The Newcastle upon Tyne Hospitals NHS
NHS Foundation Trust

Hysterectomy

(Removal of the womb)

Directorate of
Women's Services

Introduction

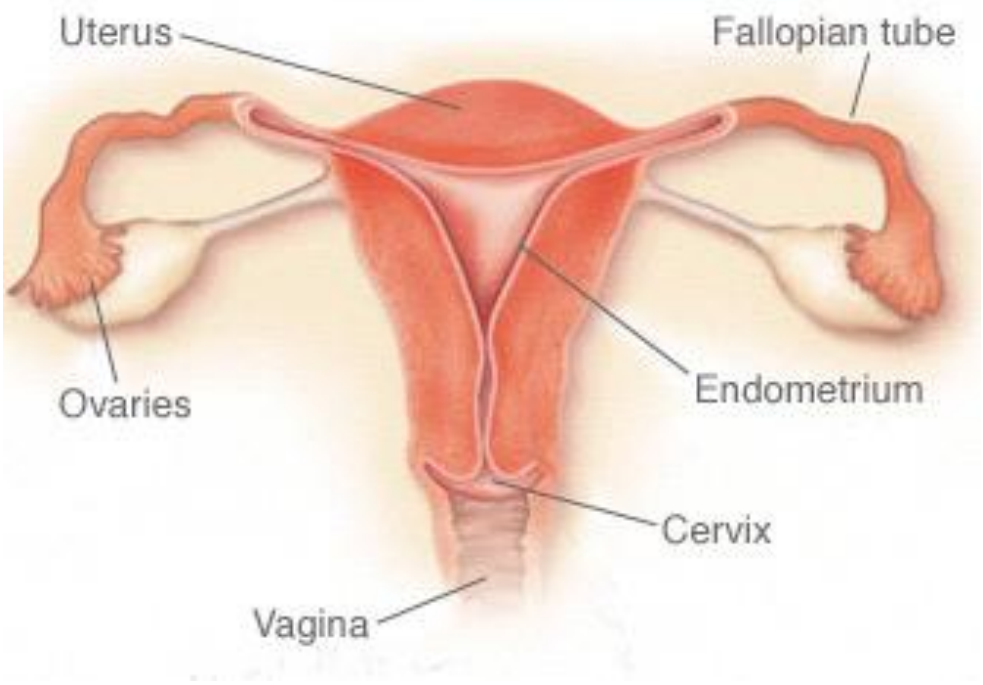
This leaflet is intended to briefly explain the reasons for having a hysterectomy, how is it performed, and what to expect before and after operation.

Please remember that every woman has different needs and recovers in different ways. Your own recovery will depend upon how fit and well you are before your operation, the reason you are having a hysterectomy, and the exact type of hysterectomy that you will have.

Please read this leaflet carefully and if you have any questions please discuss these with your gynaecologist or GP.

A hysterectomy is an operation to remove the womb (uterus).

Depending on the type of hysterectomy and the reasons for surgery, ovaries and fallopian tubes may also be removed or left intact. The cervix (neck of the womb) is usually removed. This can be discussed and some women request that the cervix is not removed.



A hysterectomy is used to treat conditions that affect the female reproductive system such as heavy periods (menorrhagia), chronic (long-term) pelvic pain, prolapse of the womb, non-cancerous tumours (fibroids, ovarian cysts) and cancer of the womb, ovaries, cervix or fallopian tubes.

A hysterectomy is a major operation with a long recovery time. It is usually performed after less invasive alternatives have been considered.

By removing the womb you will no longer be able to have children. Furthermore, by removing your ovaries before the menopause you will become menopausal (sometimes called the “change”). Some women still become menopausal shortly after hysterectomy even if the ovaries are kept.

Types of Hysterectomy

The type of hysterectomy you will have depends on the reason for your surgery. This will be discussed with you in detail by your doctor.

Total hysterectomy: This is the most commonly performed operation. The uterus (womb) and cervix are removed.

Subtotal hysterectomy: The main body of the womb is removed leaving the cervix in place. This is not considered if the surgery is to treat a possible cancer, if there is a cervical abnormality or uterine prolapse. It can be considered providing there is no history of pre-cancerous changes in the cervix. The risk of bleeding, post operative fever and duration of procedure is less but there is no evidence to support an improved bladder, bowel and sexual function.

By leaving the cervix there is a small risk of vaginal bleeding from the cervix after a subtotal hysterectomy. You must also continue having your cervical smears until the age of 64.

