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Opportunistic Salpingectomy at Benign Hysterectomy: Evaluating the Evidence

Opportunistic salpingectomy (OS) refers to the removal of both fallopian tubes during another gynecologic surgery (such as a hysterectomy for benign disease) in women at *average risk* of ovarian cancer. This strategy is motivated by evidence that many high-grade serous ovarian cancers actually originate as serous tubal intraepithelial carcinomas (STICs) in the fallopian tubes [1] [2]. By removing the tubes "opportunistically" during a routine benign hysterectomy (while preserving the ovaries), the hope is to **reduce future ovarian cancer risk** without inducing surgical menopause. Below, we examine recent evidence (primarily from the last ~5 years) **supporting** OS in low-risk women, evidence or perspectives **questioning or opposing** routine OS, and studies **comparing hysterectomy with vs. without salpingectomy** in terms of outcomes.

Evidence Supporting Opportunistic Salpingectomy in Low-Risk Women

Reduction in Ovarian Cancer Risk: A growing body of research indicates that performing a bilateral salpingectomy in average-risk women can significantly reduce the incidence of epithelial ovarian cancer. A 2025 systematic review and meta-analysis (including over 5.7 million patients from multiple countries) found that women who underwent prophylactic salpingectomy had a **significantly lower risk of developing ovarian cancer** compared to those who did not [3]. In particular, **bilateral** salpingectomy was associated with an approximate *52% relative risk reduction* in ovarian cancer (pooled OR ≈ 0.48, 95% CI 0.33–0.69) [4]. Unilateral salpingectomy did not significantly reduce risk (as expected, since one tube remains) [4]. These findings align with earlier population studies: for example, a Danish registry study (Madsen et al. 2015) found bilateral salpingectomy was associated with ~**42% lower odds** of ovarian cancer (adjusted OR ~0.58) compared to no salpingectomy [5]. Similarly, a Swedish cohort (Falconer et al. 2015) reported a substantially reduced ovarian cancer incidence in women who had prior salpingectomies [5]. More recently, a Canadian cohort analysis by Hanley et al. (2022) observed *fewer ovarian cancers than expected* among women who had undergone opportunistic salpingectomy, particularly a significant decrease in high-grade serous cancers [6]. Taken together, these data strongly suggest that removing the fallopian tubes during benign gyn surgeries **can meaningfully lower the future risk of tubo-ovarian cancer** in average-risk women.

Surgical Safety and Ovarian Function: Crucially, adding a salpingectomy does not appear to impose significant surgical or physiologic harm. Multiple studies have examined whether removing the tubes (which share blood supply with the ovaries and uterus) might increase operative complications or compromise ovarian function. The evidence to date is reassuring:

- **Operative Outcomes:** Several large observational studies and reviews have reported **no significant increase in surgical complication rates** when a salpingectomy is added to a benign hysterectomy [7] [8]. In a regional initiative in British Columbia (OVCARE study), for example, the addition of

bilateral salpingectomy did **not** increase the risk of hospital readmission or need for blood transfusion compared to hysterectomy alone [7]. The only notable difference was a modest increase in operative time – on the order of about 10–20 extra minutes for removal of the tubes [9]. This is consistent with other reports that find **no change in blood loss, length of hospital stay, or conversion to open surgery**, and only a slight prolongation of surgery when performing OS [9]. Notably, a 2017 systematic review (Kho *et al.*, 2017) focusing on *low-risk premenopausal women* found that incorporating prophylactic salpingectomy into routine hysterectomy did not adversely affect operative or postoperative outcomes [10]. Overall, the current evidence indicates that **hysterectomy with OS is just as safe as hysterectomy alone** in terms of perioperative risks.

