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QUALIDADE DE VIDA APÓS HISTERECTOMIA: AVALIAÇÃO CLÍNICA E FUNCIONAL DE MULHERES COM CONDIÇÕES GINECOLÓGICAS

QUALITY OF LIFE AFTER HYSTERECTOMY: CLINICAL AND FUNCTIONAL ASSESSMENT OF WOMEN WITH GYNECOLOGICAL CONDITIONS

CALIDAD DE VIDA DESPUÉS DE LA HISTERECTOMÍA: EVALUACIÓN CLÍNICA Y FUNCIONAL DE MUJERES CON CONDICIONES GINECOLÓGICAS

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Resumo
A histerectomia está entre os procedimentos ginecológicos mais realizados mundialmente e pode produzir repercussões físicas, emocionais e funcionais importantes na qualidade de vida (QV) das mulheres. Este estudo transversal exploratório avaliou características sociodemográficas, clínicas e a qualidade de vida de 116 mulheres submetidas à histerectomia total ou subtotal por condições ginecológicas benignas e malignas. Os dados foram obtidos por questionário eletrônico estruturado, e a QV foi avaliada pelo WHOQOL-BREF. Foram realizadas análises descritivas e inferenciais,

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incluindo correlação de Spearman com ajuste de Benjamini–Hochberg para múltiplas comparações. Predominaram mulheres entre 41–50 anos (43,1%), casadas (62,1%) e com escolaridade média ou superior. A principal indicação cirúrgica foi miomatose uterina (40,5%), seguida por neoplasias malignas (30,2%). Mais da metade das participantes relatou histórico familiar de câncer (53,4%), incluindo câncer uterino em 25,9% dos casos familiares. O escore global do WHOQOL-BREF indicou qualidade de vida intermediária (56,55/100). O domínio Físico apresentou o menor escore transformado (51,35), seguido pelos domínios Psicológico (56,47), Relações Sociais (57,40) e Meio Ambiente (59,11). As menores pontuações facetadas foram observadas para atividade sexual e capacidade para o trabalho, indicando comprometimento importante nas dimensões íntima e funcional. Correlação negativa fraca foi observada entre maior carga sintomática pré-operatória e pior escore no domínio Psicológico ($\rho = -0,214$; $p = 0,021$); entretanto, a associação perdeu significância após ajuste para múltiplas comparações (p ajustado = 0,105). As demais correlações apresentaram baixa magnitude ($\rho^2 = 2,0\%–4,6\%$). Não foram observadas diferenças estatisticamente significativas nos escores do WHOQOL-BREF entre grupos diagnósticos nem entre mulheres com e sem histórico familiar de câncer ($p > 0,05$). Conclui-se que mulheres submetidas à histerectomia apresentaram comprometimento moderado da qualidade de vida, especialmente em aspectos físicos, sexuais e ocupacionais, reforçando a importância de acompanhamento multidisciplinar no período pós-operatório.

Palavras-chave: histerectomia; qualidade de vida; saúde da mulher; função sexual; doenças ginecológicas.

Abstract

Hysterectomy is among the most frequently performed gynecological procedures worldwide and may produce important physical, emotional, and functional repercussions on women's quality of life (QoL). This exploratory cross-sectional study evaluated the sociodemographic and clinical characteristics and quality of life of 116 women who underwent total or subtotal hysterectomy for benign and malignant gynecological conditions. Data were collected using a structured electronic questionnaire, and QoL was assessed using the WHOQOL-BREF instrument. Descriptive and inferential analyses were performed, including Spearman's correlation with Benjamini–Hochberg adjustment for multiple comparisons. Women aged 41–50 years predominated (43.1%), most participants were married (62.1%), and the majority had completed secondary or higher education. Uterine fibroids represented the main surgical indication (40.5%), followed by malignant neoplasms (30.2%). More than half of the participants reported a family history of cancer (53.4%), including uterine cancer in 25.9% of familial cases. The overall WHOQOL-BREF score indicated intermediate quality of life (56.55/100). The Physical domain presented the lowest transformed score (51.35), followed by the Psychological (56.47), Social Relationships (57.40), and Environment (59.11) domains. The lowest facet scores were observed for sexual activity and work capacity, indicating substantial impairment in intimate and functional dimensions. A weak negative correlation was observed between greater preoperative symptom burden and poorer Psychological-domain scores ($\rho = -0.214$; $p = 0.021$); however, this association lost statistical significance after adjustment for multiple comparisons (adjusted $p = 0.105$). The remaining correlations demonstrated low magnitude ($\rho^2 = 2.0\%–4.6\%$). No statistically significant differences were observed in WHOQOL-BREF scores between diagnostic groups or between women with and without family history of cancer ($p > 0.05$). In conclusion, women undergoing hysterectomy presented moderate impairment in quality of life, particularly in physical, sexual, and occupational aspects, reinforcing the importance of multidisciplinary postoperative follow-up.

Keywords: hysterectomy; quality of life; women's health; sexual function; gynecological diseases.

