

Women's Health Risks Associated with Orthodox Medicine – Part 2

by Gary Null, PhD, Debora Rasio, MD, and Martin Feldman, MD

Conventional medicine would have us believe that only its treatments have passed the kind of careful scientific scrutiny needed to prove their safety and effectiveness. But this is not necessarily the case, as revealed by our review of the medical literature on a number of women's health issues.

This review, presented as a three-part series, shows that the practices of orthodox medicine may not provide the benefits generally attributed to them or may be associated with a heightened risk of health problems. Importantly, the criticism of these treatments does not come from the proponents of complementary and alternative medicine. Rather, it comes from research articles published in the mainstream medical press itself. Orthodox medicine's own journals raise questions about the efficacy of many conventional practices related to women's health.

Part 1 of this series presented research studies on antenatal care, fetal heart monitoring, home versus hospital deliveries, and breast-feeding versus formula feeding.

In this installment, we examine an area of great concern—surgical practices such as hysterectomies, cesarean sections, and episiotomies that may be performed unnecessarily by the conventional medical community.

Hysterectomy

A woman with benign uterine fibroids ends up having her uterus removed? This scenario happens quite often. Many of the nearly 600,000 hysterectomies performed in the United States each year are recommended inappropriately and/or are not medically justified, according to the reports presented here.

In many cases, women undergo hysterectomies when alternative therapies could have been explored. One study published in Obstetrics & Gynecology in 2000 found that 70% of hysterectomies in the U.S. are recommended inappropriately; most of the women studied had hysterectomies for fibroids, pelvic relaxation, pain, and bleeding.¹ An article in the Journal of Reproductive Medicine adds that while the benefits of a hysterectomy are unquestionable for women who have uterine cancer or other life-threatening diseases, the quality-of-life improvements are tough to identify when women undergo the procedure simply to alleviate symptoms.²

In fact, one study found that more than half of women who had hysterectomies subsequently developed new or worsening symptoms they attributed to the procedure.³ Another study found that urinary incontinence was a common long-term complication of undergoing a hysterectomy.⁴

A common theme in the studies is that women should consider the alternatives

*before resorting to surgery. Depending on the problem at hand, these alternatives include options such as pain treatment, pelvic floor exercises, or endometrial ablation (in which a portion of the lining of the uterus is surgically removed in women with dysfunctional bleeding).*⁵⁻⁶

The results of this study show that in the U.S. every year, an estimated 600,000 women undergo hysterectomy. The most frequent indication for hysterectomy was uterine fibroid (a benign uterine growth), with 60% of black women, 30% of white women, and 45% of women of other races undergoing hysterectomy because of this condition. During 1988-1993 increasingly more women undergoing hysterectomy also had both of their ovaries removed.

—Lepine LA, et al., Hysterectomy surveillance—United States, 1980-1993. *MMWR CDC Surveill Summ* 1997 Aug 8; 46(4): 1-15.

This article emphasizes that every year in the United States over 570,000 women undergo hysterectomy, even though, according to the opinion of several experts, the procedure is often not justified by valid medical indications. Hysterectomy is frequently performed for uterine fibroids, dysfunctional uterine bleeding, endometriosis/adenomyosis, chronic pelvic pain and genital prolapse. This practice occurs against the current literature that recommends conservative treatment of most nonmalignant conditions, and advocates hysterectomy in refractory cases only.

—Kramer MG, Reiter RC, Hysterectomy: indications, alternatives and predictors. *Am Fam Physician* 1997 Feb 15; 55(3):827-34.

The results of this study show that 70% of the hysterectomies performed in the U.S. are recommended inappropriately. The study was conducted on approximately 500 women who underwent hysterectomy mainly for fibroids (60%), pelvic relaxation (11%), pain (9%), and bleeding (8%). The authors recommend that physicians explore alternative treatments before resorting to removal of the uterus.

—Broder MS, Kanouse DE, Mittman BS, Bernstein SJ, The appropriateness of recommendations for hysterectomy. *Obstet Gynecol* 2000 Feb; 95(2):199-205.

This article emphasizes that in the U.S. approximately 590,000 hysterectomies are performed every year, implying that approximately 1 in 3 women will have their uterus removed at some point in their life. Alternative solutions to hysterectomy are presented and include simple expectant management for uncomplicated uterine fibroids, endoscopic removal or hormonal therapy for symptomatic uterine fibroids, hormone therapy for endometriosis, pain treatment for pelvic pain, and pelvic floor exercises for pelvic prolapse. In many cases, several options are available before resolving to hysterectomy.

