York and Scarborough Teaching Hospitals
NHS Foundation Trust

Hysterectomy

Information for patients, relatives and carers

ⓘ For more information, please contact

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Introduction

In this leaflet, we try to answer some common questions about having a hysterectomy but remember everyone is different and you are encouraged to ask your own questions of the doctors and nurses.

What is hysterectomy?

Hysterectomy means that the womb or uterus is surgically removed. The operation is done frequently but is a major operation. It is therefore very important that you understand why it is recommended for you and whether there are any alternatives, less major treatments you might wish to consider and discuss with your gynaecologist.

Why are hysterectomies done and what are the possible alternatives?

Bleeding

A hysterectomy may be recommended for persistent problems with periods such as severe pain or heavy bleeding.

Alternative treatments include drugs, a special intrauterine system (Mirena) or heat treatment with a variety of electrical heat generators. In some cases, the surgical removal of the lining of the womb (endometrium) may stop the problems. Some women may wish only to be reassured there is no cancer and not have a hysterectomy.

Prolapse

When a prolapse is present, the womb may no longer be supported in the proper position in the pelvis. It may drop down through the vagina causing pain and discomfort. A hysterectomy may be a choice of treatment.

Special pelvic floor exercises or the use of a pessary in the vagina, or a surgical vaginal repair without a hysterectomy may be appropriate alternative treatments.

Cancer

If cancer of the womb, the neck of the womb (the cervix, the lowest part of the womb), the ovaries or the fallopian tube is diagnosed a hysterectomy may be recommended.

Alternative or additional treatments include radiotherapy, anti-cancer drugs (chemotherapy), or hormones.

Fibroids

Fibroids are an overgrowth of the muscle of the womb. It is extremely rare for them to become cancerous, but a hysterectomy may be recommended if they cause trouble or are particularly large. Fibroids are very common in adult women and can be as small as a pea or larger than a melon. There can be just one fibroid or there can be many.

Drugs, special injections into the blood vessels of the fibroids, or the removal of only the fibroids are alternative treatment for some patients.

Endometriosis

Endometriosis occurs when little patches of the lining of the womb are in the wrong place outside of the womb, usually in the pelvis.

Endometriosis can also be treated by drugs or by less extensive surgery than a hysterectomy.

Pelvic Pain

Some patients develop unrelenting, severe pelvic pain, sometimes after pelvic infections; a hysterectomy may be recommended.

Drugs and more limited surgery are sometimes recommended.

Alternatives

For all of the above reasons, a woman may choose not to have anything done, have medical treatment or less invasive surgical treatments where appropriate.
The exact details depend on the condition being treated so please ask your doctor or nurse.

Are there different types of hysterectomy?

Total hysterectomy means the removal of the whole of the womb including the neck of the womb (cervix). Sometimes, the intention is to do a total hysterectomy but difficulty at the time of the operation dictates that your gynaecologist exercise discretion to do a subtotal hysterectomy (see below) for safety reasons. This will be explained to you after your operation.

Subtotal hysterectomy means the removal of the womb leaving the cervix in place. If you have this type done, you need to continue having smears and may have light period type bleeding. If going on HRT, this should be of the combined type.

Total hysterectomy with bilateral salpingo-oophorectomy (removal of tubes and ovaries) when a hysterectomy is done one or both tubes and or ovaries may also be removed. ("Bilateral salpingo-oophorectomy if both tubes and ovaries removed").

Radical hysterectomy some hysterectomies done to treat cancer are called "radical". When a radical hysterectomy is done the whole of the womb, including the cervix and usually both ovaries and tubes and the adjacent fat and lymph nodes and often part of the vagina are all removed.

How are hysterectomies done?

The method depends upon the reason for the operation. Your Gynaecologist will discuss with you the options appropriate for you.

An abdominal hysterectomy means that the womb is removed either through the tummy using a keyhole approach (laparoscopic hysterectomy), or a bigger cut in the tummy wall either horizontally along the bikini line or vertically running down from the navel (open abdominal hysterectomy). Your gynaecologist will discuss which of these is appropriate for you and the reasons for this advice.

If a vaginal hysterectomy is done, the womb is removed through the vagina. This is usually a total hysterectomy. There is an unseen cut at the top of the vagina.
The ovaries are usually not removed when a vaginal hysterectomy is done. Sometimes, it becomes necessary during surgery to convert a vaginal to an abdominal hysterectomy. This risk is in the order of one in 100.