Resumen

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La histerectomía se encuentra entre los procedimientos ginecológicos más realizados en el mundo y puede producir importantes repercusiones físicas, emocionales y funcionales en la calidad de vida (CV) de las mujeres. Este estudio transversal exploratorio evaluó las características sociodemográficas y clínicas, así como la calidad de vida de 116 mujeres sometidas a histerectomía total o subtotal por afecciones ginecológicas benignas y malignas. Los datos se obtuvieron mediante un cuestionario electrónico estructurado y la CV fue evaluada mediante el instrumento WHOQOL-BREF. Se realizaron análisis descriptivos e inferenciales, incluyendo correlación de Spearman con ajuste de Benjamini–Hochberg para comparaciones múltiples. Predominaron mujeres entre 41 y 50 años (43,1%), casadas (62,1%) y con educación secundaria o superior. La principal indicación quirúrgica fue la miomatosis uterina (40,5%), seguida de neoplasias malignas (30,2%). Más de la mitad de las participantes reportó antecedentes familiares de cáncer (53,4%), incluyendo cáncer uterino en el 25,9% de los casos familiares. La puntuación global del WHOQOL-BREF indicó una calidad de vida intermedia (56,55/100). El dominio Físico presentó la puntuación transformada más baja (51,35), seguido por los dominios Psicológico (56,47), Relaciones Sociales (57,40) y Medio Ambiente (59,11). Las puntuaciones facetadas más bajas se observaron en actividad sexual y capacidad para el trabajo, indicando deterioro importante en las dimensiones íntima y funcional. Se observó una correlación negativa débil entre mayor carga sintomática preoperatoria y peores puntuaciones en el dominio Psicológico ($\rho = -0,214$; $p = 0,021$); sin embargo, esta asociación perdió significancia estadística tras el ajuste por comparaciones múltiples (p ajustado = 0,105). Las demás correlaciones presentaron baja magnitud (ρ^2 = 2,0%–4,6%). No se observaron diferencias estadísticamente significativas en las puntuaciones del WHOQOL-BREF entre los grupos diagnósticos ni entre mujeres con y sin antecedentes familiares de cáncer ($p > 0,05$). En conclusión, las mujeres sometidas a histerectomía presentaron deterioro moderado de la calidad de vida, especialmente en aspectos físicos, sexuales y ocupacionales, reforzando la importancia del seguimiento multidisciplinario en el período postoperatorio.

Palabras clave: histerectomía; calidad de vida; salud de la mujer; función sexual; enfermedades ginecológicas.

1. INTRODUCTION

Hysterectomy, defined as the total or partial surgical removal of the uterus, is among the most frequently performed gynecological procedures worldwide. Approximately 30% of women in the United States undergo hysterectomy by the age of 50 years, with the main indications including benign conditions such as uterine fibroids, endometriosis, adenomyosis, and abnormal uterine bleeding, as well as malignant gynecological neoplasms (ANCHAN et al., 2023). In Brazil, hysterectomy also represents a highly prevalent gynecological intervention within the public healthcare system, particularly among women of reproductive and perimenopausal age groups (FERREIRA et al., 2024).

The gynecological conditions leading to hysterectomy are frequently associated with substantial physical, emotional, and functional burden. Symptoms

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such as abnormal uterine bleeding, chronic pelvic pain, dyspareunia, and secondary anemia may negatively affect daily activities, occupational performance, interpersonal relationships, emotional well-being, and sexual function (ANCHAN et al., 2023; TORNG et al., 2007). Previous investigations suggest that greater symptom burden may be associated with poorer quality-of-life indicators, particularly in physical-health domains, although the magnitude and persistence of these associations may vary according to clinical context, symptom severity, and postoperative adaptation (TORNG et al., 2007; TROMMELEN et al., 2025).

From an oncological perspective, cervical cancer remains one of the leading gynecological malignancies in developing countries, with persistent infection by oncogenic human papillomavirus (HPV) representing its principal etiological factor (STELA; SERENO; RODRIGUES, 2024). Additional risk factors include smoking, high parity, and prolonged oral contraceptive use (STELA; SERENO; RODRIGUES, 2024). Screening through the Papanicolaou test remains essential for early detection and reduction of cervical-cancer-related morbidity and mortality (FERREIRA et al., 2024). Furthermore, family history of cancer may represent an important clinical characteristic in women undergoing gynecological surgery, particularly considering hereditary cancer predisposition syndromes such as Lynch syndrome, which is strongly associated with endometrial and ovarian malignancies (EDWARDS; MONAHAN, 2022).

Although hysterectomy performed for symptomatic benign conditions is frequently associated with postoperative improvement in symptom severity and quality-of-life indicators, unfavorable outcomes involving urinary, intestinal, hormonal, emotional, occupational, and sexual dimensions have also been reported, particularly in women undergoing more extensive procedures or presenting persistent postoperative symptoms (VITALE et al., 2022; FIRMEZA et al., 2022; VATAMAN, 2020; OXLEY et al., 2022). These findings reinforce the multidimensional nature of postoperative adaptation and the importance of comprehensive quality-of-life assessment in women undergoing hysterectomy.

Quality of life is a multidimensional construct encompassing physical, psychological, social, and environmental domains. In this context, the WHOQOL-

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BREF instrument, developed by the World Health Organization and validated for use in Brazil, has been widely employed in clinical and epidemiological investigations evaluating subjective perceptions of health and well-being (FLECK et al., 1999). In addition to domain-level assessment, the instrument enables exploration of specific facets potentially affected by gynecological conditions and surgical treatment, including pain, work capacity, emotional well-being, and sexual activity.

