

Impact of Ovarian Conservation on Sexual Function and Menopausal Symptoms After Hysterectomy in Premenopausal Women: A Retrospective Comparative Study

 Gül Çavuşoğlu,¹  Kevser Arkan,²  Kübra Çakar Yılmaz,¹  Ali Deniz Erkmen,²
 Esra Andıç,¹  Pınar Birol İlter,³  Behzat Can²

¹Department of Obstetrics and Gynecology, Diyarbakir Gazi Yasargil Research and Training Hospital, Diyarbakir, Türkiye

²Department of Obstetrics and Gynecology, Division of Gynecologic Oncology, Diyarbakir Gazi Yasargil Research and Training Hospital, Diyarbakir, Türkiye

³Department of Obstetrics and Gynecology, Kutahya City Hospital, Kutahya, Türkiye

Submitted: 17.09.2025

Revised: 07.10.2025

Accepted: 20.10.2025

Correspondence: Gül Çavuşoğlu Çolak,
Diyarbakir Gazi Yasargil Research and Training Hospital, Department of Obstetrics and Gynecology, Diyarbakir, Türkiye
E-mail: cvs_gul_21@hotmail.com



Keywords: FSFI; hysterectomy; menopause; oophorectomy; ovarian conservation; premenopausal; quality of life; sexual function.



This work is licensed under a Creative Commons Attribution-NonCommercial 4.0 International License.

ABSTRACT

Objective: To conduct a quantitative comparison of long-term sexual function and the severity of menopausal symptoms in premenopausal women who have undergone hysterectomy with ovarian conservation versus those who have undergone hysterectomy with bilateral salpingo-oophorectomy (BSO).

Methods: This retrospective study encompassed 160 premenopausal women who had undergone hysterectomy for benign reasons at least one year prior. Participants were categorized into two cohorts: The Hysterectomy with Ovarian Conservation (HOC) group (n=80) and the Hysterectomy with Bilateral Salpingo-Oophorectomy (H-BSO) group (n=80). The study employed validated instruments, namely the Female Sexual Function Index (FSFI) and the Menopause Rating Scale (MRS), to gather data on sexual function and menopausal symptoms. Demographic and clinical information was extracted from patient records. Statistical analyses were conducted using independent samples t-tests and chi-square tests.

Results: Both groups were comparable in terms of mean age, BMI, and primary indication for hysterectomy ($p>0.05$). The HOC group reported significantly higher (better) total FSFI scores compared to the H-BSO group (27.8 ± 4.1 vs. 18.5 ± 5.5 ; $p<0.001$). Significant differences were observed across all FSFI domains, including desire, arousal, lubrication, orgasm, satisfaction, and pain (all $p<0.001$). Conversely, the H-BSO group reported significantly higher (worse) total MRS scores (23.2 ± 6.8 vs. 9.7 ± 4.5 ; $p<0.001$), with pronounced differences in somatic, psychological, and urogenital subscales.

Conclusion: Ovarian conservation at the time of hysterectomy in premenopausal women is strongly and significantly associated with preserved sexual function and a substantially lower burden of menopausal symptoms in the long term. These findings provide crucial quantitative evidence to support shared decision-making, advocating for ovarian conservation in appropriate candidates to protect long-term quality of life.

INTRODUCTION

Hysterectomy is among the most frequently performed gynecological surgeries globally, with millions of procedures conducted annually.^[1] For premenopausal women undergoing this surgery for benign reasons, a pivotal intraoperative decision involves whether to conduct a concurrent bilateral salpingo-oophorectomy (BSO). This decision poses a complex clinical challenge, requiring a balance

between the prophylactic advantage of reducing future ovarian cancer risk and the physiological implications of iatrogenic menopause.^[2,3]

The surgical removal of ovaries in premenopausal women results in an immediate and irreversible cessation of endogenous estrogen and androgen production, thereby inducing surgical menopause.^[4] The associated consequences are well-documented, including an elevated long-

term risk of cardiovascular disease, osteoporosis, cognitive decline, and all-cause mortality.^[5-8] Additionally, the emergence of severe vasomotor and urogenital symptoms can significantly affect a woman's quality of life.^[9,10]

