

Ovarian Conservation at the Time of Hysterectomy and Long-Term Health Outcomes in the Nurses' Health Study

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OBJECTIVE: To report long-term health outcomes and mortality after oophorectomy or ovarian conservation.

METHODS: We conducted a prospective, observational study of 29,380 women participants of the Nurses' Health Study who had a hysterectomy for benign disease; 16,345 (55.6%) had hysterectomy with bilateral oophorectomy, and 13,035 (44.4%) had hysterectomy with ovarian conservation. We evaluated incident events or death due to coronary heart disease (CHD), stroke, breast cancer,

ovarian cancer, lung cancer, colorectal cancer, total cancers, hip fracture, pulmonary embolus, and death from all causes.

RESULTS: Over 24 years of follow-up, for women with hysterectomy and bilateral oophorectomy compared with ovarian conservation, the multivariable hazard ratios (HRs) were 1.12 (95% confidence interval [CI] 1.03–1.21) for total mortality, 1.17 (95% CI 1.02–1.35) for fatal plus nonfatal CHD, and 1.14 (95% CI 0.98–1.33) for stroke. Although the risks of breast (HR 0.75, 95% CI 0.68–0.84), ovarian (HR 0.04, 95% CI 0.01–0.09, number needed to treat=220), and total cancers (HR 0.90, 95% CI 0.84–0.96) decreased after oophorectomy, lung cancer incidence (HR=1.26, 95% CI 1.02–1.56, number needed to harm=190), and total cancer mortality (HR=1.17, 95% CI 1.04–1.32) increased. For those never having used estrogen therapy, bilateral oophorectomy before age 50 years was associated with an increased risk of all-cause mortality, CHD, and stroke. With an approximate 35-year life span after surgery, one additional death would be expected for every nine oophorectomies performed.

CONCLUSION: Compared with ovarian conservation, bilateral oophorectomy at the time of hysterectomy for benign disease is associated with a decreased risk of breast and ovarian cancer but an increased risk of all-cause mortality, fatal and nonfatal coronary heart disease, and lung cancer. In no analysis or age group was oophorectomy associated with increased survival.

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LEVEL OF EVIDENCE: II

Bilateral oophorectomy at the time of hysterectomy for benign disease is commonly practiced to prevent subsequent development of ovarian cancer.¹ Data from the Centers for Disease Control and Prevention show that for women having a hysterectomy between ages 40 years and 44 years, 50% have concurrent oophorectomy, and between ages 45 years

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and 64 years, 78% have oophorectomy.² In all, approximately 300,000 U.S. women have a prophylactic oophorectomy every year.

Oophorectomy before menopause leads to an abrupt reduction in endogenous estrogen and androgen production.³ Postmenopausal ovaries continue to produce significant amounts of testosterone and androstenedione, which are converted to estrogen peripherally.^{4,5} Later age of menopause has been associated with a reduced risk of death from coronary heart disease and stroke, and studies show that preserving ovarian function is associated with a lower risk of coronary heart disease.⁶⁻⁹ Among U.S. women, ovarian cancer accounts for 14,700 deaths per year, whereas coronary heart disease accounts for 326,900 deaths, and stroke accounts for approximately 86,900 deaths each year.¹⁰

Ovarian conservation, therefore, might benefit overall survival in women not at high risk for ovarian cancer.¹¹ The objective of this study was to report long-term health outcomes and mortality after ovarian conservation or oophorectomy.

MATERIALS AND METHODS

We used the database from the Nurses' Health Study cohort, which included 122,700 married registered nurses who were aged 30–55 years in 1976 when the initial questionnaires were mailed. Race was self-reported and the cohort was 94% white, 2% African American, 1% Asian, 1% multiracial, and 2% other. The cohort was relatively homogeneous with regard to education, socioeconomic status, and access to health care.¹² Additional questionnaires, updating risk factors and newly diagnosed health conditions, have been sent every 2 years, with response rates of approximately 90% for each cycle. In this cohort, a validation study found self-reported oophorectomy at the time of hysterectomy to be very accurate when compared with medical records.¹³ Nurses' Health Study participants with a previous hysterectomy entered study follow-up in 1980. Others entered when they reported having a hysterectomy on the 1982 through 2002 questionnaires. All eligible Nurses' Health Study participants were initially included before application of exclusion criteria.

Through 2002, 50,432 Nurses' Health Study participants reported having a hysterectomy without a diagnosis of gynecologic cancer. Women were excluded from this study if they had unilateral or partial oophorectomy ($n=4,817$), unknown ovarian status at the time of hysterectomy ($n=2,559$), a prior history of an outcome of interest as described below ($n=8,525$) or an oophorectomy ($n=465$) before their hysterec-

tomy, or an unknown age at hysterectomy ($n=4,643$). Women with missing information on past oral contraceptive use were excluded due to the small number in this category ($n=43$). The remaining 29,380 women were included in the analysis; 16,345 (55.6%) had a hysterectomy with bilateral oophorectomy, and 13,035 (44.4%) had hysterectomy with ovarian conservation. Submission of a completed self-administered questionnaire was deemed to imply informed consent. The institutional review boards at John Wayne Cancer Institute at Saint John's Health Center in Los Angeles and Brigham and Women's Hospital in Boston approved this study.

