Gynaecology Healthcare Atlas 2015–2017

Hysterectomy and transcervical procedures

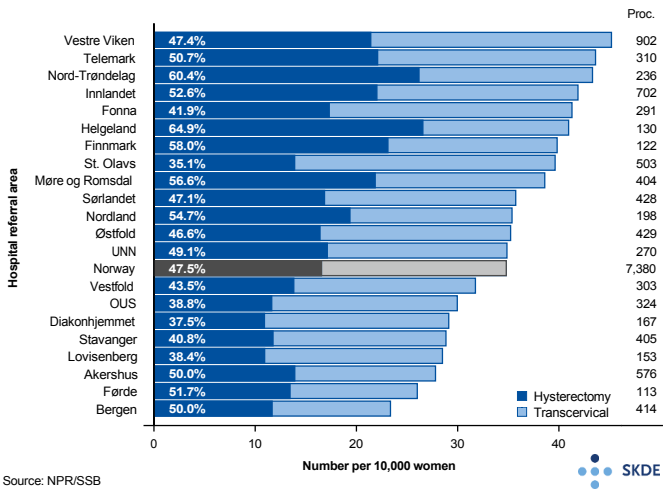
Helseatlas SKDE

The uterus can be surgically removed (hysterectomy) for different reasons. Uterine fibroids, abnormal uterine bleeding and endometriosis are all possible reasons for removing the uterus of patients who do not suffer from cancer. Hysterectomies can be performed as open, laparoscopic or vaginal procedures. Some minor uterine procedures can be done by inserting an instrument via the vagina and through the cervix. Such procedures are often referred to as transcervical procedures, and can sometimes be an alternative to hysterectomy.

Background

When a hysterectomy is performed to treat a benign condition, the ovaries will usually be left in place, particularly in women who have not reached menopause. This will prevent hormonal problems after treatment. Hysterectomies can be performed as open, laparoscopic (robot-assisted or not) or vaginal procedures. The national guidelines for gynaecology recommend the vaginal or the laparoscopic techniques.

In transcervical procedures, an electrical cutting loop can be used to resect myomas and polyps inside the uterus. Such a loop can also be used to partially or completely remove the endometrium. This is a treatment option for abnormal uterine bleeding. The endometrium is removed down to the muscle layer to prevent it from growing back. There are also other methods where heat is used to destroy the endometrium (ablation).



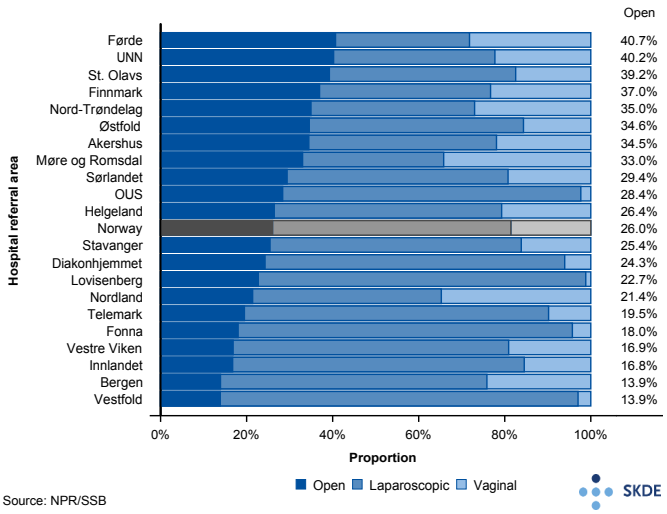
Source: NPR/SSB

Number of hysterectomies and transcervical procedures per 10,000 women, adjusted for age, average per year 2015–2017 broken down by hospital referral area.

Results

During the period 2015–2017, approximately 3,500 hysterectomies and around 3,900 transcervical procedures per year were performed in Norway on patients who had not been diagnosed with cancer.

There was great geographical variation in the use of hysterectomies. Residents of the hospital referral areas of Helgeland and Nord-Trøndelag had about 2.4 times as many hysterectomies as residents of the Lovisenberg and Diakonhjemmet areas. During the period 2015–2017, patients with a primary diagnosis of N92 (Excessive and/or frequent menstruation) or D25 (Leiomyoma of uterus) accounted for 50–70% of all hysterectomies performed on patients who had not been diagnosed with cancer.



Source: NPR/SSB

Proportion of hysterectomies performed as open, laparoscopic and vaginal procedures, respectively.

There was considerable variation between hospital referral areas in the proportion of hysterectomies performed as open procedures. For residents of Vestfold and Bergen hospital referral areas, open surgery was only used for 14% of hysterectomies during the period 2015–2017, while for residents of the areas of Førde and UNN, open surgery was used in 40% of cases during the same period.

There was moderate variation between hospital referral areas in the use of transcervical procedures. More than twice as many such procedures were performed on women living in the St. Olavs area as on women living in the Bergen hospital referral area. Most transcervical procedures are performed on patients with a primary diagnosis of N92 (Excessive and/or frequent menstruation) or N84 (Polyp of female genital tract).

Overall, there is no clear correlation between the usage rates for hysterectomy and transcervical procedures. The proportion of hysterectomies was highest in the hospital referral areas of Helgeland, Nord-Trøndelag and Finnmark, and lowest in St. Olavs, OUS, Diakonhjemmet and Lovisenberg.

Comments

There is no known geographical variation in morbidity to indicate that there should be a geographical variation in the need for hysterectomies and transcervical procedures in Norway. Nor is it likely that differences in patient preferences or chance can fully explain the observed variation. The variation observed must therefore be deemed to be unwarranted.