—Scialli AR, Alternatives to hysterectomy for benign conditions. *Int J Fertil Womens Med* 1998 Jul-Aug; 43(4):186-91.

The results of this study show that approximately 20% of women will have their uterus removed by the time they reach their mid-fifties. The most frequent indication for hysterectomy is the presence of uterine fibroids (benign tumors that commonly occur in middle-aged women), followed by menstrual disorders.

—Vessey MP, Villard-Mackintosh L, McPherson K, Coulter A, Yeates D, The epidemiology of hysterectomy: findings in a large cohort study. *Br J Obstet Gynaecol* 1992 May; 99(5):402-7.

The results of this study show that the cost of hysterectomy varies considerably from state to state. For examples, having a hysterectomy performed in Florida costs twice as much as having it performed in Oklahoma. Charges for abdominal hysterectomy are 60% higher in California than in Tennessee, and those for vaginal hysterectomy are 42% higher in California than in North Carolina.

—Mushinski M, Hysterectomy charges: geographic variations United States, 1994. *Stat Bull Metrop Insur Co* 1996 Jan-Mar; 77(1):2-12.

This article highlights that the risk of death in women undergoing hysterectomy is 12 for every 10,000 procedures performed. While the benefits derived from the operation in women with uterine cancer or other life-threatening diseases are unquestionable,

improvements in quality of life are difficult to establish for women who undergo hysterectomy merely for symptoms alleviation, indicating that the risks and benefits of the procedure should be carefully weighed before resolving to surgery.

—Bachmann GA, Hysterectomy. A critical review. *J Reprod Med* 1990 Sep; 35(9):839-62.

This article emphasizes that the long-term benefits of hysterectomy to this day are still uncertain. Less radical treatments can be as effective as hysterectomy and have the benefits of sparing the woman's uterus and ovaries.

—Mawson AR, The place of hysterectomy in the management of benign uterine disease. *HMO Pract* 1996 Jun; 10(2):69-74.

The results of this study show that persistent postmenopausal vaginal bleeding is not a valid reason for performing hysterectomy because this symptom, contrary to common belief, is not associated with increased risk of uterine cancer.

—Fung Kee Fung M, Burnett M, Faught W, Does persistent postmenopausal bleeding justify hysterectomy? *Eur J Gynaecol Oncol* 1997; 18(1): 26-8.

The results of this study show that more than 50% of women who underwent hysterectomy subsequently developed symptoms that they believed were caused or

worsened by the procedure.

—Schofield MJ; Bennett A; Redman S; Walters WA; Sanson-Fisher RW, Self-reported long-term outcomes of hysterectomy *Br J Obstet Gynaecol* 1991 Nov; 98(11):1129-36.

The results of this study show that urinary incontinence is a common long-term complication of hysterectomy. In the study, analysis of the English scientific literature on the subject revealed that women with hysterectomy have a 60% higher risk of developing urinary incontinence by 60 years or older, compared to those with an intact uterus. This finding is important, since hysterectomy is performed in 90% of cases for non-life-threatening conditions such as pelvic pain, vaginal bleeding and uterine fibroids. Doctors should inform their patients that resolving to surgery for the symptomatic relief of symptoms could result in more disability later in life.

—Brown JS, Sawaya G, Thom DH, Grady D, Hysterectomy and urinary incontinence: a systematic review. *Lancet* 2000; 356: 535-539.

The results of this study show that women aged 50-89 years who undergo hysterectomy in combination with bilateral oophorectomy (removal of the ovaries) have increased value of serum lipids, lipoproteins, glucose, and insulin, and increased blood pressure values, compared to women who undergo hysterectomy with ovarian preservation. These results indicate that removal of the ovaries may result in increased risk of

cardiovascular disease; these adverse effects are not offset by estrogen replacement therapy.

—Kritz-Silverstein D, Barrett-Connor E, Wingard DL, Hysterectomy, oophorectomy, and heart disease risk factors in older women. *Am J Public Health* 1997 Apr; 87(4):676-80.

The results of this study show that women who undergo hysterectomy for painful endometriosis before the age of 30, experience significantly more residual symptoms such as painful sexual intercourse and painful urination, significantly more sense of loss and significantly more disruption of different life aspects, compared to women who had their uterus removed after the age of 40.

