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CORRESPONDENCE

Correspondents are asked to be brief

Gynaecological Illness after Sterilization

SIR,—Like my friend Professor H. C. McLaren (29 January, p. 307) I wish to congratulate Mr. M. J. Muldoon on his report (8 January, p. 84) on subsequent gynaecological illness in sterilized patients. Unlike Professor McLaren, however, I would support Mr. Muldoon's thesis without reservation. These illnesses could have been prevented. As he points out, the commonest reason for these patients presenting again for gynaecological treatment is menstrual symptomatology. This is not to say that tubal ligation in some mysterious way predisposes to menstrual disorder. After this procedure each period becomes an irritating reminder of the presence of a functionless organ. The threshold of menstrual symptomatic tolerance is consequently lowered. The gynaecologist has little to offer but hysterectomy or oestrogen-progestogen therapy. The reason for the initial sterilization almost always involves unsuitability for "the pill" so hysterectomy is usually needed.

Professor McLaren's questions are not strictly relevant. Regardless of how many of these women would have presented with gynaecological conditions over the past ten years without prior sterilization, the gynaecologist missed an opportunity to prevent these troubles. What would have been their gynaecological morbidity rate on the pill or with the intrauterine device is even less pertinent. Most of these women, as stated, would be sterilized because pill or device were for various reasons unsuitable.

Mr. Muldoon's figures underline what can readily be deduced from available data—that most women who come to have sterilizing operations are ones at high risk of cancer of the cervix. Professor McLaren has contributed a great deal to our knowledge of the epidemiology and prevention of this disease and sterilizing hysterectomy involves applying that in a practical way.

Our approach to this matter was influenced by an unpublished survey of our patients undergoing gynaecological surgery. Liberal sterilization had been our practice for some years when it became evident that many of our patients with uterine symptomatology or pathology had been sterilized. These women were not dissatisfied with their sterilization, but it was appreciated that with a different procedure their further gynaecological trouble could have been prevented.

No one form of sterilization is universally applicable but our preference is for vaginal hysterectomy. In a patient without prolapse this takes no longer than a laparoscopy. The following day the patients are more mobile and are home within the week. In our experience significant complications are fewer and efficacy is certainly higher. In cases where no other gynaecological factors exist and a decision about a sterilizing procedure has been made, our practice is to explain the advantages of vaginal hysterectomy as a means of achieving sterilization (100% efficacy, removal of all risk of uterine cancer, freedom from menstrual symptoms and inconvenience but continued ovarian hormone activity). The decision as to which procedure —tubal ligation or vaginal hysterectomy—she prefers is then left to the patient. Some, for psychological reasons, are averse to hysterectomy. Where other gynaecological pathology or symptomatology is present, of course, we recommend whatever procedure will be likely to deal with that problem and achieve sterilization at the same time.

The implications of Mr. Muldoon's paper also apply to sterilization in association with induced abortion. A recent *Lancet* editorial[1] said " neither hysterotomy nor hysterectomy can be justified on the grounds that sterilization is required at the same time as termination. . . ." Such a view is hard to maintain in the light of observations such as Mr. Muldoon's; a sterilizing hysterectomy in such circumstances may be preventing two other operative procedures and much long-term morbidity.—I am, etc.,

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1 *Lancet*, 1971, **2**, 1239.

SIR,—I read with interest the article by Mr. M. J. Muldoon (8 January, p. 84) on "Gynaecological Illness after Sterilization."

Unfortunately, in common with most reports on the subject, no attempt was made to correlate the results against the incidence of similar gynaecological disease in non-sterilized women of similar age and parity. Thus no conclusions whatsoever can be drawn. I appreciate that Mr. Muldoon did not imply that the sterilization was in any way responsible for the subsequent gynaecological disease, but others have done so—for example, Williams *et al.*,[1] who attempted to compare their poststerilization series with a group of presumably normal women who had attended the antenatal clinic and whose case records were reviewed retrospectively. It is obviously grossly fallacious to make such a comparison, especially when leading questions about menstrual dysfunction had been put to the first group but not to the second.

One has only briefly to review the literature to observe the gross variations in reported incidences of menstrual dysfunction