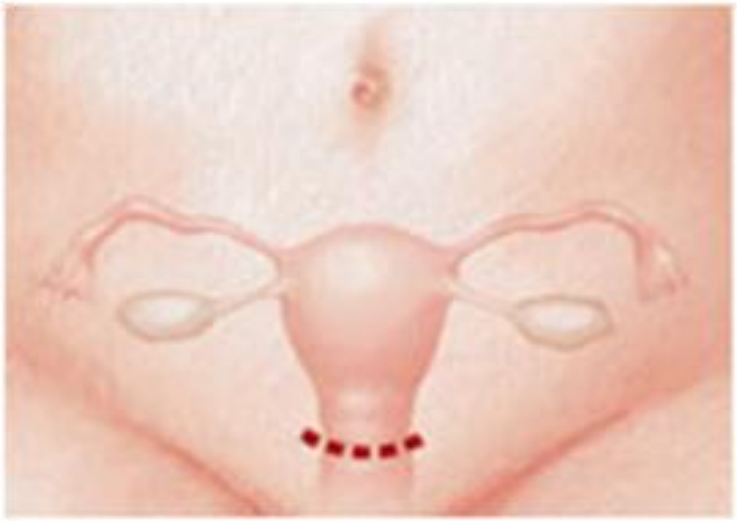
Hysterectomy with bilateral salpingo-oophorectomy (removal of tubes and ovaries): In addition to removing the womb, the fallopian tubes and ovaries are also removed. This is more commonly offered to women with an ovarian pathology (cyst or tumour) or if a woman is close to or past the menopause. Some women opt for this to reduce the risk of further problems such as ovarian pain and to reduce the risk of ovarian cancer in later life.

The effect of removing both ovaries before the menopause is largely hormonal. Women usually start to notice menopausal symptoms such as “hot flushes” in the weeks following surgery, this can be severe. Other considerations include increased risk of osteoporosis in later life and sometimes mood change or vaginal dryness. Menopausal symptoms can be treated effectively by hormone replacement therapy (HRT).

If a woman is concerned about possible risk of breast cancer with HRT or if it is not advised because of other medical conditions, then alternative measures can be discussed. These include general health advice, vitamin supplements for osteoporosis, non-hormonal therapies for flushes and vaginal pessaries for dryness.

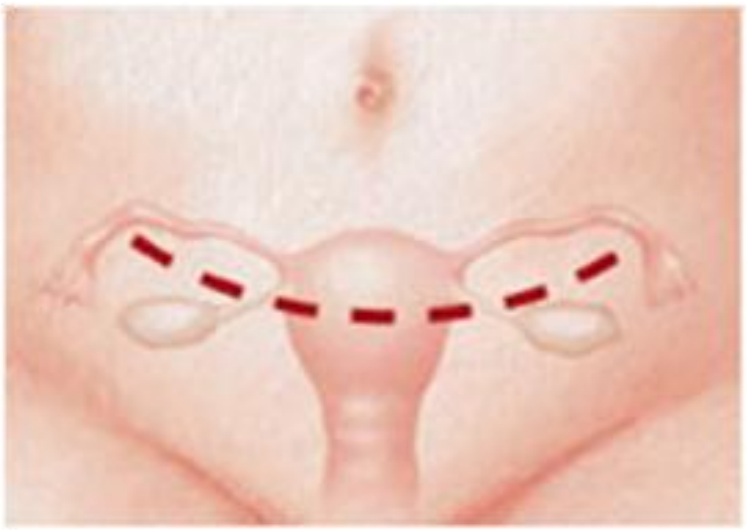
How is a hysterectomy performed?

Vaginal Hysterectomy:
The womb and the cervix are removed through a surgical incision at the top of the vagina. Therefore, there is no planned incision or scar on your abdomen (tummy). It can be done under general anaesthesia (with you asleep) or a regional anaesthesia with a spinal block (with you awake but you are numb from the waist down). During the same operation, a pelvic floor repair can be done if you have symptoms of a prolapse. This includes removal of excess tissue and suturing to tighten the supporting tissues to the vagina. Surgery to correct urinary problems may also be performed.



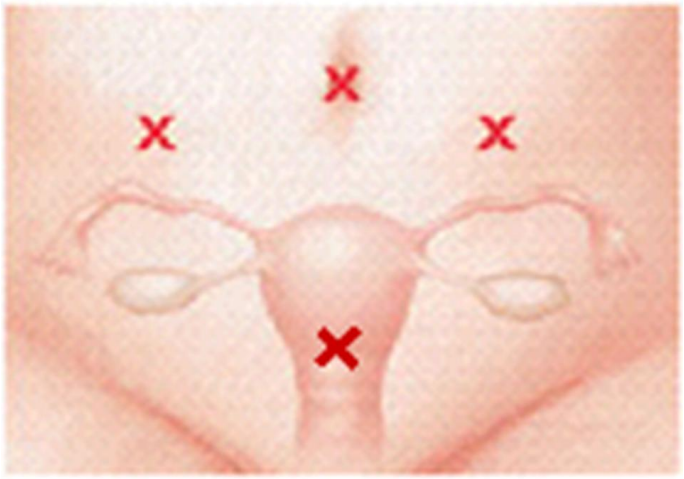
Abdominal Hysterectomy:
During this operation an incision (10 to 15cm approximately) is made on your tummy. This is usually across the lower abdomen (often said to be along the “bikini line”) or vertically up the abdomen from the pubic hair line to the belly button (umbilicus) and sometimes beyond this. You can discuss the type of incision with your doctor before the operation.