Despite the growing literature regarding hysterectomy outcomes, studies simultaneously evaluating benign and malignant gynecological conditions within exploratory quality-of-life frameworks remain relatively limited in Brazilian populations. Moreover, evidence derived from women recruited through online support communities and social-media environments remains scarce, despite the increasing relevance of digital platforms for health-related information exchange and peer support.

Conceptually, the study is guided by a hypothetical-deductive framework in which sociodemographic characteristics (e.g., age, educational level), clinical profiles (e.g., primary diagnosis, self-reported symptom burden), and reproductive history are posited as independent factors potentially influencing postoperative quality-of-life outcomes, operationalized as the WHOQOL-BREF physical, psychological, social relationships, and environmental domains. However, given the cross-sectional design, the absence of preoperative baseline data, and the reliance on retrospective self-report, no confirmatory hypotheses were pre-specified. Instead, the study adopts a descriptive, hypothesis-generating framework to identify patterns that may inform future longitudinal investigations with comprehensive surgical and clinical variables.

Therefore, this exploratory cross-sectional study aimed to characterize the sociodemographic and clinical profile of women who underwent hysterectomy and to investigate exploratory associations between self-reported symptom burden, family history of cancer, and WHOQOL-BREF quality-of-life domains. Given the exploratory nature of the study, the cross-sectional design, and the reliance on retrospective self-reported information, the analyses were intended to generate

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preliminary evidence and identify potential patterns for future longitudinal investigations rather than establish causal relationships.

2. METHODOLOGY

2.1 Study Design

This exploratory cross-sectional study employed a quantitative approach using a convenience sample recruited through social media platforms. The study aimed to evaluate quality of life in women who underwent total or subtotal hysterectomy and to characterize the sociodemographic and clinical profile of this population.

2.2 Population and Sample

A total of 116 women aged 18 years or older participated in the study. Eligible participants had undergone total or subtotal hysterectomy due to benign gynecological conditions, including uterine fibroids, endometriosis, and adenomyosis, or malignant gynecological conditions, including cervical and endometrial cancer. Women able to understand and complete the questionnaire independently or with assistance, with internet access, and who electronically signed the informed consent form were included. No exclusion criteria related to postoperative follow-up duration or time elapsed since surgery were established.

2.3 Sampling and Recruitment

A non-probabilistic convenience sampling strategy was adopted, consistent with the exploratory cross-sectional design. Participants were recruited through advertisements and invitations posted in Facebook® groups focused on hysterectomy, gynecological cancer, uterine fibroids, and endometriosis. Recruitment through online support communities was intended to facilitate access to women from different geographic regions and clinical backgrounds.

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2.4 Data Collection Instruments

Data collection was conducted using a structured electronic questionnaire developed through the Google Forms® platform. The questionnaire consisted of three sections:

Section 1 — Sociodemographic characteristics

Included questions regarding age, marital status, educational level, occupation, monthly family income, and number of children.

Section 2 — Clinical and postoperative characteristics

Included questions regarding primary indication for hysterectomy, age at diagnosis of the gynecological condition, frequency of Papanicolaou testing prior to surgery, preoperative symptoms, family history of cancer (including cancer type), timing of diagnosis (early or late), healthcare system utilized (public or private), intraoperative complications, postoperative effects, postoperative follow-up, chemotherapy requirement, cancer recurrence, and use of prescription-controlled medications.

Section 3 — Quality-of-life assessment

Quality of life was evaluated using the WHOQOL-BREF instrument, developed by the World Health Organization and validated for use in Brazil (FLECK et al., 1999). The WHOQOL-BREF consists of 26 items distributed across four domains: Physical (7 items), Psychological (6 items), Social Relationships (3 items), and Environment (8 items), in addition to two general items evaluating overall quality of life and satisfaction with health. Responses are recorded using a five-point Likert scale.

2.5 Data Collection Procedures

The questionnaire access link was disseminated within selected online groups, accompanied by a brief explanation of the study objectives and an invitation to participate. The first section of the form contained the electronic informed consent form, including information regarding study objectives, procedures, voluntary participation, confidentiality, and anonymity. Only participants selecting the option “I have read and agree” were allowed to proceed to the questionnaire.

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2.6 Study Variables

Collected variables were categorized as follows:

Sociodemographic variables

Age group, marital status, educational level, monthly family income, and number of children.

Clinical variables

Primary diagnosis leading to hysterectomy, age at diagnosis, frequency of Papanicolaou testing, preoperative symptoms, family history of cancer, timing of diagnosis, and healthcare system utilized.

Postoperative variables

Intraoperative complications, postoperative effects, postoperative follow-up, chemotherapy requirement, cancer recurrence, and use of prescription-controlled medications.

Quality-of-life variables

WHOQOL-BREF domain scores, overall quality-of-life score, and individual facet scores.

2.7 Statistical Analysis

Descriptive analyses were performed to characterize the sociodemographic, clinical, postoperative, and quality-of-life profile of the participants. Categorical variables were expressed as absolute and relative frequencies. Continuous variables were described using means and standard deviations or medians and interquartile ranges according to data distribution.

WHOQOL-BREF scores were calculated according to World Health Organization recommendations. Negatively oriented items (questions 3, 4, and 26) were reverse coded prior to score calculation. Raw scores were transformed to a 0–100 scale, in which higher values indicate better perceived quality of life. Descriptive analyses were performed at both domain and facet levels.