What are the benefits of a hysterectomy?

A hysterectomy is designed to cure the disease, which necessitated it, or to relieve the problems caused by the womb.

Most women are delighted by the improvement in their quality of life following the operation.

Afterwards you will have no more periods, and you cannot become pregnant.

If the neck of the womb (cervix) has been removed and you have not had any abnormal cells from the cervix, there will be no need for you to have cervical smears.

Your sex life should not be any different from before the hysterectomy, although some women feel that the continued presence of the cervix (neck of the womb) may enhance the pleasure of intercourse afterwards. If you feel this is important to you a subtotal hysterectomy may be appropriate and you may wish to discuss this with your gynaecologist.

What are the risks and adverse effects of a hysterectomy?

Most women have no complications as a result of a hysterectomy, but like any other operation there are some risks involved although they happen infrequently. One way of understanding risk is below:

Very common (1 in 1 to 1 in 10)	=	a person in a family
Common (1 in 10 to one in 100)	=	a person in a street
Uncommon (1 in 100 to 1 in 1000)	=	a person in a village
Rare (1 in 1000 to 1 in 10,000)	=	a person in a small town
Very rare (fewer than 1 in 10,000)	=	a person in a large town

The overall risk of serious complications from abdominal hysterectomy is approximately 4 women in every 100. These include:

- Haemorrhage requiring blood transfusion (23 in 1000)
- Damage to bladder and / or ureter (7 in 1000)
- Return to theatre because of complications appearing later, especially bleeding (7 in 1000)
- Deep vein thrombosis or pulmonary embolism (4 in 1000)

- Pelvic infection or abscess (2 in 1000)
- Bowel damage (4 in 10,000). This may need a colostomy. A colostomy is a surgical procedure to divert one end of the large intestine (colon) through an opening in the abdominal wall (tummy). The end of the bowel is called a stoma. A pouch is placed over the stoma to collect waste products that usually pass through the colon and out of the body through the rectum and anus (back passage). A colostomy can be permanent or temporary and be reverted after some time.

  The repair of any damaged organs may need an extension of the abdominal incision
- Development of a fistula (less than 1 in 1000). This is an abnormal connection between another organ, such as the bladder or bowel, and the vagina. Risk factors include more complex surgery, surgery for cancer, previous pelvic surgery, organ injuries at the time of surgery, and radiotherapy.

- Death within six weeks of the operation (32 in 100,000). This is mainly from pulmonary embolism or heart disease.

Common complications (up to 1 in 10) include:

- Wound bruising, discharge, infection, pain, breakdown, delayed healing and unsightly or keloid scar or hernia formation.

  A keloid scar is an overgrowth of tissue that occurs when too much collagen is produced at the site of the wound and the scar keeps growing, even after the wound has healed.

- Wound numbness or unusual sensation. This is temporary but can take several months to resolve.
- Bladder problems, including difficulty passing water, frequency and urinary tract infection.
- Slow return of bladder and bowel function to normal.
- Vaginal bleeding or discharge.
- Painful sexual intercourse or pelvic pains.
- Adhesions in the abdomen and pelvis, which may cause pains e.g. if the ovaries are involved.
- Ovarian failure, leading to menopause earlier than this would have naturally occurred.

  If the ovaries have been removed as part of your operation, your menopause starts immediately.

Precautions are taken to reduce the chance of complications, including antibiotics to reduce the risk of infection and special measures are taken to reduce the risk of clots and pulmonary emboli.

A hysterectomy results in total and permanent loss of fertility. Some women regret that they have had a hysterectomy and may mourn the loss of their fertility. A few women become depressed. Some women find their desire to have sex less than before the operation.

There are many causes of pelvic pains which are not related to the uterus. Women who have had a hysterectomy for pelvic pains may find that their condition has not improved.

You may feel anxious that following a hysterectomy you will feel less feminine. In fact, femininity depends on genes and hormones rather than the presence of the womb and is therefore not affected by a hysterectomy, but you may experience these feelings because childbearing is no longer possible.

How should I prepare for my operation?

Physically you should be as fit as possible so take regular exercise if you can. If you are overweight, you should lose weight. This will make your recovery smoother. If you smoke, do your best to stop smoking to limit the risk of problems with chest infections and blood clots after your hysterectomy.

Emotionally, it is important you and your partner understand the type and method of hysterectomy which has been recommended and why it has been recommended and to understand the effect, which the operation may have on your life.

