    | 16    | 20   |

**POSTERIOR CULDESEAC OBLITERATION**

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<th>Complete</th>
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<td></td>
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**ADHESIONS**

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<th>2</th>
<th>4</th>
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<tbody>
<tr>
<td>Dense</td>
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<td>8</td>
<td>16</td>
</tr>
<tr>
<td>L Filmy</td>
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<td>4</td>
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<tr>
<td>Dense</td>
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<table>
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<tbody>
<tr>
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<td>L Filmy</td>
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</tr>
<tr>
<td>Dense</td>
<td>4</td>
<td>8</td>
<td>16</td>
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*If the fimbriated end of the fallopian tube is completely enclosed, change the point assignment to 16.*

**Additional Endometriosis:**

**Associated Pathology:**

**To Be Used with Normal Tubes and Ovaries**

**To Be Used with Abnormal Tubes and/or Ovaries**

For additional supply write to: The American Fertility Society, 1209 Montgomery Highway, Birmingham, Alabama 35216-2809
EXEMPLARY & GUIDELINES

STAGE I (MINIMAL)

PERITONEUM
- Superficial Endo - 1-3cm - 2
- R. OVARY
- Flimsy Adhesions - < 1cm - 1
- L. OVARY
- Filmy Adhesions - < 1/3 - 1
- TOTAL POINTS 4

STAGE II (MILD)

PERITONEUM
- Superficial Endo - > 3cm - 6
- R. OVARY
- Deep Endo - > 1cm - 1
- L. OVARY
- Filmy Adhesions - < 1/3 - 1
- TOTAL POINTS 7

STAGE III (MODERATE)

PERITONEUM
- Deep Endo
- CULDESAC
- Partial Obliteration - 4
- L. OVARY
- Deep Endo - 1-3cm - 16
- TOTAL POINTS 20

STAGE III (MODERATE)

PERITONEUM
- Superficial Endo - > 3cm - 4
- R. TUBE
- Flimy Adhesions - < 1/3 - 1
- R. OVARY
- Dense Adhesions - < 1/3 - 1
- L. TUBE
- Dense Adhesions - < 1/3 - 16
- L. OVARY
- Deep Endo - > 1cm - 4
- TOTAL POINTS 30

STAGE IV (SEVERE)

PERITONEUM
- Superficial Endo - > 3cm - 4
- L. OVARY
- Deep Endo - 1-3cm - 16
- L. TUBE
- Dense Adhesions - > 1/3 - 4
- L. OVARY
- Deep Endo - > 2/3 - 4
- TOTAL POINTS 52

STAGE IV (SEVERE)

PERITONEUM
- Deep Endo - > 3cm - 6
- CULDESAC
- Complete Obliteration - 40
- R. OVARY
- Deep Endo - 1-3cm - 16
- L. TUBE
- Dense Adhesions - > 2/3 - 4
- L. OVARY
- Deep Endo - > 2/3 - 16
- TOTAL POINTS 114

*Point assignment changed to 16
**Point assignment doubled

Determination of the stage or degree of endometrial involvement is based on a weighted point system. Distribution of points has been arbitrarily determined and may require further revision or refinement as knowledge of the disease increases.

To ensure complete evaluation, inspection of the pelvis in a clockwise or counterclockwise fashion is encouraged. Number, size and location of endometrial implants, plaques, endometriomas and/or adhesions are noted. For example, five separate 0.5cm superficial implants on the peritoneum (2.5cm total) would be assigned 2 points. (The surface of the uterus should be considered peritoneum.) The severity of the endometriosis or adhesions should be assigned the highest score only for peritoneum, ovary, tube or culdesac. For example, a 4cm superficial and a 2cm deep implant of the peritoneum should be given a score of 6 (not 8). A 4cm deep endometriomas of the ovary associated with more than 3cm of superficial disease should be scored 20 (not 24).

In those patients with only one adnexa, points applied to disease of the remaining tube and ovary should be multiplied by two. **Points assigned may be circled and totaled. Aggregation of points indicates stage of disease (minimal, mild, moderate, or severe).

The presence of endometriosis of the bowel, urinary tract, fallopian tube, vagina, cervix, skin, etc., should be documented under "additional endometriosis." Other pathology such as tubal occlusion, leiomyomatosis, uterine anomaly, etc., should be documented under "associated pathology." All pathology should be depicted as specifically as possible on the sketch of pelvic organs, and means of observation (laparoscopy or laparotomy) should be noted.

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