PATIENT INFORMATION BOOKLET

HYSTERECTOMY

This document is intended to assist patients in their understanding of a common gynaecological procedure or condition. It does not replace discussions with the health care team and individualised clinical care.

Developed and endorsed by SASOG
as part of the BetterGYN® programme

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South African Society of Obstetricians & Gynaecologists
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WHAT IS A HYSTERECTOMY?

A hysterectomy is a surgical procedure that removes your womb (also called the uterus), the organ that bleeds during menstruation, and where a baby grows when you are pregnant.

Once you have had a hysterectomy you will no longer have your periods and you will not be able to become pregnant.

WHAT TYPES OF HYSTERECTOMY ARE POSSIBLE?

- A **total hysterectomy** means removing the uterus and the cervix or mouth of the womb.
- A **sub-total or supra-cervical** hysterectomy means removing a part of the uterus, leaving the cervix (the part of the uterus that protrudes into the vagina) in place.
- A **radical hysterectomy** means removing the womb "radically" or widely, including its attaching ligaments. This is done to treat cancer of the uterus by a gynaecologic oncologist.

The different ways in which a hysterectomy may be performed include:

- Abdominal - via an incision in the abdominal wall.
- Vaginal - through a vaginal incision which is made around the cervix.
- Laparoscopic - via several mini-incisions or key-hole surgery

Sometimes a hysterectomy includes the removal of one or both fallopian tubes (called the alpinges) and/or ovaries.

This procedure is called a hysterectomy with unilateral (one side only) or bilateral (both sides) salpingo-oophorectomy (or salpingectomy or oophorectomy).

The planned removal of ovaries should be discussed before surgery, as the removal of functional ovaries results in immediate menopause symptoms which may begin suddenly. Depending on how much these symptoms affect your quality of life, you may need treat them with hormones.

WHAT ARE THE INDICATIONS FOR A HYSTERECTOMY?

You may need a hysterectomy to treat a variety of symptoms, structural abnormalities or tumours.

Common reasons include:

- **Fibroids** are benign uterine tumours that often cause persistent bleeding, anaemia, pelvic pain or bladder pressure. Non-surgical treatments of fibroids are a possibility, depending on your discomfort level and tumour size. Many women with fibroids have minimal symptoms and require no treatment.
- **Endometriosis** is a condition where the tissue lining the inside of your uterus (endometrium) grows outside the uterus on your ovaries, fallopian tubes, or other pelvic or abdominal organs. When medication or conservative surgery doesn't improve endometriosis, you might need a hysterectomy along with removal of the diseased tissue, your ovaries and fallopian tubes.

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- **Uterine prolapse** is where the uterus protrudes into the vagina or protrudes out of the vagina. This can happen when supporting ligaments and tissues become weak (A patient information leaflet is available for this condition).
- **Abnormal uterine bleeding** is when your periods are heavy, irregular or prolonged each cycle. A hysterectomy will bring relief when the bleeding cannot be controlled by other methods.
- **Gynaecologic cancer** in the body of the uterus the cervix or ovaries may necessitate a hysterectomy as part of the best treatment plan and to gain information about the nature and spread of the cancer. Depending on the specific cancer you have and how advanced it is, other options may include radiation or chemotherapy.
- **Chronic pelvic pain** syndromes, (including pain with deep intercourse) can be so severe or difficult to treat that surgery is recommended. A hysterectomy is however not guaranteed to provide relief for all patients.

ARE THERE ALTERNATIVES TO A HYSTERECTOMY?

There are many alternative treatments available for gynaecologic disease. A hysterectomy is only recommended if these have been exhausted or if surgery will provide a superior solution to your problem. Discuss this with your doctor if you are unsure of the reasons for the recommendation.

HOW CAN I PREPARE FOR THE PROCEDURE?

Tests which your doctor will do may include:

- cervical cytology (also known as a Pap test or Pap smear);
- tumour markers and an endometrial biopsy to exclude cancer or pre-cancer;
- a pelvic ultrasound to show the nature and size of any uterine or ovarian disease;
- blood tests like a blood count for anaemia;
- kidney, ovarian and thyroid function tests; and,
- a blood sugar test, chest X-ray and ECG to prepare for general anaesthetic.

If you are using hormones, like the pill, or medicines that reduce clotting, like Grandpa, vitamin supplements, herbal medicines, aspirin, Xarelto or Warfarin, you should stop taking the optional medicines and discuss whether to stop the prescribed medicines with your doctor before surgery. Other chronic medications must be continued, taken the morning before surgery.

It is important to bring a sufficient supply of your medication to the hospital with a list of all medicines and dosages.

It is also important to inform your doctor and all medical personnel of any medical conditions you have.

On the day before and the morning of your surgery, you will be instructed to shower to reduce your risk of infection. Hair removal policies vary but it may be recommended that you clip or remove the hair around the surgical site.

HOW IS A HYSTERECTOMY DONE?

A hysterectomy is usually performed under general anaesthetic and takes about an hour, plus preparation and anaesthesia time. A urinary catheter will be inserted to keep the bladder empty. This remains in place for about one day. Your abdomen and vagina are cleaned with a sterile solution before surgery and you will usually receive a preventative dose of an antibiotic.