- **Ovarian Reserve and Menopause:** Because the ovaries are retained, an important question is whether OS might nonetheless impair ovarian blood supply or hasten menopause. Data from both biochemical and clinical outcomes are encouraging. A comprehensive review by Kotlyar *et al.* (2017) and other hormonal studies have shown *no significant decline in ovarian reserve* attributable to salpingectomy [11]. For instance, a prospective study measuring anti-Müllerian hormone (AMH), follicle-stimulating hormone (FSH), antral follicle counts, etc., found that women who had bilateral salpingectomy during laparoscopic hysterectomy had **no difference in ovarian "age" up to 5 years post-surgery** compared to those who did not [12]. Furthermore, a randomized controlled trial in 2018 (Asgari *et al.* / Rezaeinejad *et al.*) compared laparoscopic hysterectomy with vs. without prophylactic salpingectomy in premenopausal women and found **no adverse impact on ovarian reserve** (based on postoperative AMH levels) and **no increase in surgical complications or recovery time** with the added salpingectomy [13]. A 2019 Cochrane review pooled 5 RCTs' hormonal data and likewise found **no evidence of a significant difference in postoperative ovarian function** between hysterectomy-with-OS versus hysterectomy-alone; the mean change in AMH was small and not clinically meaningful (95% CI ranged from a slight increase to a slight decrease) [14]. At most, the data could allow for an earlier menopausal timing of only ~**20 months** in the OS group, which was deemed not clinically significant [15]. In fact, in that Cochrane analysis the results *"were compatible with no difference"* in ovarian reserve, and the authors concluded there was **no clinically relevant reduction in AMH** attributable to adding salpingectomy [14] [15]. Recent prospective studies also support the lack of any meaningful effect on menopausal symptoms: in a 2025 pilot study, women who underwent hysterectomy+salpingectomy reported **no worsening of menopausal symptom scores** at 6 months post-op, compared to slight symptom increases in those who had hysterectomy alone [16] [17]. (Notably, in that study the vast majority of eligible women *chose* to have OS when counseled, reflecting patient preference for cancer risk-reduction [18] [19].) In summary, **removing the fallopian tubes does not appear to compromise ovarian hormonal function or trigger premature menopause** in low-risk women, especially when compared to the much larger impact that removing ovaries would have.

- **Quality of Life and Other Outcomes:** Studies have also looked at broader outcomes. Early data indicate that performing OS has **no detrimental effect on quality of life or sexual function** after surgery [20]. In other words, patients' postoperative well-being, including sexual health, is equivalent whether or not the tubes were removed during their hysterectomy. Additionally, opportunistic salpingectomy may confer some ancillary benefits. For example, one retrospective study found that women who had their tubes removed at hysterectomy had a **lower need for re-operation** for benign tubo-ovarian issues later (such as hydrosalpinx or abscess), suggesting OS might prevent future tubal pathology requiring surgery [21]. There is also evidence that salpingectomy (instead of tubal ligation) is a highly effective means of sterilization with the added cancer prevention benefit –

this has led to salpingectomy being favored over clip/ligature methods for women requesting sterilization at time of cesarean or other surgery [13].

Endorsement by Medical Organizations: Given the above benefits and minimal downsides, many professional bodies now support opportunistic salpingectomy in appropriate patients. The **International Federation of Gynecology and Obstetrics (FIGO)** released a position statement endorsing OS as a preventative strategy for ovarian cancer in women undergoing pelvic surgery who have completed childbearing [22] [23]. Likewise, the **Society of Gynecologic Oncology (SGO)** and the **American College of Obstetricians and Gynecologists (ACOG)** have recommended offering bilateral salpingectomy for ovarian cancer risk reduction, even in women at average risk, at the time of benign hysterectomy or in lieu of tubal ligation [24]. In fact, OS is now considered a **"best practice" in the United States for ovarian cancer prevention in low-risk women** undergoing gynecologic surgery [25]. This shift in practice is reflected in real-world trends: the rate of opportunistic salpingectomy during benign hysterectomies has risen sharply in the last decade. For example, U.S. data showed adoption of OS increased from under 10% of benign hysterectomies in the early 2010s to nearly 35–40% by 2020 [26] [27]. Some regions have adoption rates even higher; in British Columbia, over 50% of benign hysterectomies now include removal of tubes as part of a province-wide ovarian cancer prevention initiative [28] [29]. **Globally**, at least half a dozen countries (e.g. Canada, USA, Denmark, The Netherlands, etc.) have issued guidelines encouraging OS in principle, and many others are actively evaluating the approach [30] [31].

Cost-Effectiveness: From a public health perspective, opportunistic salpingectomy appears to be **highly cost-effective** as a cancer prevention measure. Modeling studies have estimated that performing OS during routine surgeries could significantly reduce ovarian cancer cases and save healthcare costs. For instance, a 2015 Markov model showed that adding salpingectomy at hysterectomy was actually *less costly* than hysterectomy alone (due to future cancer cases averted) [32]. Subsequent analyses projected that wide implementation of OS could reduce ovarian cancer incidence by roughly **20–40%** over time [33] [34]. One U.S. model calculated that if salpingectomy truly reduces ovarian cancer risk by ~65%, about **5,300 ovarian cancer cases per year** (≈39% of cases) could eventually be prevented in the US, translating to hundreds of millions of dollars saved annually in treatment costs [35] [36]. Another study estimated that universal salpingectomy in eligible women might save around **$445 million** in healthcare costs per year in the US [37] [38]. Thus, OS not only has clinical benefit but also makes economic sense as a preventive strategy.

