Hysterectomy

A **hysterectomy** is an operation to remove the uterus (womb). If you have not yet been through menopause, it will mean you will no longer have menstrual periods and can no longer become pregnant.

Why might I need a hysterectomy?

A hysterectomy is major surgery and should only be undertaken after a thorough assessment of your symptoms and individual circumstances. Reasons for considering a hysterectomy may include:

- Heavy menstrual bleeding.
- Prolapse of the uterus (where the uterus drops down towards or past the opening of the vagina).
- Cancer or an increased risk of developing cancer of the uterus, ovaries or cervix.
- Chronic pelvic pain where it is felt that the uterus may be contributing to the pain.

Your gynaecology doctor(s) should discuss all available options for treating your symptoms with you, including the benefits and risks of each option.

Types of hysterectomy

There are different types of hysterectomy:

- Most commonly, the cervix (the lower, narrow end of the uterus that connects the uterus to the vagina) is removed with the uterus. This is known as a total hysterectomy.
- Less commonly, the cervix may be left in when the uterus is removed. This is known as a subtotal hysterectomy.
- Removal of the ovaries (known as an oophorectomy) is not routinely performed at the time of a hysterectomy. It is important to discuss the benefits and risks of removing the ovaries, relevant to your specific circumstances, with your gynaecology doctor(s).
- Removal of the fallopian tubes (known as a salpingectomy) may be performed at the time of a hysterectomy. It is important to discuss the benefits and risks of removing the fallopian tubes, relevant to your specific circumstances, with your gynaecology doctor(s).

It is important that you understand whether your cervix, ovaries and/ or fallopian tubes will be removed at the time of a hysterectomy and the reasons why.

How is a hysterectomy performed?

How a hysterectomy is performed depends on a number of factors, including the size of the uterus, whether there is any scarring in the pelvis or cervix (e.g. from previous surgery), whether the uterus can be manoeuvred (e.g. down the vagina) for the operation, and the doctor's recommendation based on their skills and experience. Your doctor(s) will discuss these options with you and may need to do a vaginal examination to decide how the hysterectomy is performed.

How the hysterectomy is performed will determine how you are positioned for the operation (see positioning for a hysterectomy below). A urinary catheter (a flexible tube) is usually placed in the bladder via the urethra. Your doctor(s) may also want to perform a cystoscopy at the end of the procedure, where a thin telescope is inserted into the bladder to inspect for any possible injuries.

Vaginal hysterectomy

The uterus and cervix are removed by operating through the vagina. The only wound is at the top of the vagina. Recovery may be quicker as there are no abdominal wounds. A vaginal hysterectomy will always be a total hysterectomy.

Abdominal hysterectomy

An incision (cut) is made in the abdominal wall. Most commonly, this incision is made across the lower part of the abdomen (as for a caesarean section cut) but sometimes the incision needs to be made in an up-and-down direction. The reasons for choosing a particular incision type may include a very large uterus, or for better access to the pelvic organs and other structures, such as for surgery for a gynaecological cancer. An abdominal hysterectomy may be a total hysterectomy or subtotal hysterectomy.

Laparoscopic hysterectomy

"Keyholes" or small incisions (cuts) are made in the abdominal wall to allow the passage of a telescope (camera) and other instruments to perform the hysterectomy. The procedure may be performed by keyhole (total laparoscopic hysterectomy) or performed by keyhole for part of the hysterectomy and via the vagina for the remainder (laparoscopic assisted vaginal hysterectomy).

Either way, the uterus will be removed through the vagina and there will be a wound at the top of the vagina and small abdominal wounds. A laparoscopic hysterectomy may be a total hysterectomy or subtotal hysterectomy. Some doctors may perform the hysterectomy using robotic instruments. This also involves small keyhole incisions on the abdomen.

vNOTES (or vaginal natural orifice t ransluminal e ndoscopic s urgery) i s a n emerging approach to gynaecological surgery, including hysterectomy, which involves laparoscopic surgery performed through an incision in the vagina to avoid abdominal skin incisions.

