Assessment of psychosocial domain of quality of life for women who had undergone hysterectomy

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الخلاصة

أجريت دراسة وصفية (عرضية المقطع) لتقييم نوعية الحياة النفسية والاجتماعية لـ ١٠٠ امرأة لديها عملية استئصال الرحم لاسباب غير خبيثة خلال (٦-١٢) شهر بعد العملية .أجريت الدراسة في العيادة الاستشارية لكل من مستشفى العلوية للولادة ومستشفى بغداد التعليمي، وللفترة من ٥ كانون الثاني ٢٠٠٣ ولغاية ١٠ تموز ٢٠٠٣. بينت نتائج الدراسة أن : نوعية الحياة في المجالين النفسي والاجتماعي عالي عند النساء اللواتي أجريت لهن عملية رفع الرحم.ظهور اختلاف ذات دلالة معنوية عالية بين كثير من الخصائص الديموغرافية والمجال النفسي والاجتماعي لنوعية الحياة.العمر هو أكثر المتغيرات يتنبأ بنوعية حياة أفضل في المجال النفسي والاجتماعي. أوصت الدراسة بإعداد برامج تثقيفية للنساء وأزواجهم وتوفير كتب وكراسات وإجراء دراسات اخرى على عدد أكبر من النساء.

Abstract

A descriptive (cross sectional) study was conducted to assess psychosocial domain of quality of life for (100) women who had hysterectomy for non malignant indications during 6-12 months post operative. The study carried out in both consultation clinics of Al-Elwiya Maternity Hospital and Baghdad Teaching Hospital from January 5th 2003 to July 10th 2003). The results of the study show that hysterectomy achieved a highly successful outcome in terms of psychological and social adjustments for hysterectomies women, a highly significant differences between quality of life (QoL) and some of demographic characteristics. Age was the best significant predictor of psychosocial outcome. The study recommended an education programs should be developed for women and their partners, and provision of concerned pamphlets books. Further research that confirm the present data with a large number of women is required.

Introduction

Hysterectomy is the surgical removal of the uterus, and may also be accompanied by the removal of the fallopian tubes and ovaries. Approximately 650.000 hysterectomy are performed in the US every year, making it the most common major surgical procedure for women unrelated to pregnancy[1, 2]. It has been projected that there will be 824.000 hysterectomy in the U.S in the year 2005[3]. Factors that affect adjustment of woman undergoing a hysterectomy include age , cultural background, educational level, husband's attitude , family situation, preoperation and whether causes involved [4]. Stanfill stated that the emotional stability of a patient can greatly influence the course of an illness. For this reason, pertinent information that explores the psychosocial needs of hysterectomy women is valuable in develop a holistic approach to patient care[5]. Although hysterectomy is comparatively safe procedure but it is associated with clinically significant surgical morbidity and it is important to recognize that hysterectomy is not an effective treatment for all women and some women may not good candidates for the surgery. It had been reported that many women die annually as a result of having this operation unnecessarily [6].

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Methodology

A descriptive study (cross-sectional design) was carried out to assess psychosocial aspect of QoL for 100 women had undergone hysterectomy for benign diseases from both clinical consultation of Baghdad teaching hospital and Al-Elwiya Maternity Hospital.The data were collected through the utilization of interviewing technique and the use of constructed questionnaire during the period from January 5th 2003 to July 10th 2003.Duration of the interview ranged approximately 30-40 minutes. The instrument consists of: (1) Data sheet: it concerns the respondent general characteristics. (2) Psychological domain scale: it includes 3 sections which are measured on (3 points Likert scale): (a) Section I: Self esteem – 9 items. (b) Section II: Body image – 8 items. (c) Section III: Psychological status – 14 items. (3) Social domain scale: it includes 3 sections too which are measured in the same way as mentioned above: (a) Section I: Marital relationship – 11 items. (b) Section II: Family relationship – 8 items. (c) Section III: Social relationship – 7 items. To obtain the validity of the questionnaire (25) experts. were asked for their opinions and suggestions. Alpha-Cronbach correlation coefficient was employed to determine the questionnaire reliability. The results indicated that the correlation coefficient for the psychological scale was (0.89) and for the social scale was (0.92). Data of the present study were analyzed through descriptive statistical data analysis which includes: frequency,means, percentage mean score (M.S.), standard deviation (S.D.), and inferential statistical data analysis which includes: t-test, F-test (analysis of variance-Anova), and step wise multiple regression. The significant level of all statistical procedures was determined at $P < 0.05$.