In summary, **the case *for* opportunistic salpingectomy is supported by substantial evidence**: it likely cuts ovarian cancer risk roughly in half for average-risk women, without adding surgical morbidity or compromising ovarian function, and it is endorsed by major gynecologic societies. Given the lethality of ovarian cancer and the lack of effective screening, this proactive approach during benign surgeries is an appealing opportunity. As one review concluded, adding salpingectomy at hysterectomy "should be discussed with each woman…with a clear overview of benefits and risks" [15], since the available data indicate meaningful benefit with minimal harm.

Evidence and Arguments Against Routine Opportunistic Salpingectomy

Despite the generally positive evidence above, it is important to consider contrary findings, uncertainties, and any arguments *against* routinely performing OS in low-risk women. A few key points temper the enthusiasm for opportunistic salpingectomy:

- **Lack of Long-Term (Mortality) Data:** While OS is biologically and epidemiologically promising, we do not yet have direct long-term evidence that it saves lives from ovarian cancer in the general population. Critics point out that most supporting data come from observational studies or models, not randomized trials powered for cancer endpoints. Ovarian cancer is a relatively rare outcome, and it can take **decades** to observe differences in incidence or mortality after an intervention. As of 2019, the Cochrane review noted that **no randomized trial had reported ovarian cancer incidence outcomes** for hysterectomy with vs. without salpingectomy [39] [14]. In other words, the presumed reduction in cancer risk is extrapolated from retrospective analyses (subject to bias) and our understanding of pathology, rather than proven by prospective controlled data. Some health authorities have been cautious because of this. For example, in 2017 the Oregon Health Evidence Review Commission examined OS and issued a **weak recommendation *against* routine opportunistic salpingectomy** for low-risk women, explicitly citing the *"limited evidence of benefit available"* at that time [40]. They were concerned that without conclusive proof of cancer prevention, the added procedure (and its theoretical risks or costs) might not be justified across a whole population. This conservative stance underscores the need for more definitive research.

- **Mixed Results in Recent Population Studies:** Not all epidemiologic studies have shown a clear benefit of salpingectomy. A large 2023 cohort study from Ontario, Canada (N = 131,516 women) raised some questions by finding **no statistically significant difference** in ovarian cancer risk between women who underwent salpingectomy and those who did not [41]. In that study, 0.09% of women who had a salpingectomy later developed ovarian cancer, compared to 0.12% of women with no surgical prevention – a numerically lower rate, but this difference did *not* reach significance over the follow-up period (HR ~0.82, 95% CI 0.55–1.21) [42]. The authors suggested that **with the current follow-up and the rarity of the disease, a risk reduction benefit could not yet be confirmed**, and longer observation of this cohort as they age is needed [41]. One interpretation is that salpingectomy truly might not reduce ovarian cancer as much as hoped; however, a more likely explanation is that the women who had OS were on average younger or had shorter follow-up (since OS only became common relatively recently), so insufficient time had passed to detect a difference in cancer incidence [41]. In contrast, older methods like tubal ligation have been around longer, and indeed that same Ontario study did find a significant ~23% risk reduction associated with tubal ligation (HR ~0.77) [43]. Tubal ligation's protective effect has been known (possibly by interrupting transit of cells or blood supply to tubes), and salpingectomy is presumed to be an even more complete prevention. The lack of a clear signal for OS in Ontario's 7-year data highlights that **the true impact on ovarian cancer risk in low-risk women remains an evolving story** – ongoing studies (with longer follow-up or in different populations) may yet solidify the magnitude of benefit. In the meantime, it's a point of caution that not every analysis unequivocally shows benefit; thus, universal adoption of OS is based on strong but still circumstantial evidence.

