WHAT IS A Hysterectomy?

A hysterectomy is a procedure performed in order to remove the uterus (this almost always also includes the cervix). This is what is referred to as a **Total Hysterectomy**. This does not usually mean the ovaries will be removed but if it is my intention to remove the ovaries, certainly I will discuss that fully with you. Usually this means that if we are removing the ovaries we would also remove the fallopian tubes. This operation is then called a **Total Hysterectomy** and **Bilateral (Both sides) Salpingo-Oophorectomy** (the tubes and ovaries are also being removed). If you were to have your ovaries removed, you would require ongoing hormone replacement therapy (HRT) if you were pre-menopausal and certainly a discussion of HRT would also follow if you were post-menopausal. Hysterectomy is 100% effective in stopping heavy menstrual flow and is the final stage of management of heavy bleeding. The operation is usually performed through a bikini line incision or alternatively through the vagina. A **Subtotal Hysterectomy** is the removal of only the upper portion of the uterus often leaving the cervix in place, it is done in emergency situations (such as in severe bleeding after childbirth) or where there is extreme scarring over the cervix making surgery more hazardous to remove the cervix. A **Radical Hysterectomy** is done to remove the uterus in the event of cancer.

WHY IS IT DONE?

Hysterectomy may be performed to treat a variety of gynaecological (female reproductive system) problems. It is an elective procedure ninety percent of the time.

There are numerous reasons for performing a hysterectomy:

1. **Uncontrolled heavy bleeding.**
   Heavy bleeding (menorrhagia) can be managed in many ways, full discussion of all other options will be undertaken prior to hysterectomy. A Total Hysterectomy is the only procedure to guarantee to stop all bleeding.

2. **Endometriosis**
   This is a condition where tissue similar to the lining of the uterus (endometrium) is found external to the uterus and growing in other parts of the abdomen. It can be implicated in heavy irregular bleeding with associated pain (dysmenorrhoea) and also pain with intercourse (dyspareunia).

3. **Enlargement of the uterus mainly by fibroids**
   These are usually benign (non-cancerous) tumours of the muscle wall of the uterus. Whilst not life threatening, they may cause discomfort, pressure on surrounding structures, excessive bleeding and discomfort with intercourse. They are common and usually do not require surgery unless the symptoms are intolerable or they are excessively large.

4. **Pain related to the uterus and not controlled by other treatment.**
   This is a less certain option as pain may equally come from surrounding structures such as bowel, bladder, skeletal systems etc. Therefore it is a last resort if the pain is non-specific and can not be guaranteed to alleviate the pain completely.

5. **Pre-cancerous and cancerous changes of the body of the uterus and cervix.**

6. **Part of a repair for prolapse.**
   Weakness of vaginal wall tissues and structures may necessitate the uterus’ removal and part of the vaginal repair.

7. **Pelvic Inflammatory Disease**
   Chronic infection of the reproductive organs can cause permanent scarring and chronic pain.

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WHOSE DECISION IS IT?

Ultimately, the decision is yours. The only time that it is imperative for you to have a hysterectomy is if you have a cancerous condition that may impact upon your health. Other than that, should it be for heavy periods or pain, it is entirely up to you as to whether we proceed to hysterectomy or not. You will no longer be able to get pregnant after a hysterectomy. Thus, before you choose elective hysterectomy, you must consider both the severity of your problem and your desire to have children in the future. Although this operation may improve your quality of life by relieving chronic symptoms such as pain or bleeding, some women are willing to tolerate these conditions.

Ask yourself?

Do I want to become pregnant in the future?

How do I feel about not having a uterus?

What is my husband's (or partner's) attitude toward this operation?

What will happen if I don't have a hysterectomy?

What are the risks of a hysterectomy in my particular case?

Is my condition likely to improve on its own, stay the same, or get worse?

Is a hysterectomy medically necessary or recommended to relieve my particular symptoms?

HOW LONG WILL I BE IN HOSPITAL?

Usually, you will be in hospital between 3 -7 days and will require a convalescent period of about 6 weeks. Recovery depends on a number of factors including age, type of operation, general health and complications that may occur.

AFTER THE OPERATION

When you first wake up you will have an intravenous line running and a catheter in your bladder draining urine. The fluid infused is to prevent dehydration in view of fasting prior to the operation and inability to drink in the short term, as your bowel stops functioning normally for a few days because of its exposure and handling. You will usually be slowly graded back to a normal diet (clear fluids, free fluids, soft diet, normal diet). It is not uncommon to experience some wind pain post-operatively.

You will also wear surgical support stockings and wear sequential compression devices on your legs which will compress your legs (and make a noise) to reduce the incidence of thrombosis in your legs. Blood transfusion are rarely necessary (please discuss if you want to know more about autologous transfusions.)

For the first few days, you will experience discomfort which will require strong analgesics. I would hope after that time the pain would settle and be managed quite satisfactorily with oral medication and requiring little in the way of analgesics following discharge from hospital. Initially analgesics will be administered intravenously during the period of time when you will be unable to take food by mouth. You may also be administered rectal suppositories (usually Naprosyn) for pain relief as well as oral medication.