Results

Table (1): Demographic characteristics of the study group

Age (years)	**No.**	**%**
18 - 25	2	2
26 - 33	3	3
34 - 41	12	12
42 - 49	49	49
50 - 57	22	22
≥ 58	12	12
Total	100	100
Mean + SD(47.40+ ١,٨٢)		
Educational level	No.	%
Not read and write	49	49
Read and write	12	12
Primary school graduate	15	15
Secondary school graduate	7	7
Institute and college graduate	11	11
postgraduate	6	6
Total	100	100
Occupational status	No.	%
Currently employed	27	27
Not employed	73	73
Total	100	100
Marital status	No.	%
Single	5	5
Married	80	80
Widowed	14	14
Separated and divorced	1	1
Total	100	100

Table (1) shows the following characteristics of the study group according to demographic data. The study group has age ranged from 18 - 81 years, nearly half of

them (49%) were in age group (42-49) years.and (49%) of them too were unable to read and write.The occupational status for most of them (73%) were house wives،Concerning the marital status the majority of them (80%) were married compared to (5%) were single.

Table (2): Reproductive status (gravidity, parity, number of living children and dead children and abortion) for the study group

Gravidity		
	No.	**%**
None*	7	7.0
1 – 3	9	9.0
3 – 5	13	13.0
≥5	71	71.0
Total	100	100.0
Mean + SD (3.42 ± 0.87) *single(5) + nulli gravida (2)		
Parity		
None*	7	7
1 – 3	13	13
3 - 5	24	24
≥5	56	56
Total	100	100
Mean + SD (3.17 + 0.91) *single(5) + nulli parous (2)		
No. of living children		
None	7	7
1 - 3	15	15
3 - 5	28	28
>5	50	50
Total	100	100
Mean + SD (3.09 ± 0.90)		
No. of dead children		
None	64	64
1	19	19
2	8	8
≥3	9	9
Total	100	100
Mean + SD (1.81 ± 1.04)		
Abortion		
None	54	54
1	22	22
2	13	13
≥3	11	11
Total	100	100
Mean + SD (1.62 ± 0.97)		

Table (2) shows reproductive status of the study group.The gravidity of the study group ranged from 0-13 gravida , with a mean of 3.42 ± 0.87 ,the highest percent (71%) have 5 or more gravida.

The number of parity ranged from (0 -12) a with a mean of 3.17±0.91 ,most of them (66 %) have five or more deliveries. The number of living children for the study group ranged from 0-11 with a mean of 3.09 ± 0.90, half of them (50%) have 5 or more children, while the dead children for the women ranged from 0-7 with a mean of 1.81 ± 1.04 and (19%) of women had at least one dead child, number of abortion ranged from (0-4) with a mean of 1.62 ± 0.97 and (22%) of the women had one abortion.

Table (3): Menstrual status (before the operation) for the study group

Menstrual status	No.	%
Regular	36	36.0
Irregular	48	48.0
Menopause*	16	16.0
Total	100	100

* Menopause: is the permanent cessation of menstruation after 12 consecutive months of amenorrhia from the final menstrual period (Amir, 2002).

Table (3) shows menstrual status (before the operation) for the study group (36%) of them had regular menstruation, (48%) had irregular menstruation, while (16%) were menopausal women.

Table (4): Post-operative duration for hysterectomized women

Post-operative duration (month)	No.	%
6	35	35.0
7 – 8	31	31.0
9 – 10	13	13.0
11 – 12	21	21.0
Total Mean ± SD (8.17 ± 2.17)	100	100

Table (4) shows that most of the study group (35%) were in the sixth month of postoperative period.

Table (5): Distribution of the study group according to the causes and type of hysterectomy

Causes of hysterectomy	No.	%
Benign uterine tumor (fibroid)	35	35
Heavy post-partum heamorrhage	5	5
Pelvic inflammatory disease can not controlled by medication (PID)	8	8
Endometriosis	2	2
Uterine prolapse	21	21
Menstrual problems (disturbance)	18	18
Cesarean section	4	4
Uterine rupture	4	4
pelvic pain	3	3
Total	100	100
Types of hysterectomy		
Abdominal approach	93	93.0
Vaginal approach	7	7.0
Total	100	100

Table (5) shows that, uterine fibroid was the main indication for hysterectomy (35%), and the majority of hysterectomy (93%) performed by abdominal approach.

Table (6): Analysis of variance (ANOVA) between age of the study group and the psychological and social domains of the quality of life

Age(years)		mean	SD	df	F	p.value
Psychological domain	18 - 25	41.50	0.70	94	6.95	٠,٠٠١ HS
	26 – 33	47.00	7.54			
	34 - 41	59.75	13.83			
	42 - 49	66.04	15.48			
	50 - 57	77.40	12.56			
	≥58	80.83	18.08			
Social domain	18 - 25	28.00	7.07	94	3.27	0.009 HS
	26 – 33	36.33	15.04			
	34 - 41	47.58	10.98			
	42 - 49	52.42	14.6			
	50 - 57	59.18	13.60			
	≥58	55.25	16.95			

The table shows that, there are highly significant differences between women's age and the psychological and social domains of the quality of life.