—MacDonald SR, Klock SC, Milad MP, Long-term outcome of nonconservative surgery (hysterectomy) for endometriosis-associated pain in women <30 years old. *Am J Obstet Gynecol* 1999 Jun; 180(6 Pt 1):1360-3.

In this study 56 women scheduled to receive hysterectomy for excessive uterine bleeding were randomized to receive either hormone treatment with an intrauterine system releasing the progestin levonorgestrel, or to continue their preexistent treatment for excessive or painful bleeding. After 6 months, two-thirds of the women treated with levonorgestrel and 14% of those who continued preexistent treatment cancelled the operation. These results indicate that hysterectomy for excessive bleeding can be

avoided in a large number of patients, if medical treatment and expectant management are employed before surgery.

—Lahteenmaki P, et al., Open randomised study of use of levonorgestrel releasing intrauterine system as alternative to hysterectomy. *BMJ* 1998 Apr 11; 316(7138):1122-6.

The results of this study show that endometrial ablation (the surgical removal of a portion of the lining of the uterus) in women with dysfunctional uterine bleeding is a valid alternative to hysterectomy. Only 24% of 102 women, who, instead of having their uterus removed underwent endometrial ablation, required hysterectomy in the subsequent 4 years.

—A randomised trial of endometrial ablation versus hysterectomy for the treatment of dysfunctional uterine bleeding: outcome at four years. Aberdeen Endometrial Ablation Trials Group. *Br J Obstet Gynaecol* 1999 Apr; 106(4):360-6.

Cesarean Section

A troubling trend in women's health issues is the inappropriate use of cesarean sections. This method of delivery grew significantly in recent decades, and a 1993 report in Soc Sci Med states that half of the C-sections performed in the United States are unnecessary. According to this study, the main reasons for performing a cesarean—including a previous C-section and slow or difficult labor, among others—

*have been least clearly connected to benefits.*⁷

*The studies below point to a host of potential complications associated with cesarean deliveries—starting with higher rates of maternal mortality than with vaginal deliveries.*⁸⁻⁹ *Other problems include ruptured uterus and hemorrhage, fever, urinary tract infections, and wound infection.*¹⁰⁻¹²

This article indicates that in the U.S., almost 1 out of 4 deliveries are performed by cesarean section. These rates are among the highest recorded in the developed countries. From 1970 to 1993, overall rates of primary cesarean sections increased by 4-folds, from 5.5% to 22.8%. Since deliveries by cesarean section carry a significantly higher risk of complications for both the mother and the newborn, the national health goal for the year 2000 has been to lower its rate to 15% or below, a value that has not been observed since 1978.

—Rates of Cesarean delivery—United States, 1993. *MMWR Morb Mortal Wkly Rep* 1995 Apr 21; 44(15):303-7.

The results of this study show that the rate of cesarean sections in Scotland increased by over 3-folds in the period from 1962 to 1992, with no apparent cause to justify this increase other than a lowered threshold of acceptance of the procedure in obstetric practice.

—Leitch CR, Walker JJ, The rise in caesarean section rate: the same indications

but a lower threshold. *Br J Obstet Gynaecol* 1998 Jun; 105(6):621-6.

This article emphasizes that half of the cesarean sections performed in the U.S. are unnecessary. This surplus needlessly endangers women and their babies and adds over \$1 billion to the annual health care costs. Cesarean section deliveries are associated with a 2- to 4-fold increased rate of maternal mortality and with a 5- to 10-fold increased rate of maternal morbidity, compared to vaginal deliveries. Newborns delivered via cesarean section are at increased risk of respiratory disease and of being delivered before proper time. The author highlights how decisions concerning the need for cesarean delivery seem to be influenced more by social, economic, and physicians' personal reasons than by medical factors. This is well illustrated by the fact that those women who are at highest risk of pregnancy complications and who would benefit the most from a cesarean section are the least likely to receive it. On the other hand, indications such as previous cesarean, slow or difficult labor or delivery, presentation of the rear of the baby at the uterine cervix and fetal distress, are the main reasons for performing a C-section, even though these conditions have been least clearly associated with benefits for the fetus and the mother.

—Shearer EL, Cesarean section: medical benefits and costs. *Soc Sci Med* 1993 Nov; 37(10):1223-31.

The results of this study show that approximately 40% of cesarean sections performed

in Ohio have no medical indication that justifies their use and are therefore unnecessary.

