Women who have external orgasms, may experience the least amount of change to their sexual response. Women who experience internal orgasms, for whom the contractions of the uterus and cervix comprise the majority of their pleasurable sensations, may notice a more profound impact to their sexual function.

There is research that suggests retaining the cervix decreases the possibility of sexual dysfunction post-hysterectomy. However, there does not appear to be a consensus on this issue. Currently, “nerve-sparing” hysterectomy procedures are being evaluated.

Post-hysterectomy recommendations from women who’ve “been there”:

▪The more aware a woman is about her own sexual response, the better equipped she will be to work through the possible physical and emotional adjustments that accompany hysterectomy. Some women report feelings of sadness and grief; the loss or diminishment of sexual response can intensify these feelings. While each woman’s experience will be uniquely her own, talking to other women often helps. Also, www.TWSHF.org has a forum where women can ask questions by sending an e-mail to info@twshf.org.

▪Take care of yourself. Give your body adequate rest, nutrition, and time to heal completely.

▪If your sexual response has been impaired, talk with a healthcare provider who has the expertise to help you.

▪Be aware that your body may respond somewhat differently than before your surgery. A hot water bottle applied to the genital area 5-10 minutes before sexual activity will naturally stimulate blood flow and increase responsiveness.

▪Talk with your healthcare professional about therapies that have been effective for other women in restoring sexual response: acupuncture, the use of a vacuum clitoral device, topical creams to enhance arousal, and/or the use of medications such as estrogen or testosterone, or even Viagra-like prescriptions. There is non-systemic estrogen available as an estrogen ring or as a small tablet that is inserted into the vagina that helps to increase blood flow to the vagina. Vaginal moisturizers and lubricants may also be helpful and they may be purchased over the counter.

▪Support with a support group or through a therapist may be helpful if you find that you are struggling emotionally post-hysterectomy.

RESOURCES:

Clinical Updates in Women’s Health Care: Sexuality and Sexual Disorders; The American College of Obstetricians and Gynecologists, Volume ll, Number 2, Spring 2003.

Sexuality and Cancer: For the Women Who Has Cancer, and Her Partner; American Cancer Society Brochure.

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Hysterectomy & Your Sexual Response

The Women's Sexual Health Foundation℠
www.twshf.org

The term "hysterectomy" originates from the Latin *hystericus* ("of the womb"). However, many women are uncertain what is really removed during a hysterectomy: uterus, cervix, and/or ovaries Although the term *"uterusectomy"*(the surgical removal of the uterus) might be more easily understood, it does not cover all situations. Thus, for the purposes of this brochure we will use the traditional term hysterectomy.

The removal of the uterus, while sparing the cervix is called a "*subtotal* hysterectomy"; the removal of both uterus and cervix is a "*total* hysterectomy"; the removal of the uterus, cervix, fallopian tubes, and ovaries is a "*total* hysterectomy and *bilateral salpingoophorectomy*"; while a "*radical* hysterectomy" is the surgical removal of the uterus, fallopian tubes, ovaries, part of the vagina, and cervix along with the partial removal of the pelvic lymph nodes. A radical hysterectomy is typically performed to treat cervical cancer, but may be done for ovarian, or endometrial cancer and may be performed through the abdomen or the vagina. Regardless of which method is selected, a hysterectomy is major surgery. About 600,000 women in the U.S. undergo hysterectomy every year.

Hysterectomies may be performed for many reasons, some of which are cancer, endometriosis, obstetrical emergencies, fibroids, pelvic pain, and excessive bleeding. There are alternatives to hysterectomy including medications, observation, or other surgical procedures; these alternatives should always be discussed with your doctor. The following are some of the options to be considered.

For some who experience abnormal or excessive uterine bleeding, a viable alternative to hysterectomy may be endometrial ablation. This procedure is a minimally invasive surgery that uses electrical energy, heat, or cold to destroy the endometrium, and may minimize or even stop this bleeding. A myomectomy is a surgery to cut away the fibroids without removing the uterus, so that a woman can maintain her ability to bear children. Uterine fibroid embolization (UFE**),** which is also called uterine artery embolization (UAE), is a minimally invasive procedure that blocks the arteries carrying blood to the fibroids. You should also discuss medical management alternatives such as birth control pills and other hormones and medications with your provider.

Professionals advise that a woman should seek a second opinion concerning a hysterectomy. TWSHF advises, when possible, the second opinion should be obtained from a physician affiliated with a different hospital or in another city.

Your Sexual Response

Your sexual response may be impacted by a hysterectomy. Some women experience an improvement; some experience no change; but approximately 20% experience a loss of sexual response. Every woman is different. If your sexual activity and response was impaired by your presurgical symptoms, you may experience an improvement. On the other hand, if you were functioning normally, you may notice a loss in some aspects of your sexual desire, arousal, or orgasms. The changes in sexual function may be pronounced when extensive surgery is done. Your provider should help you understand these changes and offer treatment options.

With a radical hysterectomy, which is typically done for cancer of the cervix, there may be interference with vaginal engorgement. There may also be reduced vaginal length. Since the ovaries have been removed, there will be decreases in the natural hormones estrogen and testosterone which support vaginal health and sexual responsiveness. Some women may complain of having difficulty experiencing orgasm, and decreased desire for sex.

Some women have uterine contractions that are very pleasurable when having an orgasm. Once the uterus is removed, these contractions will no longer be present for those women. Others have found that the removal of the cervix decreased their ability to have an orgasm or that their orgasms were different. On the other hand, some women find removal of the cervix eliminates painful "bumping" during intercourse.

Some experts believe there are three kinds of orgasms: external, internal, and blended. The external orgasm relies primarily on clitoral stimulation. The pelvic floor or internal orgasm includes G-spot orgasms and those reached by pressure on the cervix and/or the anterior vaginal wall. A blended orgasm combines aspects of both the internal and the external. Researchers have identified nerves that relate to these—the pudendal for clitoral stimulation, the hypogastric and pelvic nerves for vaginal stimulation, and possibly the sensory vagus nerve that goes directly from the cervix to the brain, by passing the spinal cord.