The impact on sexual function is of particular significance. Ovarian hormones play a vital role in sustaining vaginal lubrication, pelvic blood flow, and sexual desire. The sudden loss of these hormones can result in dyspareunia, reduced libido, and challenges with arousal and orgasm, leading to considerable personal and interpersonal distress.^[11,12] Although the practice of prophylactic BSO has been decreasing in recent years, particularly among women at average risk for ovarian cancer,^[13,14] the decision-making process frequently lacks comprehensive, quantitative data to provide to patients concerning long-term sexual well-being.

Although the advantages of ovarian conservation are widely recognized,^[15] there remains a necessity for high-quality comparative studies employing validated, multi-dimensional tools to accurately measure variations in sexual function and menopausal burden. The Female Sexual Function Index (FSFI) and the Menopause Rating Scale (MRS) are validated instruments that facilitate such comprehensive assessments.^[16-18]

This study aims to address the existing gap by retrospectively comparing outcomes in two well-defined cohorts of premenopausal women: Those who underwent hysterectomy with ovarian conservation and those who underwent hysterectomy with bilateral salpingo-oophorectomy (BSO). To our knowledge, this represents one of the largest comparative analyses utilizing validated Female Sexual Function Index (FSFI) and Menopause Rating Scale (MRS) tools within a homogeneous premenopausal cohort. The primary objective of this study is to furnish clear, quantitative evidence regarding the long-term impact of oophorectomy on sexual function and menopausal symptoms in this patient population, thereby enabling clinicians and patients to engage in more informed shared decision-making.

MATERIALS AND METHODS

This study was conducted in accordance with the principles of the Declaration of Helsinki. The study protocol was reviewed and approved by the Institutional Review Board of Health Sciences University Gazi Yaşargil Training and Research Hospital (No: 589, Date: 19/09/2025). Informed consent was obtained from all participants prior to data collection.

Study Design and Patient Population

This retrospective study was conducted by reviewing medical records from a tertiary care hospital. The study protocol was approved by the Institutional Review Board.

A cohort of 160 women who underwent hysterectomy for benign gynecological conditions between January 2018 and December 2022 was included in this study. The in-

clusion criteria stipulated that participants must be premenopausal at the time of surgery, as confirmed by patient history and/or hormonal levels, and aged between 40 and 50 years. This age range was selected to ensure premenopausal status while encompassing women most likely to undergo hysterectomy for benign indications. Eligible surgeries were required to be performed for benign causes such as uterine fibroids, abnormal uterine bleeding, or adenomyosis, and participants were required to have a minimum of 12 months of follow-up post-surgery.

Exclusion criteria comprised any history of gynecological or other malignancy, a pre-existing diagnosis of sexual dysfunction or severe psychiatric disorder, postmenopausal status at the time of surgery, and incomplete medical records. Patients were divided into two groups:

- **HOC Group (Hysterectomy with Ovarian Conservation):** n=80 women who underwent total hysterectomy with conservation of at least one ovary.
- **H-BSO Group (Hysterectomy with Bilateral Salpingo-Oophorectomy):** n=80 women who underwent total hysterectomy with concurrent BSO.

Demographic data, including age and BMI, as well as surgical details such as the type of hysterectomy and the indication for surgery, alongside clinical history, were extracted from electronic medical records. Subsequently, eligible patients were contacted via telephone by a trained research nurse. Upon obtaining verbal consent, participants were administered the validated FSFI and MRS questionnaires.