You may also have a small drain protruding from the abdomen. Usually you would be sat up out of the bed the day following your operation and 48 hours following surgery, usually all tubes would be removed. This would allow you to mobilise slowly to regain normal function both in terms of bladder and bowel function and indeed just slowly mobilising within your limitations of pain. You will usually have a stitch under the surface of the skin which does not require removal and will eventually dissolve.
Your bowels may be a little slow to start functioning again because of the pain relieving medications slowing down your bowel as well as your lack of “normal dietary intake”.

Avoid all lifting during the first two weeks of your recovery period and heavy lifting for at least six weeks. In the weeks following the surgical procedure, you can begin to do light chores, some driving is possible two to four weeks following the procedure.

It is normal to experience some vaginal discharge for up to six weeks as you will also have a suture line at the top of the vagina which is a little slow to heal as it does not get exposure to the outside air.

**WILL MY OVARIETIES BE REMOVED?**

As I mentioned before, this is something that will be discussed prior to your operation. It is possible sometimes that you may develop a further cyst within the ovaries and indeed possibly, more rarely, a malignant process within the ovary. Hence their easy removal at the time of the hysterectomy may prevent this problem. On the other hand, hormonally they will still produce oestrogen and some mild type of male hormones which will keep going for many years up until the natural menopause. If they are removed, then you would need to consider some hormone replacement therapy.

It is often asked whether hysterectomy affects your sex life. It should not alter the act of intercourse and intercourse should not occur for about 6 weeks following the procedure or until the wound is well healed vaginally. Desire for intercourse and indeed pleasure from intercourse should not be affected by having a hysterectomy.

Other concerns such as putting on weight or becoming "hairy" do not occur other than the normal dramatic changes that occur in your lifestyle. For instance, if you were to sit around and not do much after the hysterectomy, then obviously with over-eating and under-exercising, it is possible that you may put on weight. Therefore, it is important that you embark on some regular exercise even following the operation. If your ovaries are retained, then hormonally you will still experience a cycle. If you experienced PMT before, you may experience that again along with some cyclical mood disturbance.

**HOW IS THE HYSTERECTOMY PERFORMED?**

I can remove the uterus through a surgical incision made either inside the vagina or in the abdomen. In both the vaginal and abdominal approaches, I detach the uterus from the fallopian tubes and ovaries as well as from the upper vagina.

**Abdominal Hysterectomy**

When a hysterectomy is performed through an incision in the abdomen, it allows me to see the pelvic organs easily and gives me more operating space than is permitted in a vaginal hysterectomy. Thus, for large pelvic tumours or suspected cancer, I may decide to do the procedure abdominally. Equally if the ovaries need to be removed it may be preferential to remove the uterus abdominally. Patients who have an abdominal hysterectomy require a longer hospital stay than those who have a vaginal hysterectomy. In addition, they may experience greater discomfort immediately following the operation, and will have a visible scar. However, I can often make a less noticeable horizontal incision, called a bikini-cut, that extends along the top of the pubic hairline.

**Vaginal Hysterectomy**

The vaginal approach to hysterectomy is ideal when the uterus is not enlarged or when the uterus has “prolapsed” as a result of the weakening of surrounding muscles. This approach is technically more difficult than the abdominal procedure because it offers me less operating space and less opportunity to view the pelvic organs.

However, it may be preferred if a patient has a prolapsed uterus, if the patient is obese, or in some cases has early cervical or uterine cancer. A vaginal hysterectomy leaves no external scar.

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A variation on vaginal hysterectomy is LAVH (Laparoscopic-assisted Vaginal Hysterectomy). A laparoscope is a device the surgeon can use to examine the inside of the pelvis. LAVH is an alternative for women who have ovarian disease but previously had only one choice: an abdominal hysterectomy that leaves a long incision. With LAVH, much of the procedure is done through tiny incisions using a laparoscope. The rest of the procedure then can be finished vaginally.
RISKS THAT CAN OCCUR

Hysterectomy is regarded as one of the safest operations. Nevertheless, no operation is without risk. Severe complications and even death occasionally occur with this operation. The uterus is located between the ureters (small tubes which transport urine from the kidneys to the bladder) on each side, the urinary bladder in front, and the rectum behind. Any of these structures are subject to injury, especially if the operation is difficult, as can occur with large fibroids, endometriosis, or cancer. Listed below are the most talked about complications (note that all of these are uncommon)

Operative complications may be due to:-

a) Haemorrhage. This may prolong the operation and at times require blood transfusion, if consent for this has been given. (Approximately 1% of such cases).

b) The bladder and ureters may be unexpectedly damaged and need repair. This is uncommon.

c) It is possible for the bowel to be injured during the operation, particularly if there is unexpected scar tissue or difficulty removing an ovary. This is extremely rare.

d) In the most unlikely event that it is not possible to remove the uterus vaginally .A laparotomy (abdominal incision) may be required to complete the hysterectomy.

e) The risk of anaesthetic will be discussed with you by the Anaesthetist. Your anaesthetic will usually take the form of a General Anaesthetic.

