What is a hysterectomy?

The womb (uterus) is removed by an operation called hysterectomy whilst under an anaesthetic, usually a general anaesthetic. Some vaginal hysterectomies can be done under a regional anaesthetic, but this decision will be taken based on your medical condition, your wishes and on the advice of the anaesthetist.

A hysterectomy can be done through several routes.

- Vaginal hysterectomy (through the vagina)
- Laparoscopic Hysterectomy (Keyhole procedure) such as
- TLH (Total Laparoscopic Hysterectomy)
- LAVH – Laparoscopic Assisted Vaginal Hysterectomy
- Robotic assisted Hysterectomy (Keyhole)
- Abdominal Hysterectomy (Through a bikini line cut or a midline cut on the tummy)

A hysterectomy may be performed on its own when the uterus (womb) is removed with the cervix (most common) or without the cervix (subtotal hysterectomy).

Removal of the uterus may be accompanied by removal of one or both the Fallopian tubes (salpingectomy) and/or removal of one or both the ovaries (oophorectomy).

Total Hysterectomy+/- BSO means removal of the uterus and cervix and both tubes and both ovaries- bilateral salpingo-oophorectomy. Usually the womb and the neck of the womb (uterus and cervix) are removed at a hysterectomy. In some cases, the cervix is preserved (subtotal or supracervical hysterectomy) usually because of patient’s wishes and sometimes because of technical difficulty in reaching the cervix. The type and route of hysterectomy will be decided based on an individual’s situation, after a full discussion and informed consent. Most hysterectomies take under 2 hours.

Common Indications for Hysterectomy: This is not a comprehensive list. Indications for deciding for on a hysterectomy will depend on medical conditions, age, patient wishes, and previous treatment undertaken. The route of hysterectomy will be individualised based on discussion with your surgeon. All decisions are taken after thorough and informed consent and in the best interests of the patient.

- Uterovaginal Prolapse (Prolapsed uterus) affecting quality of life.
- Large fibroids (If fertility not desired and/or Fibroid Embolisation not an option)
- Endometrial hyperplasia/ Early Endometrial Cancer.
- Some Ovarian, Cervical and Fallopian Tubal Cancers depending on the stage of cancer.
- Persistent Post-menopausal Bleeding in the absence of any cause.
- Heavy periods not responding to Endometrial ablation or if not suitable for ablation.
- Some cases of large Ovarian Cysts
- Some cases of Endometriosis, Adenomyosis, Chronic Pelvic Pain.

In a vaginal hysterectomy, the uterus and cervix are removed through a cut at the top of the vagina. Women who have an uterovaginal prolapse often have their hysterectomy through the vaginal route. A pelvic floor repair or bladder suspension procedure may also be done at the same time if indicated.

If ovaries or fallopian tubes are to be removed or if scar tissue or endometriosis is suspected, then using laparoscopy (telescope with a camera, see separate leaflet) allows excellent views which is very helpful. Performing the entire procedure through 3-4 small incisions allows a bigger incision (laparotomy) to be avoided. The tissue is then removed through the vagina and sent for analysis.

I perform most hysterectomies through the vaginal route with the help of laparoscopic surgery (LAVH). I am also trained in Robotic Assisted Laparoscopic hysterectomy, where the Surgeon controls robotic arms that perform the operation. This gives the surgeon the ability to perform more difficult manoeuvres. It is particularly useful in women with womb cancer or where women are significantly overweight. I currently do not perform this operation as I do not have access to the robot in the hospitals I work at.

However, not all women are suitable for a keyhole or minimally invasive procedure. Some women may need an abdominal hysterectomy, usually because of very large fibroids, dense scar tissue or severe endometriosis. This involves a larger incision in the lower abdomen, which can take longer to recover from compared to the keyhole procedures but may be a better and safer option for some women.

Why is the operation performed laparoscopically?

The advantages of laparoscopic surgery and robotic assisted laparoscopy are that the patient does not have a large incision in the skin and so tends to recover from the operation quicker and spends less time in hospital. To perform laparoscopic operations, the area being operated on is inflated with gas to give the surgeon room to operate. This creates a high-pressure space and it also reduces the bleeding during the operation, which is a great advantage to the patient.

What are the advantages of laparoscopic or robotic assisted laparoscopic surgery?

Laparoscopic surgery, in general, results in smaller incisions, less post-operative pain, improved cosmetic appearance, reduced blood loss and faster return to normal activities.

Robotic assisted surgery gives the surgeons a clearer, 3D image of the field in which they are operating. This allows them to perform complex operations with improved visibility, and more precise movements through extremely small operating “ports”.