The operation is done under general anaesthesia. You will be more likely to be advised to have an abdominal hysterectomy if your womb is enlarged by fibroids or there is an ovarian tumour, as it may be not possible to complete the surgery through the vagina or laparoscopically (“key-hole” surgery).



How is a hysterectomy performed? (continued)

Laparoscopic Hysterectomy:
Laparoscopic surgery is also known as “keyhole” surgery. A small telescope with a video camera (laparoscope) is inserted through a small cut (of about 1cm in your belly button). This allows the surgeon to see inside your internal organs. Instruments are then inserted through other small cuts in your tummy (2-3 in total) to free your womb, cervix and any other parts of the surrounding reproductive system from their ligaments and blood supply. The womb and any other organs are usually removed through the vagina which will be closed at the end of the surgery.



Some laparoscopic hysterectomies are done entirely by “keyhole” surgery. Others are done partially as a laparoscopic and partially as a vaginal hysterectomy (called laparoscopic assisted vaginal hysterectomy). The reasons for each may depend on findings at the time of surgery.

If you chose to keep the cervix (laparoscopic subtotal hysterectomy) the womb would then be removed in small pieces with an instrument called a morcellator through one of the small incisions in your tummy.

What are the risks of surgery

All surgery carries the risk of complications, the relative risks are listed in the next section of this leaflet. You should, however, be aware that the quoted risks may be increased if you are obese, have pre-existing medical problems or have had previous major surgery in the past.

The complications of the surgery are divided into serious risks and frequently occurring risks as follows:

Serious risks:

- Damage to bladder and/or ureter (tube connecting the kidney to the bladder) is seven women in 1000. There may also be a long-term disturbance to the bladder (uncommon).
- Damage to the bowel is four women per 10,000 (rare).
- Bleeding requiring blood transfusion is 23 women per 1000 (common).
- Return to theatre because of bleeding or wound breakdown is seven women per 1000 (uncommon).
- Pelvic abscess or severe infection is two women per 1000 (uncommon).
- Clot formation in a blood vessel (DVT) is four women per 1000 (uncommon). There is a risk of clot formation in the lung (PE).
- There is a risk of hernia formation in any incision, less with laparoscopic surgery than open (abdominal hysterectomy): Two women per 1000 (uncommon).
- Risk of death within six weeks of the operation is 32 women per 100,000 (rare). Usually as a result of blood clot in the lungs (PE).

Frequently occurring problems:

- Some women experience wound infection, pain, bruising, delayed wound healing or thick scar (keloid) formation.
- Numbness, tingling or burning sensation around the scar is common but usually goes away over weeks or months.
- Frequency of passing urine and urine infection can occur. This usually goes away shortly after surgery or with antibiotics.
- If there is infection of vaginal vault and vaginal bleeding, it usually settles quite quickly with antibiotics. Rarely there is a localised collection of blood or abscess that may need to be drained.
- Ovaries can stop working after surgery even if they are not removed. This may cause menopausal symptoms.
- Pain with sexual intercourse is rare but slightly more common after vaginal hysterectomy.
- During a planned vaginal or laparoscopic hysterectomy it may be necessary to convert into open surgery (abdominal hysterectomy). This may be due to complications or difficulty during the intended procedure

Preparation before your Hysterectomy:

You will receive an appointment to attend the Pre-Admission Clinic to discuss your plan of care. To help improve your recovery after the operation, try to get yourself into the best physical condition you can. If you smoke cut down or stop smoking. Eat healthily and take regular exercise. Don't forget to make home arrangements before you are admitted to the hospital (e.g. work, childcare, shopping, washing, housework, vacuuming etc.).

You will be advised not to do any heavy housework or lifting for about 6-12 weeks depending on the type of surgery you have. The length of the hospital stay is variable, depending on the type of the operation, and your general health; you can expect to be in the hospital anything from one to seven days.

Admission to Hospital:

You will usually be admitted to the hospital the day of the surgery. Some women are admitted before this, the commonest reasons are to stabilise diabetes, stop warfarin or if there are difficulties in same day arrival such as having to travel a long way. You should bring with you nightwear, dressing gown and slippers, toiletries and sanitary towels. You should also bring any medication which you take regularly.

The nurse will carry out a safety checklist ensuring we have the correct details about you. You may have swabs to screen for the MRSA infection, if it hasn't already been done. You will measured for support stockings to help the circulation in your legs after surgery. They should be worn until you return to full activity, although you can remove them for washing.