Normality of continuous variables was assessed using the Shapiro–Wilk test and graphical distribution analysis. Comparisons among diagnostic groups (uterine fibroids, malignant neoplasms, and other gynecological conditions) were performed

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using one-way analysis of variance (ANOVA) for normally distributed variables or the Kruskal–Wallis test for nonparametric distributions. Effect sizes were estimated using partial eta squared (η^2p).

Associations between clinical variables and WHOQOL-BREF scores were evaluated using Spearman's rank correlation coefficient (ρ), given the nonparametric distribution of several variables. Correlation analyses included age and number of self-reported preoperative symptoms. To improve inferential robustness, 95% confidence intervals for correlation coefficients were estimated using bootstrap resampling procedures (1,000 iterations). Coefficients of determination (ρ^2) were additionally calculated to contextualize the magnitude of observed associations.

Exploratory subgroup analyses were performed according to self-reported family history of cancer. Associations between family history and categorical clinical variables, including primary diagnosis, age at diagnosis, and frequency of cervical cancer screening, were evaluated using Pearson's chi-square test or Fisher's exact test when appropriate. Comparisons of WHOQOL-BREF scores between participants with and without family history of cancer were performed using the Mann–Whitney U test due to nonparametric score distributions. Rank-biserial correlation coefficients were estimated as effect-size measures when applicable.

Because multiple inferential analyses were conducted across correlated WHOQOL-BREF domains, p values were adjusted using the Benjamini–Hochberg false discovery rate (BH-FDR) procedure to reduce inflation of type I error associated with multiple comparisons (BENJAMINI; HOCHBERG, 1995; MCDONALD, 2014). Both crude and adjusted p values are presented where applicable.

No missing data were identified in WHOQOL-BREF responses. Missing information occurred only in secondary clinical and sociodemographic variables. Therefore, no imputation procedures were performed, and inferential analyses adopted complete-case approaches according to variable availability for each analysis. Sensitivity analyses comparing participants with complete versus

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incomplete secondary clinical data demonstrated no statistically significant differences in WHOQOL-BREF scores.

An exploratory multivariable regression approach was initially considered to evaluate independent predictors of quality-of-life scores. However, given the limited subgroup sample sizes and the risk of model overfitting, the final analytical strategy prioritized descriptive and bivariate exploratory analyses. Accordingly, all inferential findings were interpreted as exploratory and hypothesis-generating rather than confirmatory.

Statistical analyses were performed using IBM SPSS Statistics (IBM Corp., Armonk, NY, USA). Additional procedures for bootstrap confidence intervals and false discovery rate correction were implemented using complementary statistical computing resources. Statistical significance was initially defined as $p < 0.05$.

2.8 Ethical Considerations

The study was conducted in accordance with Resolution No. 466/2012 of the Brazilian National Health Council (Conselho Nacional de Saúde – CNS). The research protocol was approved by the Research Ethics Committee of Universidade de Mogi das Cruzes under approval number 7.259.964 and CAAE number 84145924.0.0000.5497. All participants provided electronic informed consent prior to participation.

3. RESULTS

A total of 116 women who underwent hysterectomy were included in the study. Analyses comprised sociodemographic, clinical, postoperative, and quality-of-life variables assessed using the WHOQOL-BREF instrument.

3.1 Sociodemographic Characteristics

The sample was predominantly composed of women aged 41–50 years (41.4%), followed by those aged 31–40 years (31.9%). Most participants were married (58.6%) and had completed at least secondary education, with 27.6% reporting undergraduate education and 25.9% postgraduate specialization.

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Regarding monthly family income, the most frequent category was 2–3 minimum wages (37.1%), whereas 30.2% reported income above six minimum wages.

Most participants had children, with two children being the most frequent category among women with offspring (32.8%). Detailed sociodemographic characteristics are presented in Table 1.

Table 1. Sociodemographic characteristics of women undergoing hysterectomy **(N = 116)**

Age Group	**n**	**% (N=116)**
26–30	9	7.8
31–40	37	31.9
41–50	48	41.4
51–60	20	17.2
>60	2	1.7
Marital Status		
Married	68	58.6
Single	19	16.4
Divorced	14	12.1
Stable union	12	10.3
Widowed	3	2.6
Educational Level		
Elementary education	7	6.0
Secondary/technical education	40	34.5
University degree (undergraduate)	32	27.6
Postgraduate specialization	30	25.9
Master's degree	5	4.3
Doctoral degree	2	1.7
Monthly Family Income	**n**	**% (N=116)**
1 minimum wage	22	19.0
2–3 minimum wages	43	37.1
4–6 minimum wages	16	13.8
>6 minimum wages	35	30.2
Number of Children	**n**	**% (N=116)**
No children	25	21.6
1	34	29.3
2	38	32.8
3	12	10.3
4	4	3.4
5	3	2.6

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3.2 Clinical Characteristics and Indications for Surgery

Uterine fibroids represented the main indication for hysterectomy (43.1%), followed by malignant neoplasms (26.7%) and other gynecological conditions, including endometriosis, adenomyosis, prolapse, and preventive indications (30.2%). Standardized diagnostic classification demonstrated a similar distribution, with leiomyoma/fibroids accounting for 40.5% of cases (Table 2).

