Hysterectomy

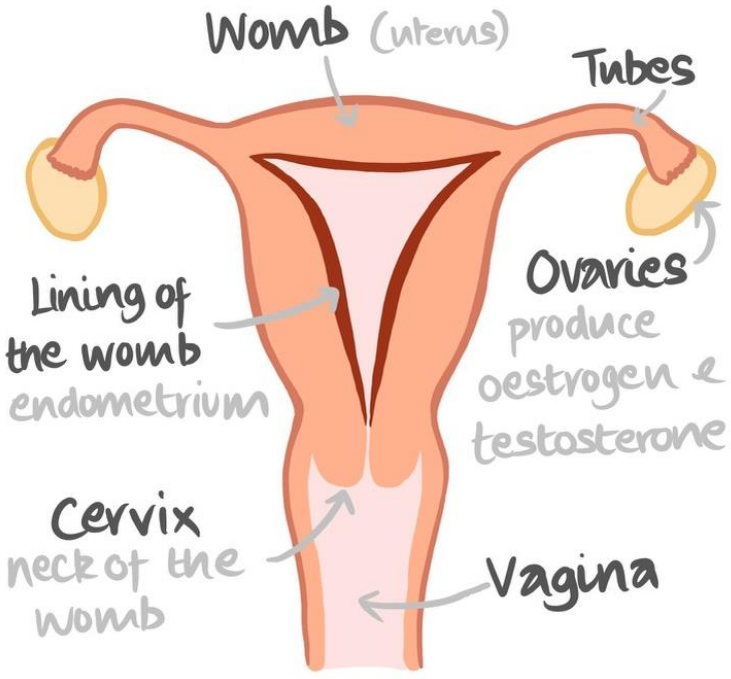
Hysterectomy involves removal of the womb. It is performed for a variety of reasons including:

- Abnormal bleeding
- Fibroids
- Chronic pelvic pain, endometriosis
- Vaginal prolapse
- Gynaecological cancer

It is a common procedure and in some cases can be performed as a daycase procedure – where you go home the same day.

What is removed

A hysterectomy involves removing the uterus (womb), cervix and fallopian tubes. Removal of the cervix means you cannot get cervix cancer and do not normally require cervical smears. The cervix will be examined under the microscope and your previous smears reviewed. In a minority of women with abnormal smears in the run up to surgery, or if pre- cancerous cells are found in the cervix then a smear test of the top of the vagina may need to be performed a few months post operatively.



Removing the uterus means that you will not have periods and cannot become pregnant. Removing the fallopian tubes does not make the operation bigger or affect recovery, however it reduces the risk of fallopian tube cancer. Removing your uterus and tubes does not change your hormones in any way and cannot make you lose or put on weight. The vagina is not usually made any shorter by the operation so sex after the operation is not affected.

If you are close to the menopause you will need to decide if you want your ovaries removing. Generally it involves minimal extra surgery and will greatly reduce the risk of ovary cancer. Ovary cancer kills 1% of women (1 woman in 100) and usually occurs late in life. If it is necessary to remove the ovaries before the menopause, hormone replacement therapy (HRT) may be recommended. Once you have had a hysterectomy, you cannot get uterine cancer and therefore you only need