The gynaecologist and the anaesthetist will see you before surgery and answer any questions. In theatre you will be given an antibiotic to help prevent infection.

After the operation:

- You will wake up in the theatre recovery unit where you will stay for about an hour.
- You may have an oxygen mask on for few hours or overnight after surgery. You will have a drip to keep you hydrated. This will remain in place until you are drinking enough.
- The nurse will be checking on you and giving you pain relief regularly and anti-sickness drugs.
- You may have a catheter in your bladder to drain urine; you may also have a drain (small tube from the operation site) to remove any surgical blood loss or a vaginal pack to stop bleeding; there will be a plan as to when the nurse will remove them.
- You will be offered sips of water on your return from theatre. Diet and fluid will be gradually given as you recover.
- The doctors will visit you to make sure you know about your operation and answer your questions.

For the first few days after your operation, it is important to perform deep breathing exercises. This is to help prevent chest infections. You should also carry out leg exercises to help prevent circulatory problems whilst you are less mobile. (Further information on physiotherapy is available).

You may not have a bowel movement for the first few days after the operation. This is normal. You will be given some suppositories to help if needed. Sometimes after a hysterectomy "wind" pain can be a problem. Peppermint water can help, and also gentle pelvic tilting and knee rolling. The best way to relieve wind is to move around early after an operation.

If you have stitches or staples that need removing after your hysterectomy, arrangements will be made and discussed with you. Most sutures are dissolvable and do not need to be removed but may take 3-4 weeks to go. It is normal to feel tearful the first few days after the operation. These feelings should pass as you get stronger and recover from surgery.

Recovering well

It takes time for your body to heal and for you to get fit and well again after your hysterectomy. There are number of positive steps you can take at this time:

- Whilst it is important to rest, it is also important to do light activities around the house the first few weeks. At the end of week one go for a short walk every day, gradually increasing the distance and speed. Ensure you don't feel vaginal heaviness when walking
- Pelvic floor exercises after prolapse surgery can be discussed with your doctor or physiotherapist
- Avoid constipation by eating plenty of fruit, vegetables and food containing whole grain. You can also discuss this problem with your GP
- After four weeks, gradually begin to do more housework, cooking, ironing, etc. By six weeks you may be back to normal, apart from prolonged standing and heavy lifting. These should not be resumed for 2-3 months
- You may go anywhere as a passenger in a car but if going long distances ensure you stretch your legs regularly
- Driving should be avoided for four weeks to help with recovery. It is essential to check with your insurance company regarding their policy
- Try to have a bath or shower regularly. It is safe to use soap, shampoo or bubble bath
- Cutting down or stopping smoking will help you reduce the risk of chest and wound infection.
- Allow four to six weeks for your body to heal before starting to have sex or use tampons. If you experience any vaginal dryness or discomfort use lubricants.

Everyone recovers at a different rate, the time to go back to work will depend on the type of work you do, the number of hours you work and how you get to work. Many women are able to go back to normal work in 6 to 8 weeks, especially if they have been building up their levels of physical activity at home. Others may take up to 12 weeks.

When to seek medical advice

Whilst most women recover well after a hysterectomy, complications can occur as with any operation. If you have any concerns please ask for advice. Examples of post-operative problems include:

- Burning and stinging when you pass urine, or passing urine too frequently. This may be due to a urine infection.
- Persistent or heavy vaginal bleeding. If you are also feeling unwell or have a fever (high temperature), this may be due to an infection or a collection of blood at the top of the vagina (haematoma).
- Red and painful skin around your scars. This may be a wound infection.
- Increasing abdominal (tummy) pain. If you also have a fever, lost appetite and are vomiting, this may be because of a more severe infection (sepsis).
- A painful or swollen leg, difficulty breathing or chest pain, it can be a sign of a clot formation (DVT, pulmonary embolism)

In the first few weeks after surgery you can call Ward 40, if there are later problems you should contact your GP, phone 111 or attend a walk-in/emergency unit.

Useful contacts

Ward 40, Level 4, Leazes Wing, Royal Victoria Infirmary, Tel no :0191 282 5640 *(*please note, there is no dedicated nurse for telephone calls. The ward staff take calls but on occasions they may need to call you back if busy with another patient)

Hysterectomy Association, 60 Redwood House, Charlton Down
Dorset, DT2 9UH. Website: www.Hysterectomy-Association.org.uk

Royal College of Obstetricians & Gynaecologists, Recovering well after hysterectomy, Patient information. Website: www.rcog.org.uk

Title: Hysterectomy patient information leaflet.
Published: Oct, 2012
Review date: Oct, 2015
Authors: Tony Chalhoub, Mark Roberts, Julie Ellis