Hysterectomy

What you need to know

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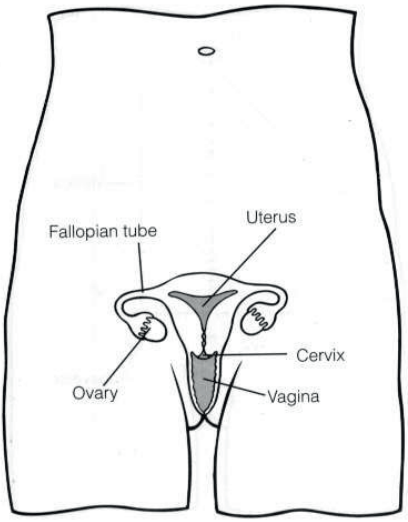
HYSTERECTOMY

Hysterectomy is an operation for removal of the uterus (womb). The uterus is a pear shaped organ about 8cm in length. It is responsible for monthly periods and child bearing. The following diagram will help you to understand the basic makeup of your reproductive organs.



Reasons for Hysterectomy

- Excessive pelvic pain *not* responding or inadequately responding to treatment.
- Heavy and frequent periods
- Prolapse of the uterus (bulging of the uterus into vagina)
- Tumourous growths of the uterus (cancerous and non-cancerous)

The operation is performed when other treatments have failed or are unsuitable. Hysterectomy is usually an elective operation that you decide to have therefore you should be satisfied the reason for this and know the alternative treatment options I have discussed with you.

After a hysterectomy

- You will have no more periods (unless it is a subtotal hysterectomy)
- Pelvic pain with your periods often is reduced
- Pregnancy is not possible
- I will often recommend removing your fallopian tubes, if possible as this reduces your risk of cancer of the ovary.

MEDICAL CONDITIONS OR DISEASES CAUSING ABOVE SYMPTOMS.

The main diseases requiring a hysterectomy are:

1. **Dysfunctional Uterine Bleeding** (heavy menses)
This is bleeding without any obvious cause, but is usually a result of hormone imbalance. Hysterectomy may need to be considered if hormone treatment and other conservative treatments have been ineffective e.g. Mirena or endometrial ablation.

2. **Endometriosis**
Endometriosis is the growth of endometrium (lining of the uterus) outside the uterus. It can cause inflammation, scarring, severe pain, painful intercourse and abnormal bleeding. (see pamphlet on endometriosis)

3. **Fibroids**
Fibroids are non-cancerous growths that can occur in various parts of the uterus and may in time increase in size. These can cause pain, discomfort and bleeding. Fibroids are common and occur in up to 25% of all women.

4**. Pelvic Inflammatory Disease**
Severe and repeated attacks of pelvic inflammation can lead to excessive scarring and adhesions with resultant distortion of pelvic organs. This can cause severe pain, painful periods and painful intercourse.

5. **Cancer**
Malignant cancerous growths in cervix, uterus or ovary can produce various symptoms (or none at all, especially in early stages).

6. **Genital Prolapse**
Weakening of the supporting ligaments that help to keep the uterus in place can lead to descent of the cervix in the vaginal canal. In extreme cases the cervix may even “drop out” of the vaginal opening especially on straining. Often, there is a bulge in the vagina. Symptoms include pelvic discomfort, low backache, lump in vagina or urinary (involuntary leakage, frequency of urination) and bowel problems.

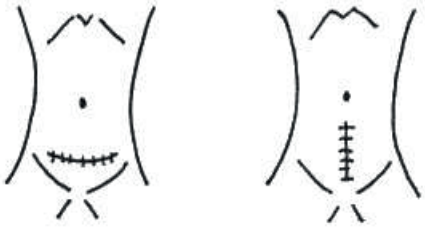
THE SURGICAL PROCEDURE

Hysterectomy can be performed in three different ways

- Abdominal Hysterectomy
- Vaginal Hysterectomy
- Laparoscopic Hysterectomy (TLH)

Abdominal Hysterectomy

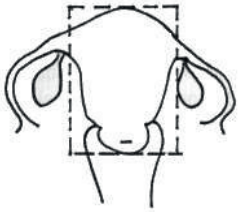
This requires an incision on the skin of the abdomen. The incision may be vertical or horizontal. The need for a particular incision depends on the underlying reason for surgery. This is usually the last resort, if a hysterectomy cannot be performed throught other minimal invasive ways



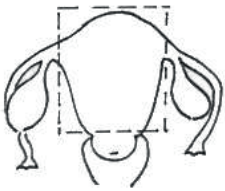
Types of Abdominal hysterectomy

Basically there are two types

(a) Total Hysterectomy - uterus and cervix removed



(b) Sub-Total Hysterectomy - Cervix is preserved.



