Information Leaflet about Hysterectomy

You will have been given this leaflet because you have been told you may need to come into hospital for an operation call a hysterectomy (hyster = womb and ectomy = removing).

This operation may be advised for several different reasons so do ask and make quite sure that you understand as clearly as possible why your own particular operation is needed. You should also be aware of all the alternatives. There will also be many more general questions about your operation, which you may not immediately think of so we hope that this leaflet will be helpful.

Your Admission Date

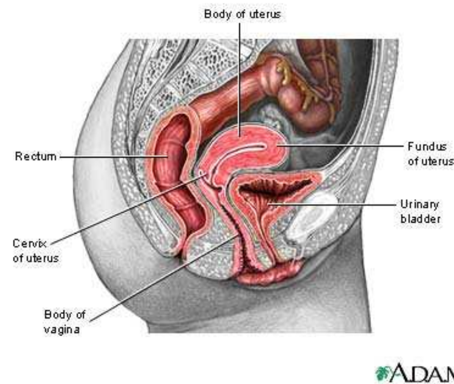
You will normally be asked to come to hospital several days before your operation. This is so your fitness can be checked and any necessary blood tests or x-rays taken. Having a period normally makes no difference to your admission date. You will need to be measured for support stockings as these minimise the rare risk of thrombosis after surgery. You will not need an enema unless major bowel surgery is planned. The top part of your pubic hair may be clipped and hair around the entrance to the vagina may be trimmed. Many women prefer to do this themselves. It is not vital and you do not need to be over zealous but it should be done approximately ten days before surgery.

The Anaesthetic

Before your operation an anaesthetist will see you to assess and explain to you what sort of anaesthetic you will need. About an hour before your operation, while you are still in the ward, a routine antibiotic may be given to reduce the risk of wound infection. You may ask for an injection or tablet to make you relaxed and drowsy. This can increase the safety of an anaesthetic and may help prevent danger from sickness.

A hysterectomy operation is normally done under general anaesthetic and this begins in the operating theatre with an injection into a vein at the back of your

hand. This produces sleep within seconds and by the time you become conscious again the operation is safely over.



Sometimes, the anaesthetist may suggest that it is safer for you to be given a “spinal” or “epidural” which means that a local anaesthetic (like the one used for child birth) is injected into the lower part of your back. If this is done then all the lower half of your body becomes numb and free of pain. This numbness will remain while you have the operation and for some hours afterwards. Sometimes this injection will be combined with a light general anaesthetic so that you will go to sleep as well.

The Operation

It is usually possible for the operation to be done via the front passage (vaginal hysterectomy). When this approach is used all the scars are out of sight so it is sometimes wrongly called the “suction” method. The advantage of this method is that you do not need an additional cut in your abdomen.

Sometimes the hysterectomy cannot be performed through the vagina. This is either because the womb is too large or because it is stuck and cannot be passed through the birth canal. Under these circumstances keyhole surgical techniques (laparoscopic surgery) are used. This technique is still better than having an incision in the abdomen. However, keyhole surgery is associated with additional risks if the womb is stuck. Under these circumstances it is better to have an abdominal incision.

An incision in the abdomen (abdominal hysterectomy) can use an incision going up and down the middle of your abdomen or (more commonly) an incision across the lower abdomen near the pubic hairline (bikini scar incision). If this incision is used the final scar is hopefully hidden by pubic hair. If you already have a scar from a previous operation in the lower abdomen, it is usually possible to use the same scar again.

What gets taken away?

A hysterectomy involves removing the womb or part of the womb. The womb is also known at the uterus. A hysterectomy involves removing the uterus and cervix. A small number of women choose to have cervix retained which is then referred to as sub-total hysterectomy. Normal ovaries do not necessarily need to be removed and women can have a choice. Removing the womb (uterus) means that you will not have periods and cannot become pregnant. The only known function of the womb is to nurture a fetus and it causes periods. Removing your womb does not change your hormones in any way and cannot make you lose or put on weight.