We focused on incident events and death due to the following conditions: coronary heart disease (International Classification of Diseases, 8th Revision [ICD-8]: 410–414), stroke (ICD-8: 430–438), breast cancer (ICD-8: 174), epithelial ovarian cancer (ICD-8: 183), lung cancer (ICD-8:162), colorectal cancer, (ICD-8: 153, 154), hip fracture (ICD-9: 820.3), pulmonary embolus (ICD-8: 450), and death due to all causes. Hip fracture was confirmed by self-report alone; ovarian cancer was confirmed by medical record review, and all other events were confirmed either by medical record or by the participant in writing or by telephone interview.¹³ If a diagnosis could not be confirmed or rejected, the event was excluded and the follow-up period was censored thereafter. Cause of death was determined using death certificates, autopsy reports, and medical records. Mortality follow-up using the National Death Index and next of kin was more than 98% complete.¹⁴

Participant's age in months and biennial questionnaire cycle were used as stratification variables in the Cox proportional hazards models. For each outcome analysis, we adjusted for related risk factors: age, age at hysterectomy, diabetes, high blood pressure, hypercholesterolemia, family history of myocardial infarction before age 60, tubal ligation, family history of breast cancer, family history of ovarian cancer, body mass index (BMI), smoking status, use of estrogen therapy (ET), duration of oral contraceptive use, alcohol consumption, physical activity and acetylsalicylic acid use (Table 1). Alcohol consumption, physical activity, and use of acetylsalicylic acid were initially queried in 1980. All data were updated at biennial questionnaire cycles. Family history of ovarian cancer (mother or sister) was first asked in 1992 and, once reported, was not updated. For all variables, missing information was separately noted.

Women contributed person-time from the return of the 1980 questionnaire or the questionnaire on which they first reported having a hysterectomy until report of



Table 1. Baseline* Characteristics of the Study Population by Oophorectomy Status at Hysterectomy

| Variables | Ovarian Conservation (N=13,035; 44.4%) | Both Ovaries Removed (N=16,345; 55.6%) |
|---------------------------------------|---|---|
| Age (y) | 50.3±8.0 | 51.9±6.8 |
| Age at hysterectomy (y) | 43.3±9.6 | 46.8±8.5 |
| Diabetes | 3.3 | 3.7 |
| High blood pressure | 22.2 | 26.5 |
| Hypercholesterolemia | 12.2 | 17.2 |
| Family history of MI before age 60 y | 17.4 | 16.8 |
| Tubal ligation | 10.8 | 14.6 |
| Family history of breast cancer | 17.4 | 16.4 |
| BMI in 1976 | | |
| Less than 25 | 70.2 | 69.7 |
| 25 to less than 30 | 21.3 | 21.0 |
| More than 30 | 7.6 | 8.3 |
| Unknown/missing | 0.9 | 1.0 |
| Smoking status | | |
| Past smoker | 29.5 | 32.0 |
| Years since quit smoking | 14.8±10.2 | 15.6±10.3 |
| Current smoker | 23.2 | 20.6 |
| Cigarettes/day among current smokers | 20.3±10.8 | 19.7±10.4 |
| ET use | | |
| Past/current users | 36.0 | 78.3 |
| Years of use among past/current users | 4.5±4.6 | 4.1±4.4 |
| OC use | | |
| Past users | 49.5 | 47.4 |
| Years of use among past users | 3.7±3.6 | 3.6±3.7 |
| Parity | | |
| Parous | 93.8 | 89.9 |
| Number of children among parous women | 3.3±1.4 | 3.0±1.3 |
| Alcohol consumption | | |
| Drinkers | 58.2 | 54.5 |
| Alcohol intake (g/day) | 9.4±11.6 | 9.0±11.3 |
| Mean physical activity (h/wk) | 3.0 | 2.9 |
| ASA use | | |
| ASA current users | 35.9 | 35.4 |
| Years of ASA use among current users | 15.7±12.5 | 14.4±12.6 |

MI, myocardial infarction; BMI, body mass index; ET, estrogen therapy; OC, oral contraceptive pill; ASA, acetylsalicylic acid. Data are mean±standard deviation or % unless otherwise indicated.

* For each participant, baseline is her time of hysterectomy when she began follow-up for this analysis.

an outcome of interest, oophorectomy subsequent to hysterectomy, death, or end of follow-up on June 1, 2004. In analyses of incident events, women were censored only upon report of the event under analysis, therefore the numbers of person-years varied for each outcome. We calculated incidence rates by dividing the number of incident cases by the total number of person-years for simple hysterectomy or hysterectomy with bilateral oophorectomy. For multivariable analyses, we used Cox proportional hazards models to estimate relative risk (RR) and corresponding 95% confidence intervals (CIs). Age and questionnaire cycle were stratifying variables in the analyses and were controlled for multiple potential confounders, as described in Table 1 and listed in the footnotes of each table.

The study design stratified the cohort into three subcohorts based on age at hysterectomy: younger

than 45 years, 45–54 years, and 55 years or older, and we conducted modeling separately for each. In a secondary analysis of oophorectomy status among those who never used estrogen therapy, women were stratified into two age groups (younger than 50 years and 50 years or older) to gain statistical power, and all analyses were repeated. All data transformations and statistical analyses were performed using SAS 9.1. (SAS Institute Inc., Cary, NC) All *P* values were based on two-tailed tests with significance of 0.05.