Table 2. Clinical characteristics, indications for hysterectomy, and main preoperative symptoms

Cause of surgery	**n**	**%**
Fibroids	50	43.1
Malignant cancer	31	26.7
Other causes	35	30.2
Standardized diagnosis	**n**	**%**
Leiomyoma/Fibroids	47	40.5
Malignant cancer	35	30.2
Endometriosis/Adenomyosis/Others	34	29.3
Age at diagnosis	**n**	**%**
26–30 years	25	21.6
31–35 years	22	19.0
36–45 years	52	44.8
46–55 years	10	8.6
Other age ranges	7	6.0
Frequency of Papanicolaou Testing	**n**	**%**
Never performed	2	1.7
Very rarely/Less than once per year	21	18.1
Once per year	80	69.0
More than once per year	13	11.2
Main preoperative symptoms	**n**	**%**
Abnormal uterine bleeding	69	59.5
Pelvic pain/cramps	63	54.3
Anemia/fatigue/weakness	12	10.4
Dyspareunia	8	6.9
Abnormal vaginal discharge	5	4.3
Abdominal enlargement/distension	7	6.0
Urinary symptoms	4	3.4
Systemic symptoms	5	4.3
Asymptomatic	17	14.7

Participants could report more than one preoperative symptom; therefore, percentages may exceed 100%. Symptoms were self-reported without clinical hierarchy; some symptoms (e.g., anemia/fatigue/weakness) may represent secondary manifestations of other conditions such as abnormal uterine bleeding.

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Most participants reported identification of the gynecological condition between 36 and 45 years of age (44.8%). Regarding cervical cancer screening practices, 69.0% reported annual Papanicolaou testing, whereas 11.2% reported undergoing the examination more than once per year (Table 2).

Preoperative symptoms were highly prevalent. Abnormal uterine bleeding was the most frequently reported symptom (59.5%), followed by pelvic pain and cramps (54.3%). Other reported symptoms included anemia/fatigue/weakness (10.4%), dyspareunia (6.9%), abdominal enlargement/distension (6.0%), abnormal vaginal discharge (4.3%), urinary symptoms (3.4%), and systemic manifestations (4.3%). Approximately 14.7% of participants reported being asymptomatic, with diagnosis occurring during routine examinations (Table 2).

The distribution of symptoms according to diagnostic category demonstrated predominance of abnormal bleeding among women with fibroids, whereas pelvic pain and cramps were more frequently reported among participants with adenomyosis and endometriosis (Table 2).

3.3 Family History of Cancer and Surgical Follow-up

More than half of the participants (53.4%) reported a family history of cancer, and uterine cancer among relatives was reported by 25.9% of the sample. Breast and gynecological cancers represented the most frequently reported familial neoplasms.

Regarding healthcare access, 56.9% of hysterectomies were performed within the private healthcare system. Early diagnosis was reported by 42.2% of participants, whereas 40.5% described receiving a late diagnosis (Table 3).

Most women did not report intraoperative complications (84.5%) and underwent postoperative follow-up after surgery (81.0%). Chemotherapy was required in 13.8% of cases. Cancer recurrence or unclear recurrence status was identified in 14.7% of participants, while 26.7% reported postoperative use of prescription-controlled medication (Table 3).

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Table 3. Family history of cancer, healthcare access, and postoperative characteristics.

Family history of cancer		
Yes	62	53.4
No	54	46.6
Uterine cancer in the family		
Yes	30	25.9
No	86	74.1
Healthcare system for surgery		
Private	66	56.9
Public	50	43.1
Timing of diagnosis		
Early	49	42.2
Late	47	40.5
Not applicable/other responses	20	17.3
Surgical complications		
No	98	84.5
Yes	18	15.5
Postoperative effects reported		
No	69	59.5
Yes	47	40.5
Postoperative follow-up		
Yes	94	81.0
No	22	19.0
Need for chemotherapy		
No	100	86.2
Yes	16	13.8
Cancer recurrence		
No	99	85.3
Yes/Other/Not informed	17	14.7
Use of controlled medication		
No	85	73.3
Yes	31	26.7

3.4 Exploratory Analyses According to Family History of Cancer

Exploratory subgroup analyses were performed to investigate whether self-reported family history of cancer was associated with selected clinical variables. No statistically significant association was observed between family history of cancer and the primary diagnosis leading to hysterectomy ($p = 0.492$) or age at diagnosis of the gynecological condition ($p = 0.754$) (Table 4).

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Table 4. Distribution of selected clinical variables according to family history of cancer

Variable	Family history absent n (%)	Family history present n (%)	p value
Primary diagnosis			0.492
Fibroids	25 (46.3%)	22 (35.5%)	
Malignant cancer	15 (27.8%)	20 (32.3%)	
Other causes	14 (25.9%)	20 (32.3%)	
Age at diagnosis			0.754
18–20 years	2 (3.7%)	2 (3.2%)	
20–25 years	1 (1.9%)	0 (0.0%)	
26–30 years	12 (22.2%)	13 (21.0%)	
31–35 years	8 (14.8%)	14 (22.6%)	
36–45 years	25 (46.3%)	27 (43.5%)	
46–55 years	5 (9.3%)	5 (8.1%)	
56–65 years	0 (0.0%)	1 (1.6%)	
>66 years	1 (1.9%)	0 (0.0%)	
Frequency of Papanicolaou testing			0.210
Once per year	32 (59.3%)	48 (77.4%)	
More than once per year	8 (14.8%)	5 (8.1%)	
Less than once per year	6 (11.1%)	4 (6.5%)	
Very rarely	6 (11.1%)	5 (8.1%)	
Never performed	2 (3.7%)	0 (0.0%)	

Data are presented as absolute frequencies and percentages. P values were calculated using Pearson's chi-square test or Fisher's exact test, when appropriate.

