Pan-Birmingham NHS
Cancer Network

Hysterectomy

Your operation explained

Patient Information

Introduction

This booklet is designed to give you information about having a hysterectomy and the care you will receive before, during and after your operation. We hope it will answer some of the questions that you, or those who care for you, may have at this time. It is not meant to replace the discussion between you and your surgeon but helps you to understand more about what is discussed.

If you have recently been told that you need a hysterectomy, it is normal to feel a wide range of emotions. For some women it can be a frightening and unsettling time. If you have any questions regarding the information or any aspect of your treatment there are doctors, specialist nurses and nursing staff to listen and answer any of your questions. Some useful contact numbers and support agencies are listed at the back of the booklet.

What is a hysterectomy?

A hysterectomy is an operation to remove the uterus (womb), usually with the cervix (neck of womb). Sometimes both the ovaries and fallopian tubes are removed at the same time (bilateral salpingo-oophrectomy).

Why do I need a hysterectomy?

The common reasons for having a hysterectomy are:

Benign conditions

These include heavy, sometimes painful menstruation (periods) caused by hormonal imbalance, uterine fibroids (benign growths in the womb), endometriosis and vaginal prolapse, where weakened ligaments and muscles cause the womb to drop.

Atypical endometrial hyperplasia

This is a condition where there are changes in the cells lining the womb (endometrium). This can indicate an increased chance of developing cancer or can have areas of cancer around it. When atypical endometrial hyperplasia is diagnosed following endometrial biopsy, a hysterectomy is usually recommended as the treatment.

Cancer

A hysterectomy can be performed as a treatment for cervical or endometrial cancer. A biopsy will have been taken which showed that

cervical or endometrial cancer was present. (Surgery for cancer of the ovary, peritoneum or fallopian tube is discussed in a separate booklet on Ovarian Debulking Surgery).

When a diagnosis of cancer is suspected
You are likely to have had a scan which showed a growth in the womb. In order to find out for certain whether the growth is benign (not cancer) or malignant (cancer) we need to perform the operation. The tissue removed will then be carefully examined under a microscope.

How is a hysterectomy performed?

Abdominal hysterectomy
This is performed through a surgical incision using either a vertical (up and down the abdomen) or a horizontal (across the bikini line) cut (see diagram below). Your surgeon will discuss the options available and the reasons why a particular incision has been chosen. The surgeon may need to examine you under anaesthetic to decide which type of cut you need.

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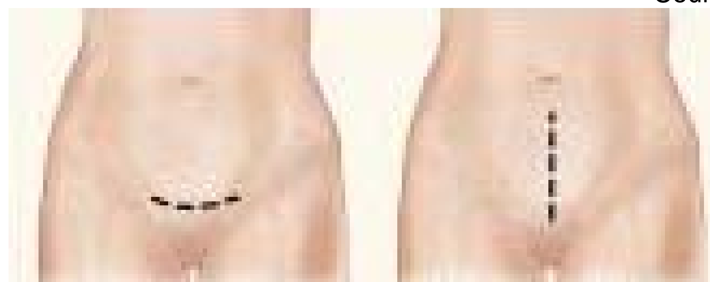


Horizontal cut Vertical cut

Vaginal hysterectomy
This means the entire operation is carried out through the vagina and there is no external scar.

Laparoscopic hysterectomy
Where the operation is performed through key-hole surgery. The operation is performed through four or five small cut on your abdomen (tummy). At the end of the operation the uterus is removed through the vagina.

What types of hysterectomy are there?

(see diagrams on the next page)

Subtotal hysterectomy

The body of the uterus is removed leaving the cervix in place. Some women cannot have this operation, as there is still a risk of cervical cancer. Your surgeon will discuss if this option is available for you. If you have this operation it is important to continue to have cervical smears afterwards.

