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Early surgical menopause and its correlates: A case series from a tertiary healthcare institute in a tribal area of Jharkhand, India

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Abstract:

In India, unjustified and mass hysterectomy is an alarming issue in rural and semi-urban areas. Fear of cancer and reiterating the idea that uterus removal will alleviate unrelated somatic issues are two methods used to persuade women to have the surgery. It becomes easier to counsel them for hysterectomy, especially when they belong to the rural population, come from lower socioeconomic strata, are young and illiterate, and do nothing for their livelihood. Many patients from the Santhal Pargana division (tribal region) came to gynecology Out Patient Department after having a hysterectomy without any medical indication at an age below 30 years to cure their common symptoms such as lower abdominal pain and vaginal discharge, and this is our major concern from them. We have taken three patients for this case series to highlight this problem at the community level. Unfortunately, the adverse health consequences of early loss of ovarian function accelerate the menopause state, affect multiple systems including cardiovascular, neurological, bone, and connective tissues, and, most importantly, affect the quality of life owing to vasomotor symptoms, mood, sleep, and sexual function. This case series emphasizes the serious complications of unnecessary hysterectomies and problems and gender inequities in the healthcare system for poor women.

Keywords:

Maternal health, menopause, surgical

Introduction

Menopause is a physiological condition that affects women at the peak of their natural fertility and causes them to stop having menstrual cycles. At the age of 45 years onward, the ovaries stop releasing mature oocytes, altering regular menstruation cycles and lowering levels of estrogen and progesterone. Typically, amenorrhea lasting for 12 months is defined as natural menopause along with other characteristics such as vasomotor, psychological, and sexual symptoms.^[1] Menopause frequently happens naturally, but it can also be artificially induced medically or surgically for various reasons. Surgical menopause is

the cessation of natural estrogenic activity in a premenopausal woman following bilateral oophorectomy.^[2] Bilateral oophorectomy is commonly performed alongside a hysterectomy due to various underlying conditions, whether they are non-cancerous, such as heavy menstrual bleeding, fibroids, endometriosis, and persistent pelvic pain, or cancerous, like ovarian carcinoma, Lynch syndrome, and BRCA1/2 gene mutations. Women undergoing this procedure often experience symptoms of surgical menopause, which resemble those of natural or chemically induced menopause. However, due to the abrupt loss of ovarian function, they may face more severe side effects, including an elevated risk of pulmonary and colorectal cancer, coronary disease, stroke,

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cognitive impairment, Parkinson's disease, psychiatric disorders, and osteoporosis refulgences.^[3-6]

Statistics from the National Family and Health Survey-5 indicate that the prevalence of hysterectomy in India is 3.2%, with notable variations between different states, such as Bihar (5.4%) and Andhra Pradesh (8.9%). Nearly 70% of these procedures are carried out in the private healthcare sector, with higher rates among less educated and rural populations. Unfortunately, data from specific regions, like Jharkhand, especially the Santhal area, is not available as per the information we have.^[7]

In the Indian context, non-indicated hysterectomy is a widespread procedure, often driven by concerns about reproductive organ cancer and the misconception that removing the uterus can address unrelated somatic issues.^[7] Many Indian women, particularly those in rural areas, follow a reproductive life plan characterized by early marriage, low literacy, unhygienic menstrual practices, and frequent childbirth at short intervals. This leads to pelvic inflammatory disease and, consequently, unregistered and registered practitioners performing hysterectomies at a young age. This trend is particularly prevalent in the largest tribal region of India, Santhal Pargana, located in Jharkhand.

This situation highlights the growing incidence of non-indicated hysterectomies in India and the need for comprehensive care for women dealing with chronic pelvic pain, which is a debilitating condition. As a clinician, we usually see patients with two of the most frequent chief complaints: lower back pain and vaginal discharge, and these are not indications of pelvic inflammatory disease and hysterectomy. In a nation like India, which is still battling urgent issues such as maternal mortality and cervical cancer screening, the misuse of women's health fears and doubts is a public health concern. Here, in this case series, we will discuss three unfortunate cases of patients who are suffering from medical ailments such as low back pain and white discharge, which are due to early surgical hysterectomy as per our clinical knowledge.

Case Description

Case 1

A 27-year-old multiparous woman with three living issues (last childbirth 3 years), coming from a low socioeconomic status, and being a housewife by occupation came into OPD with a chief complaint of discharge per vagina and backache for the last 2 to 3 years. For that, she underwent a total abdominal hysterectomy with bilateral salpingo-oophorectomy 2 years ago. She had a history of bilateral tubal ligation 3 years ago. At the first visit on examination, she was

normotensive, has a pulse of 80 beats/min, and had mild pallor. An per abdominal examination shows a soft, non-tender abdomen. As per speculum examination, moderate vault discharge was present with granuloma of 5 × 5 mm, non-fragile, and non-tender at right fornices, and in per vaginal examination, two small vaginal cysts were found, one on the upper two-third of a posterior vaginal wall of around 1 × 1 cm and the second on the anterior vaginal wall near the urethra of 2 × 2 mm. The patient was counseled to maintain perineal hygiene, and an antibiotic course for both partners with vitamin D and calcium supplementation was prescribed. A vault smear was taken and sent for cytological examination. Follow-up was done weekly in which vaginal discharge was decreased after antibiotic coverage, vault smear showed nonspecific inflammation, the size of granuloma decreased, the patient felt comfortable, and further follow-up was carried out.

