Advice about Hysterectomy

Introduction

If you are considering the possibility of having a hysterectomy there are some points that you should think about carefully. Most patients make a rapid recovery after their operation and do not experience serious problems or complications. The long term satisfaction rates after hysterectomy operations are high and most women are pleased with the results of their surgery once they have completed their recovery period. A hysterectomy is, however, a major operation and you should know about minor difficulties which are associated with the surgery and also about more serious problems which are rare. The section ‘Potential Complications or Possible Risks’ describes these and we particularly ask you to read this.

What is a hysterectomy?

This procedure will remove the womb usually together with the cervix. The ovaries and tubes may or may not be removed at the same time depending on the reasons for the procedure. If the ovaries are removed and you have not had your menopause, you may experience this. We may also perform other procedures at the same time to remove endometriosis or repair prolapse or free organs from scar tissue or disease. A hysterectomy is a major surgical procedure which is not undertaken lightly.

Why is this done?

Common reasons include:

- Heavy or painful periods which have not resolved with medical treatment.

- A prolapase of the uterus (where it has dropped down into the lower part of the vagina and is causing discomfort).

- Fibroids (extra lumps of muscle which grow in the wall of the uterus often causing heavy painful periods).

- Persistent, recurrent or old infection (pelvic inflammatory disease).

- Persistent endometriosis - which can also cause pain or heavy periods.

- Severe problems with pain from other causes or pre-menstrual tension which has not responded to other forms of treatment.

- Cancer or potentially cancerous conditions of the uterus or cervix.

You should have a clear understanding of your reason for this surgery. A number of other conservative interventions may be appropriate for your particular condition and will normally have been considered prior to your surgery.

What effect will it have?

- It will permanently stop your periods and make it impossible for you to conceive or bear children.

- If the cervix is removed (as occurs in most cases, unless you request otherwise) it will no longer be necessary for you to have to continue cervical smear tests. The exception to this is if the operation was performed because of cancer of the cervix or if you have a history of recent abnormal cells on the cervix.
It may reduce or abolish pre-menstrual tension (PMT) particularly if the operation is combined with the removal of your ovaries.

It is not expected:
- to result in an adverse effect on your sex life;
- to relieve pain not coming from the womb;
- to stop ovulation pains or cyclical symptoms such as PMS unless the ovaries are removed.

Are there different types of Hysterectomy?

There are different types of hysterectomy but each should be performed by the most appropriate route for the patient in the least debilitating way and allowing the speediest recovery of function. The different types are:

1. **Total abdominal hysterectomy (TAH)**
   This technique requires a 10-20cm abdominal incision to remove the uterus and ovaries if needed. It can be done for any sized uterus regardless of whether the patient has had children and the abdominal scar is either sideways or up and down as required for the specifics of each case. This procedure usually entails 2-3 days in hospital and 6-12 weeks off work to recover. Almost all Gynaecologists will perform this procedure except where cancer is suspected as in these cases a Gynaecological oncologist should be consulted.

2. **Total abdominal hysterectomy and bilateral salpingo-oophorectomy**
   Identical to procedure (1) except with the additional removal of both ovaries and fallopian tubes.
   Removal of the ovaries in a pre-menopausal woman will cause premature menopause. You can discuss hormone replacement therapy with your consultant or GP.

3. **Sub-total hysterectomy**
   Identical to procedure (1) except where the cervix (neck of the womb) is left in place. This procedure may be associated with fewer bladder symptoms following surgery and by preserving some of the supporting structures close to the top of the vagina may partially protect against future prolapse. It is no longer thought to have advantages in enjoyment of sex and will mean cervical smear tests should continue. Some women will need to have the cervix removed at a later date if problems develop, and small period-like bleeds can still occur.

4. **Vaginal hysterectomy**
   This is the most frequently employed technique of hysterectomy. The operation is performed entirely through the vagina without an abdominal incision with the womb drawn down through the vagina in order to disconnect the cervix and the rest of the uterus from its attaching structures. For a vaginal hysterectomy a women must usually have had a baby which widens the vagina and relaxes the connections of the uterus to allow it to descend sufficiently. There is also the requirement for the womb to be not overly enlarged and for there not to be other conditions within the pelvis such as excessive scarring from surgery or from infection or endometriosis. It is often not possible to remove the ovaries by this route but if all the specific requirements are met this is often the preferred route of hysterectomy. There is no abdominal scar and it usually requires only 1-2 days in hospital and approximately 6-8 weeks from work.

5. **Laparoscopic assisted vaginal hysterectomy (LAVH)**
   This is similar to vaginal hysterectomy, however keyhole surgery through the abdomen is performed to cut the ovarian and upper womb attachments with the view obtained through a telescope placed within the umbilicus (tummy button). LAVH is performed on women who can have a vaginal hysterectomy but need to be certain that the ovaries are removed or who have
had surgery or disease which makes the vaginal route alone more risky or less successful. There must be some vaginal laxity and openness and descent of the womb into the vagina (prolapse). Abdominal scars consist of 2-4 1.5cm incisions. There are usually 1-2 days in hospital and 6 weeks away from work. Some operating Gynaecologists with laparoscopic experience can perform this procedure, but not all.