Table (7): Analysis of variance (ANOVA) between educational level of the study group and the psychological and social domains of the quality of life

Educational level		Mean	SD	df	F	p.value
Psychological domain	Not read and write	69.73	16.36	94	3.69	0.004 HS
	Read and write	74.75	18.42			
	Primary school graduate	60.53	15.17			
	Secondary school graduate	59.42	11.78			
	Institute and college graduate	62.45	16.28			
	postgraduate	87.50	8.11			
Social domain	Not read and write	52.53	14.44	94	3.74	0.004 HS
	Read and write	61.25	11.16			
	Primary school graduate	51.06	13.48			
	Secondary school graduate	45.14	13.09			
	Institute and college graduate	42.90	18.89			
	postgraduate	67.83	7.46			

The table shows that, there are highly significant differences between women's educational level and their psychological and social domains of the quality of life.

Table (8): Relationship between occupational status of the study group and the psychological and social domains of the quality of life

Occupational status		Mean	SD	df	t	p.value
Psychological domain	Currently employed	70.66	15.31	98	0.60	0.43 NS
	Not employed	67.69	17.48			
Social domain	Currently employed	54.81	16.19	98	0.72	0.39 NS
	Not employed	51.91	14.70			

The table reveals that, there are no significant differences found between women's occupational status and both psychological and social domains of the quality of life.

Table (9): Analysis of variance (ANOVA) between marital status of study group and the psychological and social domains of the quality of life

Marital status.		Mean	SD	df	F	p.value
Psychological domain	Single	62.80	24.24	96	1.01	0.39 NS
	Married	68.32	16.93			
	Widowed	73.00	13.57			
	Separated &divorced	48.00	0.00			
Social Domain	Single	44.80	23.45	96	4.91	0.003 HS
	Married	55.20	13.67			
	Widowed	43.50	14.10			
	Separated &divorced	21.00	0.00			

In this table a highly significant differences appeared between women's marital status and their social domain of the quality of life.

Table (10): Analysis of variance (ANOVA) between reproductive status of the study group and the psychological and social domains of the quality of life.

Gravidity		Mean	SD	df	F	p.value
Psychological domains	non	52.80	17.00	96	7.54	0.001 HS
	1 - 3	52.00	13.39			
	3 - 5	68.00	14.4291			
	≥5	72.79	15.94			
Social Domain	non	25.40	10.50	96	12.10	0.001 HS
	1 - 3	40.63	13.98			
	3 - 5	55.90	14.12			
	≥5	55.90	12.68			
Parity						
Psychological domain	non	44.85	3.1320	96	9.39	0.001 HS
	1 - 3	58.23	15.86			
	3 - 5	72.75	16.19			
	≥5	71.81	14.93			
Social domain	non	21.42	5.53	96	20.81	0.001 HS
	1 - 3	45.00	8.75			
	3 - 5	56.77	14.35			
	≥5	56.61	11.15			
Number of living children						
Psychological domain	non	44.85	3.13	96	8.98	0.001 HS
	1 - 3	59.73	15.82			
	3 - 5	72.15	15.66			
	≥5	72.47	15.54			
Social domain	non	21.42	5.5334	96	19.68	0.001 HS
	1 - 3	46.80	10.05			
	3 - 5	56.27	13.82			
	≥5	57.02	11.52			

The table reveals that, there are highly significant differences between women's reproductive status (gravidity , parity , number of living children) and the psychological and social domains of quality of life.

Table (11). Analysis of variance (ANOVA) between menstrual status of study group and the psychosocial and social domains of the quality of life

Menstrual status		Mean	SD	df	F	p.value
Psychological domain	Regular	63.52	16.81	96	4.66	0.01 Sig.
	Irregular	68.91	16.56			
	Menopause	78.43	14.12			
Social Domain	Regular	48.75	15.78	96	1.96	0.14 NS
	Irregular	54.95	14.13			
	Menopause	54.81	15.41			

The table reveals that, there are significant differences between women's menstrual status and psychological domain of the quality of life.

Table (12): Analysis of variance (ANOVA) between post-operative duration of the study group and the psychological and social domains of the quality of life

Post-operative duration		Mean	SD	df	F	p.value
Psychological domain	6 months	61.71	17.45	96	4.82	0.004 HS
	7-8 months	69.61	15.69			
	9-10 months	68.15	13.30			
	11-12 months	78.38	15.32			
Social domain	6 months	44.17	15.87	96	8.57	0.001 HS
	7-8 months	57	12.13			
	9-10 months	51.23	11.73			
	11-12 months	61.47	12.54			

The table reveals that, there are highly significant differences between post-operative duration and the psychological and social domains of the quality of life.