Socially you will want to tell your relatives and employers that you are having an operation. You may want to tell them how long you will be in hospital or away from work.

Most women are in hospital about two to five days.
A return to full activity can be expected within six to twelve weeks.

What about coming into hospital?

Before your operation, you will be invited to attend the hospital so that all the details of the operation can be checked. You will have some blood tests and will be asked some general questions about your health and fitness. You will meet some of the nurses who will be looking after you and this is an ideal opportunity to ask any outstanding questions.

We will give you a leaflet explaining what to expect when you come into hospital for surgery and a leaflet from the physiotherapists suggesting some exercises to help you to recover well from the operation.

When you have decided with your gynaecologist the type of hysterectomy that you will be having, you will be given further information. Details about your stay in hospital and advice for when you go home will be discussed when you attend the pre-operative assessment clinic.

Before the procedure, you will be asked to sign a consent form (reference FYCON6-1 Total open abdominal hysterectomy or FYCON8-1 Vaginal hysterectomy, depending on the procedure you are having done). You sign to confirm that you agree to the procedure and understand the information given to you. The form will be kept in your patient notes, and you will be given a copy for your own records.

What should I know about my recovery?

This advice is intended as a general guide as everyone is different. You may also receive additional information, which is more specific to you, to aid your recovery.

Recovery takes time, which can leave you feeling very tired, emotionally low, or tearful. This often happens during the early days and is a normal reaction.
Your body needs time and energy to build new cells, to repair and to adapt emotionally.

To help you prepare for your discharge from hospital we have put together questions most commonly asked.
If you feel your question has not been answered by this leaflet please ask the staff who are looking after you.

It is usual to be discharged home between two and five days following a hysterectomy, depending on the type of operation performed and the speed of your recovery post-op. If your operation was straightforward with no complications, you may not need any follow-up appointments at the hospital. The doctor or nurse involved in your care will advise you about that when you are discharged.

After two weeks, you can gradually start to do more.
By six weeks, you are likely to be back to normal.

How much rest will I need?

It is normal to feel quite tired when you go home, everyone's recovery rate is different, don't expect to have lots of energy straight away. It is important to start exercising and doing light activities around the house within the first few days. When you're feeling tired lie down and rest, your body will tell you when you have done too much. Try and avoid standing for long periods.

When can I start to do exercise?

It is important that you that you go for a little walk every day; start gradually and build it up. Swimming is a very good gentle exercise to do; we recommend you can do this once any discharge has stopped. Contact sports and power sports should be avoided for at least six weeks although this will depend on your level of fitness before surgery.

Heavy lifting must be avoided for the first three months, let somebody else help you.

What about my personal hygiene?

We recommend having a shower rather than a bath. If you do not have a shower, avoid putting anything perfumed in the water such as bubble bath.

With vaginal surgery, it is common to have brownish vaginal discharge whilst the stitches dissolve. You may also have some fresh vaginal bleeding but it should not be heavy or contain clots, if this is the case you need to either see your GP or if you feel unwell (feverish, dizzy) go to A+E.

You should use sanitary towels rather than tampons as using tampons could increase the risk of infection.

Will my bladder be affected?

Your bladder may be bruised for a while so it can be common to pass more urine than normal, and you may also have an altered sensation when passing urine. This may last a few weeks.

When you are passing urine try not to strain and take your time.

Some women do suffer from urine infections after surgery so if you feel that you have any pain or burning sensation when you pass urine when you are back home please contact your GP.

Will my bowels be affected?

Following pelvic surgery constipation can sometimes be a problem. Straining to pass a motion can be harmful so avoid this. Exercise and a diet with plenty of roughage or high fibre and fluids will help.

Drink at least eight glasses of non-sugary drinks every day to avoid constipation. If you need a laxative, we recommend something mild, like lactulose. If these remedies don’t work, contact your GP.

What about my diet?

As highlighted above, a diet low in roughage can lead to constipation therefore we advise you to eat plenty of fruits and vegetables. High fibre foods such as wholemeal bread and brown rice will also help.

You will be less active than before your operation so try to consider what you are eating and avoid sugary, fatty foods.

Will I have a scar?

If you have a vaginal hysterectomy or vaginal repair there will not be visible scars as all the surgery will have been performed internally. Some stitch material may come away on your pad or when wiping.

With an abdominal hysterectomy, you will have a scar across your tummy; usually on your bikini line. If you have had previous abdominal surgery such as a caesarean, the doctor may choose to use this incision site again. The scar will gradually fade, but it will take some time. The sensation in your skin, near the area will also be altered and can take many months to return to normal.