Post Operative problems may occur:-

a) Bleeding may occur within the first 24 hours post operatively, or later. It is usually controlled with vaginal packs or with antibiotics. If it is uncontrollable, it may be necessary for the patient to be taken back to the operating theatre for treatment to the bleeding points. (Less than 1% of such cases). Wound bleeding (Haematoma) can occur and usually resolves spontaneously or may occasionally need an operation to evacuate it.

b) Infection may occur. Usually at the top of the vagina inside the abdomen or in the urinary tract. Antibiotic treatment may be required.

c) Clotting can occasionally take place in the veins in the legs. This may require treatment with medication (anticoagulants) to dissolve the clot. A life threatening complication may occur if part of the clot is swept away to the lungs (pulmonary embolus). This is very rare.

d) Bladder catheterisation is almost a routine part of hysterectomy. Following removal of the catheter, there is usually no difficulty passing urine, however, sometimes it is necessary to replace the catheter, or teach intermittent self catheterisation for a short duration usually a few days only. Because of the need for catheterisation (initially performed under the anaesthetic) there is a small risk of a urinary tract infection.

e) It is possible for a small communication (fistula) to develop between areas involved in the operation. For example, if a hole is present between the bladder and the vagina, urine may be passed vaginally. Other openings (or fistulas) are possible between the ureter and the vagina, or the bowel and the vagina. This is a very rare complication of such surgery.

f) Following a vaginal hysterectomy, the vagina may be excessively narrowed. This may cause difficulties with sexual intercourse initially until healing is complete or stretching occurs.

g) The ovaries may become involved with adhesions to bowel or cause pain and this sometimes requires repeat surgery in the years to follow.

h) Removal of the ovaries would require Hormone Replacement Therapy if premenopausal.

i) Keloid scarring may occur. This occurs because of excessive healing and may produce an elevated itchy scar. It is not dangerous but may be unsightly and annoying. Alteration in sensation around the scar may be present for many months and can occasionally be permanent.

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LONG TERM EFFECTS

After having a hysterectomy, you will no longer be able to get pregnant and will no longer have menstrual periods. If you were premenopausal (still menstruating) before the operation and have your fallopian tubes and ovaries removed, you will experience all of the symptoms of menopause as your body gets used to different hormone levels. These symptoms may include hot flushes and perhaps irritability and depression. If the symptoms are severe, I may prescribe hormone replacement medication. Hysterectomy usually has no physical effect on your ability to experience sexual pleasure or orgasm.

Following Hysterectomy, the ovaries will continue to function; however, the actual occurrence of menopause will be difficult to determine since the uterus has been removed and you will no longer have periods. As the age of menopause, approximately age 50, is approached, symptoms such as hot flushes may warrant testing to see if hormone replacement therapy is indicated.

If you experience vaginal dryness, it can be remedied by using prescription hormone creams or pills, or water-soluble lubricants that you can purchase at the pharmacy.

A sense of loss following the removal of any organ is normal and takes time for adjustment. While depression following hysterectomy does not happen to everyone, it is more common if the operation was done because of cancer or severe illness, rather than as an elective operation.

Additionally, if you are under age 40 or the operation interfered with your plans to have children, depression is more likely to occur. This depression can be temporary, depending on your general outlook on life, and the availability of a good support group of family and friends.

Most women experience an improvement of mood and increased sense of well-being following hysterectomy. For many, relief from fear of pregnancy results in heightened sexual enjoyment following the procedure.

If you have had your cervix removed at the time of the surgery (usually always unless you had a subtotal hysterectomy) there is no need for a pap smear in the future unless you have had a previous abnormal pap smear or cancer of the cervix. If so you will be advised of the appropriate interval in which to have a pap smear.

COST OF SURGERY

Please ask for a written quote to outline costs for your operation, it will vary depending on the actual procedure performed and is only intended as a guide. Please remember that there will be extra costs for an assistant, pathology services, pharmaceutical supplies, hospital excesses not covered by your fund. The cost of the anaesthetist can be obtained by ringing my Rooms in the week prior to the surgery so his/her rooms can be contacted for their relevant costs. I have no control over these extra costs as they depend on availability etc.

PRIOR TO ADMISSION

Often I would ask you to have some blood tests prior to your surgery to check to make sure you are not anaemic and that your body chemistry is within normal limits. Other tests may be required such as an ECG (heart trace) or chest Xray or even bowel preparation. These will be mentioned if required.

If you are overweight or smoke you are at a greater risk of complications and and reduction in weight or cessation of smoking would be beneficial.

Please notify me of any drugs you may be on. In particular it may be pertinent for you to stop drugs such as the oral contraceptive pill or drugs like aspirin well prior to surgery.

Having your menstruation at the time of the surgery will not interfere with your hysterectomy.

You will be given admission papers prior to admission and the hospital would usually contact you prior to the surgery to arrange time of admission etc.