6. **Total laparoscopic hysterectomy**

This procedure involves disconnecting the uterus and other structures as needed by operating laparoscopically only through keyhole incisions in the abdomen. The entire uterus is released from its attachments using micro surgical instruments and all tissues are removed by passing out through the vagina. The abdominal incisions are as with LAVH but there is no operating through the vagina. This procedure is possible for women who have not had children and who do not have prolapse. The procedure can also be combined with prolapse surgery, and it is also possible to remove endometriosis deep within the pelvis. Only a few of the Gynaecologists, in this Trust, can perform this procedure, although it is becoming more widely available nationwide.

**What will happen?**

You will probably be have been referred by your GP to a Consultant, if you have been suffering from any of the previously mentioned symptoms. You will have the opportunity to discuss these symptoms at your consultation, and if it is thought appropriate you will be added to the waiting list. Most women will be asked to attend a pre-operative assessment clinic a few days before admission. A leaflet about this clinic will be sent to you with your appointment.

Your nurse will advise you when you need to stop eating and drinking depending on the time of your operation. You may be given two high calorie drinks. These are to be drunk during your clear fluids only period - the pre-op nurse will give you further instructions. This is part of our enhanced recovery programme and you will also be asked to complete a diary whilst you are in hospital. This is to be left on the ward when you are discharged.

You should stop smoking, according to Trust Policy. Should you develop an illness prior to your surgery or have further questions please contact your Consultant’s secretary or Wynard Ward on 01392 406512.

**Important:** Women on the oral contraceptive pill should discontinue it at least one month before the planned operation and, if necessary, use alternative forms of contraception. Women on hormone replacement therapy do not necessarily have to discontinue this before the operation unless specifically advised to do so.

**The day of your operation**

Have a bath or shower before you come into hospital.

You will usually be admitted to the ward on the morning of your operation. After reporting to the ward at the appointed time you will be shown to either your bed or the lounge area if a bed is not available at that time. A nurse will take your blood pressure, pulse and temperature.

The anaesthetist will see you on the ward prior to your operation, to discuss your anaesthetic and pain relief with you.

You will be asked to put on your theatre gown and anti-embolic stockings (elastic stockings to prevent thrombosis). Some people will have electronic boots to prevent thrombosis.

Very occasionally a pre-med is given, and this can be discussed with the anaesthetist beforehand.

About 15-30 minutes before your operation one of the nurses will take you to theatre. You have the option to walk or go in a wheelchair if your mobility is impaired, or if you have had a pre-med you may wish to go on a trolley.

You will be taken into the anaesthetic room, which is next to the theatre where you will meet the anaesthetist again and their assistant. You will be anaesthetised in this room and then transferred
asleep into the operating theatre. Someone stays with you the whole time from when you leave the ward until you return.

**After the operation**

The anaesthetist will wake you up after the operation is completely finished. The ‘waking up’ procedure takes place in the operating theatre itself, but this is rarely remembered. You will be transferred to the recovery room and checked regularly by the nursing team until you are sufficiently awake and recovered to return to the ward. Regular checks are continuous on the ward to ensure that your pulse and blood pressure are satisfactory, and to give pain killing drugs if needed.

If you have had an abdominal hysterectomy, you may have PCA (patient controlled analgesia) or an epidural in place or you may have two small fine tubes called rectus sheath catheters inserted into the skin in your tummy, all of which deliver pain relief. There are separate information leaflets about these, please ask for one.

You may have an oxygen mask on for some hours following your operation. There is usually a fluid ‘drip’ connected to a plastic tube into your arm and usually there is also a catheter tube going into the bladder ensuring that it does not become over-full. Your fluid input and output will be recorded by the nursing staff.

You will be given a small injection in the top of your arm, this is an anti-coagulant, to help prevent deep vein thrombosis (blood clots, usually in the legs).

A doctor will check your progress every day. It is often possible to remove the drip and catheter within the first 24 hours and to start drinking on the day of your operation. Eating solid food is usually possible over the next day. At some stage there may be a visit from the physiotherapist to give further advice on getting back to normal activities and certain exercises which may be helpful. You may have glue or sutures in the wound, which sometimes are dissolvable or otherwise will be removed by your practice nurse.

You may be allowed home within 1-3 days depending on your progress and the type of operation. Your GP will be sent details of your operation and will be alerted when you go home. You may also be given specific discharge medication or painkillers if required. You may otherwise use Paracetamol if needed (1-2 tablets every 4 hours up to a maximum of 8 tablets per day.