Outcome Measures

- **Female Sexual Function Index (FSFI):** A 19-item validated questionnaire that assesses female sexual function over the past 4 weeks across six domains: Desire, arousal, lubrication, orgasm, satisfaction, and pain.^[16] The total score ranges from 2 to 36, with higher scores indicating better sexual function. A total score of ≤ 26.55 is commonly used as a clinical cutoff for diagnosing female sexual dysfunction (FSD).^[17]
- **Menopause Rating Scale (MRS):** An 11-item validated questionnaire that assesses the severity of age-related menopausal symptoms across three domains: Somatic (e.g., hot flashes, heart discomfort), psychological (depressive mood, irritability), and urogenital (vaginal dryness, bladder problems). Higher scores indicate greater symptom severity.^[18]

Statistical Analysis

All statistical analyses were performed using SPSS for Windows, Version 27.0 (IBM Corp., Armonk, NY). Continuous variables were presented as mean \pm standard deviation (SD) and compared between groups using an independent samples t-test. Categorical variables were presented as frequencies and percentages (%) and compared using the Chi-square test or Fisher's exact test, as appropriate. A p-value of <0.05 was considered statistically significant for all analyses.

RESULTS

The demographic and clinical characteristics of the 160 patients are presented in Table 1. There were no statistically significant differences between the HOC and H-BSO groups in terms of mean age, BMI, or the primary indication for hysterectomy, indicating that the two groups were well-matched at baseline. The most common indication for surgery in both groups was uterine fibroids.

Sexual Function Outcomes (FSFI)

The comparison of FSFI scores is shown in Table 2. The HOC group demonstrated significantly better sexual function across all domains. The mean total FSFI score was 27.8 in the HOC group, compared to a severely dysfunc-

tional score of 18.5 in the H-BSO group ($p < 0.001$). The largest differences were observed in the domains of lubrication and desire. Importantly, 68.8% of women in the H-BSO group had an FSFI score below the clinical cutoff for FSD (≤ 26.55), compared to only 22.5% in the HOC group.

Menopausal Symptom Outcomes (MRS)

The burden of menopausal symptoms was significantly higher in the H-BSO group, as detailed in Table 3. The mean total MRS score for the H-BSO group was 23.2, indicating severe symptomatology, whereas the HOC group had a mean score of 9.7, indicating mild symptoms ($p < 0.001$). The most striking differences were seen in the somatic (hot flashes, sweating) and urogenital (vaginal dryness, bladder problems) subscales.

Table 1. Baseline demographic and clinical characteristics of the study groups

Characteristic	HOC Group (n=80)	H-BSO Group (n=80)	p-value
Age (years), mean \pm SD	46.2 \pm 3.1	46.8 \pm 2.9	0.215
BMI (kg/m ²), mean \pm SD	28.1 \pm 4.5	27.7 \pm 4.9	0.582
Indication for Hysterectomy, n (%)			0.881
Uterine Fibroids	45 (56.3%)	43 (53.8%)	
Abnormal Uterine Bleeding	21 (26.3%)	23 (28.8%)	
Adenomyosis/Endometriosis	14 (17.5%)	14 (17.5%)	
Type of Hysterectomy, n (%)			0.745
Abdominal	35 (43.8%)	38 (47.5%)	
Laparoscopic/Robotic	45 (56.3%)	42 (52.5%)	

HOC: Hysterectomy with Ovarian Conservation; H-BSO: Hysterectomy with Bilateral Salpingo-Oophorectomy.

Table 2. Comparison of Female Sexual Function Index (FSFI) scores

FSFI Domain	HOC Group (n=80)	H-BSO Group (n=80)	p-value
Desire, mean \pm SD	4.5 \pm 0.9	2.8 \pm 1.1	<0.001
Arousal, mean \pm SD	4.8 \pm 0.8	3.1 \pm 1.2	<0.001
Lubrication, mean \pm SD	4.9 \pm 1.0	2.5 \pm 1.3	<0.001
Orgasm, mean \pm SD	4.6 \pm 1.1	3.4 \pm 1.4	<0.001
Satisfaction, mean \pm SD	4.7 \pm 0.9	3.5 \pm 1.2	<0.001
Pain, mean \pm SD	4.3 \pm 1.2	3.2 \pm 1.5	<0.001
Total FSFI Score, mean \pm SD	27.8 \pm 4.1	18.5 \pm 5.5	<0.001