An **abdominal hysterectomy** is done though a cut or incision in your lower abdomen, which can be a vertical or a horizontal 'bikini-line' incision. The type of incision depends on the reason for the hysterectomy, the need to explore the upper abdomen, the size of your uterus and any previous scars. After entering the abdomen with care, your anatomy is identified and restored if necessary. The uterus is then isolated and removed by clamping and tying the blood vessels, ligaments, and vaginal attachment. Care is taken not to injure the bladder, kidney pipes (ureters) and bowel. Where these organs are injured, care is taken to repair any possible damage with suturing (stitches). Removal or sparing of the ovaries is confirmed and any remaining bleeding is stopped. The vagina top as well as the abdominal wall are carefully sutured in layers.

A **vaginal hysterectomy** is done through an incision inside your vagina. The uterus is then separated from below and removed through the vaginal opening. In this procedure, absorbable stitches are usually used. Removal of the ovaries may be possible, but this is more difficult than via the abdomen.

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If unexpected difficulties or complications occur, surgery may need to be completed through an abdominal incision or with a laparoscopy. This will be done to improve safety or to enable completion of the planned procedure.

A **laparoscopic hysterectomy (LH), sub-total hysterectomy (LASH) and laparoscopically assisted vaginal hysterectomy (LAVH)** are minimally invasive surgeries. These procedures are done using a thin fibre-optic lensed instrument called a laparoscope, which is inserted into the abdomen to provide light and a view of the surgical procedure on a screen. Following this, thin surgical instruments are inserted through the incisions. The uterus can be removed through the vagina or through a small incision or in small pieces through one of the keyholes. In case of difficulty, these procedures may also require conversion to open surgery.

WHAT ARE THE RISKS AND COMPLICATIONS WITH HYSTERECTOMY?

A hysterectomy is generally very safe with an overall serious complication rate of about 4%. The risks are related to other conditions that you may have; previous surgery; risks related to the anaesthetic; the indications and disease; and, the route of surgery. Common, minor problems include bladder and superficial wound infection and short-term bowel dysfunction.

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Major problems are not common, but the list of possibilities is long.
The most important of these are:

- Blood clots in the large veins which can migrate to the lung.
- Major infections can occur in the lung (pneumonia), wound or pelvis.
- Excessive bleeding during or after surgery.
- Anaesthetic complications can be major and include drug reactions, problems with intubation, etc.
- When damage to your urinary tract occurs during surgery, e.g. bladder or ureteric injury, but is not detected, or it occurs after surgery, repair may be complicated and require follow-up surgery and prolonged catheterization.
- Damage to any part of the bowel is also easily repaired, but when not detected or if it occurs after surgery, it can cause severe illness which will require further surgical intervention.
- Feeling of depression or anxiety.

WHAT CAN I EXPECT DURING MY HOSPITAL STAY?

You will remain in the recovery room until you are fully conscious before returning to the ward where nursing staff will continue to monitor your progress. For the first hours, you will receive strong pain medication through a drip or into the muscle. Your urine volumes and vital signs will be regularly monitored.

The intra-venous drip and urinary catheter will usually be removed the next day and you will be allowed to drink, eat and move about. You will be given oral pain medication.

An abdominal hysterectomy usually requires a hospital stay of two to four nights, but you will be discharged when you and your doctor agree that you will be safe.

It is normal to have bloody vaginal drainage for a few days to a few weeks after a hysterectomy. Let your surgeon know if the discharge is heavy or has a bad smell.

Sutures may be dissolvable or may need to be removed between 5 and 10 days later.

The pain and recovery time for vaginal and laparoscopic surgery will be shorter.

RECOVERY

It takes time to get back to your usual self after a hysterectomy - about six weeks for an abdominal and four weeks for a vaginal or laparoscopic hysterectomy. During this time, the following tips are important:

- Get plenty of rest.
- Take your prescribed pain medicines if you need them.
- You may only drive when you can do so safely.
- Don't lift anything heavy for a full six weeks after the operation.
- Stay active after your surgery but avoid strenuous physical activity for the first six weeks.
- Wait six weeks before you resume sexual activity.
- Follow your doctor's recommendations about returning to your other normal activities.

WHAT OTHER EFFECTS CAN I EXPECT?

A hysterectomy permanently changes some aspects of your life, such as:

- You will no longer have menstrual periods and you won't be able to become pregnant.
- You will usually get relief from the symptoms that made your surgery necessary.
- Before you have reached menopause, having your ovaries removed along with your hysterectomy starts menopause. If your ovaries are not removed during your hysterectomy you may still experience a slightly earlier menopause.
- You will also need to have regular Pap tests if you have had a subtotal hysterectomy or if your hysterectomy was for pre-cancer or cancer.
- The effects of a hysterectomy on pelvic organ prolapse in later years, and on bladder function in the long term, is not clear.
- Sexual function is not much affected by hysterectomy on its own, although more dryness, less pain, and a shorter vagina are sometimes reported.
- Some women feel a sense of loss, especially if they are young and were still hoping to become pregnant and have children.

WHAT ELSE DO I NEED TO KNOW?

If you have any further questions or concerns before or after surgery, it is of utmost importance that you inform your treating gynaecologist. Always make sure you know where and how you can make contact with him/her or the colleague who is on standby when you doctor is not on duty.

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Some authors and contributors may have elected to remain unnamed; some sources may not have been listed.

Guidelines are works in progress. The authors welcome any contributions, which should be sent to the SASOG secretariat.

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