RESULTS

Women with ovarian conservation and those with bilateral oophorectomy had similar baseline distributions of risk factors for cardiovascular disease and cancer, but the latter were slightly older and more likely to be current or past users of hormone therapy



Table 2. Risk of Incident Events (Cancers) by Oophorectomy Status at Time of Hysterectomy

| Event | Age at Hysterectomy | | | All |
|--|---------------------|------------------|------------------|------------------|
| | Younger Than 45 y | 45–54 y | 55 y or Older | |
| Breast cancer | | | | |
| Ovarian conservation* | | | | |
| Cases (n) | 507 | 205 | 63 | 775 |
| Incidence rate per 100,000 PY | 315 | 385 | 444 | 339 |
| Both ovaries removed | | | | |
| Cases (n) | 292 | 520 | 83 | 895 |
| Incidence rate per 100,000 PY | 222 | 363 | 445 | 305 |
| Age-adjusted HR (95% CI) | 0.67 (0.58–0.78) | 0.94 (0.80–1.11) | 1.04 (0.75–1.44) | 0.84 (0.76–0.93) |
| Multivariate† HR (95% CI) | 0.62 (0.53–0.74) | 0.89 (0.75–1.06) | 1.05 (0.71–1.55) | 0.75 (0.68–0.84) |
| Ovarian cancer | | | | |
| Ovarian conservation* | | | | |
| Cases (n) | 67 | 21 | 11 | 99 |
| Incidence rate per 100,000 PY | 40 | 38 | 75 | 42 |
| Both ovaries removed | | | | |
| Cases (n) | 2 | 2 | 1 | 5 |
| Incidence rate per 100,000 PY | 1 | 1 | 5 | 2 |
| Age-adjusted HR (95% CI) | 0.03 (0.01–0.14) | 0.04 (0.01–0.16) | 0.07 (0.01–0.60) | 0.04 (0.01–0.09) |
| Lung cancer | | | | |
| Ovarian conservation* | | | | |
| Cases (n) | 118 | 39 | 13 | 170 |
| Incidence rate per 100,000 PY | 71 | 71 | 89 | 72 |
| Both ovaries removed | | | | |
| Cases (n) | 141 | 121 | 22 | 284 |
| Incidence rate per 100,000 PY | 105 | 82 | 115 | 94 |
| Age-adjusted‡ HR (95% CI) | 1.34 (1.05–1.72) | 1.21 (0.84–1.74) | 1.54 (0.79–2.99) | 1.17 (0.97–1.42) |
| Multivariate§ HR (95% CI) | 1.21 (0.91–1.61) | 1.30 (0.87–1.94) | NA | 1.26 (1.02–1.56) |
| Colorectal cancer | | | | |
| Ovarian conservation* | | | | |
| Cases (n) | 92 | 41 | 21 | 154 |
| Incidence rate per 100,000 PY | 56 | 74 | 145 | 66 |
| Both ovaries removed | | | | |
| Cases (n) | 96 | 113 | 25 | 234 |
| Incidence rate per 100,000 PY | 72 | 77 | 131 | 78 |
| Age-adjusted HR (95% CI) | 1.20 (0.90–1.61) | 1.04 (0.73–1.49) | 0.99 (0.56–1.77) | 1.08 (0.88–1.32) |
| Multivariate§ HR (95% CI) | 1.36 (0.98–1.89) | 1.16 (0.79–1.72) | 1.11 (0.49–2.51) | 1.23 (0.98–1.54) |
| Total cancer | | | | |
| Ovarian conservation* | | | | |
| Cases (n) | 1,121 | 439 | 156 | 1,716 |
| Incidence rate per 100,000 PY | 712 | 841 | 1,128 | 768 |
| Both ovaries removed | | | | |
| Cases (n) | 837 | 1,147 | 199 | 2,183 |
| Incidence rate per 100,000 PY | 651 | 822 | 1,089 | 762 |
| Age-adjusted HR (95% CI) | 0.86 (0.79–0.95) | 0.99 (0.89–1.10) | 1.02 (0.82–1.26) | 0.92 (0.86–0.98) |
| Multivariate HR (95% CI) | 0.83 (0.75–0.92) | 0.95 (0.85–1.07) | 1.01 (0.79–1.29) | 0.90 (0.84–0.96) |

PY, person-year; HR, hazard ratio; CI, confidence interval; NA, not analyzed.

* Reference group.

† Adjusted for age, age at hysterectomy, hypercholesterolemia, tubal ligation, family history of breast cancer, body mass index in 1976, smoking status, use of estrogen therapy, duration of oral contraceptive use, parity, average daily alcohol consumption, and total hours of weekly physical activity.

‡ For lung cancer, risk estimates for all women were not encompassed by those within strata of age at hysterectomy due to confounding by age and age at hysterectomy and the high correlation between these variables.

§ Adjusted for age, age at hysterectomy, diabetes, high blood pressure, hypercholesterolemia, body mass index in 1976, smoking status, use of estrogen therapy, duration of oral contraceptive use, parity, average daily alcohol consumption, total hours of weekly physical activity, and acetylsalicylic acid use.

^{||} Sample size is too small. No multivariate analysis was conducted.

^{||} Adjusted for age, age at hysterectomy, diabetes, high blood pressure, hypercholesterolemia, tubal ligation, body mass index in 1976, smoking status, use of estrogen therapy, duration of oral contraceptive use, parity, average daily alcohol consumption, total hours of weekly physical activity, and acetylsalicylic acid use.