Are there any risks of keyhole surgery?

Laparoscopy is a safe procedure, but like any other operation, comes with some small risks. There may be a risk of needing an open operation (laparotomy) in the event of a complication such as bleeding, damage to nearby organs, for example bladder or bowel or ureter injury. There is a small risk of wound infection, bleeding needing blood transfusion or thrombosis.

All precautions are taken to perform the operation as safely as possible. Complications occur in less than one in thousand cases, unless there are other risk factors, such as previous abdominal surgery. After the operation, most women recover usually within a couple of weeks. If however, you start feeling unwell or have concerns, you must contact the hospital where you were operated, so that you can receive the correct medical advice.

Possible Complications of Hysterectomy

While every treatment has its benefits, there are also possible risks that you should be aware of before you agree to have a hysterectomy.

We take a lot of precautions to reduce these complications from happening but despite this, complications both major (1 in a 100 risk) or minor (1 in 10 risk) may happen. That is why all major surgery should be carefully discussed with your surgeon, once a decision is made and again, ideally at a consent appointment. I like to give my patients my own success and complication rates before operating on them.

Rare but potentially serious risks (Being an experienced surgeon helps in reducing all these risks).

Injury to the bladder or bowel or ureter (the tube between the kidney and bladder): To reduce these risks, we insert a tube in your bladder (catheter) to keep it empty during surgery and monitor the urine afterwards to check the colour and amount of urine produced. A detailed history is taken with regards to previous surgery that may result in scar tissue (adhesions) making bladder or bowel injury more of a risk. Women are advised to have a light diet and keep well hydrated in the few days running up to surgery and avoid constipation. Women with severe endometriosis may be at a higher risk of ureteric injury.

Blood loss severe enough to need a blood transfusion: If you are a Jehovah’s Witness or feel strongly against blood transfusions, then please discuss this with the surgeon beforehand. (The risk is about 1 in 100 women). Immediate repair of any damaged blood vessel is undertaken.

Return to theatre to control bleeding or repair injury to an internal organ: This may require a cut in your lower abdomen, called a laparotomy which may be a midline, or a bikini line cut on your tummy.

Serious infection in the pelvis or in the bloodstream: We usually try and pre-empt this by giving you antibiotics during the operation and avoid surgery if you are already suffering from an infection that needs treating first.

Thrombosis (blood clot in the leg or lung): We make sure you are mobilised early after surgery to get your circulation moving, avoid dehydration, advise specialised

TED compression stockings and use injections called low molecular weight heparin drugs to help thin your blood to avoid clots and thrombosis. You must wear your stockings properly (the nurses will advise you) while you are in hospital and for at least 4- 6 weeks after, until you have recovered from your operation and are fully mobile.

More frequent but less serious risks:

- Urine infection
- Wound infection
- Collection of blood (haematoma) in the pelvis.

Urinary Retention: You may find it difficult to empty your bladder properly after surgery. A catheter may need to be put back into the bladder if this happens.

Women who have an operation for prolapse have a risk of developing another prolapse (vault) in the future. This is because their body tissues may be already weak, having usually been damaged during pregnancy and childbirth.

It is important to remember that extra procedures during the hysterectomy will only be done if it is necessary to save your life or prevent serious harm to your future health.

Should I keep both my ovaries or remove one or both?

Removal of ovaries is known as oophorectomy. Removal of the fallopian tubes is known as salpingectomy. The ovaries and tubes may be removed during hysterectomy. This is not always needed, and the decision depends upon several factors.

Premenopausal women may decide to keep the ovaries to provide a continued, natural source of hormones, including oestrogen, progesterone, and testosterone. These hormones are important in maintaining sexual interest and preventing hot flushes and loss of bone density. However, women who have severe endometriosis or severe premenstrual syndrome (PMS) may have an improvement in symptoms when hormone levels are reduced by removing the ovaries.

Usually women under the age of 45 years are recommended to keep their ovaries, between the ages of 45-50, it’s the woman’s choice guided by her surgeon and after

50 years and after the menopause, women are usually advised to have their ovaries removed. This is to minimise the risk of needing further surgery because of problems with the ovaries such as ovarian cysts or residual ovary syndrome causing pain and scarring.

The risk of ovarian cancer, which is 1 in 70 women and a cancer that is very difficult to diagnose early, is greatly reduced when ovaries are removed in perimenopausal women. However, there is some evidence that ovaries may continue to produce small amounts of oestrogen even after the menopause, so its worth having a discussion with your surgeon to help come to a decision.

