Advice about Hysterectomy

Introduction

A hysterectomy is one of the most common gynaecological surgical procedures. Most patients make a rapid recovery after their operation and do not experience serious problems or complications. The long term satisfaction rates after hysterectomy are high once women have completed their recovery period. A hysterectomy is, however, a major operation and you should know about the potential risks involved.

What is a hysterectomy?

A hysterectomy is the surgical removal of the uterus. The cervix is usually removed with the uterus ,(called a “total” hysterectomy). If the cervix is not removed this is referred to as a “subtotal” hysterectomy. You may discuss with your surgeon which is right for you. The ovaries and tubes may or may not be removed at the same time. If the ovaries are removed and you have not had your menopause, you will become menopausal, and may experience menopausal symptoms.

Other procedures may also be performed at the same time to remove endometriosis or repair prolapse or free organs from scar tissue or remove other disease. If these are planned your surgeon will discuss them with you before the surgery.

Why is a hysterectomy performed?

Common reasons include:

- Heavy or painful periods which have not resolved with medical treatment.
- A prolapse 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).
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How is a hysterectomy performed?

There are different ways of carrying out a hysterectomy:

1. Abdominal hysterectomy

This technique requires a 10-20cm abdominal incision to remove the uterus and usually the cervix and fallopian tubes. The ovaries may also be removed (ask your doctor what is right for you).. It can be done for any sized uterus regardless of whether you have had children. The abdominal scar is either along the bikini line or up and down as required. This procedure usually entails 2-3 days in hospital and 6-12 weeks off work to recover.

2. Vaginal hysterectomy

This is the most frequently employed technique of hysterectomy. The operation is performed entirely through the vagina with the womb removed through the vagina.. For a vaginal hysterectomy to be performed a woman usually needs to have had a vaginal birth which widens the vagina and relaxes the connections of the uterus to allow it to descend sufficiently. It is not normally possible to remove the ovaries by this route. There is no abdominal scar and it usually requires only 1-2 days in hospital and approximately 6-8 weeks from work.

3. Laparoscopic hysterectomy

This procedure involves operating through 3-4 keyhole incisions in the abdomen. The uterus is removed through the vagina, or occasionally through enlarging one of the keyhole incisions on the abdomen. It is also possible to remove endometriosis deep within the pelvis. A variation on this is a laparoscopically assisted vaginal hysterectomy where part of the surgery is done through the vagina. This Is commonly used when prolapse surgery also needs to be performed.

Women will usually be in hospital for one night, and require 6 - 8 weeks off work to recover.

What will happen?

If you and your consultant have reached the decision that a hysterectomy is the right option for you, you will be added to the waiting list. Women will be asked to attend a pre-operative assessment clinic around a week before admission. A leaflet about this clinic will be sent to you with your appointment.

The pre-operative assessment nurse will advise you when you need to stop eating and drinking depending on the time of your operation. You will be given two high calorie drinks. These are to be drunk during your clear fluids only period - the pre-op nurse will give you clear instructions about this. As part of our enhanced recovery programme 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 blood clots).

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. Women will normally walk with the nurse up to the operating theatre.

You will be taken into the anaesthetic room, 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

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. Each operation is different and more complicated surgery may increase your risk.

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 (tube connecting the kidneys and the bladder), bowel or blood vessels.** Some of these structures are attached to the womb and need to be released during a hysterectomy. Damage is more likely 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. 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). Blood clots can form in the veins in the legs following major surgery. This is known as a deep vein thrombosis. Rarely a clot can travel to the lungs, which is known as a pulmonary embolism.

  Pulmonary emboli can be fatal. To try and reduce the risk of DVT and PE we give a blood thinning injection each day that you are in hospital, compression stockings that help keep the blood flowing normally through the legs, and we encourage you to move and walk as soon as you are able. It is important to continue to be mobile while at home recovering from your surgery.
- **Long-term complications**. These may be difficult to evaluate. There is evidence of increased risk of prolapse after hysterectomy. Bladder irritability is a common after-effect following hysterectomy. 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 a hysterectomy, the top of the vagina can open, particularly if there is an infection or trauma to the area. We ask you to delay sexual intercourse for up to 10 weeks after a laparoscopic hysterectomy, depending on the advice given at your follow up appointment.
- **Death.** This is very rare after hysterectomy unless you have significant co-existing medical problems.

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.** 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.

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

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