Case 2

A 32-year-old multiparous woman with three living issues and two abortions (last childbirth 12 years), coming from low socioeconomic status, and being a housewife by occupation came into OPD with a chief complaint of discharge per vagina and backache for the last 6 years. 6 years ago, she underwent a total abdominal hysterectomy with a bilateral salpingo-oophorectomy for abnormal uterine bleeding for 2 months. No history of bilateral tubal ligation was found. On examination, she was normotensive, has a pulse of 80 beats/min, and had mild pallor. An per abdominal examination shows a soft, non-tender abdomen. A moderate vault discharge was present in the per speculum examination, and in per vaginal examination, bilateral forniceal tenderness was present. A vault smear was taken and sent for cytological examination, counseled to maintain perineal hygiene, and an antibiotic course for both partners with vitamin D and calcium supplementation was prescribed. The patient was counseled for regular follow-up, and her smear shows a nonspecific infection.

Case 3

A 26-year-old multiparous woman with two living issues and one abortion (last childbirth 3 years), coming from a low socioeconomic status, and being a housewife by occupation came into OPD with a chief complaint of discharge per vagina, and backache for the last 3 years. For that, she underwent a total abdominal hysterectomy with a bilateral salpingo-oophorectomy 2 years ago. No history of bilateral tubal ligation was found. On examination, she was normotensive, has a pulse of 80 beats/min, and had mild pallor. On abdominal examination, a soft, non-tender abdomen was present. A mild vault discharge was present per speculum examination. As per a vaginal examination,

Table 1: Sociodemographic details

Characteristics	Patient 1	Patient 2	Patient 3
Age	27	32	26
Age at menarche	12.5 years	13 years	12 years
Age at marriage	16 years	13 years	18 years
Education (illiterate/literate)	Illiterate	Up to 5 th standard	Up to 12 th standard
Occupation	Housewife	Housewife	Housewife
Socioeconomic status (BPL/APL)	BPL	BPL	BPL

Table 2: Clinical details

Characteristics	Patient 1	Patient 2	Patient 3
Obstetrics score	P3L3	P3L3A2	P2L2A1
Indication of TAH/TAH + BSO	PID	AUB with PID	PID
Setup (govt./private)	Private	Private	Private
Duration of hysterectomy	2 years	6 years	1.5 years
Complaint after hysterectomy	Discharge per vagina and backache	Discharge per vagina and lower abdominal pain	Discharge per vagina and backache
Follow-up after hysterectomy	24 months	24 months	18 months

no abnormality was detected. A vault smear was taken and sent for cytological examination, and an antibiotic course for both partners with vitamin D and calcium supplementation was prescribed. Follow-up was done thereafter.

Discussion

In our study, we analyzed the case series of three patients in whom early surgical menopause occurred in their early 30s and we are following them for the long-term consequences associated with this [Tables 1 and 2]. All of them suffer from low back pain and persistent vaginal discharge. Women who had undergone surgically induced early menopause were significantly more prevalent in states such as Andhra Pradesh, Telangana, and Bihar. It is clear from the current study that women from rural areas have a higher risk of premature menopause due to both natural and surgical factors than women from metropolitan areas.^[8] As per our knowledge, there is a paucity of literature from Jharkhand state, even in India, regarding surgical menopause. According to S A. Kingsberg *et al.*, surgical therapy for benign gynecologic problems is one reason why more and more women are going through early menopause. The menopausal state is accelerated by early ovarian function loss, which is unfortunate. It also affects many different systems, including the cardiovascular, nervous, bone, and connective tissue systems, and lowers the quality of life due to vasomotor symptoms, mood, sleep, and sexual function.^[9] In a study by Yoshida *et al.*, however, it was discovered that bone loss in premenopausal women with bilateral salpingo-oophorectomy was more than twice as greater as in women who experienced natural menopause.^[10] Stephanie S. Faubion *et al.* studied women with early estrogen shortage, and it is crucial to customize hormone

therapy, and greater doses could be required to mimic the physiological concentrations seen in premenopausal women.^[11]

Conclusion

The present study suggests that early surgical menopause directly causes psychomotor, skeletal, and functional abnormalities. This issue needs to be urgently addressed from all angles. There is a need for women's empowerment by increasing knowledge about sexual health, and they should get equitable access to reproductive health care in primary care. The common public should be informed about sexual health, emphasizing the roles played by various organs, through local popular Information, Education, and Communication (IEC) and Behaviour Change Communication (BCC).

Recommendation

Further multicentric large-scale studies can be conducted to explore the prevalence of surgical menopause in India.

Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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Conflicts of interest

There are no conflicts of interest.

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