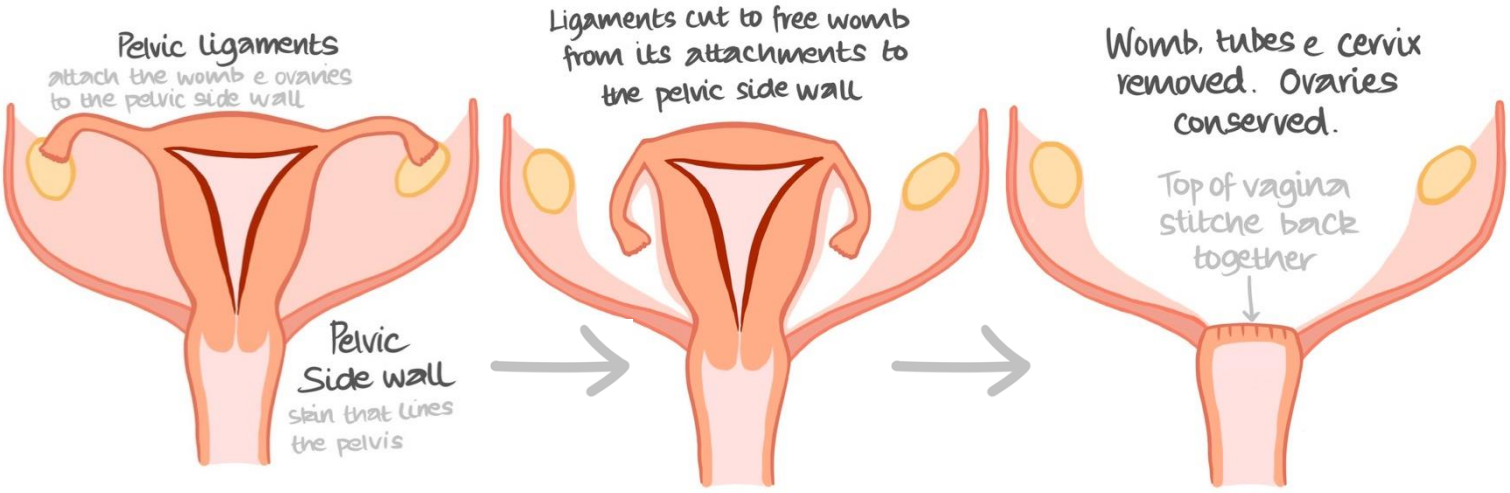
to take oestrogen HRT. You will not need progesterone HRT unless you have a history of severe endometriosis.

The ovaries continue to produce testosterone for 20 years after the menopause. Therefore, removing the ovaries, even in post-menopausal women can negatively impact libido. Testosterone can be replaced with testosterone gels but these can be difficult to dose and require monitoring.

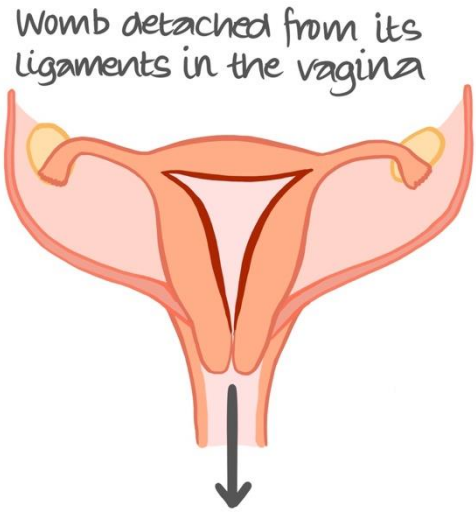
Types of hysterectomy

The surgeon will discuss with you the most suitable approach for your surgery. Sometimes it is necessary to examine you whilst you are asleep (when all your muscles have relaxed) so we can work out which is the most appropriate route.

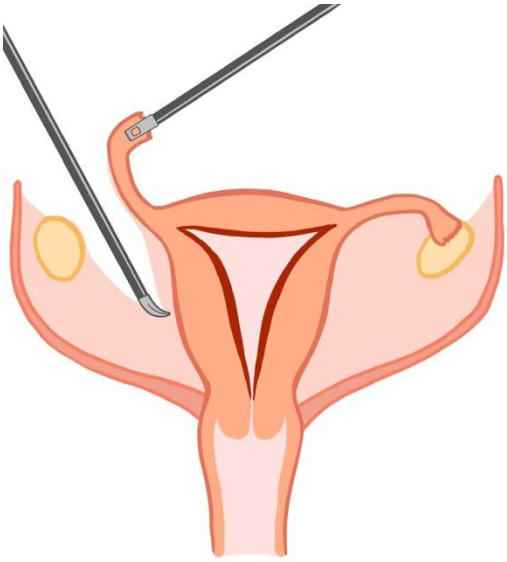
The basic steps are involve separating the womb from the bladder, pelvic ligaments and blood vessels. The womb is then removed via an incision in the abdomen or vaginally. The top of the vagina (vaginal vault) is then sutured closed.