Table 3. Comparison of Menopause Rating Scale (MRS) scores

MRS Domain	HOC Group (n=80)	H-BSO Group (n=80)	p-value
Somatic Score, mean \pm SD	3.1 \pm 1.8	9.5 \pm 3.2	<0.001
Psychological Score, mean \pm SD	4.2 \pm 2.1	7.9 \pm 2.9	<0.001
Urogenital Score, mean \pm SD	2.4 \pm 1.5	5.4 \pm 2.3	<0.001
Total MRS Score, mean \pm SD	9.7 \pm 4.5	23.2 \pm 6.8	<0.001

DISCUSSION

This study presents compelling quantitative evidence indicating that the preservation of ovaries during hysterectomy in premenopausal women significantly benefits the maintenance of long-term sexual function and alleviates menopausal symptoms.^[19-21] Our findings reveal a marked disparity in quality of life outcomes, highlighting the critical importance of considering “the ovarian factor” in surgical decision-making.

The markedly lower FSFI scores observed in the H-BSO group directly reflect the physiological consequences of surgical menopause. The sudden cessation of ovarian estrogen and androgen production results in vaginal atrophy, diminished blood flow, and reduced lubrication, as evidenced by the poor scores in the lubrication and pain domains.^[22,23] Additionally, ovarian androgens are crucial for female libido; their removal directly contributes to the decreased desire and arousal reported by the H-BSO group.^[24] The mean total FSFI score of 18.5 in this group is significantly below the clinical threshold for FSD, indicating that the majority of these women experience clinically significant sexual dysfunction.^[25]

The pronounced menopausal symptoms observed in the H-BSO group, with a mean MRS score of 23.2, represent an anticipated yet significant finding. The abrupt hormonal deprivation leads to severe vasomotor symptoms, psychological distress, and urogenital atrophy, collectively diminishing overall well-being.^[26] Conversely, the HOC group reported only mild symptoms, suggesting that their preserved ovaries continued to offer essential hormonal support, even following the removal of the uterus.

A noteworthy aspect of our findings is that while significantly better than the BSO group, a subset of women in the HOC group (22.5%) still reported FSFI scores indicative of sexual dysfunction. This suggests that hysterectomy itself, even with ovarian preservation, is not entirely benign in its impact on sexual function.^[27] Potential explanations include alteration of pelvic anatomy, disruption of nerve pathways during cervical dissection, or loss of uterine-specific contributions to orgasm.^[28] This highlights that while preserving hormones is paramount, the uterus itself may play a role in sexual response, a factor requiring further investigation.

From a clinical perspective, these data should be integral to contemporary shared decision-making practices. The traditional rationale for prophylactic bilateral salpingo-oophorectomy (BSO) has been the reduction of ovarian cancer risk. However, for women at average risk, the absolute risk of developing ovarian cancer is relatively low.^[29] Our study reveals that the outcome of this risk-reducing surgery is not merely a possibility but a certainty: It induces significant, measurable declines in sexual function and overall quality of life. Clinicians can now utilize this quantitative data to counsel patients more effectively, framing the decision not as “preventing a future risk” versus “no benefit,” but as “preventing a small future risk”

versus “preserving definite, high-quality years of sexual and psychological well-being.”^[30]

The strengths of this study include its well-defined cohort and the utilization of internationally validated, multi-dimensional questionnaires (FSFI and MRS) to capture patient-reported outcomes.^[16-18] The primary limitation is its retrospective design, which introduces the potential for recall bias and depends on patient self-reporting. Additionally, the absence of pre-operative baseline FSFI or MRS scores precluded a longitudinal assessment of change. Future prospective studies should aim to collect baseline data to more accurately measure post-surgical outcomes.^[31] And as this study was based on questionnaire data, serum estrogen levels and other hormonal or biochemical parameters were not assessed, which limits the ability to directly correlate our findings with physiological mechanisms.