The vagina (front passage) is not usually made any shorter by the operation so sex after the operation is not affected.

The cervix is part of the womb and is normally removed during a vaginal hysterectomy. This means you cannot get cervix cancer and do not normally require cervical smears. Scandinavian surgeons are reluctant to remove the cervix and occasionally open the abdomen and just remove the top half of the womb. They argue that removing the cervix can affect the bladder or orgasms. Most gynaecologists reject these arguments but you may wish to discuss whether your cervix should be left or removed.

Whenever possible the surgeon will leave both ovaries complete but it is worth knowing that even one quarter of one ovary is sufficient to allow normal function. If it is necessary to remove all ovarian tissue before the menopause, hormone replacement therapy (HRT) may be specially recommended to postpone the menopause. However once you have had a hysterectomy, you cannot get uterine cancer and therefore you only need to take the female hormone called oestrogen. You will not need the hormone called progesterone. This is important because progesterone is the hormone that normally causes symptoms.

If you are close to the menopause you will need to decide if you want your ovaries removing. It may involve no extra surgery and will prevent ovary cancer. Ovary cancer kills 1% of women (1 woman in 100) and usually occurs late in life.

Possible Complications of the Operation

Following is the list of complications quoted by the RCOG which may not be all inclusive. If you have any particular concerns, do aske the surgeon.

Women who are obese, who have significant pathology, who have had previous surgery or who have pre-existing medical conditions must understand that the quoted risks for serious or frequent complications will be increased.

Serious Risks Include:

● the overall risk of serious complications from abdominal hysterectomy is approximately four women in every 100 (common)
● damage to the bladder and/or the ureter (seven women in every 1000) and/or long-term disturbance to the bladder function (uncommon)
● damage to the bowel: four women in every 10 000 (rare)
● haemorrhage requiring blood transfusion, 23 women in every 1000 (common)
● return to theatre because of bleeding/wound dehiscence, and so on: seven women in every 1000 (uncommon)
● pelvic abscess/infection: two women in every 1000 (uncommon)
● venous thrombosis or pulmonary embolism, four women in every 1000 (uncommon)
● risk of death within 6 weeks, 32 women in every 100 000 (rare). The main causes of death are pulmonary embolism and cardiac disease.

Frequent Risks Include:

● wound infection, pain, bruising, delayed wound healing or keloid formation
● numbness, tingling or burning sensation around the scar (the woman should be reassured that this is usually self-limiting but warned that it could take weeks or months to resolve)
● frequency of micturition and urinary tract infection
● ovarian failure.

Extra procedures which may become necessary during the procedure:

● Blood transfusion
● Repair to bladder, bowel or major blood vessel
● Oophorectomy for unsuspected disease.

After the Operation

When you wake up you may have a tube with fluid running into a vein in your arm. This 'drip' is not usually needed for any longer than about 36 hours after the operation. A blood transfusion is rarely needed and will be avoided if possible.

A small tube (a drain) is sometimes put into the wound at the operation and removed after a day or two. Stitches or clips will be taken out between five and ten days afterwards but often there will not be outside stitches to be removed at all.

There will be some pain from your tummy scar, which often remains hard or a little discomforting and may itch for some weeks.

Most women get wind in their bowels for three or four days after the operation and this can make your tummy look blown up and be quite uncomfortable. Medicines

can be given to help this and it usually does not last long. Research has shown that glycerine suppositories are effective (peppermint water is not very good).

It is common and quite normal to feel a little 'low' or weepy after the operation. The nurses do understand, so do not be afraid to show your emotions, especially as this may well help to speed up your recovery.

Going Home

Although a hysterectomy is a major operation you are normally well on the way to recovery within days. You may be able to leave hospital on the 2nd or 3rdth day after the operation but this is variable.

An inconvenient yellow or brown discharge from the vagina often occurs during the first few months. You may also loose dissolving stitches - this is normal. If it has not cleared up by the time of the 'follow-up' visit mention this to the doctor.