The risks and benefits of removing or conserving ovaries will be discussed in detail once a decision is made to proceed to a hysterectomy.

Hormone Replacement Treatment (HRT) (*Please see separate leaflet on the Perimenopause and Menopause*)

Oestrogen treatment may be recommended after surgery for women who have not yet reached menopause if their ovaries are removed. It may be prescribed as patches, tablets or gel and can help to prevent hot flushes, night sweats, and loss of bone density, which may occur when the ovaries are surgically removed. Progesterone supplements are not needed after a hysterectomy.

Women who have completed menopause generally do not require HRT after hysterectomy, unless they are already on it, in which case they need to take only oestrogen afterwards.

Early menopause — Women who have undergone hysterectomy may experience menopause earlier than the average age of menopause (age 51). This may be due to an interruption in blood flow to the ovaries as a result of removing the uterus.

Pre and Post Surgery Advice (*Please also see pre and post surgery advice FAQs separate leaflet*)

Do I need to use Contraception?

You must not be pregnant at the time of the procedure. You must use effective contraception or abstain from sex in the menstrual cycle of the procedure. Even though you will have a urine pregnancy test before your procedure, this does not

always pick up very early pregnancies and if there is any doubt, your procedure will be cancelled on the day and rescheduled.

How long will I stay in hospital?

You will be discharged home in 24 – 72 hours, depending on how you feel. If you have any surgical complications, you may stay in the hospital for longer.

Do I need to fast before the operation?

Yes, if you are having a general anaesthetic, no food, not even chewing gum should be consumed for at least 6 hours before your procedure. You can drink water up to 2 hours before your procedure. The hospital will advise you as to the timing of your procedure and guide you.

Do I need to stop my medications before my procedure?

You normally should not stop any of your essential medications. Please take your usual essential medications with a tiny sip of water at the regular time, unless advised not to by the nurse or doctor. Do remember to bring a list of all your medications to show the nurse at your pre-assessment (if you are having one) and let your admitting nurse and anaesthetist know all the medications you are on. This is because your medications may influence your anaesthetic and surgery. You should also inform the nurse and anaesthetist of any allergies that you have to foods, metals, drugs etc. Some important notes on certain conditions are listed below.

DIABETES (insulin or tablet)

In general, you should not take your insulin injection or your tablet, when you are fasting. For example, if your operation is in the morning, DO NOT TAKE your morning dose or injection as you will be fasting overnight, but do take the previous dose as normal. If your operation is in the evening, take your doses as normal in the morning, but stop injection/tablets if you are taking any at lunchtime (you will fast for 6 hours).You can resume your normal regime, once you are eating and drinking normally. If in any doubt, consult your surgeon or anaesthetist.

ASPIRIN, WARFARIN, CLOPIDOGREL, CLEXANE or any blood thinning agent

You will need to stop most blood thinning agents such as Aspirin or Clopidogrel at least 1-2 weeks before your procedure. This is to avoid excessive bleeding at your operation. If you are on Warfarin or Clexane or any of the above blood thinners, you will need to liaise with your surgeon and if needed, your cardiologist. If in any doubt, consult your surgeon or anaesthetist and certainly inform them when you see them, as it may influence your management.

Will I have stitches?

You will usually have glue to seal the skin wounds if it’s a keyhole procedure or you may have a couple of dissolvable stitches, one in your umbilicus (belly button) and one or two just below, either to the right or left of your abdomen. These will dissolve in approximately 10-14 days. You will not usually need a dressing, once you take off the ones covering the wounds when you leave the hospital.

If you are having a cut in your tummy (laparotomy), you will usually have a dissolvable continuous stitch that dissolves and does not need removal. There will usually be some dissolving stitches at the top of the vagina. You will usually not need a dressing, once you take off the ones covering the scars when you leave the hospital.

What will happen before the operation?

You will see your surgeon to discuss any further questions. You should have had your consent appointment a week or two before your procedure; otherwise this is the time a written consent will be obtained from you.

You will see an Anaesthetist who will assess and explain the type of anaesthetic that is best suited for you. Post-operative pain relief will also be discussed with you.

Pre assessment appointment: A Nurse will assess you and explain the preparation required for your operation a few days before your hysterectomy and arrange blood tests, swabs and any other tests that you may require.

Why do some women need an injection before hysterectomy?

Some women need a long acting hormone injection (GnRh Prostap injection) that shrinks fibroids and the womb temporarily, with the effects lasting for 3-4 months. This allows the iron levels to rise by stopping the periods, reducing blood loss and reducing the need for blood transfusion.