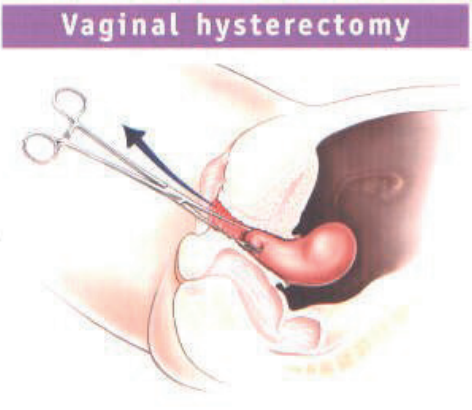
POINTS FOR DISCUSSION

- Removal of your ovaries
- Removal of your cervix
- Removal of your tubes

I will discuss the reasons for and against removal of your ovaries and cervix with you

Vaginal Hysterectomy

The incision here is made internally and hence there is no visible scar on the abdomen. Vaginal Hysterectomy is usually done if there is prolapse or if the utems is small and easy to remove from below. In a Vaginal Hysterectomy both the uterus and cervix are always removed. The ovaries, as a general rule are not removed. However, if the need arises, e.g. ovarian cysts found at the time of operation, the ovaries can he removed at the same time.



The operation is performed through the vagina. It is suitable if fibroids are not too big. In some cases, a vaginal hysterectomy can be more difficult to perform than an abdominal hysterectomy, although this may not be so in the case of a prolapsed uterus. For a vaginal hysterectomy, only dissolving sutures are used and do not need to be removed.

POINTS FOR DISCUSSION

- Is a repair operation required at the same time as a hysterectomy?
- What type of repair operation will be done?

Basically, a repair involves operative procedures to correct prolapse of the bladder and/or bowel. These can be undertaken at the same time as the operation for removal of the uterus.

The type of repair will be influenced greatly by two additional points of information:

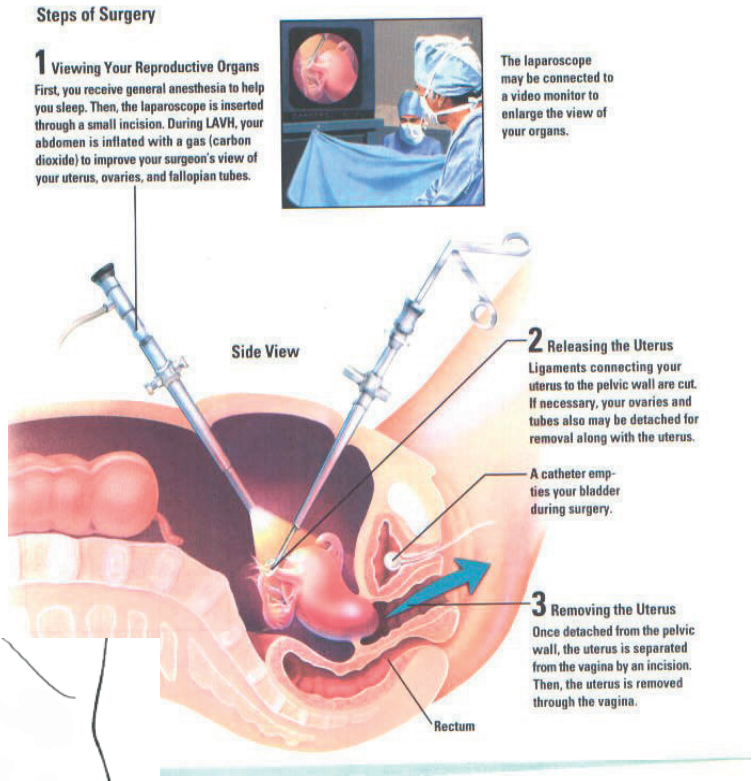
* **Your sexual activity**: Do inform me if you are sexually active. If not, are you contemplating resuming sexual intercourse at sometime in the future?
* **Your bladder control**: Do you lose control of your bladder at times of exertion, e.g. laughing, coughing, straining?