Women reporting family history of cancer demonstrated a tendency toward higher adherence to cervical cancer screening practices, particularly annual Papanicolaou testing; however, this association did not reach statistical significance ($p = 0.210$) (Table 4).

Additional exploratory analyses compared WHOQOL-BREF scores between participants with and without family history of cancer. No statistically significant differences were observed in the Physical, Psychological, Social Relationships, Environment, or Overall Quality-of-Life domains (all $p > 0.05$) (Table 5).

Participants reporting family history of cancer demonstrated slightly lower mean scores in the Psychological and Social Relationships domains; however, the magnitude of these differences was small. Overall, these findings suggest that family history of cancer was not clearly associated with the evaluated clinical or quality-of-life variables within the limitations of this exploratory cross-sectional study.

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Table 5. Comparison of WHOQOL-BREF domain scores according to family history of cancer.

WHOQOL-BREF domain	Family history absent Mean ± SD	Family history present Mean ± SD	p value
Physical	60.19 ± 20.21	58.60 ± 23.47	0.816
Psychological	58.02 ± 22.93	53.09 ± 23.65	0.239
Social Relationships	60.96 ± 23.67	54.30 ± 24.78	0.150
Environment	57.93 ± 22.50	60.13 ± 22.55	0.583
Overall Quality of Life	63.66 ± 25.27	63.31 ± 27.15	0.930

Data are presented as mean ± standard deviation (SD). Comparisons between groups were performed using the Mann–Whitney U test due to nonparametric score distributions. WHOQOL-BREF scores were transformed to a 0–100 scale, with higher scores indicating better perceived quality of life.

3.5 WHOQOL-BREF Scores

The overall WHOQOL-BREF score indicated an intermediate perception of quality of life among women undergoing hysterectomy, with a mean transformed score of 56.55 on the 0–100 scale. Among the evaluated domains, the Physical domain presented the lowest transformed score (51.35), followed by the Psychological domain (56.47), Social Relationships domain (57.40), and Environment domain (59.11) (Table 6). These findings indicate greater impairment in physical aspects of quality of life, whereas social and environmental dimensions demonstrated comparatively higher scores.

Table 6. WHOQOL-BREF domain scores among women undergoing hysterectomy (N = 116)

Domain	Mean ± SD	Transformed Score (0–100)	95% CI
Physical	12.22 ± 2.38	51.35	[47.0; 55.7]
Psychological	13.03 ± 2.96	56.47	[51.7; 62,6]
Social Relationships	13.18 ± 3.90	57.40	[52.7; 67.1]
Environment	13.46 ± 3.59	59.11	[54.9; 68.1]
Overall quality-of-life perception	**13.05 ± 2.72**	**56.55**	**[51.6; 61.5]**

WHOQOL-BREF scores were transformed to a 0–100 scale according to World Health Organization recommendations. Higher scores indicate better perceived quality of life.

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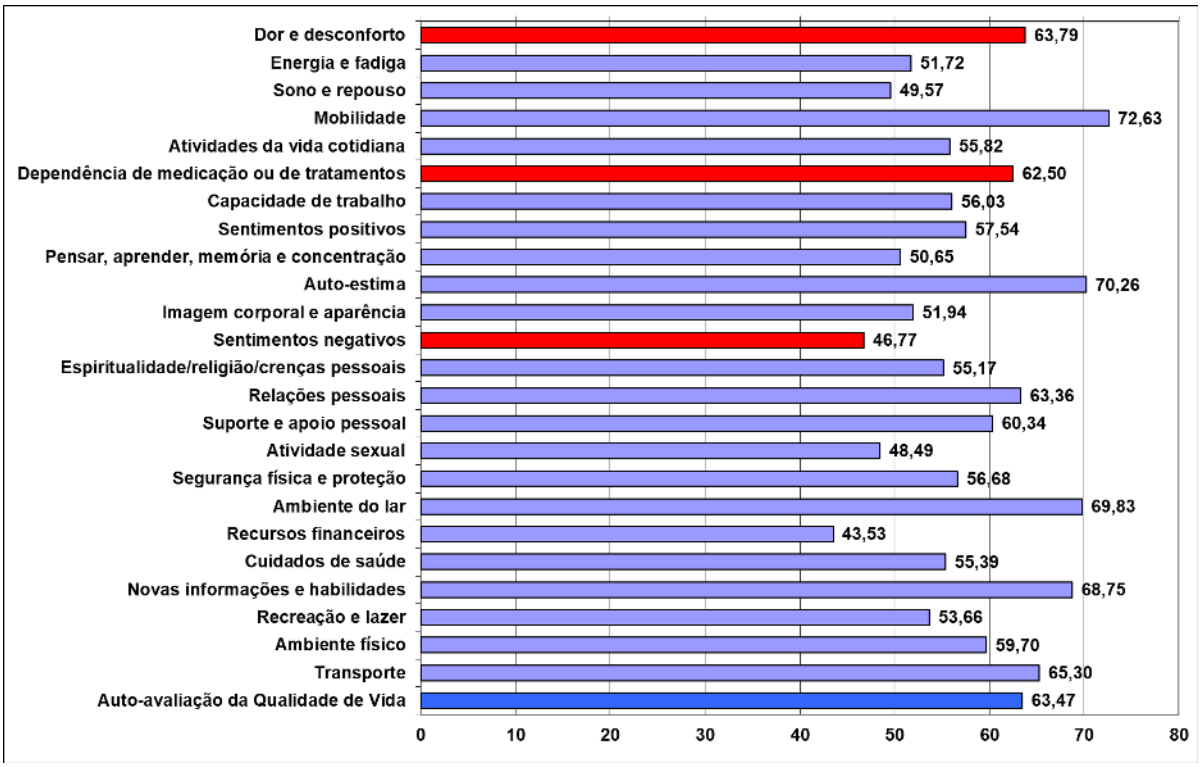
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3.6 WHOQOL-BREF Facet Analysis