- **Concerns About Ovarian Function in Very Young Women:** Although most studies show no significant impact on ovarian reserve, the existing trials have short-term hormone follow-up (often 6 months). Some experts urge caution in *very young premenopausal women* undergoing OS, since even a small accelerated loss of ovarian function could be more consequential when a woman is far from natural menopause [15]. The Cochrane reviewers pointed out that any **potential subtle reduction in ovarian blood supply might only manifest over longer periods** or might affect the ovarian follicle count in younger patients who have a high reserve to start with [15]. There is also the fact that a **hysterectomy itself** (even with ovaries conserved) can lead to an earlier ovarian failure by 1–2 years on average, likely due to disruption of uterine-ovarian blood flow [44]. The incremental effect of also removing the tubes is probably negligible in most cases, but in principle it could further affect vascularization [44]. Thus, while **no clinically important harm has been demonstrated, continued research is needed on long-term ovarian function** after OS, particularly for women in their 30s who might keep their ovaries for 10–20 more years. It's prudent to counsel that we believe OS is safe for the ovaries, but absolute confirmation of no long-term hormone changes will come from ongoing studies (e.g. the Dutch "STOPOVCA" trial tracking menopause timing [45]).

- **Surgical Considerations:** From a surgical technique standpoint, there are a few scenarios where OS might be more challenging, raising theoretical risk. For instance, during a **vaginal hysterectomy** (with no laparoscopic assistance), removing the fallopian tubes can be technically difficult because the surgeon's access and view of the adnexal region are limited. Surgeons must weigh the benefit of OS against potential risks of additional dissection in a confined field. In such cases, some might choose not to perform an OS to avoid traction or injury to the ovaries or blood vessels. That said, skilled surgeons have reported techniques to successfully remove tubes vaginally in many cases, or to use a laparoscopic **assist** to take the tubes even if the uterus is removed vaginally. Another consideration is **surgical training and operating time**: a surgeon not familiar with salpingectomy might take longer or be hesitant to add to the procedure. However, as noted, the learning curve is modest and studies have not found significantly higher complication rates with OS when performed by experienced gynecologists [46]. In 2018, a FIGO survey found that a substantial number of gynecologists worldwide were still *unaware* of the tubal origin theory or not yet routinely offering OS [47] [48]. This indicates that **dissemination of knowledge and training** is important – the argument *against* could simply be that if OS isn't done properly (or if one is not trained), it could cause a problem. Fortunately, educational efforts are underway to address these barriers [48].

- **Residual Cancer Risk:** It must be emphasized that even if OS is performed, it **does not eliminate the risk** of ovarian cancer [49]. The ovaries remain in situ, and women could still develop other subtypes of ovarian cancer (such as endometrioid, clear cell arising from endometriosis, or truly ovarian-origin tumors) or primary peritoneal carcinomas. OS is primarily aimed at preventing high-grade serous carcinoma that starts in the tubes, which is a large share of cases but not all. An analysis from British Columbia observed that the few ovarian cancers that did occur after salpingectomy were generally **less aggressive** types or occurred many years later [50] [51]. Patients must understand that OS reduces risk, but **cannot guarantee prevention** – continued vigilance in terms of symptom awareness is still needed. Some skeptics argue that without removing the ovaries, the **absolute risk reduction** for an average-risk woman (whose baseline lifetime ovarian cancer risk is on the order of 1.2–1.5%) may be relatively small in terms of absolute numbers. For example, even a 50% risk reduction lowers lifetime risk to ~0.6–0.7%, meaning roughly 1 in 150 women might be spared cancer. The *number-needed-to-treat* (perhaps on the order of 200 women treated to prevent one ovarian cancer case) is much higher than for high-risk women undergoing prophylactic BSO.

However, given the low cost and safety of OS, many argue this is still worthwhile – but it's a point raised in *cost-benefit* discussions. Indeed, the Oregon guideline that initially advised against OS did so partly on a population cost basis, thinking the benefit might not justify doing it universally [40] (though as newer analyses show, the cost argument actually favors OS due to the high costs of cancer care that could be averted [32] [52]).

In summary, **the arguments against or the cautionary perspectives** highlight that opportunistic salpingectomy, while promising, is not a completely settled matter. We have *strong indirect evidence* of benefit but not definitive proof yet; one large study has not seen a significant risk reduction so far (likely due to limited follow-up); and there remain theoretical or practical considerations, especially in younger women or certain surgical contexts. Nonetheless, it's important to note that **no study to date has identified any *harm* from OS in low-risk women** – the worst case appears to be that it might not help as much as hoped. As evidence continues to accumulate (with ongoing trials like HOPPSA in Sweden and STOPOVCA in the Netherlands), the medical community is monitoring to ensure that OS's promised benefits are indeed realized. If future data were to show no risk reduction, guidelines would be revisited. For now, most experts feel the potential upside (preventing a deadly cancer) outweighs the very minimal downside, making OS a reasonable option to offer.