(Table 1). After adjustment for multiple relevant risk factors, we compared the two groups in relation to the incidence of fatal and nonfatal events during 24 years of follow-up (Table 2—cancer events, Table 3—non-cancer events, Table 4—deaths). Oophorectomy was associated with an increased risk of coronary heart disease; this increase was statistically significant for all women (HR 1.17, 95% CI 1.02–1.35) and for women

having oophorectomy before age 45 years (HR 1.26, 95% CI 1.04–1.54). Breast cancer was less frequent among all women having oophorectomy (HR 0.75, 95% CI 0.68–0.84), and the risk was lower among women having oophorectomy before the age of 45 years (HR 0.62, 95% CI 0.53–0.74). Oophorectomy was associated with a markedly reduced risk of ovarian cancer (HR 0.04, 95% CI 0.01–0.09), an increased risk

Table 3. Risk of Incident Events (Noncancers) by Oophorectomy Status at Time of Hysterectomy

| Event | Age at Hysterectomy | | | |
|-------------------------------|---------------------|------------------|------------------|------------------|
| | Younger Than 45 y | 45–54 y | 55 y or Older | All |
| Coronary heart disease | | | | |
| Ovarian conservation* | | | | |
| Cases (n) | 240 | 105 | 35 | 380 |
| Incidence rate per 100,000 PY | 147 | 193 | 243 | 163 |
| Both ovaries removed | | | | |
| Cases (n) | 281 | 294 | 42 | 617 |
| Incidence rate per 100,000 PY | 212 | 201 | 222 | 207 |
| Age-adjusted HR (95% CI) | 1.34 (1.13–1.60) | 1.08 (0.86–1.35) | 0.99 (0.64–1.54) | 1.15 (1.01–1.30) |
| Multivariate† HR (95% CI) | 1.26 (1.04–1.54) | 1.07 (0.84–1.37) | 1.31 (0.73–2.36) | 1.17 (1.02–1.35) |
| Stroke | | | | |
| Ovarian Conservation* | | | | |
| Cases (n) | 198 | 87 | 36 | 321 |
| Incidence rate per 100,000 PY | 120 | 159 | 250 | 137 |
| Both ovaries removed | | | | |
| Cases (n) | 211 | 276 | 46 | 533 |
| Incidence rate per 100,000 PY | 159 | 189 | 243 | 179 |
| Age-adjusted* HR (95% CI) | 1.21 (1.00–1.47) | 1.20 (0.94–1.53) | 1.17 (0.76–1.80) | 1.17 (1.02–1.34) |
| Multivariate† HR (95% CI) | 1.19 (0.96–1.49) | 1.20 (0.93–1.55) | 1.51 (0.86–2.64) | 1.14 (0.98–1.33) |
| Hip fracture | | | | |
| Ovarian Conservation* | | | | |
| Cases (n) | 98 | 41 | 24 | 163 |
| Incidence rate per 100,000 PY | 59 | 75 | 166 | 70 |
| Both ovaries removed | | | | |
| Cases (n) | 67 | 116 | 18 | 201 |
| Incidence rate per 100,000 PY | 50 | 79 | 94 | 67 |
| Age-adjusted HR (95% CI) | 0.79 (0.58–1.08) | 1.07 (0.75–1.53) | 0.60 (0.33–1.09) | 0.87 (0.71–1.07) |
| Multivariate§ HR (95% CI) | 0.81 (0.56–1.17) | 1.08 (0.73–1.59) | 0.65 (0.27–1.57) | 0.89 (0.71–1.12) |
| Pulmonary embolism | | | | |
| Ovarian Conservation* | | | | |
| Cases (n) | 55 | 19 | 13 | 87 |
| Incidence rate per 100,000 PY | 33 | 34 | 89 | 37 |
| Both ovaries removed | | | | |
| Cases (n) | 63 | 62 | 7 | 132 |
| Incidence rate per 100,000 PY | 47 | 42 | 37 | 44 |
| Age-adjusted HR (95% CI) | 1.34 (0.94–1.92) | 1.30 (0.78–2.16) | 0.46 (0.18–1.15) | 1.11 (0.85–1.45) |
| Multivariate† HR (95% CI) | 1.31 (0.87–1.98) | 1.17 (0.67–2.03) | NA | 1.14 (0.85–1.54) |

PY, person-year; HR, hazard ratio; CI, confidence interval; NA, not analyzed.

* Reference group.

† Adjusted for age, age at hysterectomy, diabetes, high blood pressure, hypercholesterolemia, family history of myocardial infarction before age 60 years, body mass index in 1976, smoking status, use of estrogen therapy, duration of oral contraceptive use, parity, average daily alcohol consumption, total hours of weekly physical activity, and acetylsalicylic acid use.

‡ For stroke, risk estimates for all women were not encompassed by those within strata of age at hysterectomy due to confounding by age and age at hysterectomy and the high correlation between these variables.

§ Adjusted for age, age at hysterectomy, diabetes, high blood pressure, hypercholesterolemia, family history of myocardial infarction before age 60 years, tubal ligation, family history of breast cancer, body mass index in 1976, smoking status, use of estrogen therapy, duration of oral contraceptive use, parity, average daily alcohol consumption, total hours of weekly physical activity, and acetylsalicylic acid use.

|| Sample size is too small. No multivariate analysis was conducted.