Vaginal hysterectomy

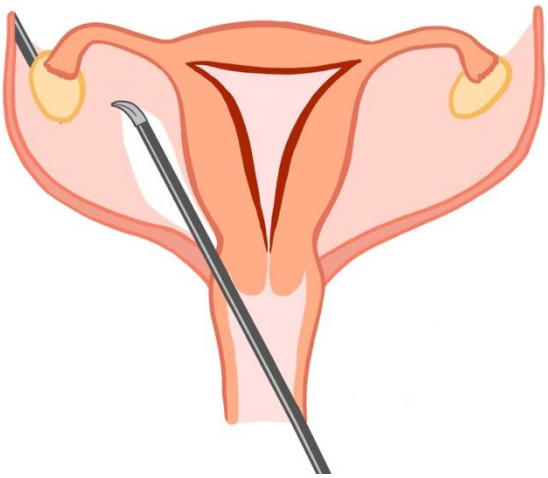


Surgery is performed through the vagina and all the scars are out of sight. The advantage of this method is that you do not need an additional cut in your abdomen. This is commonly the operation of choice for management of uterine prolapse. Often a vaginal wall repair may be performed at the same time.



Laparoscopic (keyhole) hysterectomy

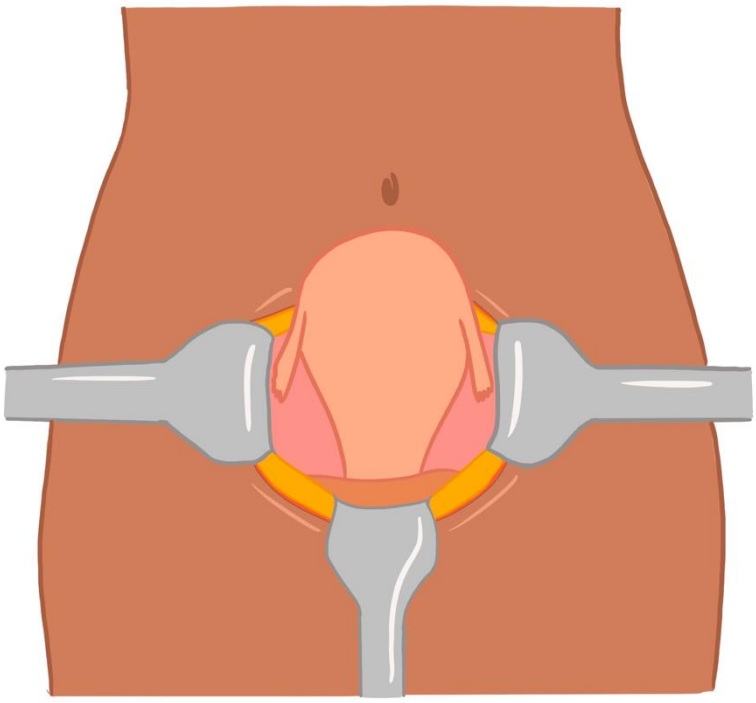
A camera is inserted through the bellybutton and a further 2 small (1cm) incisions will be made in the abdomen. Instruments pass through these incisions and the womb is disconnected from the pelvic ligaments and 'delivered' through the vagina. The top of the vagina is then sutured closed.



vNOTES Hysterectomy

A camera and instruments are inserted vaginally and instruments inserted. The womb is then disconnected from the pelvis and then 'delivered' through the vagina like in a laparoscopic hysterectomy. The advantage of this method is that you do not need an additional cut in your abdomen.

