Hysterectomy

Summary

- Hysterectomy is the surgical removal of the womb (uterus), with or without the cervix.
- Hysterectomy is used to treat a number of conditions, including heavy or painful periods, fibroids and prolapse.
- The operation may be performed through the abdomen or the vagina.
- Apart from cancer, many gynaecological conditions can often be successfully treated using other methods, so hysterectomy is recommended if other methods fail.

Hysterectomy is the surgical removal of the womb (uterus), with or without the cervix. The operation may also be with or without the removal of the ovaries and the fallopian tubes.

The uterus is a muscular organ of the female body, shaped like an upside-down pear. The lining of the uterus (the endometrium) thickens and, after ovulation, is ready to receive a fertilised ovum (egg).

If the ovum is unfertilised, the lining comes away as bleeding. This is known as menstruation (period). If the ovum is fertilised, the developing baby is nurtured inside the uterus throughout the nine months of pregnancy.

If a woman has a hysterectomy, she will no longer have menstrual periods or be able to have a child, and will not need to use contraception.

Reasons for a hysterectomy

Conditions that may be treated by hysterectomy include:

- **fibroids** – non-cancerous growths that form within the muscular walls of the uterus, outside the uterus or within the uterine cavity
- heavy or **irregular menstrual periods** – however, new techniques now used to treat this include endometrial ablation (which is surgical destruction of the uterus lining) or use of a levonorgestrel-releasing inter-uterine device (IUD)
- **severe period pain (dysmenorrhoea)** – due to adenomyosis or severe recurrent endometriosis
- cancer of the cervix, uterus, ovaries or fallopian tubes
- **endometriosis** – a condition in which cells similar to those in the lining of the uterus grow in other areas of the body, especially around the ovaries and peritoneum (lining inside the abdomen) in the pelvis
- adenomyosis – a condition where endometrial-like cells grow in the muscle of the uterus
- **prolapse** – the uterus falls into the vagina because of loose ligaments or damage to the pelvic floor muscles, usually from childbirth
- **pelvic inflammatory disease** (acute or chronic PID), caused by bacterial infection, often from sexually transmitted infections (STIs).

Hysterectomy for women of childbearing age

Once a woman has had a hysterectomy of any kind, she cannot become pregnant. If the ovaries of a premenopausal woman are removed, she has had a surgical menopause. This means she will have a drop in production of the sex hormones oestrogen, progesterone and testosterone. Vaginal dryness, hot flushes, sweating and other symptoms of natural menopause may occur.

Women who undergo bilateral oophorectomy (removal of both ovaries) usually take hormone replacement therapy (also called menopause hormone therapy) ,This is also known as oestrogen replacement therapy, as usually only oestrogens are required to maintain their hormone levels and prevent the long-term risks of premature menopause.

Other roles of the uterus and ovaries

The uterus has important functions other than childbearing, including:

- sexuality – the uterus rhythmically contracts during orgasm, contributing to sensations of pleasure
- self-image – the uterus is of great psychological importance to some women for many reasons, including fertility, femininity, sexuality and body image.

The ovaries play a major role in maintaining the female hormonal system. Their removal results in menopausal symptoms (within 24 hours, oestrogen levels fall by 50 per cent). Therefore, unless diseased, a woman's ovaries are not usually removed during hysterectomy

Treatments other than hysterectomy

Except if a woman has cancer, doctors recommend that hysterectomy should be a procedure of last resort, when all other treatment options have failed.

Some conditions that in the past have been treated with hysterectomy, now have alternative treatment options. These include:

- fibroids
- heavy or irregular menstrual periods
- uterine prolapse
- endometriosis.

Fibroids

Fibroids are non-cancerous growths that form within the muscular walls of the uterus. 50 to 70 per cent of women have fibroids. However, most fibroids are small, do not cause symptoms and do not require treatment. For those that do, **treatment choice** depends on the size, position, and symptoms caused by the fibroids.

Heavy menstrual bleeding

Heavy menstrual bleeding may be due to fibroids, adenomyosis, cancers, bleeding disorders, other medical conditions and also unknown causes.