Table 4. Risk of Cause-Specific and All-Cause Death by Oophorectomy Status at Time of Hysterectomy

| Event | Age at Hysterectomy | | | All |
|--|---------------------|------------------|-------------------|------------------|
| | Younger Than 45 y | 45–54 y | 55 y or Older | |
| Breast cancer | | | | |
| Ovarian Conservation* | | | | |
| Cases (n) | 64 | 27 | 6 | 97 |
| Incidence rate per 100,000 PY | 39 | 49 | 41 | 41 |
| Both ovaries removed | | | | |
| Cases (n) | 43 | 80 | 10 | 133 |
| Incidence rate per 100,000 PY | 32 | 54 | 52 | 44 |
| Age-adjusted HR (95% CI) | 0.78 (0.53–1.15) | 1.11 (0.71–1.72) | 1.28 (0.46–3.54) | 0.96 (0.74–1.25) |
| Multivariate [†] HR (95% CI) | 0.74 (0.47–1.18) | 1.16 (0.71–1.88) | NA [‡] | 0.94 (0.70–1.26) |
| Ovarian cancer[‡] | | | | |
| Ovarian Conservation* | | | | |
| Cases (n) | 21 | 10 | 3 | 34 |
| Incidence rate per 100,000 PY | 13 | 18 | 21 | 14 |
| Both ovaries removed | | | | |
| Cases (n) | 1 | 2 | 0 | 3 |
| Incidence rate per 100,000 PY | 1 | 1 | 0 | 1 |
| Age-adjusted HR (95% CI) | 0.06 (0.01–0.43) | 0.07 (0.02–0.35) | NA | 0.06 (0.02–0.21) |
| Lung cancer | | | | |
| Ovarian Conservation* | | | | |
| Cases (n) | 93 | 25 | 9 | 127 |
| Incidence rate per 100,000 PY | 56 | 45 | 62 | 54 |
| Both ovaries removed | | | | |
| Cases (n) | 107 | 87 | 15 | 209 |
| Incidence rate per 100,000 PY | 80 | 59 | 78 | 69 |
| Age-adjusted [§] HR (95% CI) | 1.30 (0.98–1.72) | 1.35 (0.86–2.11) | 1.56 (0.69–3.50) | 1.14 (0.92–1.43) |
| Multivariate HR (95% CI) | 1.13 (0.82–1.56) | 1.41 (0.85–2.33) | NA [‡] | 1.31 (1.02–1.68) |
| Colorectal cancer | | | | |
| Ovarian Conservation* | | | | |
| Cases (n) | 26 | 11 | 5 | 42 |
| Incidence rate per 100,000 PY | 16 | 20 | 34 | 18 |
| Both ovaries removed | | | | |
| Cases (n) | 31 | 43 | 2 | 76 |
| Incidence rate per 100,000 PY | 23 | 29 | 10 | 25 |
| Age-adjusted HR (95% CI) | 1.43 (0.85–2.38) | 1.49 (0.77–2.88) | 0.33 (0.07–1.61) | 1.28 (0.88–1.87) |
| Multivariate HR (95% CI) | 1.08 (0.59–1.96) | 2.01 (0.96–4.31) | NA [‡] | 1.35 (0.88–2.06) |
| Total cancer | | | | |
| Ovarian Conservation* | | | | |
| Cases (n) | 355 | 134 | 40 | 529 |
| Incidence rate per 100,000 PY | 214 | 242 | 274 | 225 |
| Both ovaries removed | | | | |
| Cases (n) | 352 | 410 | 61 | 823 |
| Incidence rate per 100,000 PY | 262 | 277 | 318 | 273 |
| Age-adjusted HR (95% CI) | 1.14 (0.99–1.33) | 1.17 (0.96–1.42) | 1.28 (0.86–1.90) | 1.10 (0.98–1.22) |
| Multivariate HR (95% CI) | 1.08 (0.91–1.27) | 1.21 (0.98–1.49) | 1.50 (0.91–2.45) | 1.17 (1.04–1.32) |
| Coronary heart disease | | | | |
| Ovarian Conservation* | | | | |
| Cases (n) | 81 | 31 | 13 | 125 |
| Incidence rate per 100,000 PY | 49 | 56 | 89 | 53 |
| Both ovaries removed | | | | |
| Cases (n) | 103 | 107 | 15 | 225 |
| Incidence rate per 100,000 PY | 77 | 72 | 78 | 75 |
| Age-adjusted HR (95% CI) | 1.41 (1.05–1.89) | 1.33 (0.89–2.00) | 1.09 (0.54–2.21) | 1.25 (1.00–1.56) |
| Multivariate [§] HR (95% CI) | 1.14 (0.81–1.61) | 1.15 (0.73–1.81) | 4.10 (0.41–41.06) | 1.28 (1.00–1.64) |

(continued)

Table 4. Risk of Cause-Specific and All-Cause Death by Oophorectomy Status at Time of Hysterectomy (continued)

| Event | Age at Hysterectomy | | | All |
|---------------------------------------|---------------------|------------------|------------------|------------------|
| | Younger Than 45 y | 45–54 y | 55 y or Older | |
| Stroke | | | | |
| Ovarian Conservation* | | | | |
| Cases (n) | 49 | 24 | 6 | 79 |
| Incidence rate per 100,000 PY | 30 | 43 | 41 | 34 |
| Both ovaries removed | | | | |
| Cases (n) | 52 | 74 | 14 | 140 |
| Incidence rate per 100,000 PY | 39 | 50 | 73 | 46 |
| Age-adjusted HR (95% CI) | 1.17 (0.80–1.73) | 1.17 (0.74–1.85) | 2.26 (0.85–5.95) | 1.23 (0.93–1.62) |
| Multivariate [§] HR (95% CI) | 0.85 (0.54–1.34) | 1.16 (0.70–1.91) | NA [†] | 1.11 (0.82–1.51) |
| All-cause death | | | | |
| Ovarian Conservation* | | | | |
| Cases (n) | 797 | 323 | 122 | 1,242 |
| Incidence rate per 100,000 PY | 481 | 584 | 836 | 527 |
| Both ovaries removed | | | | |
| Cases (n) | 830 | 977 | 148 | 1,955 |
| Incidence rate per 100,000 PY | 618 | 660 | 773 | 648 |
| Age-adjusted HR (95% CI) | 1.18 (1.07–1.30) | 1.17 (1.03–1.32) | 1.10 (0.87–1.40) | 1.10 (1.03–1.18) |
| Multivariate [¶] HR (95% CI) | 1.06 (0.95–1.18) | 1.15 (1.01–1.32) | 1.14 (0.85–1.52) | 1.12 (1.03–1.21) |

