Hysterectomy

In a retrospective population-based cohort study from 2000 to 2013. Women aged ≥30 years who underwent hysterectomy between 2000 and 2012 were included in this study. The comparison group was randomly selected from the database with a 1:4 matching with age and index year. Incidence rate and hazard ratios of osteoporosis and bone fracture between hysterectomized women and the comparison group were calculated. Cox proportional hazard regressions were used to calculate hazard ratios (HRs) and 95% confidence intervals (CIs).

Yeh et al. identified 9,189 hysterectomized women and 33,942 age-matched women without a hysterectomy. All women were followed for a median time of about 7 years. The adjusted hazard ratio (aHR) of subsequent osteoporosis or bone fracture was higher in the hysterectomy women (2.26, 95% confidence interval [CI] = 2.09-2.44) than in the comparison group. In the subgroup analysis, oophorectomy and estrogen therapy increase the risk of osteoporosis or fracture in both groups. Regarding the fracture site, the aHR of vertebral fracture (4.92, 95% CI = 3.78-6.40) was higher in the hysterectomized women than in the comparison group. As follow-up time increasing, the aHR of vertebral fracture in hysterectomized women were 4.33 (95% CI = 2.99-6.28), 3.89 (95% CI = 2.60-5.82) and 5.42 (95% CI = 2.66-11.01) for <5, 5-9 and ≥9 years of follow-up, respectively.

In conclusion, they found that hysterectomized women might be associated with increased risks of developing osteoporosis or bone fracture [1].

Findings suggests that women with hysterectomy are more likely to be diagnosed with hypertension in the follow-up period [2].

Use of estrogen after bilateral salpingo-oophorectomy at hysterectomy for benign diseases reduces the risk of stroke in women aged 50 years or more [3].

1)
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2)
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3)
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