If more than slight bleeding occurs do get in touch with your doctor earlier.

Getting back to Normal

From about three weeks after the operation you may want to start activity. This type of gentle activity encourages the muscles, particularly the back muscles, to get back to normal quickly. Vacuum cleaning, lifting heavy items and more energetic activities like sports can pull on the wound and be uncomfortable. Although it may be uncomfortable or slightly painful this sort of exercise is completely safe and will do no harm. The old fashioned advice was to wait for four to six weeks but we now know you should do what you feel like. Nothing will fall apart and exercise will not harm your wound. 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. Frequent rests will be necessary, as you will find any exertion makes you tired. Your family and friends will expect you to take things more easily than usual and advise plenty of sleep. Use your common sense and be ready to accept offers of help from friends or family. A lot of concern is shown about the "strength" of the scar but this is rarely a cause for any problem. 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. Moderate activities are best and remember to bend your knees when lifting.

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

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cloudy and smells unpleasant, inform your doctor, you may have an infection which should be treated with antibiotics.

Work, Driving and Sex

You should be able to start work again around six to eight weeks after the operation but people vary and some are ready sooner, some later, so it is difficult to be exact as to when you can take up your full duties again. It is a case of pacing yourself wisely. The hospital can provide "in-patient certificates" however, it is your G.P. who provides long-term sick notes.

You may be advised not to drive a car too soon but there is no real evidence that it is harmful if you do not drive too far. Check your car insurance to ensure you are covered. Do not drive if your concentration is not perfect or if you have any discomfort.

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. Lovemaking should be gently and if much discomfort is felt you should be prepared to wait a little longer. A little lubricating jelly can sometimes be helpful at first. You may wish to try intercourse before returning for a check-up so you can discuss any problems.

Long Term Effects

If your ovaries have been left intact you will continue to ovulate and the menopause will occur naturally in its own time.

If your ovaries have to be removed and you have not already reached that time of your life, you will experience an artificial menopause. Because of this you may get hot flushes, night sweats, irritability and a dry vagina. This can be upsetting but is usually easy to prevent or treat with hormone replacement therapy (HRT). This simply replaces oestrogen, one of the two main hormones produced by the ovaries. Sometimes a small pellet is placed under the skin at the time of your operation. This slowly releases oestrogen into the system. It begins to decline towards the end of six months when a new one may be needed.

More commonly you may be given hormone tablets to take by mouth daily or advised to put a special patch on the skin 2-3 times a week. There is no need to fear HRT, as the quantity of hormone used to replace the natural state is low.

Again do not be afraid to discuss any fears you may have with your doctor.

Post-operative Check

When you leave the hospital you might want to make an appointment to see your GP and have the opportunity to ask questions. Most women do not want hospital appointments and they are usually unnecessary.

Cancer prevention Smear Tests

The mouth of the womb is almost always removed so routine smear tests are not generally required, although they may be suggested if the hysterectomy is recommended for the treatment of pre-cancerous cells.

More Information

If you would like to know more the following books or booklets are suggested:

“Hysterectomy” by Wendy Savage
Hamlyn Pocket Health Guides

“Hysterectomy” by Elliot Phillips
Family Doctor Publications BMA, Tavistock Square, London WC1

“Experiences of Hysterectomy” by Ann Webb Optima Macdonald

“Hysterectomy - The Positive Recovery Plan” by Ann Dickson and Henriques (previously known as “Women on Hysterectomy or When can I start Hang Gliding” - Claire Rainer)

Any More Questions?

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 use to answering questions (01225 824664/4436)

We suggest that you also show this leaflet to your partner or friend so that they can also understand what to expect. Do not hesitate to keep asking questions until you understand all you want to know.

(Johnson, 2017)

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Please contact the Patient Advice and Liaison Service (PALS) if you require this leaflet in a different format, or would like to feedback your experience of the hospital. Email ruh-tr.PatientAdviceandLiaisonService@nhs.net or telephone 01225 825656.

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