PY, person-year; HR, hazard ratio; CI, confidence interval; NA, not analyzed.

* Reference group.

[†] Adjusted for age at hysterectomy, hypercholesterolemia, tubal ligation, family history of breast cancer, body mass index in 1976, smoking status, use of estrogen therapy, duration of oral contraceptive use, parity, average daily alcohol consumption, and total hours of weekly physical activity.

[‡] Sample size is too small. No multivariate analysis was conducted.

[§] Adjusted for age, age at hysterectomy, diabetes, high blood pressure, hypercholesterolemia, family history of myocardial infarction before age 60 years, body mass index in 1976, smoking status, use of estrogen therapy, duration of oral contraceptive use, parity, average daily alcohol consumption, total hours of weekly physical activity, and acetylsalicylic acid use.

^{||} Adjusted for age, age at hysterectomy, diabetes, high blood pressure, hypercholesterolemia, body mass index in 1976, smoking status, use of estrogen therapy, duration of oral contraceptive use, parity, average daily alcohol consumption, total hours of weekly physical activity, and acetylsalicylic acid use.

[¶] Adjusted for age, age at hysterectomy, diabetes, high blood pressure, hypercholesterolemia, tubal ligation, body mass index in 1976, smoking status, use of estrogen therapy, duration of oral contraceptive use, parity, average daily alcohol consumption, total hours of weekly physical activity, and acetylsalicylic acid use.

[#] Adjusted for age, age at hysterectomy, diabetes, high blood pressure, hypercholesterolemia, family history of myocardial infarction before age 60 years, tubal ligation, family history of breast cancer, body mass index in 1976, smoking status, use of estrogen therapy, duration of oral contraceptive use, parity, average daily alcohol consumption, total hours of weekly physical activity, and acetylsalicylic acid use.

of lung cancer (HR 1.26, 95% CI 1.02–1.56), and a reduction in total cancers (HR 0.90, 95% CI 0.84–0.96). Risks of stroke, hip fracture, colorectal cancer, and pulmonary embolism did not differ significantly between groups.

We documented 3,197 deaths from any cause: 350 women (10.9%) died from coronary heart disease, 219 (6.9%) died from stroke, 230 (7.2%) died from breast cancer, 37 (1.2%) died from ovarian cancer, 336 (10.5%) died from lung cancer, 118 (3.7%) died from colorectal cancer, none died due to hip fracture, 12 (0.4%) died from pulmonary embolism, and 1,895 (59.3%) died from other causes.

Among women having a simple hysterectomy, 1,242 died (527 per 100,000 person-years), and among women having a hysterectomy with bilateral oophorectomy, 1,955 died (648 per 100,000 person-years).

In multivariable analysis, oophorectomy increased the risk of death from any cause (HR 1.12, 95% CI 1.03–1.21). For every 24 women having bilateral oophorectomy, at least one woman will die prematurely from any cause as a result of the oophorectomy. Analysis of cause-specific mortality found an increased risk of death from CHD (HR 1.28, 95% CI 1.00–1.64), lung cancer (HR 1.31, 95% CI 1.02–1.68), and all cancers (HR 1.17, 95% CI 1.04–1.32), a reduced risk of death from ovarian cancer (HR 0.06, 95% CI 0.02–0.21), and no overall difference in deaths from stroke, breast cancer, or colorectal cancer. For every 130 women having bilateral oophorectomy, one extra death from CHD will occur as a result of the oophorectomy. Analysis of death from pulmonary embolism was precluded by the small numbers of deaths.



Table 5. Risk of Incident Events and All-Cause Death by Oophorectomy Status at Time of Hysterectomy Among Those Who Never Used Estrogen Therapy