Anaesthetic

A hysterectomy is performed under general anaesthetic, which means you will be asleep throughout the procedure and will not feel anything. An anaesthetist (the doctor who is responsible for your anaesthetic) or staff from your hospital's pre-admission clinic may wish to speak with you or examine you before the procedure. Every patient is different, and the anaesthetist will tailor the plan for your anaesthetic as required, to suit your needs. The Royal Australian and New Zealand College of Anaesthetists provides information through its website about the types of anaesthesia, how to prepare for an anaesthetic and what to expect afterwards (see useful resources below).

Positioning for a hysterectomy

How you are positioned for a hysterectomy will depend on how the hysterectomy is performed (see above). Often a patient is placed in the lithotomy position, which means you are lying on your back with your legs bent up and supported in stirrups. This allows the doctor(s) to access the vagina and cervix, to place instruments through the vagina and into the uterus so the uterus can be moved or positioned during the operation, or to perform a cystoscopy. You will usually be positioned for your surgery once you are under anaesthesia. Positioning is performed carefully to limit the risk of nerve problems in the arms or legs.

What are the potential benefits of a hysterectomy?

The outcomes of a hysterectomy can depend on the reason for surgery and individual circumstances. Following a hysterectomy, you may:

- No longer have heavy menstrual bleeding, and may be able to stop medicines, including hormones, to treat heavy periods (thus avoiding potential medication adverse effects, and associated financial costs).
- Avoid future endometrial cancer.
- Be able to stop using pessaries, or avoid the need for other treatments, for prolapse and incontinence.
- Have an improvement or resolution of period pain or pelvic pain.

What are the potential risks of a hysterectomy?

A hysterectomy is a common and generally safe procedure. However, all operations have potential risks. The severity and likelihood of these risks vary depending on individual factors. It is important to discuss these risks and how they apply to you.

Potential complications that may occur with hysterectomy include:

- Bleeding- Most surgical procedures result in a small amount of bleeding. In some cases, bleeding can be heavier than expected. If heavier bleeding occurs, it is most commonly during the operation and may mean the surgery takes longer or a different surgical approach is needed. Sometimes bleeding can occur after the surgery is completed. This usually resolves without treatment, but it can slow your recovery and, in some cases, may require drainage. In rare cases, a transfusion with blood (or blood products) may be necessary.
- Blood clots in your legs or lungs- Thrombosis is the formation of a clot in a blood vessel, usually in the legs. In rare circumstances, part of the clot can break off and travel to the lungs. This can be life threatening. The risk is increased by factors such as the duration of the surgery, or if you are overweight or smoke. The risk can be minimised by using compression stockings, injections of a blood-thinning medicine after surgery, and early movement after surgery (e.g. standing up and walking).
- Infection- The most common infection with hysterectomy is a bladder infection, usually associated with the use of a urinary catheter. You can also develop a wound infection, either in the abdominal incision(s), or the wound at the top of the vagina. Antibiotics are usually given during the operation to help reduce the risk of infection.
- Injury to surrounding organs- The uterus and ovaries lie close to a number of important structures within the pelvis, including the bladder, ureters, bowel and several important blood vessels. Whenever surgery is performed on the organs of the pelvis, there is a small possibility of damage to these organs. This risk depends on the complexity of the operation, and whether scarring is present.

Complications from blood clots, infection, bleeding and injury to surrounding organs may mean additional medications (e.g. antibiotics) or investigations, a longer hospital stay, unplanned return to surgery or a longer recovery time than expected. There may be longer term consequences of serious complications.

Other uncommon risks

Short-term

- Nerve injury- Nerves in the skin or in the abdomen and pelvis can be injured during surgery resulting in pain, altered sensation, and rarely, problems with bladder and bowel sensation.
- Risks of anaesthesia- This often depends on your general health prior to surgery. The anaesthetist(s) will speak with you, or examine you, before the procedure. The consultation with your anaesthetist(s) prior to surgery is a good time for you to ask any questions.
- If the hysterectomy is performed laparoscopically, there is a very small possibility of carbon dioxide gas becoming trapped in the skin or body wall, or very rarely a blood vessel.
- Fistula- Rarely an abnormal connection can develop between the vagina and a pelvic organ, most commonly the bladder. If a fistula develops, further surgery to resolve it would be required.