Open abdominal hysterectomy



The womb is removed via an incision in the abdomen. The incision goes across the lower abdomen near the pubic hairline (bikini scar incision). If the womb is particularly large (lots of big fibroids) then an incision going up and down the abdomen may be required. Open abdominal hysterectomy tends to be performed in women who have large wombs which cannot fit through the vagina or in women who have had lots of complex abdominal surgery before. As a larger incision is required, recovery is often longer and it is typical to stay in hospital overnight. The procedure is also associated with more blood loss which can make you feel tired and lethargic.

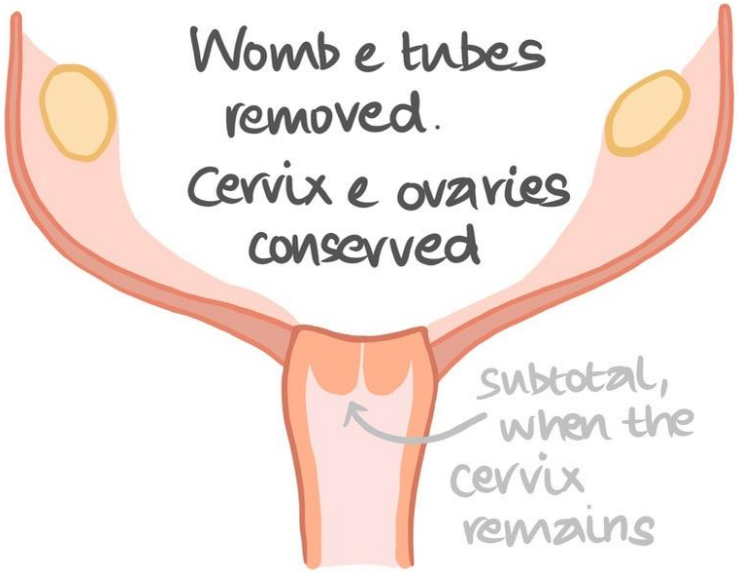
Sometimes it may be necessary to perform an unplanned open hysterectomy. This may occur if we are unable to complete a hysterectomy laparoscopically or vaginally. The common reasons for conversion are below:

- The womb is too big and won't fit out the vagina

- There is a complication such as bleeding or damage to abdominal organs (bowel, ureters) which needs repairing. Often this requires better access to the pelvis which can be obtained doing an open incision.

Subtotal hysterectomy

The womb is removed but the cervix (neck of the womb) is left behind. This is usually done as an open procedure but in some instances can be performed laparoscopically with morcellation of the womb inside the abdomen.



A subtotal may be performed if the womb has large fibroids which makes it technically difficult to reach the cervix. Some patients may also choose to have a subtotal hysterectomy as the pelvic ligaments holding the cervix up are maintained thereby reducing the chance of vaginal vault prolapse in the future. There are also some gynaecologists who believe that by removing the cervix, a subgroup of women may have reduced orgasm and sexual pleasure. However, the evidence for both these theories is limited.

If your cervix is left behind then you will still need to continue having smear tests if you are still within the screening programme age range. If you are still getting periods then occasionally a small amount of lining of the womb (endometrium) may be left at the top of the cervix. This endometrium will continue to bleed every month. In this instance you would be advised to have combined HRT rather than oestrogen only.

Before the day of surgery

In preparation for your operation you will be asked to complete an online assessment called ‘My Pre-Op’, this should take approximately an hour and you should be as accurate with your answers as possible. A Specialist Nurse or Anaesthetist will review your answers to assess your fitness and decide on any investigations that may be needed before your surgery such as bloods tests or electrocardiogram (ECG), you may be asked to attend the pre-operative department at the hospital.

Preparing for surgery

Please bring an overnight bag with lose fitting night clothes, slippers and toiletries. If you are booked for a daycase procedure it is still worth bringing this in case the surgeon recommends you are admitted overnight, or you do not feel comfortable to go home.