| Event | Age at Hysterectomy | | |
|--|---------------------|------------------|------------------|
| | Younger Than 50 y | 50 y or Older | All |
| Breast cancer | | | |
| Ovarian conservation* | | | |
| Cases (n) | 176 | 20 | 196 |
| Incidence rate per 100,000 PY | 267 | 276 | 268 |
| Both ovaries removed | | | |
| Cases (n) | 33 | 34 | 67 |
| Incidence rate per 100,000 PY | 234 | 469 | 314 |
| Age-adjusted HR (95% CI) | 0.73 (0.50–1.05) | 1.81 (1.03–3.19) | 0.95 (0.72–1.26) |
| Multivariate [†] HR (95% CI) | 0.66 (0.43–1.03) | 1.88 (0.66–5.32) | 0.85 (0.61–1.20) |
| Ovarian cancer | | | |
| Ovarian conservation* | | | |
| Cases (n) | 12 | 2 | 14 |
| Incidence rate per 100,000 PY | 18 | 27 | 19 |
| Both ovaries removed | | | |
| Cases (n) | 0 | 0 | 0 |
| Incidence rate per 100,000 PY | 0 | 0 | 0 |
| Lung cancer | | | |
| Ovarian conservation* | | | |
| Cases (n) | 27 | 7 | 34 |
| Incidence rate per 100,000 PY | 40 | 95 | 45 |
| Both ovaries removed | | | |
| Cases (n) | 16 | 7 | 23 |
| Incidence rate per 100,000 PY | 111 | 94 | 106 |
| Age-adjusted HR (95% CI) | 1.89 (0.97–3.66) | 0.85 (0.29–2.52) | 1.45 (0.84–2.50) |
| Multivariate [‡] HR (95% CI) | 2.36 (0.78–7.17) | NA [§] | 2.09 (1.01–4.33) |
| Coronary heart disease | | | |
| Ovarian conservation* | | | |
| Cases (n) | 72 | 19 | 91 |
| Incidence rate per 100,000 PY | 107 | 261 | 122 |
| Both ovaries removed | | | |
| Cases (n) | 40 | 14 | 54 |
| Incidence rate per 100,000 PY | 283 | 190 | 251 |
| Age-adjusted HR (95% CI) | 1.73 (1.17–2.57) | 0.70 (0.34–1.44) | 1.33 (0.94–1.87) |
| Multivariate HR (95% CI) | 1.98 (1.18–3.32) | NA [§] | 1.42 (0.93–2.16) |
| Stroke | | | |
| Ovarian conservation* | | | |
| Cases (n) | 47 | 7 | 54 |
| Incidence rate per 100,000 PY | 70 | 95 | 72 |
| Both ovaries removed | | | |
| Cases (n) | 30 | 11 | 41 |
| Incidence rate per 100,000 PY | 210 | 149 | 189 |
| Age-adjusted HR (95% CI) | 1.88 (1.18–3.02) | 1.21 (0.48–3.00) | 1.62 (1.08–2.43) |
| Multivariate HR (95% CI) | 2.19 (1.16–4.14) | NA [§] | 1.85 (1.09–3.16) |
| All-cause death | | | |
| Ovarian conservation* | | | |
| Cases (n) | 162 | 36 | 198 |
| Incidence rate per 100,000 PY | 240 | 488 | 264 |
| Both ovaries removed | | | |
| Cases (n) | 82 | 35 | 117 |
| Incidence rate per 100,000 PY | 569 | 469 | 535 |
| Age-adjusted HR (95% CI) | 1.54 (1.17–2.02) | 1.13 (0.71–1.79) | 1.28 (1.01–1.62) |
| Multivariate HR (95% CI) | 1.40 (1.01–1.96) | 2.05 (0.87–4.79) | 1.20 (0.91–1.57) |

PY, person-year; HR, hazard ratio; CI, confidence interval; NA, not analyzed.

* Reference group.

[†] Adjusted for age, age at hysterectomy, hypercholesterolemia, tubal ligation, family history of breast cancer, body mass index in 1976, smoking status, duration of oral contraceptive use, parity, average daily alcohol consumption, and total hours of weekly physical activity.

[‡] Adjusted for age, age at hysterectomy, diabetes, high blood pressure, hypercholesterolemia, body mass index in 1976, smoking status, duration of oral contraceptive use, parity, average daily alcohol consumption, total hours of weekly physical activity, and acetylsalicylic acid use.

[§] Sample size is too small. No multivariate analysis was conducted.

^{||} Adjusted for age at hysterectomy, diabetes, high blood pressure, hypercholesterolemia, family history of myocardial infarction before age 60 years, body mass index in 1976, smoking status, duration of oral contraceptive use, parity, average daily alcohol consumption, total hours of weekly physical activity, and acetylsalicylic acid use.

^{||} Adjusted for age, age at hysterectomy, diabetes, high blood pressure, hypercholesterolemia, family history of myocardial infarction before age 60 years, tubal ligation, family history of breast cancer, body mass index in 1976, smoking status, duration of oral contraceptive use, parity, average daily alcohol consumption, total hours of weekly physical activity, and acetylsalicylic acid use.



We performed an analysis of the 10,094 women who had either bilateral oophorectomy or ovarian conservation and had never used estrogen therapy (ET), stratified by age at hysterectomy younger than 50 years and 50 years or older (Table 5). Those who never used ET who had oophorectomy before age 50 years had a higher risk of incident coronary heart disease (HR 1.98, 95% CI 1.18–3.32). Oophorectomy was associated with a significantly increased risk of stroke for all women (HR 1.85, 95% CI 1.09–3.16) and for women aged younger than 50 years at the time of surgery (HR 2.19, 95% CI 1.16–4.14). Oophorectomy was associated with an increased the risk of lung cancer (HR 2.09, 95% 1.01–4.33). The risk of all-cause death was significantly higher among women aged younger than 50 years at the time of surgery (HR 1.40, 95% CI 1.01–1.96). The risks of breast cancer, colorectal cancer, total cancer, hip fracture, and pulmonary embolus were no different among women who had never used ET.