Longer-term

- Continuing pain and persistent use of opiate/ opioid (strong pain relief) medicines.
- Hernia- Abdominal incisions may weaken, allowing the organs of the abdomen to bulge through. While this occurs rarely, risk may be increased with larger skin incisions.
- Hysterectomy is associated with an increased risk of developing a vaginal prolapse (this is where the vaginal walls or top of the vagina can come down and form a vaginal bulge). To help minimise this risk, it is important to address risk factors for prolapse before and after surgery (e.g. constipation, excess weight) and to perform regular pelvic floor muscle exercises (see useful resources for more information).
- Some research suggests that a hysterectomy is associated with risk of diabetes, depression and urinary incontinence. While this type of research is useful for examining associations, it does not necessarily indicate that hysterectomy has directly caused the problem.
- If you are younger, especially under 35 years old, there are important long term health risks that should be considered. Having a hysterectomy may bring on earlier menopause by up to a few years, even if your ovaries are left in. Having your ovaries removed at the time of hysterectomy may be associated with an increased risk of heart disease and stroke in the long term. There is the risk of regret if you change your mind about having children or having more children. A hysterectomy is permanent and irreversible, so you need to be sure of the decision.

Recovery after a hysterectomy

For healthy women who have a hysterectomy that goes well, recovery is often complete within two to six weeks. Your recovery will depend on several things:

- Your health and fitness before the operation.
- The type of hysterectomy you have - when an incision is made on the abdomen, recovery often takes a couple of weeks more.
- If the operation is more complex or has any complications, recovery may be slower.

Pain relief

After a hysterectomy you can expect pain and discomfort for a few days, but this can usually be managed well with medications. It is important to have a discussion with your doctor(s) before and after your surgery, about the most appropriate types and expected amounts of pain medicines you may need as you progress through your recovery. Appropriate, regular pain relief is important to your recovery and will enable you to get out of bed sooner and walk around. This will help speed up your recovery and reduce the risks of thrombosis.

Urinary catheter

This is removed either at the end of the procedure or in the couple of days following surgery. If you have difficulty passing urine, or if there were complications during surgery, the catheter may need to stay in longer.

Care of your wound

If you have had an abdominal or laparoscopic hysterectomy, you will have an incision(s) on your abdomen, which will be closed by stitches, staples or glue. Some stitches and glue dissolve by themselves. Staples, and some types of stitches, will need to be removed. This usually occurs either prior to discharge from hospital or will be organised by your doctor(s)/ team to be removed five to seven days after your operation. Your incision(s) will be covered by a dressing which may be removed before you leave hospital. If this has not occurred before leaving hospital, ensure your nurse(s) or doctor(s) talk to you about how to care for the dressing at home.

Keep your wound clean and dry. Wear loose clothing and look for signs of infection (such as redness, pain, swelling of the wound or bad smelling discharge). Report these to your doctor(s) or nurse. If you have had a vaginal hysterectomy, any stitches within your vagina will be dissolvable and will not need to be removed. You may notice stitches coming away after a few weeks. This is normal and nothing to worry about.

Vaginal Bleeding

It is normal to experience some vaginal bleeding for one to two weeks after your operation, similar to a light period. Some women have no initial bleeding at all but will then experience a gush of old blood or fluid after a week. This will usually stop quickly. Avoid the use of tampons and menstrual cups to reduce the chance of infection. Any heavy bleeding should be reported to your doctor(s).

Activity

It is important to move around after a hysterectomy, and to have adequate rest if tired. Walking or moving every day and trying to increase the amount of exercise you do will be beneficial to your recovery. It is also important to avoid dehydration, so drinking enough fluid is advisable. To avoid the complication of a hernia or recurrence of a prolapse, you should not do any heavy lifting or straining for four to six weeks after surgery.