You may experience some pain and discomfort for the first few days after surgery, please ensure you have paracetamol and ibuprofen (if you are able to take it) at home, as well as over the counter laxatives in case of constipation (for example; Docusate, Movicol). You will also be

provided with some stronger prescription painkillers. Do not worry if you are having a period on the day of surgery as it does not affect the procedure.

You should have a responsible adult to accompany you home and be with you for the first 24 hours after your operation. If you live alone please make arrangements to have someone to stay with you. You will also need a means of transport available in the unlikely event of any complications requiring you to return to hospital. If you live more than an hour's journey from the hospital by car it may be more appropriate for you to stay in hospital overnight.

The day of surgery

You will be asked to attend the Day Surgery Unit on the morning of your operation, you will see the surgeon, who will confirm your consent; and the anaesthetist will see you to explain what sort of anaesthetic you will need. While you are on the Day Surgery Unit, before you are taken to theatre you may be given some pre-medication to help reduce any post-operative pain and nausea and you will be given support stockings to minimise the rare risk of thrombosis after surgery

Possible complications

Following is the list of complications quoted by the Royal College of Obstetricians and Gynaecologists (RCOG) (2009) which may not be all inclusive. If you have any particular concerns, do ask the surgeon.

Women who are obese, who have had previous open abdominal surgery or who have pre-existing medical conditions are at a higher risk of having complications.

Serious Risks Include:
● The overall risk of serious complications from abdominal hysterectomy is approximately (4 in 100 - common)
● Damage to the bladder / ureter (7 in 1000 uncommon)
● Damage to the bowel (4 in 10 000 - rare)
● Heavy bleeding requiring blood transfusion (23 in1000 - common)
● Return to theatre because of bleeding/wound break down / organ damage (7 in 1000 - uncommon)
● Pelvic infection (2 in 1000 uncommon)
● Clots in the legs or lungs (4 in 1000 uncommon)
● Risk of death within 6 weeks (32 in 100 000 rare). The main causes of death are clots in the lungs and heart disease.

Frequent Risks Include:
● Wound infection, pain, bruising, delayed wound healing or keloid formation
● Numbness, tingling or burning sensation around the scar (usually this is self-limiting but can take weeks or months to resolve)
● Frequently passing urine and urine infection
● Earlier menopause

After your operation

When you wake up you may have a tube with fluid running into a vein in your arm. This will be removed when you are drinking fluids freely. You will be encouraged to drink and eat some light food. You will be given painkillers and anti-sickness medication as required. If you had a laparoscopic or vaginal approach hysterectomy you will be encouraged to gently mobilise.