DISCUSSION

This large prospective study of women having a hysterectomy for benign disease indicates that concurrent bilateral oophorectomy, after adjustment for multiple independent risk factors, is associated with a higher risk of all-cause mortality, primarily from coronary heart disease and lung cancer, when compared with ovarian conservation. Furthermore, prophylactic oophorectomy did not improve survival at any age. During 24 years of follow-up, among 13,305 women who had ovarian conservation, 34 (0.26%) died from ovarian cancer. We did not find increased risks for colorectal cancer, pulmonary embolus, or hip fracture in any analysis. Whereas breast cancer, ovarian cancer, and all cancers were less frequent, the overall risk of death from cancer was greater among women having oophorectomy. The basis for this paradox is unclear and warrants further study. In a secondary analysis of women who never used estrogen therapy, oophorectomy was associated with an increased risk for incident stroke and lung cancer, and oophorectomy before age 50 years was associated with an increased risk of fatal plus nonfatal coronary heart disease, stroke, and deaths from all causes. Total cancer risk was neither increased nor decreased among women with oophorectomy who had never used ET.

Our study has several strengths. This is the largest prospective study, with the longest follow-up, to examine the effect of oophorectomy on health outcomes in women. Although our study is observational, the Nurses' Health Study cohort is particularly homoge-

nous relative to a study in the general population, with regard to educational and socioeconomic factors that may possibly confound nonrandomized studies. To reduce the possibility of confounding due to the indication for surgery, women with any prior diagnosis of cancer or prior unilateral oophorectomy were excluded from our analysis. To reduce the possibility of confounding due to the family history, our main analysis was adjusted for both family history of breast or ovarian cancer. We also performed a subset analysis that excluded women with a family history of ovarian cancer (approximately 4.5% of study subjects) and found results similar to those presented in our report (data not shown).

Many previous studies were small or did not adjust for known risk factors for cardiovascular disease.^{6,15,16} Our study included 29,380 women who had hysterectomies, nearly equally divided between bilateral oophorectomy and ovarian conservation. Although baseline characteristics differed somewhat between groups, we used multivariable analysis to correct for multiple known risk factors associated with all the conditions of interest. Follow-up over the 24 years was high for reported incident diagnoses and updated information on risk factors, and identification of deaths is approximately 98% complete.

Several limitations of our study deserve comment. The study was observational, and oophorectomy or ovarian conservation was self-selected. Despite the biologic plausibility of many of our results and despite accounting for multiple risk factors, it is possible that our findings could be related to the underlying indication for which participants chose oophorectomy or due to uncorrected differences between the groups. Most of the women in this study were white and the results may not be applicable to nonwhite women.

Our results for cardiovascular disease are biologically plausible and supported by experimental evidence. Reduction in endogenous estrogen increases serum lipids, reduces carotid artery blood flow, and increases subclinical atherosclerosis as measured by carotid artery intima-media thickness.^{17–19}

Our results are consistent with other studies. A decision analysis found that ovarian conservation improved survival for women aged younger than 65 years at the time of surgery.²⁰ A cohort study of 1,097 women who underwent hysterectomy and bilateral oophorectomy for benign disease who were matched by age to 2,390 women choosing ovarian conservation found mortality to be higher in women who had prophylactic bilateral oophorectomy before the age of 45 years.¹⁶

Earlier age of surgical or natural menopause correlates with increased risk of cardiovascular



events.^{15,21,22} Previous reports from the Nurses' Health Study found that women with oophorectomy between the ages of 40 years and 44 years, compared with women with intact ovaries, had double the risk of myocardial infarction (RR 2.2, 95% CI 1.2–4.2).⁷ Oophorectomy after age 50 years increased the risk of developing a first myocardial infarction compared with controls (RR 1.4, 95% CI 1.0–2.0).⁸ When adjusted for age, death from stroke was reduced 6% per year of delayed menopause (RR 0.94, 95% CI 0.89–1.00).⁶ A meta-analysis of observational studies found that oophorectomy doubled the risk of cardiovascular disease (RR 2.62, 95% CI 2.05–3.35).⁹ In that cardiovascular disease is the main cause of death among U.S. women, any increased risk would be expected to increase overall morbidity and mortality, as found in our study.

Ovarian cancer is a low-prevalence disease, and simple hysterectomy may reduce the risk of ovarian cancer. Suggested mechanisms include interruption of transport of potential carcinogens through the reproductive tract, alteration in hormone levels, or induction of protective anti-MUC1 antibodies.^{23–25} Our analysis found a decreased risk of breast cancer among women after oophorectomy. Women with oophorectomy before age 50 years have been shown to have a 50% decreased risk of breast cancer that persisted for 10 years after surgery.²⁶

We found the increased risk of dying of other cancers exceeded the risk of dying from ovarian cancer (low incidence) and breast cancer (high long-term survival rate) among women having an oophorectomy. The association of oophorectomy with lung cancer was unexpected and warrants further study.

Although postmenopausal estrogen therapy may reduce some of the increased risks we found, after publication of the Women's Health Initiative results, many women discontinued hormone therapy, and 77% fewer women now start hormones at the time of menopause.²⁷ Likewise, continuation rates for medications that can reduce the risk of cardiovascular disease, such as statins, are as low as 18% for women after one year.²⁸

Our findings provide evidence that, for women not at high risk for ovarian cancer, oophorectomy may adversely affect long-term health outcomes and mortality, and at no age was oophorectomy associated with a survival benefit. Preventive surgery should not be performed if it does not clearly benefit the patient. Therefore, prophylactic oophorectomy, with the goal of improving survival by reducing ovarian cancer, seems not to be supported by our study. Given that approximately 300,000 U.S. women per year undergo

elective oophorectomy, these findings have important public health implications.

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