Hysterectomy

Patient Information – Gynaecology Services

What is a hysterectomy?

A hysterectomy is an operation to remove the uterus (womb) and cervix. The fallopian tubes are usually removed at the same time, as this has been shown to reduce the risk of a rare type of ovarian cancer that is now understood to arise in the fallopian tubes. The ovaries are not usually removed if you are having a hysterectomy to treat a benign condition as this would put you in to a surgical menopause. Following a hysterectomy operation, a woman no longer has periods and is not able to able to get pregnant.

Why might a hysterectomy be done?

The most common reasons for having a hysterectomy are:

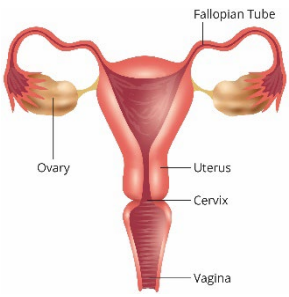
1. Painful or heavy periods: when other treatments have not helped.
2. Uterine fibroids: non-cancerous growths in the uterus.
3. Prolapse of the uterus: when weak muscles and supporting tissues cause the uterus to drop down into the vagina.
4. Cancer or pre-cancer of the uterus, cervix or ovaries.

What types of hysterectomy operations are there?

Total hysterectomy with bilateral salpingectomy is the removal of the uterus, cervix, and fallopian tubes. The ovaries are not removed.

Total hysterectomy with bilateral salpingo-oophorectomy is the removal of the uterus, cervix, ovaries and fallopian tubes. Removal of the ovaries will bring on menopause for women who have not reached menopause.

Subtotal hysterectomy is the removal of the main body of the uterus, but leaving the lower part of the uterus (the cervix) in place. Occasionally this is performed if it is thought to be safer to leave the cervix in place, or if a woman requests it.



How is the operation performed?

There are a number of ways a hysterectomy operation can be performed; the surgeon will discuss this with you. How your surgery is performed depends upon factors such as the size of your uterus and if you have had previous surgery.

Laparoscopic hysterectomy (keyhole)

A laparoscope (a thin tube with a video camera attached) is put into your abdomen (tummy) through a small incision in the umbilicus. Your abdomen will be filled with carbon dioxide gas so that the surgeon can see your internal organs more clearly. Additional small cuts are made to allow the use of laparoscopic instruments. The uterus, cervix and fallopian tubes are then separated from their supporting structures and removed through the vagina. The top of the vagina is then closed with dissolvable stitches.

Vaginal hysterectomy

This operation is performed through your vaginal opening, rather than a cut in your abdomen. The only incision made is internal and dissolvable stitches are used. If you are having a vaginal hysterectomy for a prolapse the fallopian tubes are not normally removed.

Laparoscopic assisted vaginal hysterectomy

This is a combination of both laparoscopic and vaginal hysterectomy. The ovaries and fallopian tubes can be removed during this procedure.

V-notes hysterectomy Removal of the uterus, tubes and/or ovaries through the vaginal opening using an endoscopic technique.

Abdominal hysterectomy
This involves having your uterus removed through a cut in your abdomen. The incision (cut) is either a horizontal cut low on your abdomen ('bikini line') or a vertical midline cut from the naval (belly button) downwards.

Risks and complications

- Failure to resolve initial reason for surgery, eg. recurrence of prolapse/failure to resolve pain
- Chronic post-surgical pain (ie. a new pain) develops in up to 30% of women
- Haemorrhage
- Infection
- Deep vein thrombosis (blood clots)
- Bladder function problems
- Constipation
- Vaginal prolapse – when the top of the vagina sags and falls into the vaginal canal
- Adhesions (scar tissue that can form internally after surgery)
- Very rarely, the surgery can cause injury to the bladder, the ureters (the tubes that transport urine between the kidneys and the bladder) the blood vessels or the bowel

A hysterectomy is a common and safe procedure, however all operations have potential risks. Every operation is different, and no two patients are alike. All surgical procedures carry a small amount of risk. Some operations will be more difficult. It is important to discuss your own individual risks with your gynaecologist.