Alternative treatment to a hysterectomy for heavy bleeding may include:

- hormone therapies – such as progestins (progesterone-like medications), levonorgestrel -releasing IUDs, etonogestrel-releasing implants and Depo Provera
- combined oral contraceptive pill
- surgery – endometrial ablation.

Since the introduction of the levonorgestrel-releasing IUD and endometrial ablation to treat heavy or irregular periods, hysterectomy rates have reduced.

Uterine prolapse

Alternative treatment to a hysterectomy for **uterine prolapse** depends on the degree of prolapse, but may include:

- pelvic floor exercises
- the insertion of a pessary into the vagina to prop up the uterus
- surgical repair without hysterectomy.

Endometriosis

For **endometriosis**, alternative treatment to a hysterectomy may include hormonal therapies, surgical removal of areas of endometriosis, or a combination of both.

Types of hysterectomy

There are five types of hysterectomy:

- total hysterectomy – where the uterus and cervix are removed
- subtotal (partial) hysterectomy – where the uterus is removed, but the cervix is left in place. While removal of the cervix is generally advised because it is a potential cancer site, some women feel that it serves a purpose during penetrative sex. If the cervix is kept, regular cervical screening is still necessary
- hysterectomy and bilateral salpingo-oophorectomy – where the uterus, fallopian tubes and ovaries are removed. This operation is performed if the woman has cancer of the ovaries or the uterus, or for chronic pain due to recurrent pelvic infection or recurrent endometriosis
- radical hysterectomy – the most extensive version of the operation. It involves the removal of the uterus, fallopian tubes, ovaries, upper part of the vagina, and associated pelvic ligaments and lymph nodes. This is performed if the woman has cancer of the cervix, ovaries, fallopian tubes or uterus
- hysterectomy with prophylactic bilateral salpingectomy –most doctors now recommend removing the fallopian tubes at the time of hysterectomy due to research suggesting that early 'ovarian' cancers originate in the tubes.

Before choosing a hysterectomy

If, after talking about all the options with your doctor, you choose to have a hysterectomy, your doctor should discuss several things with you before the operation. These include:

- your medical history – as some pre-existing conditions may influence decisions on surgery and anaesthetics
- the pros and cons of abdominal (open or laparoscopic) surgery versus vaginal surgery
- your support options after surgery
- your feelings about the surgery.

You will have a range of tests before your hysterectomy, including a complete blood-count test to check for problems such as anaemia (deficiency in red blood cells or haemoglobin).

Hysterectomy operation

The operation may be performed via an incision (cut) in your lower abdomen (abdominal hysterectomy), three to four small incisions in your abdomen (laparoscopic hysterectomy), or through your vagina (vaginal hysterectomy).

Abdominal hysterectomy

For an abdominal hysterectomy, the surgeon usually makes a horizontal cut along your pubic hairline (your pubic hair may have been shaved around the incision). For most women, this leaves a small scar. Some women may need a vertical midline incision in the lower abdomen, especially if the hysterectomy is for a large uterine fibroid.

An abdominal hysterectomy is generally recommended when a woman has very large fibroids or cancer.

Laparoscopic hysterectomy

For a laparoscopic hysterectomy, the surgeon inserts a telescope (laparoscope) to see your pelvic organs through a small incision in your navel, and makes another three or four small incisions through which other instruments are used. Carbon dioxide gas is used to distend (inflate) your abdomen, like a balloon, so all of your organs can be clearly seen.

The surgeon then removes the uterus, with or without fallopian tubes and ovaries, through the vagina. If the top of the vagina is sutured (stitched) through keyhole incisions, the operation is called a total laparoscopic hysterectomy. If the gynaecologist stitches the top of the vagina through the vagina, it is called a laparoscopically assisted vaginal hysterectomy.

This type of hysterectomy may be performed with the aid of a robot.

Vaginal hysterectomy

A vaginal hysterectomy is performed through an incision at the top of the vagina. It is usually performed where there is a uterine prolapse (the cervix and uterus come down into the vagina, or protrude out of the vaginal entrance).