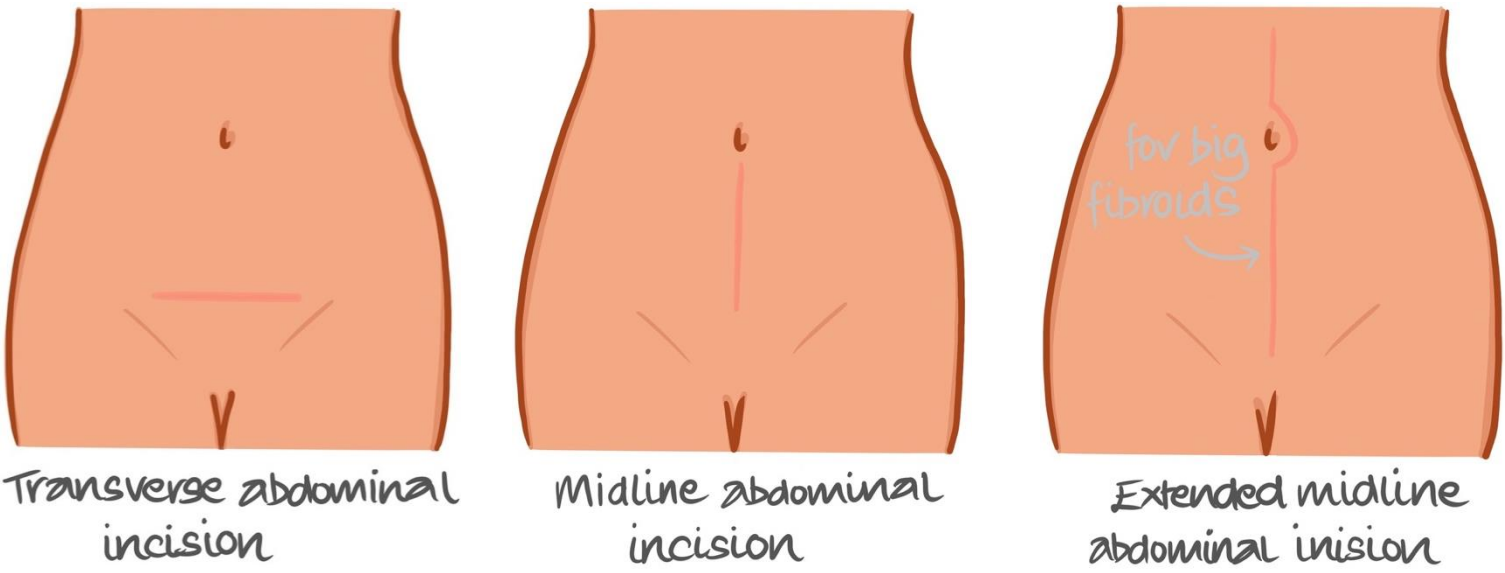
You may have some pain in your lower abdomen, experience trapped wind or shoulder pain and feel bloated in the first few days after your operation. These symptoms can be eased with regular analgesia, over the counter laxatives and gentle walking.

Any incisions or abdominal wounds will be closed with dissolvable stitches that do not need to be removed, they will be covered with either skin glue which will peel away after 5-10 days, or a small dressing which can be removed after 1 or 2 days.

It is common and quite normal to feel a little ‘low’ or tearful after the operation.

If you are booked for a daycase procedure and your surgery is uncomplicated then the nurses will continue to monitor you and if you remain well you should be able to go home later that day. Specifically you will have to have passed urine, be able to mobilise and have your pain controlled. The following morning you will be called in by one of the gynaecology doctors who assess how you are getting on and address any questions / concerns you might have.

If you have had an open abdominal procedure then anticipate an overnight stay in hospital. An extended stay may be required if your procedure was particularly complex, or a very large midline incision was necessary (extended midline abdominal incision).



Getting back to normal

You can start to resume some normal activities at home within a few days when you feel ready and gradually increase over the next few days and weeks. Gentle activity encourages the muscles, particularly the back muscles, to get back to normal quickly. From about three weeks after the operation you may do more strenuous activity. Vacuuming, lifting heavy items and more energetic activities like sports may be uncomfortable or slightly painful but is safe and will do no harm. The back muscles are the most important part of the body to be concerned with. Too much, or too little activity can result in backache. A little gentle swimming is particularly good exercise, as it often causes no discomfort. Any exercise is better than none although it will be tiring and frequent rests will be necessary. Typically, women who have had an open hysterectomy take a bit longer to recover and resume normal activities.

The operation may temporarily affect your ability to pass urine. During your operation, the muscles of your vagina and those that support your bladder may have been cut or stretched. The bladder may also be bruised and this may make it irritable. This means you may want to pass urine frequently and feel your bladder is not completely empty. This feeling settles quickly with time. The "Pelvic Floor Exercises" explained to you by the physiotherapist are important. They will help you retain and regain bladder tone and control. Practice them regularly when at home. If you experience any "burning" when you pass urine or feel that it looks cloudy and smells unpleasant, inform your doctor, you may have an infection which should be treated with antibiotics.

Work, driving, sex

You should be able to start work again around six to eight weeks after the operation but this does vary a lot between people. A doctor's certificate for time off work can be provided for you on the day of surgery, however, it is your G.P. who provides long-term sick notes.