Analysis of individual WHOQOL-BREF facets demonstrated marked heterogeneity across quality-of-life dimensions (Figure 1). The lowest scores were observed for sexual activity and work capacity, indicating impairment in intimate and occupational aspects of daily life. Financial resources also demonstrated comparatively reduced scores.

In contrast, mobility, self-esteem, and access to health-related support presented comparatively higher scores. Overall, facet distribution demonstrated that quality-of-life impairment extended beyond physical symptoms, encompassing sexual, emotional, and socioeconomic dimensions.

Figure 1. WHOQOL-BREF facet scores among women undergoing hysterectomy.



Distribution of transformed WHOQOL-BREF facet scores on a 0–100 scale. Higher scores generally indicate better perceived quality of life. For negatively worded facets—Pain and discomfort, Dependence on medication or treatments, and Negative feelings—higher scores indicate greater impairment. Dashed vertical lines represent 10-point intervals along the horizontal axis.

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3.7 Correlations Between Clinical Variables and WHOQOL-BREF Scores

Spearman correlation analyses were performed to investigate associations between preoperative symptom burden and WHOQOL-BREF scores. A weak negative correlation was observed between the number of preoperative symptoms and the Psychological domain (ρ = −0.214; p = 0.021), indicating that women reporting a greater number of symptoms before surgery tended to present lower psychological quality-of-life scores after hysterectomy. However, after adjustment for multiple comparisons using the Benjamini–Hochberg false discovery rate (BH-FDR) procedure, this association did not remain statistically significant (adjusted p = 0.105) (Table 7).

Weak negative correlations were also identified for the Physical domain (ρ = −0.142), Social Relationships domain (ρ = −0.180), Environment domain (ρ = −0.163), and overall quality-of-life score (ρ = −0.166), although none reached statistical significance after correction for multiple testing (Table 7).

Coefficients of determination (ρ^2) demonstrated that preoperative symptom burden explained only a small proportion of variability in WHOQOL-BREF scores, ranging from 2.0% to 4.6% (Table 7).

Overall, these findings suggest limited associations between symptom burden and postoperative quality of life within this exploration sample.

Table 7. Spearman correlations between preoperative symptom burden and WHOQOL-BREF scores

Variable	Spearman's ρ	95% CI	ρ^2	p value	Adjusted p value (BH-FDR)
Physical domain	−0.142	−0.304 to 0.033	0.020	0.129	0.161
Psychological domain	−0.214	−0.383 to −0.032	0.046	0.021	0.105
Social relationships	−0.180	−0.337 to 0.002	0.032	0.053	0.132
Environment domain	−0.163	−0.323 to 0.011	0.026	0.081	0.135
Overall quality-of-life perception	**−0.166**	**−0.326 to 0.006**	**0.028**	**0.075**	**0.135**

BH-FDR: Benjamini–Hochberg false discovery rate correction for multiple comparisons. QoL: quality of life.

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3.8 Comparative Analysis According to Surgical Indication

Comparative analyses among diagnostic groups (uterine fibroids, malignant neoplasms, and other gynecological conditions) did not demonstrate statistically significant differences in WHOQOL-BREF domain scores (ANOVA/Kruskal–Wallis; all $p > 0.05$).

Although women with malignant disease tended to demonstrate lower Psychological domain scores, these differences did not reach statistical significance. Effect sizes were small across all evaluated domains (partial $\eta^2 < 0.06$), indicating limited between-group variability in quality-of-life outcomes according to surgical indication.

4. DISCUSSION

This exploratory cross-sectional study investigated the sociodemographic and clinical characteristics, self-reported symptom burden, and quality of life (QoL) of 116 women who underwent hysterectomy recruited through a convenience sample from social media. The findings revealed an intermediate overall QoL perception, with greater impairment in physical and sexual-activity facets, while also showing high adherence to cervical cancer screening. No causal inferences can be drawn due to the cross-sectional design and the absence of a preoperative QoL baseline.

The sociodemographic profile was predominantly composed of women aged 41–50 years, married, and with secondary or higher education. This distribution is consistent with Brazilian studies indicating that hysterectomy is most frequent in the fourth and fifth decades of life (ARAÚJO; AQUINO, 2003; SANTOS et al., 2025). However, because recruitment was performed via convenience sampling in Facebook® groups, the sample is not representative of the broader Brazilian population of women undergoing hysterectomy, most of whom are operated within the public healthcare system (SUS) and have lower educational levels. Therefore, findings should be interpreted as descriptive of this specific convenience cohort and not generalized.