After a hysterectomy

Immediately after a hysterectomy operation, you can expect to:

- wake up in the recovery room
- feel some soreness around the operation site – you will be given pain-relieving medication to enable you to maintain some mobility
- experience wind pain for a few days
- have the intravenous (IV) tube removed from your arm sometime during the first few days, depending on the procedure and your condition
- have the catheter (drainage tube) removed from your bladder within 24 hours of surgery, unless your bladder was traumatised during surgery, then it will remain in longer
- be encouraged to get out of bed and go for short walks around the hospital ward as soon as possible (for this reason, adequate pain relief is very important)
- stay in hospital for two to four days, depending on the type of surgery, sometimes longer.

With good pain relief, recovery may be similar for all forms of the hysterectomy. (Although, more care is required regarding the pelvic floor, urination and bowel function after vaginal hysterectomy.)

It is important to start pelvic floor and abdominal exercises within the first few weeks after surgery. These exercises strengthen the muscles in your pelvis, and help maintain normal bladder function and vaginal muscle tone. Your doctor or physiotherapist will let you know how soon you can start these particular exercises.

Hysterectomy – potential complications

The possible complications of a hysterectomy include:

- a reaction to the anaesthetic during the operation, which may be due to allergy
- nausea and vomiting – post-anaesthetic or medication induced – for the first one to three days
- infection
- internal haemorrhage (internal bleeding)
- build-up of blood beneath the stitches (haematoma) or in the abdomen
- internal scar tissue
- blood clots (for example, thrombosis, deep vein thrombosis or pulmonary embolism)
- difficulties with urination
- injury to the bowel, bladder or ureters (tubes that carry urine from the kidneys to the bladder) – rare
- fistula (abnormal hole between internal structures, such as the bowel and vagina) – rare
- vaginal vault prolapse (when the top of the vaginal wall sags or bulges down)
- decreased sexual desire (or you may have an increase in sexual desire due to the treatment of your symptoms)
- constant pelvic pain – rare, and post-operatively usually shows improvement
- feelings of grief and loss – if not counselled appropriately before the hysterectomy.

Self-care after hysterectomy

Be guided by your doctor, but general suggestions for the four to six-week post-operative period include:

- rest – try to rest as much as possible for at least two weeks. You should avoid driving during this time. Always rest lying down
- exercise – continue with the exercises you were shown in hospital. You should aim to go for a walk each day, unless advised otherwise by your doctor
- standing – avoid standing for more than a few minutes at a time in the early post-operative period. You can increase standing time as your recovery progresses
- lifting – avoid heavy lifting and stretching
- constipation – to avoid constipation, drink plenty of fluids and eat fresh fruits and vegetables. You may be advised to take stool softeners for the first few days
- medication – if you have been prescribed antibiotics, make sure you take the full course, even if you feel well

- sex – it is advised that you avoid vaginal sex until after the post-operative check (about four to six weeks after the operation) to make sure the vagina is fully healed. If vaginal dryness is a problem, it may be helpful to use a lubricant, or sweet almond oil or olive oil.

Long-term outlook after hysterectomy

After hysterectomy, you will no longer need contraception or have menstrual periods. If your ovaries were removed, you may experience menopause symptoms starting within a few days of your surgery.

If you were still having periods before your hysterectomy, your doctor should discuss oestrogen replacement therapy or other options with you. How long you might need oestrogen replacement therapy will depend on your age.

Hysterectomy can be an effective treatment for gynaecological conditions such as fibroids, endometriosis and adenomyosis, though sometimes endometriosis may recur.

If you have had a hysterectomy to treat cancer, depending on the stage of the cancer you will need to have regular check-ups to make sure you are cancer free. You may need to have a regular vault smear test – similar to a cervical screening test but involving cells from the top of your vagina instead of the cervix.

If you have had a subtotal hysterectomy (uterus removed but cervix retained) then you will need to continue having cervical screening.

Where to get help

- Your GP
- Gynaecologist
- Local women's health centre
- Community health centre
- Family planning clinic

This page has been produced in consultation with and approved by:

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