Depending on the type of hysterectomy, and the type of work you do, after surgery you may be recommended to take between two and six weeks away from work and may need to arrange for help with caregiving responsibilities during this time. This can be discussed with your doctor(s)/ team. It is recommended to avoid vaginal sex for six to twelve weeks after a hysterectomy to allow adequate healing of the wound at the top of the vagina.

Frequently asked questions

Will having a hysterectomy send me into menopause?

Menopause happens when a woman no longer releases eggs from her ovaries. Unless both ovaries are removed as part of the hysterectomy, menopause will not happen immediately as a result of the procedure. However, having a hysterectomy can bring menopause on a little earlier, sometimes by a few years, even if your ovaries were not removed. If you have not yet been through menopause and have your ovaries removed at the time of hysterectomy you will develop menopausal symptoms and may need to take hormonal medication following a discussion with your doctor(s).

Will having a hysterectomy have an effect on my enjoyment of sex?

Many women will have increased enjoyment of sex if hysterectomy improves problems such as heavy or painful periods, or discomfort from prolapse. Some women will find there is no change after hysterectomy. Occasionally, there may be decreased enjoyment of sex.

Do I still need to have cervical screening tests after my hysterectomy?

If your cervix is removed and is normal, then you will not usually need to have any further cervical screening tests. If you have a subtotal hysterectomy (where the cervix is not removed), or if your cervical screening test was abnormal just prior to the hysterectomy, then you should continue to have cervical screening tests as guided by the national screening program. Please check with your gynaecology doctor(s) as to the recommendations for your own care.

Preparing for surgery checklist

If you and your gynaecology doctor(s)/ team think a hysterectomy is likely to benefit you, the process may involve:

- You doctor(s) gaining your informed consent to have the procedure performed.
- Carrying out/ attending any tests in preparation for the surgery (e.g. blood tests and radiology/ imaging tests), if required.
- A discussion with your doctor(s) about your pre-surgery health, including any medications you take (including herbal or vitamin supplements), or whether you smoke or vape.
- Making the necessary arrangements for your surgery with the hospital or day procedure unit. Ensure you have discussed any pre-surgery requirements (e.g. fasting, medicines, etc.).
- Planning for your recovery. Ensure you have discussed with your doctor(s) what your recovery may look like, including if you will be recommended to take leave from work, arrange for help with caregiving responsibilities, or avoid certain activities.

Useful resources

ANZCA | Patient information (Anaesthetic information)
https://www.anzca.edu.au/patient-information

Pelvic Organ Prolapse (RANZCOG Patient Information)
https://ranzcog.edu.au/wp-content/uploads/Pelvic-Organ-Prolapse.pdf

Informed consent

If you are undergoing any kind of healthcare treatment, procedure, or other intervention, you have the right to make an informed choice about your care. Informed consent is your permission, given voluntarily, to proceed with treatment.

It is your doctor's responsibility to ensure informed consent is properly obtained, meaning:

- You have had the opportunity to discuss all management options with your doctor(s)/ team.
- You have had the opportunity to review written information.
- You have understood what is involved with the treatment/ procedure, in advance of it.
- You have had the opportunity to see your doctor(s)/ team more than once or been given the option and time to consult another doctor, if you require another opinion.

When preparing for any kind of healthcare treatment, procedure, or other intervention, it is important that you discuss all details about your care. Questions you can ask may include:

- Specific cultural or personal considerations that are important to you, so that these can be included in your care where possible.
- Reasons for your doctor recommending a particular treatment/ procedure and alternative options.
- What you can expect on the day of a treatment/ procedure, including who will be involved, how you will be positioned, and equipment/ instruments that will be used.
- What to expect after a treatment/ procedure, including anticipated time in hospital and expectations for your recovery.
- Expected immediate and long-term outcomes and risks.
- Whether there are permanent or irreversible consequences of the procedure.

RANZCOG currently uses the term 'woman' in its documents to include all individuals needing obstetric and gynaecological healthcare, regardless of their gender identity. The College is firmly committed to inclusion of all individuals needing O&G care, as well as all its members providing care, regardless of their gender identity.

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