Comparative Studies: Hysterectomy With vs. Without Salpingectomy

To directly address how adding a salpingectomy compares to the standard hysterectomy-alone approach, several studies in recent years have conducted **head-to-head comparisons**. These include randomized trials and controlled cohort studies focusing on surgical and functional outcomes (since, as noted, cancer outcomes require decades of follow-up). Here we summarize the key findings from such comparative studies:

- **Surgical Complications:** When comparing *hysterectomy + OS* versus *hysterectomy alone*, studies consistently report **no increase in intraoperative or short-term postoperative complications** with the addition of a salpingectomy. In the Cochrane analysis of 7 RCTs (350 women) published in 2019, the pooled odds of any surgical adverse event were slightly lower in the OS group (OR ~0.66) but with wide confidence intervals crossing 1, indicating no significant difference [39] [14]. Essentially, the rate of complications (e.g. bleeding, organ injury, infection, readmission) was **equally low** in both groups. Large observational series (including >49,000 patients) similarly found **no elevated risk of postoperative infections or readmissions** after salpingectomy; if anything, the OS group had a non-significant trend toward *fewer* complications [8]. These data reassure that adding salpingectomy does not make the procedure more dangerous.

- **Operative Time and Hospital Stay:** The most consistently observed difference is a modest **increase in operative time** when performing OS. On average, removing the tubes adds about **10–20 minutes** to the surgery [9]. For example, one regional study noted a mean increase of 16 minutes for hysterectomy-with-OS vs. hysterectomy alone [9]. This is logical due to the extra steps of isolating and excising the fallopian tubes. Importantly, this small extension in OR time has not translated into any longer **hospital stay** or delayed recovery. Length of hospitalization and postoperative recovery metrics are unchanged with OS in most analyses [7]. In minimally invasive cases, those extra 15

minutes are usually inconsequential in the overall outpatient or overnight stay. Thus, the efficiency trade-off is minimal.

- **Blood Loss and Pain:** Studies have not found notable differences in **estimated blood loss** during surgery whether or not salpingectomy is done [7]. Removing the tubes, when done carefully, doesn't contribute significantly to bleeding (as the blood supply is cauterized). Regarding postoperative pain, patients generally report similar pain levels. One large database study did find that women who had salpingectomy were *slightly* more likely to fill a prescription for analgesics in the two weeks after surgery (20% higher odds of an extra pain-med prescription) [8]. This could suggest a minor increase in post-op discomfort or simply reflect provider practice (some surgeons might preemptively prescribe more pain medication when doing additional procedures). In any case, no significant difference in long-term pain or recovery has been documented.

- **Ovarian Function and Menopause Markers:** Direct comparisons of ovarian reserve markers before and after surgery show **no appreciable difference attributable to salpingectomy**. In randomized trials measuring AMH levels at 3–6 months post-hysterectomy, the decline in AMH (which occurs after any hysterectomy due to altered blood flow or stress) was virtually the same in the OS group and the no-OS group [14]. The Cochrane review calculated that postoperative AMH in the salpingectomy group was on average only 0.94 pmol/L lower than in the control group – a difference so small it was deemed not clinically relevant [53]. FSH and estradiol changes were likewise not significantly different. Additionally, studies assessing ovarian blood flow by ultrasound Doppler have found **no impairment in ovarian perfusion** after salpingectomy up to years later [12]. In summary, comparative trials confirm that **ovarian function is preserved** with OS, which is critical for premenopausal patients.

- **Menopause Onset:** As noted earlier, the available data (short-term) do not indicate earlier menopause from OS. The **time to menopause** is a longer-term outcome still under study (ongoing trials are following women for many years). However, based on hormone trajectories, researchers estimate that even if there is an undetectable difference, it would translate to at most a **1–2 year earlier menopause** in the OS group in a worst-case scenario [54] [15]. So far, even that theoretical slight advance has not been proven, and no difference is expected for most women. Comparative cohorts with ~5-year follow-up have found **no higher incidence of premature ovarian insufficiency** after OS versus ovaries-alone hysterectomy [12].

- **Quality of Life and Sexual Function:** Few randomized studies have specifically quantified quality of life, sexual satisfaction, or other patient-reported outcomes comparing the two procedures. However, observational data and subset analyses have not shown any negative impact of salpingectomy. Women report **similar or even improved peace of mind** knowing they had taken a cancer-preventive step, without experiencing differences in libido, vaginal dryness, or other hormonal symptoms (as would occur if ovaries were removed). A small trial from 2018 reported **no differences in postoperative sexual function scores** between those who had salpingectomy vs not, and overall quality-of-life metrics related to surgery recovery were equivalent [20]. The pilot study on menopausal symptoms (discussed above) actually hinted that women who *did not* get OS had higher menopause symptom scores (possibly because their ovaries might have been more affected by the hysterectomy alone, or due to chance in a small sample) [16] [19]. In any event, **no detriment in QoL has been attributed to OS** in comparative research.

