HYSTERECTOMY

THE SOCIETY OF OBSTETRICIANS AND GYNAECOLOGISTS OF CANADA

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Learn about the types of hysterectomy, and whether one is right for you.

Common reasons for a hysterectomy

Uterine fibroids (myomas) — non-cancerous tumours that usually shrink after menopause. These normally don't need treatment unless they cause bleeding, pain during sex, anaemia, pelvic pain or bladder pressure.

Endometriosis —the tissue that usually lines the uterus grows onto surrounding organs, causing painful periods, abnormal vaginal bleeding, scarring, adhesions and infertility.

Uterine prolapse —the tissue that holds the uterus in place weakens, leading to problems holding your urine, pelvic pressure or difficulty with bowel movements.

Pelvic pain — There are many causes and symptoms of pelvic pain, and not all can be successfully treated with a hysterectomy. That is why it is important to carefully diagnose the problem and try other treatments first. Endometriosis, fibroids, adhesions, infections or injury may be a few causes of pelvic pain.

Abnormal uterine bleeding — heavy or long periods, bleeding between periods or bleeding after menopause. Other surgical or medical approaches can often treat the condition successfully.

Cancer — endometrial cancer (cancer of the lining of the uterus), cervical cancer and cancer of the ovaries or fallopian tubes often require a hysterectomy to stop it from spreading to other organs.

There are several reasons why a woman might need to have her uterus removed. There are also different types of operations. The problem you are having will determine which type of operation you need and whether your fallopian tubes, ovaries or cervix will also be removed.

Before you decide what to do, it is important to understand why your doctor has suggested this surgery and what your options are. If you are still having your periods, a hysterectomy will stop them and you will no longer be able to get pregnant.

Your doctor may also suggest other medical treatments which should be tried first. You might decide not to go ahead with the operation and live with the problem; but sometimes, there is no choice. This might be the case with some cases of cancer, unbearable pain or excessive bleeding.

How do I prepare for the hysterectomy?

- You may need to have some tests done such as blood work, urine tests, x-rays, ultrasounds and an electrocardiogram (ECG) before your surgery
- You may be prescribed antibiotics or laxatives to take in advance
- Most hospitals will ask you to check with their admitting department to find out what time you should come to the hospital on the day of your operation
- Shower or bathe the night or morning before the operation.
- Do not eat or drink (even water) after midnight on the night before the operation
- Your doctor may also have additional instructions for you.

Types of hysterectomies

A hysterectomy is an operation to remove the uterus, but sometimes other organs that surround the uterus are also removed to properly treat your condition. These organs include the cervix, the fallopian tubes and the ovaries. Your medical history and the reason for the operation will affect which type hysterectomy is best.

A **complete or total hysterectomy** removes the uterus, including the cervix. The name is confusing because it does not remove "everything". In fact, the ovaries and fallopian tubes remain. This is the most common type of hysterectomy.

A **partial or subtotal hysterectomy** only removes the upper part of the uterus and leaves the cervix and other organs in place.

A **radical hysterectomy** removes the uterus, the cervix, the upper part of the vagina, supporting tissues and usually the pelvic lymph nodes. This operation is usually performed to treat cancer.

In addition to the hysterectomy, you may need to have one or both ovaries or fallopian tubes removed. This is called a **salpingectomy** (fallopian tubes are removed) or a **salpingo-oophorectomy** (fallopian tubes and ovaries are removed). It involves removing these organs from one side (unilateral) or both sides (bilateral). This is done mostly in cases of cancer, infection or adhesions. In general, the ovaries and fallopian tubes are left in place unless something is wrong with them.

How is the operation done?

A **vaginal hysterectomy** is the removal of the uterus through the vagina. This method is often used for uterine prolapse, early cervical cancer, and in cases where the uterus is not enlarged. It causes less pain and results in faster recovery of day-to-day activities than abdominal hysterectomy.

A **laparoscopic hysterectomy** might be used in combination with the vaginal hysterectomy. This allows the uterus to be detached from inside the body by laparoscopic instruments (tiny instruments passed through small cuts into the abdomen) while the doctor looks at the pelvic organs through a camera attached to a telescope. After the uterus is detached, it is removed through a small cut at the top of the vagina.

An **abdominal hysterectomy** is usually chosen for large pelvic tumours, adhesions or cancer. The uterus is removed through a 15-20 cm-long cut (6-8 inches) in the abdomen, either as a midline or bikini cut. An abdominal hysterectomy is associated with a longer hospital stay and recovery time, as well as greater discomfort following the operation.

What are the risks?

Although a hysterectomy is a safe operation, there still remains a small risk as with all operations. Safety measures are taken and you are monitored throughout the operation to reduce potential risks. Although rare, severe complications can occur:

- Problems related to the anaesthesia (drugs that reduce the pain during the operation)
- Blood clots in the veins (DVT: deep-vein thromboses) can break off and travel to the lungs
- Infection
- Bleeding
- Injury to internal organs (urinary tract, bladder or bowel) and the skin
- Loss of ovarian function.
- Injuries to your ureter
- Complications from blood transfusion
- Atelectasis, a complication in which a lung collapses

What will happen after the operation?

After the operation, you may need to stay a few days in the hospital to recover. Some laparoscopic surgeries allow you to be discharged the same day or the next day. Most patients return to work within four weeks after a laparoscopic hysterectomy, depending on the type of work they do.

Your doctor might prescribe antibiotics to prevent infections, as well as pain medication.

Complete recovery from abdominal hysterectomy usually takes six to eight weeks. During this time, you can slowly increase the level of your activities, but don't overdo it! Listen to your body and do everything in moderation.

Get plenty of rest and avoid lifting during the first two weeks. You can then begin to do light chores, some driving, and even return to work as long as your job does not involve too much physical activity. Once the bleeding, pain and abdominal pressure have stopped, you can resume normal activities. Around the sixth week following the operation, you can take baths and resume sexual activity, but demanding exercises should be put off until 3 months after your operation.

Women who have had a vaginal hysterectomy generally recover more quickly and are able to resume their activities earlier than women who have undergone an abdominal hysterectomy.

What will change?

If a woman hasn't already been through menopause, her periods will stop after the hysterectomy. She can no longer get pregnant. If the ovaries are removed, she might go through distressing menopausal symptoms (hot flashes, mood swings, sleep disturbance, vaginal dryness etc). This may cause more severe symptoms than a natural menopause.

Some women have also reported a decrease in sexual pleasure with the removal of the cervix but this has not been scientifically proven. In fact, most women report either an increase in sexual pleasure or no change at all.

Call your doctor or go directly to hospital if you have:

- Heavy vaginal bleeding
- Fever: temperature of 38Âº Celsius (101Âº Fahrenheit) or higher
- Any urinary incontinence (urine leaking or dripping) or painful urination
- Severe vaginal, abdominal, leg or chest pain
- Wound draining, discharge, opening, inflammation or swelling
- Persistent nausea and vomiting
- A swollen abdomen or if you are no longer able to pass gas
- Shortness of breath

Further resources from the Society of Obstetricians and Gynaecologists of Canada

- The SOGC's public education websites **menopauseandu.ca** and **endometriosisinfo.ca**