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EDITORIAL

Hysterectomy for Treatment of CIN: Is there Any Advantage for a Patient?

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The concept of cervical intraepithelial disease was started in 1947. During the early decades that followed this recognition, carcinoma in situ (CIS) was treated very aggressively with total hysterectomy, whereas women with any grade of dysplasia were considered to have lower risk and were either not treated or treated by cryosurgery. Soon afterwards, the concept of spectrum of cervical intraepithelial neoplasia (CIN) was introduced, when it was later realized that all dysplasia had the potential for progression. Proper management should be done according to the severity of CIN. Traditionally, hysterectomy has been performed as definitive treatment of CIN especially in woman with CIN3 who has completed family or has other pathology in which hysterectomy is indicated. Most of women with CIN can now be effectively treated with ablative or excisional procedures such as large loop excision of the treatment of the transformation zone (LLETZ). However, the better understanding about human papilloma virus (HPV), the availability of colposcopy and the effective outpatient treatment have dramatically changed the measures of the precancerous lesion management. These conservative procedures have high primary cure rates without serious complication therefore, hysterectomy is currently not necessary for CIN.

CIN arises only within an area of susceptibility including the cervical surface containing columnar epithelium, which starts out as the entire area between the original squamocolumnar junction and the cellular junction of endocervical epithelium and endometrium. Removal of the uterus does not help to eradicate CIN which is confined only in the limited area as described. The morbidity associated with hysterectomy such as significant bleeding, infection, and other complications, including death, is higher than with other methods whereas the cure rate is similar. Even after hysterectomy, patients are still have high chance of vaginal intraepithelial neoplasia (VAIN). Evidence has shown that VAIN can subsequently occur approximately 1% of women who have undergone hysterectomy for CIN. However, 25% of those diagnosed with VAIN have history of hysterectomy for CIN. Moreover, two-third of the patients diagnosed after hysterectomy for CIN do not have CIN at the outmost ectocervix or vaginal fornix before performing hysterectomy. This implies that the cause of VAIN may not caused by incomplete removal of CIN at time of surgery and it is possible that development of VAIN is related to trauma to the vaginal tissue at the time of hysterectomy.

VAIN at vaginal vault is more difficult to manage than VAIN occur in women with intact uterus and cervix. From literature, women treated by hysterectomy appear to have a similar risk of invasive recurrence compared with those who have received conservative therapy. This group of women must be followed up in the same way. Therefore, compared with other new conservative methods, hysterectomy adds little benefit of slightly more cure rate of CIN but is not superior regarding prevention of recurrence cancer. So, this procedure seems to be worthless.

Besides, hysterectomy does affect the women feeling. Psychological morbidity from this procedure is well known. Many women think the uterus is a symbol of femininity and the loss of the uterus and scarring after surgery may result in impairment of body image, which includes the perception of a loss of femininity and vitality.

In my opinion, the normal uterus could be preserved when there is only CIN and no other surgical indication in the uterine corpus, such as dysfunctional uterine bleeding not responding to other treatment methods, fibroids or uterovaginal prolapse. In fact, the most acceptable standard indication for performing hysterectomy at the present time is for women with incomplete excision of transformation zone and a repeat diagnostic excision of residual cervix is not feasible. It is also acceptable for women with a histologic diagnosis of recurrent or persistent CIN2/3.

In conclusion, women with CIN should be informed and counselled before treatment. Sometimes the patients, may request for hysterectomy. The severity of disease should be evaluated before initiating treatment in order to satify the patients. Finally, I hope that this comment will make the readers aware of this overlooking matter.