Total hysterectomy

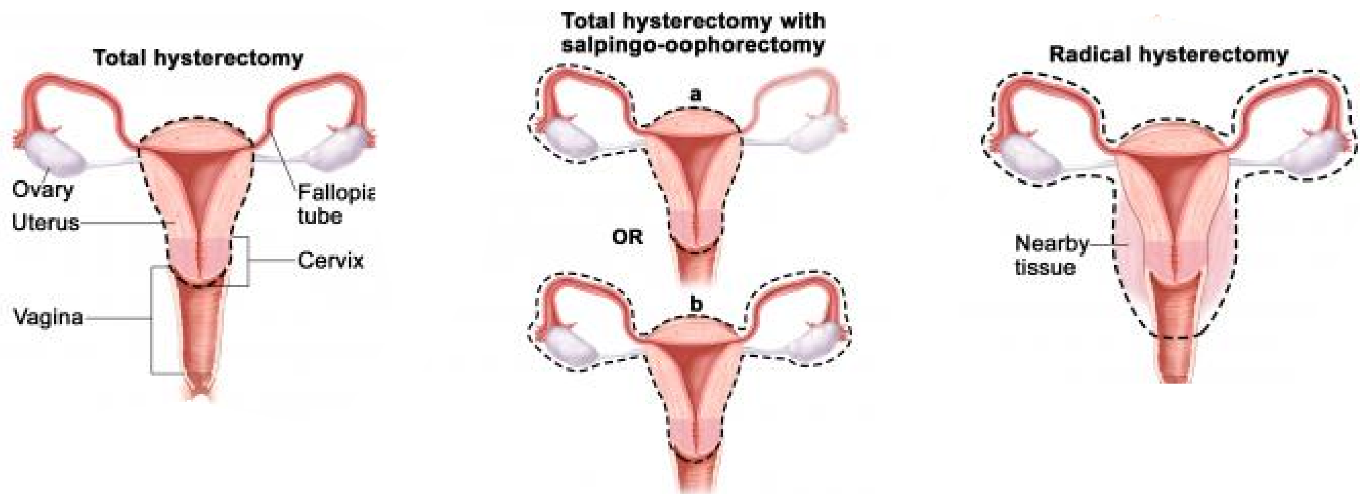
Both the uterus and cervix are removed. Advice relating to smear tests is available from your doctor or clinical nurse specialist (CNS) and in the final section of this leaflet.

Total hysterectomy and bilateral or unilateral salpingo-oophorectomy

The uterus, cervix, fallopian tube(s) and ovary(ies) are removed. Removal of both ovaries will bring on a sudden menopause, due to the loss of the ovarian hormones. The menopause and its symptoms will be discussed later in the booklet.

Radical or Wertheim's hysterectomy

The uterus, cervix, part of the vagina fallopian tubes and ovaries, parametrium (the broad ligament below the fallopian tubes) and lymph glands and fatty tissue in the pelvis are removed. This type of hysterectomy is also called a radical hysterectomy (see 'Radical Hysterectomy' leaflet, if you are having this type of hysterectomy).



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Are there any alternatives to this operation?
Yes, but they vary from patient to patient. The surgeon will discuss the options available to you.

Are there any risks associated with a hysterectomy?
There are risks, as with any medical procedure, but it is important to realise that most women do not have complications, and no one will develop all complications. Every care will be taken to minimise the risks.

As with any operation, there is a risk associated with having a general anaesthetic. Also, with any abdominal surgery, there is a risk of infection in the wound, pelvis, bladder or chest. This is easily treated with antibiotics. Occasionally, an abscess may form which may require surgical drainage under anaesthetic. A blood transfusion may be needed to replace blood lost during surgery. Occasionally, if blood collects in the pelvis it may need to be drained surgically under anaesthetic.

Patients occasionally suffer from blood clots in the leg or pelvis (deep vein thrombosis or DVT). This can lead to a clot in the lungs (pulmonary embolism or PE). Moving around is encouraged after your operation, it will help preventing this. We will give you special surgical stockings (known as TEDS) to wear in hospital and a small daily injection to thin the blood.

After the operation the bladder and bowels may take a few days to start

working properly. The bladder and the ureter (tubes connecting the bladder to your kidneys) lie very close to the womb and can be damaged during a hysterectomy. This is rare, but if it occurs may require further surgery. This is more common when you have previous surgery, adhesions of the bladder and if the disease is found to be close to the area of the bladder and ureter.

Most people will not experience any serious complications from their surgery. However, risks do increase with age and for those who already have heart, chest or other medical conditions, such as diabetes or if you are overweight or smoke. Occasionally, patients die from major surgery. Your surgeon will discuss these risks with you.

What else might happen as a result of the surgery?
When cancer is present the surgery can involve working close to or including the bowel. If an injury during surgery affects the bowel or an area of bowel affected by cancer must be removed, it may be possible to join the unaffected parts of the bowel together. This is called 'anastamosis'.