Table (13): Analysis of variance (ANOVA) between hysterectomy causes of the study group and the psychosocial and social domains of the quality of life

Hysterectomy causes		Mean	SD	df	F	p.value
Psychological domain	Benign uterine tumor (fibroid)	63.48	16.29	91	3.94	0.001 HS
	Heavy post-partum heamorrhage	49.80	9.47			
	Pelvic inflammatory disease (PID) (do not respond to medication)	73.87	13.51			
	Endometriosis	60.50	17.67			
	Uterine prolapse	73.61	14.83			
	Menstrual problems (disturbance)	72.88	15.58			
	Cesarean section	83.50	14.79			
	Uterine rupture	51.50	16.27			
	Pelvic pain	89.66	4.04			
Social domain	Benign uterine tumor (fibroid)	50.05	16.89	91	1.783	0.09 NS
	Heavy post-partum heamorrhage	42.80	8.49			
	Pelvic inflammatory disease (PID) (do not respond to medication)	56.87	14.99			
	Endometriosis	39.50	10.89			
	Uterine prolapse	54.85	14.35			
	Menstrual problems (disturbance)	59.55	10.89			
	Cesarean section	60.00	9.20			
	Uterine rupture	40.2500	14.17			
	pelvic pain	48.3333	11.01			

The table reveals that, there are highly significant differences between hysterectomy causes and the psychological domain of the quality of life.

Table (14): Relation-ship between type of operation of the study group with psychological and social domains of quality of life

		Mean	SD	df	t	p.value
Psychological domain	Abdominal	67.62	16.69	98	3.66	0.58 NS
	Vaginal	80.14	16.36			
Social domain	Abdominal	52.76	14.72	98	0.023	0.87 NS
	Vaginal	51.85	20.81			

This table reveals that non-significant differences are found between type of operation and women's psychological and social domains of quality of life.

Table (15): Step-wise multiple regression for the prediction of the psychological and social domains of quality of life

Predictor	B	R-squire	Adjusted R-squire	p.value
Age	6.262	0.369	0.136	<0.0001

This table shows that women's age was identified to be the best predictor of the psychological and social domains of quality of life for hysterectomized women.

Discussion

Discussion of the relationships between the psychological – social Domains of QoL and the demographic characteristics of the hysterectomized women.

It had been found out of such characteristics that (49%) of women their ages ranged between (42-49) years. (Table 1).Many clinical studies have agreement with the present study results, which they reported that most common age at hysterectomy was (40-45) years [8,9,10,11,12]. The study findings identified the age at operation has an important bearing on women's psychological and social status (Table 6).In regard to the educational level of the study group the present findings indicated that nearly half (49%) of women were unable to read and write.Furthermore (Table 7) shows highly significant differences between the educational level of the study group and their psychological and social status. Most of the study group (73%) were not employed.This finding was consistent with which revealed that women who had never worked were more likely to undergo a hysterectomy[13]. The present finding indicated that occupation was not significant associated with psychological and social status of the women Table (8). The majority (80%) were married (Table 1). Furthermore marital status of the study group had highly significant impact upon women's socials status (Table 9). The study finding indicates that women who had five or more gravdia constituted (71%) of the study group, and shows that reproductive status for the women have a high significant impact upon women's psychological and social outcome (Table 10).The present finding indicates that most women (48%) had irregular menstrual cycle at the time of surgery, and (16%) of them were menopause (Table 3). In addition menstrual status for the study group significantly affects women's psychological status (Table 11). (35%) were at 6 months of post-operative period (Table 4) In addition highly significant differences found between post-operative duration and their psychological and social status (table 12)[14]. Results indicated that there was a significant improvement at four-six months following operation, and that the longer follow up unnecessary. (35%) have benign uterine tumor (Fibroid) (Table 5). Hysterectomy causes have a highly significant impact on women's psychological status as shown in (Table 13)

The majority of hysterectomy approach were abdominal (93%), and only (7%) were vaginal (Table 5). Furthermore the results of the present study indicate that type of operation don't influence on both psychological and social status of hysterectomized women (Table 14). Women's age at operation was identified to be the best predictor of psychological and social aspects of quality of life (table 15). It means more women's age at operation, will have best (high) quality of life. Many studies supported that hysterectomy correct serious problems that interfere with normal function, save woman's life, and improve the quality of her life [16].

Recommendations

1. Women faced with the hysterectomy decision need a lot of related information's. Availability of books, pamphlet could meet this need.
2. An educational program should be developed and implemented for woman and her partner in order to increase her knowledge and correct old attitude and support positive attitude.
3. Establishing a special center for hysterectomy women to share and open the doors of communication, and discuss openly benefits and risks of operation.
4. Further research that confirm the present study data with a larger number of women.

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