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Uterine fibroids were the leading surgical indication (40.5%), followed by malignant neoplasms (30.2%), a distribution that mirrors international evidence (BARJON, et al., 2025; YANG et al., 2022). Abnormal uterine bleeding (59.5%) and pelvic pain (54.3%) were the most frequently reported preoperative symptoms. Spearman correlations between the number of self-reported symptoms and WHOQOL-BREF scores were weak (ρ ranging from −0.142 to −0.214) and explained only 2.0% to 4.6% of the variance (ρ^2). After adjustment for multiple comparisons using the Benjamini–Hochberg procedure, none of the correlations remained statistically significant (adjusted $p > 0.05$ for all domains) (Table 7). Thus, in this sample, self-reported preoperative symptom burden showed only a very modest and non-significant association with postoperative QoL after correction. These results should not be interpreted as evidence that symptom burden "influences" QoL more than diagnosis.

The WHOQOL-BREF analysis showed an intermediate global QoL score (56.55/100). The Physical domain presented the lowest transformed score (51.35), followed by Psychological (56.47), Social Relationships (57.40), and Environment (59.11) (Table 6). Facet-level analysis (Figure 1) indicated that sexual activity and work capacity were the most impaired dimensions, whereas mobility and self-esteem were relatively preserved. These descriptive findings align with previous Brazilian reports of persistent physical limitations after hysterectomy (TOSTES et al., 2020) and with international evidence on postoperative sexual dysfunction (DEDDEN et al., 2023; FORSGREN; JOHANNESSON, 2025). However, critical surgical variables (surgical approach, concomitant oophorectomy, hormone replacement therapy, time since surgery) were not collected, which restricts interpretation of the determinants of physical and sexual outcomes.

More than half of the participants (53.4%) reported a family history of cancer, including uterine cancer in 25.9% of familial cases. Exploratory subgroup analyses (Tables 4 and 5) showed no statistically significant associations between family history of cancer and primary diagnosis ($p = 0.492$), age at diagnosis ($p = 0.754$), frequency of Papanicolaou testing ($p = 0.210$), or any WHOQOL-BREF domain (all $p > 0.05$). Although women with a family history tended to report higher annual

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screening rates and slightly lower psychological and social scores, the differences were small and not clinically meaningful. Thus, in this exploratory sample, family cancer history alone did not appear to be a major determinant of postoperative QoL.

No statistically significant differences in WHOQOL-BREF domains were observed between women with fibroids, malignant neoplasms, or other benign conditions (ANOVA/Kruskal–Wallis; all $p > 0.05$). Effect sizes were small (partial $\eta^2 < 0.06$). However, due to the limited sample size within subgroups (fibroids n≈47, malignant n≈35, other n≈34), the study had insufficient statistical power to detect small-to-moderate differences. Therefore, these non-significant findings should not be interpreted as evidence of clinical equivalence between benign and malignant conditions; they may reflect type II error or residual confounding (e.g., age, chemotherapy exposure, healthcare system access) rather than a true absence of difference. Comparisons between diagnostic groups were not adjusted for these potential confounders, a limitation explicitly acknowledged.

The elevated adherence to Papanicolaou testing (80.2% annual or more frequent) is higher than Brazilian national averages (INCA, 2019) and likely reflects the sample's high educational level and predominant private healthcare access, further evidence of selection bias.

Several limitations must be emphasized. First, the cross-sectional design and retrospective data collection preclude causal inferences and are subject to recall bias; the absence of a preoperative QoL baseline means that associations between symptom burden and current QoL may be influenced by participants' current status. Second, convenience sampling via social media introduced severe selection bias, the sample's high education and private healthcare access contrast with national epidemiological data indicating that most hysterectomies in Brazil are performed within the SUS among women with lower formal education (ARAÚJO; AQUINO, 2003). Consequently, findings should not be generalized. Third, critical surgical variables (surgical approach, concomitant oophorectomy, hormone replacement therapy, time since surgery) were not collected, restricting interpretation of physical and sexual outcomes. Fourth, comparisons between diagnostic groups were not adjusted for potential confounders such as age, chemotherapy, or healthcare

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access; non-significant differences may reflect residual confounding or insufficient power. Fifth, the limited sample size within subgroups precluded robust multivariable modeling. Finally, although the Benjamini–Hochberg procedure was applied to control for multiple comparisons, all analyses are exploratory and hypothesis-generating, not confirmatory. Future studies with a priori sample size calculations, preoperative QoL assessments, and detailed surgical variables are needed to validate the observed patterns.

5. CONCLUSION

In this convenience sample, women who underwent hysterectomy reported an intermediate overall quality of life, with greater impairment observed in physical functioning and sexual activity. A weak association was identified between the self-reported number of preoperative symptoms and lower postoperative quality-of-life scores; however, this relationship explained only a small proportion of the variance and should be interpreted cautiously due to the cross-sectional design and the absence of a preoperative quality-of-life baseline.

No statistically significant differences in quality-of-life domains were observed across diagnostic groups, but given the limited statistical power for subgroup comparisons, these non-significant findings should not be interpreted as evidence of clinical equivalence. The high prevalence of family history of cancer underscores the value of comprehensive oncological anamnesis and the potential relevance of genetic counseling in clinical practice.

These exploratory findings highlight the importance of multidisciplinary postoperative care, including psychological support, sexual-health assessment, and individualized long-term follow-up. Future longitudinal investigations with a priori sample size calculations, preoperative quality-of-life assessments, and detailed surgical variables are necessary to clarify the determinants of long-term well-being after hysterectomy.

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