If this is not possible the bowel will be diverted to open on the surface of the tummy. This is known as a 'colostomy' or 'stoma' and allows the faeces (stools) to be collected in a bag attached to your tummy which can be removed and emptied.

If this procedure is a likely possibility it will be explained to you in more detail by the doctors and nurses before the operation. Most patients do not need this type of surgery.

What about losing my fertility?
At any age having to have your womb and/or ovaries removed can affect the way you feel about yourself. A hysterectomy will prevent you from having children in future. The loss of fertility can have a huge impact if you have not started or completed your family and you have an operation that takes that choice away. You may want to make sure you have explored all your options. It is important to have the opportunity to discuss this and how you feel about it with your CNS before your operation, who will continue to offer you support during your recovery. Advice is also available from our specialist fertility team (there is also a leaflet available called 'Information for Women Referred for Fertility

Preservation).

Will my ovaries continue to produce eggs?
Yes, if you have your ovaries after your operation. As you have had a hysterectomy, you will not menstruate (have periods) each month and so your body will absorb the eggs harmlessly.

Will I need hormone replacement therapy (HRT)?
If you have had a hysterectomy and your ovaries have been removed and you have not already been through the menopause you may start having menopausal symptoms. These can include hot flushes, dry skin, and dryness of the vagina, feeling low and anxious and being less interested in sex for a time. Many of these symptoms can be eased by hormone replacement therapy (HRT). HRT is available in many forms – as implants, patches, tablets, gels, sprays and vaginal creams. There are also alternative ways of managing the potential symptoms. Please discuss the options available to you with your CNS for further information or advice.

Is there anything I should do to prepare for the operation?
Yes, make sure that all your questions have been answered to your satisfaction and that you fully understand what is going to happen to you. You are more than welcome to visit the staff before you are admitted to hospital. Just ask your CNS to arrange this for you.

If you smoke, it would benefit you greatly to stop smoking or cut down before you have your operation. This will reduce the risk of chest troubles as smoking makes your lungs sensitive to the anaesthetic.

You should also eat a well balanced diet and if you feel well enough, take some gentle exercise before your operation, as this will also help your recovery afterwards. Your GP, the practice nurse at his/her surgery or the doctors and nurses at the hospital will be able to give you further advice about this.

Before you come into hospital for your operation, try to organise things for when you get home. If you have a freezer, stock it with easy to prepare food. Arrange for relatives and friends to do your heavy work (such as changing your bed sheets, vacuuming and gardening) and to look after your children if necessary. You may wish to discuss this further

with your CNS.

If you have any concerns about your finances whilst you are recovering from your operation, you may wish to discuss this with your CNS. You can do this either before you come into hospital or whilst you are recovering on the ward.

What tests will I need before my operation?
You will be asked to attend the pre-admission clinic about one or two weeks before your operation. Tests will be arranged to ensure you are physically fit for surgery. Recordings of your heart (ECG) may be taken as well as a chest X-ray. A blood sample will also be taken to check that you do not have anaemia. The nurses on the ward will then take some details and ask some questions about your general health.

Your temperature, pulse, blood pressure, respiration, weight and urine are measured to give the nurses and doctors a base line (normal reading) from which to work.

The nurses will explain to you about the post-operative care following your operation. You will have the opportunity to ask any questions that you or your family may have. It may help to write them down before you come to the clinic.

When will I come in for my operation?
You will be admitted the day before, or the day of your operation. You will be asked to ring the ward the morning of your admission. The ward clerk or the nurse will give you a time to come into the ward. On your arrival the ward clerk or one of the nurses will greet you and show you to your bed.

You will meet the ward nurses and doctors involved in your care. If you have not signed a consent form in the clinic, you will be asked to sign a consent form on admission to confirm that you understand and agree to the operation. The anaesthetist will visit you to discuss the anaesthetic and to decide whether you will have a ‘pre-med’ (tablet to relax you) before you go to the operating theatre.

You will not be allowed to have anything to eat or drink (‘nil by mouth’), including chewing gum or sweets, for at least six hours before your

operation. If you are on any medication, you may need to take your tablets in the morning with a little water. The nurses on the ward will tell you which medication you need to take.