**When can I return to normal?**

There are no absolute rules. It is normal for people to feel tired and for the tummy to be quite sore for 3-4 weeks after a hysterectomy. The tiredness is believed to be partly due to a general loss of fitness due to inactivity while in hospital and partly due to after effects of the anaesthetic drugs. This can last several weeks. The soreness is due to bruising internally in the area where the womb used to be. In the case of abdominal hysterectomy there will be bruising in the abdominal wound as well. A small amount of bleeding or brownish discharge from the vagina is not unusual and may occasionally persist for a few weeks. It is best to avoid sexual intercourse for 6 weeks and until the discharge has settled.

In the absence of any complications and depending on which type of hysterectomy has been performed, a woman may feel well enough to return to normal activities anything from 3-12 weeks after the operation. It can, however, take longer. It is best to build up slowly with gentle exercise once the initial discomfort of the operation and worn off with the aim of restoring general physical fitness which has been lost. Driving may also be resumed once you are sufficiently comfortable and able to perform and emergency stop. It may be helpful to consult your insurance company for advice in this area. You will receive a follow up appointment usually for
6-8 weeks following your operation but if you have concerns prior to this please ask your GP to contact your Consultant’s team. Alternatively, please phone Wynard Ward on 01392 406512.

### Possible risks and complications of your procedure

All operations carry some degree of risk. Serious complications involving a risk to your life are rare if you are otherwise reasonably healthy and not excessively overweight.

#### Rare major problems

- **Anaesthetic problems**. General anaesthetic complications are unusual but more common if you have other serious medical problems or are excessively overweight.

- **Haemorrhage (bleeding)**. Unexpected bleeding may occur especially when the operation has been complex. This may require transfusion of blood or extra fluid and occasionally bleeding can occur some hours after the surgery necessitating a second procedure.

- **Damage to the bladder, ureter (connection between kidneys and bladder) and other organs**. Some of these structures are attached to the womb and need to be released during a hysterectomy. Damage can occur if they are particularly adherent (stuck), for example due to previous surgery or Caesarean delivery. If this damage is identified at the time of the operation it can usually be repaired successfully with no long-term effects on your health. Very occasionally urine can leak through a connection that develops between the bladder and the vagina and a further repair operation is required. Urinary tract injury may be more common after a laparoscopic hysterectomy.

- **Thrombosis and pulmonary embolism** (clots in the blood that may affect the legs and the lungs). This can be a very dangerous complication. You will be given protection with anti-coagulant injections before and after your operation to reduce this risk. You will also wear stockings or boots to help with your circulation.

- **Death**. Death is very rare after hysterectomy unless you have co-existing medication problems or poor fitness for major surgery.

- **Long-term complications**. These may be difficult to evaluate. There is evidence of increased risk of prolapse after hysterectomy and statistically this risk appears to be highest following vaginal hysterectomy. Bladder irritability is a common after-effect following hysterectomy and usually settles within a few weeks. It may, however, continue for longer. There are also risks or internal scarring (adhesions) after every form of hysterectomy. This is thought to be lowest following keyhole techniques.

- **Premature menopause**. Even if the ovaries are preserved at the time of hysterectomy, it is possible that the menopause will occur approximately 1-2 years earlier. This increases the risk of osteoporosis and heart disease. If the symptoms of the menopause (hot flushes, sweats, vaginal dryness and mood changes) occur it may be advisable to discuss hormone replacement with your GP.

- **Vaginal Vault Dehiscence**. After an hysterectomy, the vagina is repaired with stitches that need time to dissolve and allow strong healing. This process may take many weeks, especially after Total Laparoscopic Hysterectomy, where we ask you to delay sexual intercourse for up to 10 weeks, depending on the advice given at your follow up appointment. Intercourse begun too early may result in damage to the top of the vagina resulting in pain, or bleeding, or the need for further surgery.

#### Minor complications

Certain complications are not uncommon during the first few weeks. Your GP would treat these sometimes in consultation with your Consultant Team.
■ **Wound infection.** If there is an abdominal incision this occasionally becomes increasingly swollen, red and painful, indicating infection. Sometimes the wound may produce a discharge. You should see your GP or practice nurse if this occurs. Very occasionally it is necessary to perform a small operation to release an abscess (collection of infection) if it forms within the wound.

■ **Internal infection.** If the site where the womb used to be becomes infected, there may be an increasingly smelly discharge and increased bleeding from the vagina. Your GP will prescribe antibiotics to treat this.

■ **Bladder infection.** If there is discomfort or a desire to pass water excessively, please take a fresh sample of urine to your GP.

■ **Chest infection.** This is more likely to be a complication if you continue to smoke.

**Prevention** - antibiotics are given during your anaesthetic to try and reduce the chance of these infections.

Overall, most women are pleased with the outcome of their surgery and feel that their quality of life has improved. We endeavour to care for you with this philosophy in mind.

**Where can I get further information?**

- www.obgyn.net
- www.endometriosis.org
- www.nice.org.uk
- www.rcog.org.uk

**If you have any questions, please contact:**

- Wynard Ward ......................... 01392 406512
- Pre-assessment nurses............ 01392 406530/1