CONCLUSION

In premenopausal women undergoing hysterectomy for benign conditions, the decision to preserve the ovaries is unequivocally linked to enhanced long-term sexual function and a significantly reduced incidence of menopausal symptoms. The removal of healthy ovaries results in severe, clinically significant sexual dysfunction and menopausal distress in the majority of patients. This study offers robust, quantitative evidence supporting the paradigm of ovarian conservation whenever feasible in average-risk premenopausal women, emphasizing the importance of long-term quality of life in the shared decision making process.^[32]

Acknowledgments

The authors would like to thank the clinical staff of the Department of Obstetrics and Gynecology at Health Sciences University Gazi Yaşargil Training and Research Hospital for their support in patient care and data collection.

Availability of data and materials

The datasets generated and analyzed during the current study are available from the corresponding author upon reasonable request.

Ethics Committee Approval

The study protocol was reviewed and approved by the Institutional Review Board of Health Sciences University Gazi Yaşargil Training and Research Hospital (Date: 19.09.2025, Decision No: 589).

Informed Consent

Informed consent was obtained from all participants prior to data collection.

Peer-review

Externally peer-reviewed.

Authorship Contributions

Concept: G.C.C., K.A.; Design: G.C.C., K.A.; Supervision: A.D.E., B.C., K.C.Y.; Fundings: P.B.I., B.C.; Materials: E.A,

K.C.Y.; Data collection &/or processing: G.C.C., K.A., K.C.Y.; Analysis and/or interpretation: P.B.I., B.C.; Literature search: G.C.C., K.A.; Writing: G.C.C., K.A.; Critical review: P.B.I., B.C., K.C.Y.

Funding

The authors received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

Conflict of Interest

None declared.