- **Cancer Incidence (Long-term):** Direct comparative evidence on cancer outcomes will come from large ongoing trials/registries. The *HOPPSA trial* (a register-based RCT in Sweden) is following thousands of women randomized to hysterectomy vs hysterectomy+OS to assess ovarian cancer rates over time [55] [56]. While we await those results, we rely on existing cohort comparisons (as described in the prior sections). **No trial has yet shown a difference in cancer incidence**, but observational comparisons strongly suggest fewer cancers with OS (e.g. the 2022 BC study comparing observed vs expected cases) [6]. The 2023 Ontario study, as mentioned, did not show a significant difference at ~7 years follow-up [41]. These mixed findings underscore that **comparative cancer outcomes are not fully resolved**. It will likely take longer follow-up and perhaps pooled international data to conclusively demonstrate ovarian cancer reduction in low-risk women.

In summary, studies directly comparing hysterectomy with vs. without opportunistic salpingectomy have found **no disadvantages and several potential advantages to performing OS**. The procedures are equivalent in terms of surgical risk and recovery, with only a slight increase in OR time when removing tubes. Ovarian function and patient-centered outcomes are unchanged. The main expected benefit – cancer risk reduction – is supported by indirect comparison (epidemiologic data) although direct proof is pending. Given this balance of evidence, many clinicians and patients are opting for salpingectomy during benign hysterectomy as a prudent measure. Indeed, one commentary summed up the state of evidence by saying: we have enough data to "*choose to act, not wait*," offering OS to women as a low-risk intervention that could save lives [57].

Conclusion

Opportunistic salpingectomy at the time of benign hysterectomy has emerged in the last 5–10 years as a promising strategy to prevent ovarian cancer in women at average risk. **On the "pro" side**, a wealth of recent studies indicate that removing the fallopian tubes can substantially cut the risk of future serous ovarian carcinoma, which is supported by our evolving understanding of tubal carcinogenesis. This risk reduction is achieved *without* the downsides of oophorectomy – ovarian hormonal function is preserved, and randomized trials show no adverse surgical or quality-of-life outcomes from adding salpingectomy [13] [8]. These findings have led to broad endorsement of OS by gynecologic oncology experts and rapid uptake in surgical practice worldwide. **On the "con" side**, it is fair to note that definitive evidence (in terms of long-term cancer incidence and mortality reduction) is still being collected. Cautious voices remind us that ovarian cancer is rare, and the absolute benefit of OS for any given woman is small – meaning large numbers need the procedure to prevent a single case [5]. However, because the procedure is so low-risk, the **risk-benefit calculus** remains strongly favorable. The few skeptical or neutral studies (such as the Ontario cohort finding no significant association yet [41]) mainly highlight the need for ongoing research, rather than revealing any fundamental flaw in the approach.

In practice, most would agree that **if a woman is undergoing a hysterectomy for benign reasons and does not need her fallopian tubes for any future fertility, it is reasonable and often recommended to remove them**. This is especially true for women who wish to maximize cancer prevention but keep their ovaries for hormonal benefits. In postmenopausal women, some surgeons historically removed ovaries at hysterectomy to prevent ovarian cancer; now, many prefer to leave the ovaries (to avoid negative health effects of oophorectomy) and instead do a salpingectomy as a cancer-preventive compromise [58]. Thus OS can be seen as **an evolution in gynecologic preventive care**, balancing risk reduction with quality of life.

To conclude, **the evidence in the last five years strongly supports opportunistic salpingectomy as a safe, feasible, and beneficial adjunct to benign hysterectomy in low-risk women**, with multiple studies demonstrating risk reduction and no harm. While we should remain vigilant for more data (and adapt recommendations if needed), current research and expert consensus lean in favor of OS to help "STIC it" to ovarian cancer before it starts [59] [60]. Women should be counseled about this option – informed that it **might halve their future ovarian cancer risk** [3] [4] – and the decision individualized based on their values and surgical situation. In summary, opportunistic salpingectomy represents a proactive step in cancer prevention that, according to recent global research, offers significant potential benefit with minimal downside in both premenopausal and postmenopausal low-risk women.

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