It also may help in allowing the surgeon to do the procedure through a smaller incision or as a keyhole hysterectomy. The operation is usually performed 8-12 weeks after the injection. During this time, some women may experience symptoms like the menopause such as hot flushes and low mood. These symptoms disappear once the injection wears out of the system in 3-4 months. This will all be discussed and explained to you thoroughly before you make a decision.

After the operation

You will spend some time in the recovery bay before being moved back to the ward. A catheter will be left in place to enable urine to drain freely. It will be removed usually after a day. You may have a vaginal gauze pack to stop any vaginal bleeding, especially after a vaginal repair. This will be removed within the next 24 hours.

You will be discharged home, dependent on how you feel in 24-72 hours.

What else can I expect after my operation?

Nausea: You may feel slightly nauseated or groggy just as you are coming out of your anaesthetic. This will pass soon and if needed, medication will be given to you to make you feel better. You will be able to resume normal activities soon.

Vaginal bleeding: Some amount of vaginal bleeding and discharge is to be expected, usually for 4-6 weeks or so. If this is heavy, or has an offensive smell or causes you concern, seek medical advice. Avoid tampons to reduce risk of infection.

Abdominal distension, wind and shoulder-tip pain: Abdominal distension is not uncommon after a laparoscopy accompanied by shoulder-tip pain. This is due to gas that has been inserted into the abdomen (tummy) so that the abdomen will distend (rise), thereby allowing easier viewing of the pelvic organs.

This bloated feeling, wind and shoulder-tip pain is temporary and will resolve itself in approximately 24-48 hours, as the gas gets re-absorbed into your system. Early mobilisation will help to increase the re-absorption process. The pain is relieved by taking your usual painkillers or medication prescribed by the hospital. Some women may need stronger pain killers.

Wound pain: For a couple of weeks after your operation, you will have a feeling of soreness on the abdomen. This is normal and should not cause concern. Pain killers such as Paracetamol or Ibuprofen are usually effective in controlling discomfort.

Other issues

Bathing: You can have a shower or a bath when you feel able. Dry the stitches carefully. Do not use talcum powder in this area. Take off the dressings and leave to air. There is no need to cover the scars.

Work: You should be able to return to work after approximately 4-8 weeks – taking into consideration the type of work you do. However, if you have had keyhole surgery, you will be advised by your doctor how long you need to be off work as it could be shorter.

Lifting: Mobilise as normal, but do not do any heavy lifting for 3-4 weeks.

Sex: You will be able to resume sexual intercourse usually after your postoperative follow up appointment with your surgeon, usually 4-6 weeks. If you are bleeding, wait for this to stop. If you are not bleeding, go ahead when you feel comfortable after you have been given the all clear.

Other physical activities: You will be able to resume other activities such as sport and swimming as soon as you feel able, usually in 4 – 6 weeks.

Driving: Usually 4 weeks post-surgery, once you can do the emergency stop safely. Do check with your car insurance for their regulations as well.

Travelling abroad: Avoid until after your post-operative medical check.

What can I do when I get home?

Take regular steady exercise.

Eat a well-balanced diet, including plenty of fruit, vegetables, and beans and grains i.e. a naturally occurring low fat high fibre diet. Avoid constipation. (see nutrition leaflet)

Bath or shower daily. Do not worry about get the wounds wet, you can wash but remember to leave the area dry afterwards to avoid infection. Leave any wounds exposed as much as possible, again to avoid the area from getting infected.

Wear loose clothing.

Light housework e.g. dusting after the first couple of weeks

Continue your abdominal and pelvic floor exercises as soon as you feel able to do your exercises.

You must wear your stockings properly (the nurses will advise you) while you are in hospital and for at least 4-6 weeks after, until you have recovered from your operation and are fully mobile.

If you have any further questions, please do not hesitate to discuss this either before or after your operation. However, nursing staff will contact you should you wish, the day following your discharge to see how you are. You will also be given a ward contact phone number to use, should you have any problems.

When will I know the results of my surgery?

Following your surgery, the findings and their implications will be discussed with you. Plans will be made for any further treatment and any necessary appointments will usually be made before you leave the hospital. The results of any biopsy or tissue being analysed takes a couple of weeks to come back. You will be seen in clinic for a follow up. If you need further surgery or other treatment, this will be discussed in detail with you, usually in the clinic. Your GP will be sent a letter with the findings from your procedure, and any results. You will be copied into this.

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