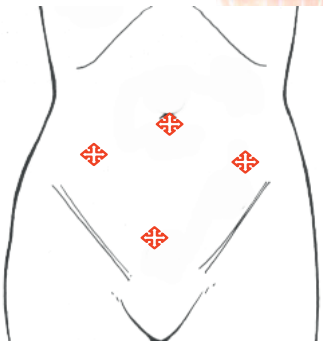
Do not be embarrassed and DO volunteer this information even if not directly questioned.

Laparoscopic Hysterectomy

This is the newest technique to perform a hysterectomy through key hole surgery. A telescope (laparoscope) is used to visualize your internal organs and through 4 to 5 further 5-10mm incisions made on your abdomen, the hysterectomy is performed. This is a highly specialised technique that requires great skill, special instruments, but the advantage to you is a shorter stay in hospital and quicker recovery compared to an abdominal hysterectomy. Laparoscopic hysterectomy is performed to replace an abdominal hysterectomy.

Also **you will NOT have a BIG tummy incision.**





I will discuss with you if you are suitable for a laparoscopic hysterectomy.

RISKS & COMPLICATIONS OF HYSTERECTOMY.

The operation of hysterectomy is quite safe. However, as with any major surgery, there are some risks involved and you should be aware of them.

- **Risk of anaesthetic**. These are rare, although unpredictable reactions to anaesthetic gases and drugs may occur. The risk of death from anaesthetic during hysterectomy is about 1:20,000
- **Bleeding and possible blood transfusion.** This incidence of this is <5%.
- **Infection** especially wound infections and bladder infections. These are usually minor. Severe and widespread infections, are exceedingly rare these days, because of common use of prophylactic antibiotics.
- **Damage to nearby organs**

  Three main organs lie in close proximity to the uterus

  a) Bladder in the front
  b) Bowel in the back
  c) Ureters (tubes carrying urine from kidney to bladder) on each side of the uterus

  Damage to these organs can occur, particularly if there is widespread disease with adhesions and scar tissue (e.g. severe endometriosis or after previous surgery). The damage is usually recognised at the time of operation and can be rectified at the same time. Occasionally the damage is unrecognised and you may end up having a second or third operation to fix this up. This may also involve having a temporary colostomy (bag in the tummy) if an unrecognised bowel injury occurs, but fortunately this is rare with an incidence of <1/1000 cases.
- **Blood clots**. Deep Vein Thrombosis (DVT)is likely to occur during any major operation, particularly if the legs are kept immobile during the procedure. Some people are more at risk for this complication to occur (elderly, obese, heavy smokers, high blood pressure, diabetics). Measures to prevent this complication from occurring are employed during surgery. Intermittent mechanical compression of leg muscles, electrical stimulation of legs, wearing of special stockings and use of agents to thin blood, e.g. clexane
- **Laparotomy.** Although I am confident to perform your hysterectomy vaginally or laparoscopically, there is always the possibility that I may have to **convert to an open tummy cut** if there are complications or unanticipated pathology.

WHAT TO EXPECT AFTER SURGERY

First 24 Hours

- You will be drowsy
- You may experience pain. This can be relieved with morphine like injection or narcotic infusion in a drip (known as PCA or patient controlled analgesia)
- You will have a catheter in your bladder. This is usually removed in 24 hours. You will be allowed to drink and eat as tolerated.
- You may have a small drainage tube coming out from one side of your abdominal incision. This is to prevent collection of blood under your skin and will be removed after 24-48 hours.