—Koroukian SM, Trisel B, Rimm AA, Estimating the proportion of unnecessary Cesarean sections in Ohio using birth certificate data. *J Clin Epidemiol* 1998 Dec; 51(12):1327-34.

The results of this study show that 1 in 4 cesarean sections performed for lack of progression during labor are done in disagreement with professional guidelines, and are therefore inappropriate. Every year, 1 million women deliver by cesarean section in the U.S. In approximately 300,000 cases, the reason for the cesarean section is lack of progress in labor, meaning that the head of the baby is progressing slowly through the birth canal. According to the American College of Obstetricians and Gynecologists' guidelines, "lack of progress" can be diagnosed only after the cervix is dilated by 3 centimeters in primiparous (first time mothers) and by 4 centimeters in women who had delivered in the past. This study, conducted on 733 women who had an unplanned cesarean section, showed that in 68% of them the reported reason for the C-section was lack of progress in labor. When the researchers reviewed their medical records they found that, counter to published guidelines, 24% of them had undergone C-section before their cervix was dilated enough to justify a diagnosis of slow progress. These findings suggest that every year in the U.S., approximately 75,000 cesarean sections may be performed too early during labor, for unnecessary reasons.

—Gifford DS, Morton SC, Fiske M, Keesey J, Keeler E, Kahn KL, Lack of

progress in labor as a reason for Cesarean. *Obstet Gynecol* 2000 Apr; 95(4):589-95.

The results of this study show that 30% of cesarean sections performed in an English teaching hospital were unnecessary. There was significant disagreement between physicians as to whether or not to perform a cesarean section. Even more importantly, when physicians were presented at different times with the same information, their opinion as to whether or not to perform a cesarean section was inconsistent in 25% of cases. These data indicate that clinical decisions in obstetrics are often influenced by physicians' personal reasons rather than by medical factors.

—Barrett JF, Jarvis GJ, Macdonald HN, Buchan PC, Tyrrell SN, Lilford RJ, Inconsistencies in clinical decisions in obstetrics. *Lancet* 1990 Sep 1; 336(8714):549-51.

The results of this study show that maternal mortality rates in women delivering by cesarean section are 7 times higher than those of women delivering by vaginal route.

—Schuitemaker N, et al, Maternal mortality after Cesarean section in The Netherlands. *Acta Obstet Gynecol Scand* 1997 Apr; 76(4):332-4.

The results of this study show that cesarean section delivery is associated with a 7-fold increased risk of maternal death, compared to vaginal delivery. After the exclusion of

women who experienced medical complications before delivery, the risk of maternal death associated with cesarean section was estimated to be 5 times higher than that associated with vaginal delivery.

—Lilford RJ, et al., The relative risks of caesarean section (intrapartum and elective) and vaginal delivery: a detailed analysis to exclude the effects of medical disorders and other acute pre-existing physiological disturbances. *Br J Obstet Gynaecol* 1990 Oct; 97(10):883-92.

The results of this study show that cesarean section delivery carries an overall 15% risk of intra-operative maternal complications and a 36% risk of postoperative maternal morbidity. In particular, the risk of intra-operative complications is 7.4% in women who undergo elective cesarean section, and 23% in women who deliver by cesarean section after failure of attempted vaginal delivery. The most common intra-operative complications are ruptured uterus and hemorrhage. The most frequent postoperative complications are fever, hemorrhage, haematoma and urinary tract infections.

—van Ham MA, van Dongen PW, Mulder J, Maternal consequences of caesarean section. A retrospective study of intra-operative and postoperative maternal complications of caesarean section during a 10-year period. *Eur J Obstet Gynecol Reprod Biol* 1997 Jul; 74(1):1-6.

The results of this study, conducted on a cohort of 1,335 women who underwent

Caesarean section in a Canadian teaching hospital, show that the rate of hospital-acquired infections in women delivered by primary and secondary caesarean section is 42.1% and 46.1%, respectively. Women delivered by primary section had significantly higher incidence of deep wound infections, endometritis and bacteraemia, compared to those delivered by secondary section. Hospital-acquired infections significantly prolonged length of hospital stay and costs of care.

—Henderson E, Love EJ, Incidence of hospital-acquired infections associated with caesarean section. *J Hosp Infect* 1995 Apr; 29(4):245-55.