You should not drive for 24 hours after a general anaesthetic and should check your car insurance to ensure you are covered. Do not drive if your concentration is not perfect or if you have any discomfort. You must feel able to perform an emergency stop when driving.

In most cases it is safe to have sexual intercourse after about four to six weeks and it should actually help your tissues become supple again, this should be gentle and if much discomfort is felt you should be prepared to wait a little longer, you may find a vaginal lubricant helpful at first.

More information

Well-meaning friends and relatives, or even other patients may tell you things that can be alarming and often inaccurate. Try instead to get your advice from the doctors, nurses or other people who have seen many women who have had this operation. A useful source of information is the ward. The nurses are very used to answering questions. You can contact them by telephone: 01225 824664 or 824436.

More information is available on the Royal College of Obstetricians and Gynaecologists website:

www.rcog.org.uk/for-the-public

The following QR codes link to RCOG patient leaflets which discuss the recovery following each different type of hysterectomy in depth (if you are having a vNOTES hysterectomy please refer to the laparoscopic hysterectomy leaflet):

Abdominal Hysterectomy

https://www.rcog.org.uk/for-the-public/browse-our-patient-information/abdominal-hysterectomy-recovering-well/

Vaginal hysterectomy

Laparoscopic Hysterectomy

Royal United Hospitals Bath NHS Foundation Trust
Combe Park, Bath, BA1 3NG
01225 428331 | www.ruh.nhs.uk

If you would like this leaflet in email form, large print, braille or another language, please contact the Patient Support and Complaints team on 01225 825656.

Date of publication: October 2024 | Ref: RUH GYN/022

	Abdominal Hysterectomy	Vaginal Hysterectomy	V-NOTEs (keyhole) Hysterectomy	Laparoscopic (keyhole) Hysterectomy
Can ovaries/tubes be removed?	YES	NO	YES	YES
Can I keep my cervix?	YES	NO	NO	YES
Abdominal incision(s)?	YES – large incision	NO	NO	YES 3-4 small incisions
Operating time	45-90 min	30-60 min	30-45 mins	45-60 mins
Limited by size of uterus?	NO most appropriate for big fibroids	YES – not suitable if there are large fibroids	YES – not suitable if there are large fibroids	YES – not suitable if there are large fibroids
Limited by previous births	NO	YES – not suitable if 2 or more C/Sections	YES – not suitable if 2 or more C/Sections	NO
Can my pelvis be assessed at the time of surgery?	YES	NO	YES	YES
What type of anaesthetic do I have?	Combined General anaesthetic and spinal anaesthetic	General Anaesthetic OR spinal anaesthetic	General Anaesthetic OR spinal anaesthetic	General Anaesthetic
Patient limitations	Associated with most intra-operative blood loss Higher risk of VTE	May not be possible if impaired access to the vagina or where you have conditions that have caused significant scarring to the area between the cervix and the rectum eg low colorectal surgery, pelvic radiation, severe pelvic inflammatory disease, and severe endometriosis.	May not be possible if impaired access to the vagina or where you have conditions that have caused significant scarring to the area between the cervix and the rectum eg low colorectal surgery, pelvic radiation, severe pelvic inflammatory disease, and severe endometriosis.	May not be possible if you have certain medical conditions which means you are anaesthetically unable to have a laparoscopy eg raised BMI or heart or lung disease Previous complex abdominal surgery
Hospital stay	Longest – 24-48 Hrs	Short – can be Day case	Day case surgery	Day case surgery
Return to normal activity	Slowest (6-12 wks) Greater post op pain	4-6 weeks	4-6 weeks	4-6 weeks
Risk of complications	Associated with most intra-operative blood loss. Similar of major long-term complications	Similar of major long-term complications.	Similar risks of long-term complications	Highest risk (although small) of intra-operative damage to the urinary tract – bladder/ureter Similar of major long-term complications.