What will happen the day of the operation?
Before going to the operating theatre, you will be asked to take a bath or shower and change into a theatre gown. All make-up, nail varnish, jewellery (except wedding rings which can be taped over), contact lenses, wigs and scarves must be removed.

What will happen after the operation?
One of the nurses will collect you from recovery (where you wake up after your surgery) and escort you back to the ward.

When you return from theatre please tell us if you are in pain or feel sick. We have tablets/injections that we can give you to relieve these symptoms as and when required. Above all, we want you to remain comfortable and pain free. You may have a device that you use to control your pain yourself. This is known as a PCA (patient controlled analgesia) and how to use it will be explained to you. Alternatively, an epidural may be inserted in your back for pain relief. The anaesthetist will discuss the choice between a PCA and epidural with you before surgery.

You may still be very sleepy and be given oxygen through a clear mask to help you breathe comfortably immediately after your operation. To allow your abdomen (tummy) to recover from surgery, and while you are nil by mouth, a drip will be attached to your arm or hand to give you fluids and prevent dehydration. This will remain in for a couple of days.

You may have a drain in your abdomen so that any blood or fluid that collects in the area can drain away safely and will help prevent swelling. The tube will be removed when it is no longer draining any fluid, which can take a few days.

Your wound will be covered with a dressing. This will be removed two days after your operation and the wound left exposed. You will be asked to take a shower to help keep your wound clean. Avoid highly scented soaps and do not rub the wound area. When drying pat the area dry and avoid rubbing the wound. Your wound will be looked at daily to ensure it is healing. The stitches or clips will be removed around 7 to 10 days

following surgery. A district nurse will be booked to do this at your home.

A catheter (tube) will be inserted into your bladder in theatre to drain urine away. As the bladder is positioned close to the cervix, uterus and vagina, where the surgery has taken place, the catheter will allow the area to recover and heal. The catheter will need to stay in for approximately one to two days. When the catheter is removed, the nurses will monitor how much urine you are passing to ensure you are emptying your bladder properly.

You may also have trouble opening your bowels as it takes a few days before they start to work properly. You may have discomfort due to the build up of wind for the first few weeks following surgery. This is temporary and we can give laxatives if needed and hot peppermint water to help relieve wind pain.

You may have some vaginal bleeding for the first few days following surgery. The bleeding normally turns to a red/brownish discharge before disappearing after a few days to a few weeks.

When can I go home?
You will be in hospital between 3 to 7 days, depending on the type of operation you have had, your individual recovery, how you feel physically and emotionally and the support available at home. This will be discussed with you before you have your operation and again whilst you are recovering.

When can I get back to normal?
It is usual to continue to feel tired when you go home. It can take up to six weeks to fully recover from this operation. However, your energy levels and what you feel able to do will usually increase with time. For the first 6 weeks avoid lifting or carrying anything heavy (including children and shopping).

When can I return to work?
If you work then this will depend on the type of work that you do, how well you are recovering and how you feel physically and emotionally. Any job requiring heavy lifting may take a bit longer to return to, but you are the best judge as to how you feel.

Most women need approximately 4-6 weeks away from work to recover fully before returning to work or their usual routine. However, this will depend upon your recovery, and you can discuss it further with your doctor, specialist nurse or GP.

When can I start driving again?
We advise you not to drive for at least 4 weeks after your operation or until you have had your check up at the hospital. You can normally resume driving when you can stamp your feet hard on the ground without causing any pain or discomfort, as this movement is required in an emergency stop. It is advisable to check the details of your car insurance policy, as some contain clauses about driving following an operation.

What about exercise?
It is important to continue to do the exercises that you are advised to do in hospital for at least 6 weeks after your operation. Ideally you should carry on doing them for the rest of your life, particularly the pelvic floor exercises. Avoid all aerobic exercise, jogging and swimming until advised. The physiotherapist or your clinical nurse specialist (CNS) will be happy to give advice on your individual needs.

When can I have sex?
You may resume sexual activity when you feel fit and able to do so, but it is advisable to give your stitches time to heal (usually about 6 weeks). Many women find it reassuring to know that following a hysterectomy there should be little change to their sexual response as the vagina is essentially unaltered. If an orgasm is a normal experience for you during sexual activity then this should continue.

During this time, it may feel important for you and your partner to maintain intimacy, despite refraining from sexual intercourse. However, some couples are both physically and emotionally ready to resume having sex much sooner and this can feel like a positive step. If you have any individual worries or concerns, please discuss them with your CNS.

