In the 1990s, there were approximately 600,000 hysterectomies performed in the United States annually and 55% of these also involved bilateral salpingo-oophorectomy,1 many done solely to reduce the risk for ovarian cancer. It has been suggested that elective bilateral salpingo-oophorectomy be considered for women older than 40 years,2–4 whereas surveys in the United Kingdom revealed that 85–90% of physicians recommended bilateral salpingo-oophorectomy for postmenopausal women coming to hysterectomy. 5,6 However, Parker et al,7 citing evidence that postmenopausal ovaries secrete androgens important to health, performed a risk–benefit analysis and concluded that ovarian conservation benefits long-term survival for women at “average risk” for ovarian cancer undergoing hysterectomy for benign disease. A subsequent study using observational data from the Nurses’ Health Study on all and various causes of mortality for hysterectomized women with and without oophorectomy supported their conclusion.8

In addressing the value of bilateral salpingooophorectomy, Parker et al distinguished average-risk women from those with known *BRCA1* or *BRCA2* mutations or a strong family history of breast and ovarian cancer. In the latter group, bilateral salpingooophorectomy may truly be beneficial in reducing risk for both breast and ovarian cancer.9 Genetic or familial risk factors or both, however, account for a small proportion of ovarian cancer. Consequently, it is important to assess ovarian cancer risk among women who lack the genetic or familial profile. In this article, we describe a risk-factor score that may be of value in further categorizing risk for ovarian cancer in women without a personal or family history of cancer to provide additional guidance to women and their physicians regarding elective bilateral salpingo-oophorectomy at the time of hysterectomy. (271 words)

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Average-risk women may be different from those with known *BRCA1* or *BRCA2* mutations or a strong family history of breast and ovarian cancer. In the latter group, bilateral salpingooophorectomy may truly be beneficial in reducing risk for both breast and ovarian cancer.9 Genetic or familial risk factors or both, however, account for a small proportion of ovarian cancer. Consequently, assess ovarian cancer risk among women who lack the genetic or familial profile. we describe a risk-factor score that may be of value in further categorizing risk for ovarian cancer in women without a personal or family history of cancer to provide additional guidance to women and their physicians regarding elective bilateral salpingo-oophorectomy at the time of hysterectomy.

Over half of the 600,000 hysterectomies performed annually in the United States include bilateral salpingo-oophorectomy. Presumably, these procedures are done to reduce ovarian cancer risk. But the benefits of elective bilateral salpingo-oophorectomy among women older than 40 years are unclear.2–4 To date, bilateral salpingo-oophorectomy has had no demonstrable impact on mortality. And bilateral oophorectomy eliminates beneficial ovarian androgen secretion in postmenopausal women.

The potential risks and benefits of bilateral salpingo-oophorectomy are likely to be heterogeneous: Women with known *BRCA1* or *BRCA2* mutations or a strong family history of ovarian or breast cancer likely benefit more than average risk women. But genetic or familial risk factors account for only a small proportion of ovarian cancer. Consequently, most women may benefit from risk stratification to guide clinical decision-making regarding bilateral salpingo-oophorectomy.

Here, we describe a risk-factor score to categorize risk for ovarian cancer in women without a personal or family history of cancer. (152 words)