Surgical consent

- Before your surgery you will usually be seen or phoned for a preadmission and a surgical consent discussion.
- At this appointment you will often meet or speak to members of the team who will be performing your operation.
- This is an opportunity to ask questions and seek any more information that you need to make an informed decision.
- You will be asked about whether you are willing to receive a blood transfusion in the event of unexpected heavy bleeding during surgery. This is just so we can understand your wishes relating to this.
- You will also be asked if you would like your body parts (eg. te whare tangata – the uterus) and other specimens returned to you after they have been checked in the laboratory.
- In addition, you will be asked whether you have any spiritual, cultural or other needs that you would like us to consider. Please let us know.

After the operation

- You will be given pain medications for the first few days, both while you are in hospital and to take home with you
- You will be able to eat and drink within a few hours of having the operation
- You may have a catheter (a thin tube going into your bladder, which drains urine) for 1 day
- You may have some light bleeding from the vagina, which can last for 1-2 weeks after your surgery. Some women have no initial bleeding at all but then will experience a gush of old blood or fluid after a week. This will usually stop quickly. You should use pads instead of tampons to reduce the chance of infection
- If you had a vaginal hysterectomy, a vaginal pack is sometimes placed in your vagina after your surgery. This will be removed later in the day or the morning following your operation
- If you have had a laparoscopic hysterectomy you can expect to go home on the day of the surgery or the following day. For abdominal or vaginal hysterectomy you can expect to be in hospital between one and three days
- It is important to follow all the advice you have been given, when you go home
- When you are discharged from hospital you will be advised what follow up is required. In most cases the follow up will be with your GP if needed and the surgical team will write to you with the results from the analysis of the tissues removed (histology)

How long will it be before I can return to my normal activities?

- This varies from woman to woman and depends on the type of hysterectomy you have had
- Most women need to rest more than usual for a few weeks after a hysterectomy
- You will have light exercises to do and will gradually build up the amount of activity you do
- Full recovery commonly takes around six weeks depending on what type of hysterectomy you had
- We advise vaginal rest (ie. no intercourse, tampons, etc) for at least six weeks

Preventing infection

- If you have been prescribed antibiotics, please finish all the tablets
- Use sanitary pads rather than tampons until the vaginal bleeding/discharge has stopped. Tampons should not be used until six weeks after surgery
- Do not use baths, spa pools and swimming pools until all the vaginal bleeding/discharge has stopped

Will having a hysterectomy affect my sex life?

- Most women do not notice a change in their sexual feelings or function following recovery from a hysterectomy. For many women there is an improvement
- For some women, coming to terms with the loss of their reproductive organs can take time and requires patience and support
- You can usually begin to have sex again about six weeks after the operation
- You will no longer need to use any form of contraception after a hysterectomy
- For some women, the use of a vaginal lubrication or oestrogen cream may make intercourse more comfortable. Please feel free to discuss this with your doctor

Will I still need to have cervical smear tests?

- Most women no longer need cervical smear tests after a hysterectomy, however you should confirm this with your Gynaecologist doctor as it depends upon your cervical screening history and how up to date you are with this
- If you have had a hysterectomy that leaves your cervix in place, or if you have had abnormal smears then you may be advised to continue having cervical smear tests

What should I do if I have a problem?

If you experience any of the following:

- Heavy vaginal bleeding (which is bright red)
- Severe pain
- A high temperature — above 38.0^{o}C
- Vaginal discharge which is heavy or smelly
- Persistent nausea or vomiting

Contact your GP or afterhours clinic. If it is an emergency call an ambulance (111)

Follow-up with your doctor

You will be advised if any follow up is required at the time of discharge. In most cases we write to you with the results of the testing that has been performed on your uterus but leave a face-to-face follow up for you to have with your GP if all has gone well.

For more information about:
hospital and specialist services, go to www.cdhb.health.nz | your health and medication, go to www.healthinfo.org.nz