REFERENCES

1. Wu JM, Wechter ME, Geller EJ, Nguyen TV, Visco AG. Hysterectomy rates in the United States, 2003. *Obstet Gynecol* 2007;110:1091–5. [\[CrossRef\]](#)
2. Parker WH. Bilateral oophorectomy versus ovarian conservation: Effects on long-term women's health. *J Minim Invasive Gynecol* 2010;17:161–6. [\[CrossRef\]](#)
3. Parker WH, Feskanich D, Broder MS, Chang E, Shoupe D, Farquhar C, et al. Long-term mortality associated with oophorectomy compared with ovarian conservation in the Nurses' Health Study. *Obstet Gynecol* 2013;121:709–16. [\[CrossRef\]](#)
4. Rocca WA, Gazuola-Rocca L, Smith CY, Grossardt BR, Faubion SS, Shuster LT. Adverse health outcomes after oophorectomy in premenopausal women. *JAMA Netw Open* 2021;4:e2123992.
5. Shuster LT, Rhodes DJ, Gostout BS, Grossardt BR, Rocca WA. Premature menopause or early menopause: Long-term health consequences. *Maturitas* 2010;65:161–6. [\[CrossRef\]](#)
6. Rivera CM, Grossardt BR, Rhodes DJ, Brown RD Jr, Roger VL, Melton LJ 3rd, et al. Increased cardiovascular mortality after early bilateral oophorectomy. *Menopause* 2009;16:15–23. [\[CrossRef\]](#)
7. Rocca WA, Bower JH, Maraganore DM, Ahlskog JE, Grossardt BR, de Andrade M, et al. Increased risk of cognitive impairment or dementia in women who underwent oophorectomy before menopause. *Neurology* 2007;69:1074–83. [\[CrossRef\]](#)
8. Parker WH, Broder MS, Chang E, Feskanich D, Farquhar CM, Liu Z, et al. Ovarian conservation at the time of hysterectomy and long-term health outcomes in the Nurses' Health Study. *Obstet Gynecol* 2009;113:1027–37. [\[CrossRef\]](#)
9. Faubion SS, Kuhle CL, Shuster LT, Rocca WA. Long-term health consequences of premature or early menopause and considerations for management. *Climacteric* 2015;18:483–91. [\[CrossRef\]](#)
10. Sarrel PM. Ovarian hormones and vaginal blood flow: Using laser Doppler velocimetry to evaluate vaginal response. *Fertil Steril* 2002;77:S64–9.
11. Kingsberg SA. The impact of aging on sexual function in women and their partners. *Arch Sex Behav* 2002;31:431–7. [\[CrossRef\]](#)
12. Faubion SS, Kuhle CL, Shuster LT. Surgical menopause: Risks, consequences, and management. *Climacteric* 2015;18:556–62. [\[CrossRef\]](#)
13. Parker WH. Ovarian conservation at the time of hysterectomy for benign disease. *Clin Obstet Gynecol* 2007;50:354–61. [\[CrossRef\]](#)
14. Committee on Gynecologic Practice. Committee opinion no. 774: Opportunistic salpingectomy as a strategy for epithelial ovarian cancer prevention. *Obstet Gynecol* 2019;133:e279–84. [\[CrossRef\]](#)
15. Farquhar CM, Sadler L, Harvey SA, Stewart AW. The association of hysterectomy and menopause: A prospective cohort study. *BJOG* 2005;112:956–62. [\[CrossRef\]](#)
16. Rosen R, Brown C, Heiman J, Leiblum S, Meston C, Shabsigh R, et al. The Female Sexual Function Index (FSFI): A multidimensional self-report instrument for the assessment of female sexual function. *J Sex Marital Ther* 2000;26:191–208. [\[CrossRef\]](#)
17. Wiegel M, Meston C, Rosen R. The Female Sexual Function Index (FSFI): Cross-validation and development of clinical cutoff scores. *J Sex Marital Ther* 2005;31:1–20. [\[CrossRef\]](#)
18. Heinemann LA, Potthoff P, Schneider HP. International versions of the Menopause Rating Scale (MRS). *Health Qual Life Outcomes* 2003;1:28. [\[CrossRef\]](#)
19. Santoro N, Epperson CN, Mathews SB. Menopausal symptoms and their management. *Endocrinol Metab Clin North Am* 2015;44:497–515. [\[CrossRef\]](#)
20. Forman EJ, Anders CK, Behera MA. A national survey on menopausal symptom management: Comparing oophorectomy and ovarian conservation. *Am J Obstet Gynecol* 2008;198:e1–4.
21. Shifren JL, Gass ML; NAMS Recommendations for Clinical Care of Midlife Women Working Group. The North American Menopause Society recommendations for clinical care of midlife women. *Menopause* 2014;21:1038–62. [\[CrossRef\]](#)
22. Huang AJ, Subak LL, Thom DH, Van Den Eeden SK, Ragins AI, Kuppermann M, et al. Sexual function and aging in racially/ethnically diverse women. *J Gen Intern Med* 2009;24:541–6. [\[CrossRef\]](#)
23. Kingsberg SA, Schaffir J, Simon JA, Kellogg-Spadt S, Parish SJ, Graham S, et al. Female sexual health: Barriers to optimal outcomes and a roadmap for improved patient-clinician communications. *J Women's Health* 2019;28:432–43. [\[CrossRef\]](#)
24. Labrie F, Archer DF, Koltun W, Vachon A, Young D, Frenette L, et al. Efficacy of intravaginal dehydroepiandrosterone (DHEA) on moderate to severe dyspareunia, the most bothersome symptom of vulvovaginal atrophy. *Menopause* 2015;22:693–702.
25. Nappi RE, Cucinella L, Martella S, Rossi M, Tiranini L, Martini E. Female sexual dysfunction (FSD): Prevalence and impact on quality of life (QoL). *Maturitas* 2016;94:87–91. [\[CrossRef\]](#)
26. Muka T, Oliver-Williams C, Kunutsor S, Laven JS, Fauser BC, Chowdhury R, et al. Association of age at onset of menopause and time since onset of menopause with cardiovascular outcomes, intermediate vascular traits, and all-cause mortality: A systematic review and meta-analysis. *JAMA Cardiol* 2016;1:767–76. [\[CrossRef\]](#)
27. Faubion SS, Kuhle CL, Shuster LT, Rocca WA. Long-term health consequences of hysterectomy with or without oophorectomy in premenopausal women. *Maturitas* 2017;103:82–8.
28. Yoo EH, Lee PY. Hysterectomy on benign disease in young women and sexual function: A systematic review. *Korean J Obstet Gynecol* 2011;54:532–40.
29. Reid BM, Permut JB, Sellers TA. Epidemiology of ovarian cancer: A review. *Cancer Biol Med* 2017;14:9–32. [\[CrossRef\]](#)
30. Parker WH. Bilateral oophorectomy versus ovarian conservation: Effects on sexual function and health. *Menopause* 2014;21:245–7. [\[CrossRef\]](#)
31. Kuhle CL, Faubion SS, Shuster LT, Rocca WA. Menopause and multimorbidity: Implications for health outcomes and management. *Curr Opin Obstet Gynecol* 2016;28:366–72.
32. Shifren JL, Davis SR. Androgens in postmenopausal women: A review. *Menopause* 2017;24:970–9. [\[CrossRef\]](#)