The results of this study show that over 90% of women who deliver by cesarean section develop post-operative morbidity such as wound infection, intrauterine infection, urinary tract infection, urinary catheterization, chest infection, fever, and hemorrhage.

—Hillan EM, Postoperative morbidity following Caesarean delivery. *J Adv Nurs* 1995 Dec; 22(6):1035-42.

This study investigated some of the possible long-term effects associated with cesarean section delivery, and focused on the rate of occurrence of ectopic pregnancy and placental complication in a cohort of almost 17,000 women who underwent cesarean section and a similar number of women who delivered by the vaginal route. Women with a history of cesarean section were found to have a 30% increased risk of subsequent ectopic pregnancy (gestation occurring elsewhere than in the uterus, for

example in a fallopian tube or in the peritoneal cavity) and a 4-fold increased risk of placental complications (placenta previa and abruptio placentae), compared to those with a history of vaginal delivery.

—Hemminki E, Merilainen J, Long-term effects of Cesarean sections: ectopic pregnancies and placental problems. *Am J Obstet Gynecol* 1996 May; 174(5):1569-74.

Episiotomy

The effectiveness of this delivery practice is called into question by two reports, both published in 2000. A report in Obstetrics & Gynecology challenges the very reasons that physicians perform episiotomies. The authors say the practice has no scientific foundation—its assumed benefits have not been confirmed by studies—and that episiotomies should no longer be performed routinely.¹³

The second study indicates that episiotomies are associated with a significant increase, rather than decrease, in the risk of anal incontinence in women in the months following delivery.¹⁴

This review emphasizes that the common obstetrical practice of cutting the tissue between the vagina and the anus (episiotomy) in women at stage 2 of delivery, has no scientific foundation and may, in fact, result in more trauma and suffering for the mother. Doctors perform episiotomy with the belief that this practice reduces the occurrence of pelvic prolapse and urinary incontinency in the mother, and the risk of

brain damage in the baby. However, none of these assumptions have been confirmed by scientific studies. On the contrary, research has shown that leaving enough time for the muscles of the pelvic floor to stretch naturally results in lower rates of maternal incontinence. Among the reasons cited in the article for this practice to still be in use are: shorter time of delivery (which is advantageous for the physician), lack of experience with natural slow stretching of the pelvic floor muscles, and an interventionist attitude of the physician. The authors conclude that, based on available evidence, episiotomy should no longer be routinely performed during delivery.

—Eason E, Feldman P, Much ado about a little cut: is episiotomy worthwhile? *Obstet Gynecol* 2000 Apr; 95(4):616-8.

The results of this study show that episiotomy, the surgical incision of the perineum and vagina performed during delivery to reduce the risk of injury to the pelvic floor, is associated with a 3- to 5.5-fold increased risk of anal incontinence, compared to vaginal delivery. The study, conducted on 626 women followed-up for 6 months after delivery, found that the rate of fecal incontinence was 5.5-fold higher in those who underwent episiotomy, compared to those who did not have such procedure. In addition, 6 months after delivery, women who underwent episiotomy had a 3-fold increased rate of fecal incontinence and a 2-fold increased rate of gas incontinence, compared to women who had spontaneous laceration. These findings demonstrate that episiotomy is associated with a significant increase, rather than reduction, in risk of anal incontinence.

—Signorello, LB, et al., Midline episiotomy and anal incontinence:

retrospective cohort study. *BMJ* 2000; 320:86-90 (8 January).

Resources:

Hysterectomy Educational Resources and Services Foundation (HERS)

Provides information on alternatives to hysterectomy.

422 Bryn Mawr Avenue

Bala Cynwyd, PA 19004

Tel.: 610-667-7757

Web site: www.ccon.com/hers

The No-Hysterectomy Option: Your Body—Your Choice

By Herbert A. Goldfarb, M.D., F.A.C.O.G., with Judith Greif, R.N., F.N.P., C.

(John Wiley & Sons Inc., New York, NY, Revised & Updated Edition, 1997)

Fibroid Tumors & Endometriosis Self Help Book

By Susan M. Lark, M.D.

(Celestial Arts, Berkeley, CA, Revised & Updated, 1995)

Fibroids: The Complete Guide to Taking Charge of Your Physical,

Emotional, and Sexual Well-Being

By Johanna Skilling

(Marlowe & Company, New York, NY, 2000)

For Women Only! Your Guide to Health Empowerment

By Gary Null and Barbara Seaman

(Seven Stories Press, New York, NY, 1999)

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