If you have had a Laparotomy, the surgeon may have to do a vertical cut. This is usually discussed with you at pre-assessment. As stated above, this scar can also take some time to fade.

Will I still need cervical smear tests?

When you have a hysterectomy and your cervix is removed as well, you no longer require a smear. If your cervix is not removed, as in a sub-total hysterectomy, then your smear tests should be continued as normal.

If you are having a hysterectomy because of abnormal smears or pre-cancerous cells on your cervix, you may need a smear from the vaginal vault depending on the final histology. Your consultant will advise you how often this needs to be.

When can I start to drive again?

You can start driving again after two to four weeks as long as you feel comfortable and confident to do so, unless your consultant has advised otherwise.

You need to be able to do an emergency stop, so you can prepare by gently trying this out (and reversing) on a quiet road when you have someone with you. This way, you will have an idea of your level of comfort or discomfort. Also, check with your insurance company about their policy on driving after surgery.

When can I return to work?

We usually advise returning to work six to twelve weeks after your operation. This depends on:

- How quickly you recover.
- The type of operation you have had (abdominal or vaginal).
- The kind of work you do. For example, if you have had a vaginal repair and your work involves heavy lifting, then you would be off for a longer time. You might also need to look at your workload when you return to work.

Will I go through the menopause?

Symptoms such as hot flushes may develop after the operation especially if you have had your ovaries removed. Hormone replacement therapy (HRT) will probably be discussed with your consultant before your operation. Your GP will usually start you on HRT if required after your surgery.

How will I feel?

Many women feel quite relieved after their surgery because they have put up with a variety of problems before. You may feel that you can get on with your life without those annoying problems such as pain and bleeding, but not everyone feels the same.

Some women feel tearful, depressed, and lethargic and need more time to recover emotionally.

It is important to let your family and friends know you may feel this way after your surgery so that they can support you.

If you are continually feeling down and depressed after your surgery seek help from your GP practice.

When can I start having sex intercourse again?

It is normal to have a low libido (sex drive) after your operation, but things will gradually return to normal.

You or your partner may be feeling anxious about sex being painful after your operation. Unless your doctor has advised otherwise, refrain from full penetration for about four weeks. This will allow time for everything to heal. Lubricants such as KY jelly may help. Stop if you experience any pain.

If you have any questions about this part of your recovery, we would encourage you to discuss it with the doctor before you leave hospital. If you do experience any problems when you resume sexual intercourse, you can discuss it with your GP.

Where can I find further support?

For further information and support, please visit the following websites:

www.patient.co.uk
www.nhs.uk
www.womenshealthlondon.org.uk
www.womens-health.co.uk
www.rcog.org.uk

What are the important points to remember?

- Talk to your partner and family about how you feel about the operation.
- Try to get some gentle exercise every day.
- Avoid heavy lifting for about three months unless advised by your consultant or nurse.
- Rest when you feel tired.
- Have a shower or bath every day.
- Drink plenty of water.
- See your GP if you have any heavy vaginal loss, signs of urine infection and any menopausal symptoms.
- Do not go back to work until you feel ready.
- Eat a healthy, well-balanced diet.

Tell us what you think of this leaflet

We hope that you found this leaflet helpful. If you would like to tell us what you think, please contact:
Miss Nicola M Dean, Consultant Obstetrician and Gynaecologist, Department of Obstetrics and Gynaecology, York Hospital, Wigginton Road, York, YO31 8HE, telephone 01904 721682.

Teaching, training and research

Our Trust is committed to teaching, training and research to support the development of health and healthcare in our community. Healthcare students may observe consultations for this purpose. You can opt out if you do not want students to observe. We may also ask you if you would like to be involved in our research.

Patient Advice and Liaison Service (PALS)

PALS offers impartial advice and assistance to patients, their relatives, friends and carers. We can listen to feedback (positive or negative), answer questions and help resolve any concerns about Trust services.

PALS can be contacted on 01904 726262, or email yhs-tr.patientexperienceteam@nhs.net.

An answer phone is available out of hours.

Leaflets in alternative languages or formats

If you would like this information in a different format, including braille or easy read, or translated into a different language, please speak to a member of staff in the ward or department providing your care.

Patient Information Leaflets can be accessed via the Trust's Patient Information Leaflet website: www.yorkhospitals.nhs.uk/your-visit/patient-information-leaflets/

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