Premenopozal Kadınlarda Histerektomi Sonrası Overyen Korumanın Cinsel Fonksiyon ve Menopoz Semptomları Üzerine Etkisi: Retrospektif Karşılaştırmalı Bir Çalışma

Amaç: Premenopozal kadınlarda overlerin korunduğu histerektomi ile bilateral salpingo-ooferektomi (BSO) yapılan histerektomi sonrası uzun dönem cinsel fonksiyon ve menopoz semptomlarının şiddetini nicel olarak karşılaştırmak.

Gereç ve Yöntem: Bu retrospektif çalışmaya, benign nedenlerle en az bir yıl önce histerektomi geçirmiş 160 premenopozal kadın dahil edildi. Katılımcılar iki gruba ayrıldı: Overyen Koruma ile Histerektomi (HOC) grubu (n=80) ve Bilateral Salpingo-Ooferektomi ile Histerektomi (H-BSO) grubu (n=80). Cinsel fonksiyon ve menopoz semptomlarına ilişkin veriler, geçerliliği kanıtlanmış araçlar olan Kadın Cinsel Fonksiyon İndeksi (FSFI) ve Menopoz Değerlendirme Ölçeği (MRS) kullanılarak toplandı. Demografik ve klinik bilgiler hasta kayıtlarından elde edildi. İstatistiksel analizler bağımsız örneklem t-testi ve ki-kare testi ile gerçekleştirildi.

Bulgular: Her iki grup yaş ortalaması, BKİ ve histerektomi endikasyonu açısından karşılaştırılabilir bulundu ($p>0.05$). HOC grubunun toplam FSFI skorları H-BSO grubuna göre anlamlı derecede daha yüksek (daha iyi) idi (27.8 ± 4.1 'e karşı 18.5 ± 5.5 ; $p<0.001$). İstek, uyarılma, lubrikasyon, orgazm, tatmin ve ağrı dâhil tüm FSFI alt alanlarında anlamlı farklılıklar izlendi (tüm $p<0.001$). Buna karşılık, H-BSO grubunun toplam MRS skorları anlamlı derecede daha yüksek (daha kötü) bulundu (23.2 ± 6.8 'e karşı 9.7 ± 4.5 ; $p<0.001$) ve somatik, psikolojik ve ürogenital alt ölçeklerde belirgin farklılıklar mevcuttu.

Sonuç: Premenopozal kadınlarda histerektomi sırasında overlerin korunması, uzun dönemde cinsel fonksiyonun devamlılığı ve menopoz semptomlarının belirgin şekilde daha düşük olması ile güçlü ve anlamlı şekilde ilişkilidir. Bu bulgular, uygun adaylarda overlerin korunmasını savunarak uzun dönem yaşam kalitesini korumaya yönelik paylaşımlı karar verme sürecine önemli nicel kanıt sunmaktadır.

Anahtar Sözcükler: Cinsel Fonksiyon; FSFI; histerektomi; menopoz; ooferektomi; overyen koruma; premenopozal; yaşam kalitesi.