It can be a worrying time for your partner. He or she should be encouraged to be involved in discussions about the operation and how it is likely to affect your relationship afterwards.
If you do not have a partner at the moment, you may have concerns

either now or in the future about starting a relationship after having a hysterectomy.

Please do not hesitate to contact your CNS if you have any queries or concerns about your sexuality, change in body image or your sexual relationship either before or after surgery.

Will I need to visit the hospital again after my operation?
Yes, it is very important that you attend any further appointments arranged either at City Hospital or back at the hospital, which referred you for treatment. If the histology (tissue analysis) is not available before you are discharged home, an early appointment for the outpatients clinic will be made to discuss the results and your treatment plan, if further treatment is necessary. You will have a six week appointment following your operation to assess your progress, follow up after this will be determined by the results of your surgery.

Do I need to have cervical smears?
You only need to attend for regular smear tests if you have had a sub-total hysterectomy. Before you are discharged the doctor or nurse specialist will let you know if this applies to you.

It is important that you make a list of all medicines you are taking and bring it with you to all your follow-up clinic appointments. If you have any questions at all, please ask your surgeon, oncologist or nurse. It may help to write down questions as you think of them so that you have them ready. It may also help to bring someone with you when you attend your outpatients appointments.

Glossary of medical terms used in this information:

Anaemia: a condition in which the blood is lacking in red blood cells.

Catheter: a flexible tube used to drain fluid from the bladder.

Cervix: the narrow outer end of the uterus or womb.

Chemotherapy: the treatment of cancer with drugs.

ECG: also known as an electrocardiogram, is a test which measures the electrical activity of the heart.

Epidural: a pain reliving injection into the spinal column.

Fallopian tubes: one of a pair of long, slender tubes that transport eggs released from the ovary to the womb.

Histology: the study of cells and tissues on a microscopic level.

Lymph nodes: hundreds of small oval bodies that contain lymph. These act as a first line of defence against infections.

Ovary: one of two small oval bodies in which eggs and hormones are developed.

Physiotherapist: a therapist who treats injury or dysfunction with exercises and other physical treatments of the disorder.

Radiotherapy: X-ray treatment that uses high energy rays to damage or kill cancer cells.

Uterus: a hollow muscular organ in the female pelvis, in which a fertilised egg develops into an embryo.

Local sources of further information

You can visit any of the health/cancer information centres listed below:

Birmingham Women's NHS Foundation Trust
Health Information Centre
Birmingham Women's Healthcare NHS FoundationTrust
Metchley Park Road
Edgbaston
Birmingham B15 2TG
Telephone: 0121 627 2608

Heart of England NHS Foundation Trust
Health Information Centre
Birmingham Heartlands Hospital
Bordesley Green
Birmingham B9 5SS

Telephone: 0121 424 2280

Cancer Information and Support Centre
Good Hope Hospital
Rectory Road
Sutton Coldfield B75 7RR
Telephone: 0121 424 9486

Sandwell and West Birmingham Hospitals NHS Trust
The Courtyard Centre
Sandwell General Hospital (Main Reception)
Lyndon
West Bromwich B71 4HJ
Telephone: 0121 507 3792
Fax: 0121 507 3816

University Hospital Birmingham NHS Foundation Trust
The Patrick Room
Cancer Centre
Queen Elizabeth Hospital
Edgbaston
Birmingham B15 2TH
Telephone: 0121 697 8417

Walsall Primary Care Trust
Cancer Information & Support Services
Challenge Building
Hatherton Street
Walsall WS1 1YB
Freephone: 0800 783 9050

About this information
This guide is provided for general information only and is not a substitute for professional medical advice. Every effort is taken to ensure that this information is accurate and consistent with current knowledge and practice at the time of publication.

We are constantly striving to improve the quality of our information. If you have a suggestion about how this information can be improved, please contact us via our website: http://www.birminghamcancer.nhs.uk.

This information was produced by Pan Birmingham Cancer Network and was written by Consultant Surgeons, Clinical Nurse Specialists, Allied Health Professionals, Patients and Carers from the following Trusts:

Birmingham Women's Hospital Foundation Trust
Heart of England NHS Foundation Trust
Sandwell and West Birmingham NHS Trust
University Hospital Birmingham Foundation Trust
Walsall Hospital NHS Trust

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