Next 24-72 Hours

- You will be allowed out of bed and encouraged to walk, usually by the following morning. Your catheter, drain and drip will probably have been removed by now. (The catheter may stay in for several days if bladder repair is done).
- You may experience wind pains. These can be relieved by walking, changing position and by simple medications such as peppermint water or charcoal tablets.
- Passing urine may be difficult. Don't be alarmed. Take your time and your bladder function will return to normal. It may be easier to pass urine sitting on the toilet, than into a bed pan.
- You may have a shower after the first day.
- Continue wearing your special TED stockings until you are fully mobile (3-4 days).
- You may still require occasional tablets for pain relief but the need for this will lessen with passage of time.
- There will be some blood stained vaginal discharge for up to four to eight weeks after your operation. Discharge will be initially bright red (first 24 hours) but will gradually become darker and then yellowish brown or clear. The discharge is due to the healing of the top of the vagina, which resolves once the sutures have dissolved, which may take up to 8 weeks.Any bright bleeding after the first few days should be brought to the attention of medical and nursing staff

GOING HOME

Most patients leave hospital by the 5th or 6th day.

For laparoscopic hysterectomy the average stay will be 2 to 3 days.

1st Two Weeks

- No work
- Frequent rest periods
- No housework

Two to Four Weeks

- Commence light housework, but avoid lifting, pushing or pulling.
- Commence light exercise, such as short periods of gentle non-strenuous walking.

Four to Six Weeks

- You may now drive if you feel up to it.
- Continue light duties.
- Return to my rooms for your checkup.
- You may now resume sexual intercourse provided your recovery is adequate and tissues at the top of your vagina have healed.
- Gradually ease back into normal life by the 8th week.

For laparoscopic hysterectomy you can anticipate your hospital stay and recovery to be quicker.

FREQUENTLY ASKED QUESTIONS

Q: DO I NEED HORMONES?

Ans: You need hormones if the ovaries have been removed. If the ovaries have been left behind, hormone replacement therapy (HRT) will not be required unless you experience any of the symptoms of menopause.

Q: WHAT TYPE OF HORMONE DO I NEED?

Ans: As you do not have a uterus, there is no need to take the progesterone component of HRT (in most situations) i.e. Oestrogen alone is adequate, unless you have had severe endometriosis.

Q: HOW SHALL TAKE THE HORMONE?

Ans: The choice is yours. You can take oestrogen in any of three forms:

- Once daily tablet
- Twice weekly skin patch
- Once a year oestradiol implant

Q: AS I WILL NOT BE MENSTRUATING NOW, HOW WILL I KNOW THAT I HAVE GONE "THROUGH THE CHANGE OF LIFE"?

Ans: You may experience some of the symptoms of menopause, e.g. hot flushes indicating that your hormone levels are now declining. If you are not experiencing any menopausal symptoms despite being at an age when menopause tends to occur, you may have a blood test to check your hormone level.

Q: WHEN SHALL I RESUME SEXUAL INTERCOURSE?

Ans: Provided your six weekly checkup is adequate, intercourse maybe resumed.

Q: WILL I STILL HAVE FEELINGS DURING SEXUAL INTERCOURSE? WILL MY SEXUAL CAPACITY DIMINISH?

Ans: It is natural to be apprehensive about sexual intercourse on the first few occasions after the operation. Your partner needs to understand this and needs to be very gentle on these occasions

If you have been troubled with heavy periods or pain during intercourse prior to the hysterectomy, you will experience a great improvement in sexual function after the operation and this will naturally lead to a better sexual relationship with your partner.

Q: DO I NEED TO HAVE PAP SMEARS?

Ans: If you had a sub-total hysterectomy then you should continue to have pap smears like all other women

If you have had previous abnormal pap smears or if your hysterectomy was done because of cancer or even pre-cancerous changes in your *cervix* or uterus, then you should continue to have regular pap smears on a yearly basis.

If you have never had an abnormal papsmear in the past and pathology tests on the removed cervix or uterus show no sign of cancer cells, you do not need to have regular pap smears. A pap smear every 5 years or so should suffice You should, however, continue to have regular breast checks, especially if you are on hormone replacement

It is also important to have regular pelvic checks if your ovaries were not removed. Regular pelvic checks may help to detect any ovarian problems (e.g. cysts)

If you have any further questions, please do not hesitate to ask me at your preoperative or next visit.