Patient Information for Consent

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OG01 Abdominal Hysterectomy

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COVID-19 (Coronavirus)

On 11 March 2020 the World Health Organization confirmed COVID-19 (coronavirus) has now spread all over the world (this means it is a 'pandemic'). Hospitals have very robust infection control procedures. If you catch the coronavirus, this could affect your recovery and might increase your risk of pneumonia and even death. Talk to your healthcare team about the balance of risk between waiting until the pandemic is over (this could be many months) and going ahead with your procedure. If your procedure is routine (rather than urgent), your doctor may recommend a delay.

Please visit the World Health Organization website: https://www.who.int/ for up-to-date information.

What is a hysterectomy?

A hysterectomy is an operation to remove your uterus (womb). Your cervix (neck of your womb) is usually also removed. Your fallopian tubes and ovaries may need to be removed at the same time (see figure 1).

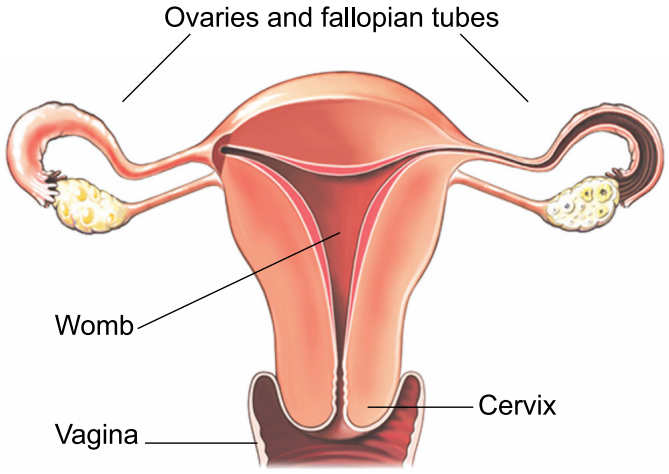

Figure 1
The womb and surrounding structures

Your gynaecologist has recommended an abdominal hysterectomy, where your womb is removed through a cut in your lower abdomen. However, it is your decision to go ahead with the operation or not.

This document will give you information about the benefits and risks to help you to make an informed decision. If you have any questions that this document does not answer, ask your gynaecologist or the healthcare team.

What are the benefits of surgery?

There are common reasons for having an abdominal hysterectomy.

- Heavy or painful periods not controlled by other treatments.
- Fibroids, where part of the muscle of your womb becomes overgrown making it too large to remove through your vagina.

The following are less common reasons for having an abdominal hysterectomy.

- Endometriosis, where the lining of your womb grows outside your womb.
- Adenomyosis, where the lining of your womb grows into the muscle of your womb.
- Chronic pelvic inflammatory disease, where inflammation of your pelvis leads to chronic pain and, sometimes, heavy periods.

Your gynaecologist will discuss with you why they have recommended an abdominal hysterectomy.

A hysterectomy may cure or improve your symptoms. You will no longer have periods. It is important to realise that pain may continue after the hysterectomy, depending on what causes it.

If your ovaries are not removed you may continue to have your usual premenstrual symptoms.

Are there any alternatives to an abdominal hysterectomy?

A hysterectomy is a major operation usually recommended to women after simpler treatments have failed to control their symptoms.

For some women there may be no suitable alternatives and a hysterectomy may be recommended immediately but this is unusual.

The alternatives to a hysterectomy depend on the cause of the problem.

- Uterine prolapse – Symptoms may be improved by doing pelvic floor exercises. Depending on your age, a pessary (a ring that fits into your vagina) may prevent your womb from dropping down.
- Heavy periods can be treated using a variety of non-hormonal and hormonal oral (by mouth) medications. Other alternatives include an IUS (intra-uterine system - an implant containing a synthetic form of the hormone progesterone that fits in your womb) or 'conservative surgery' to remove the lining of your womb (endometrial resection) or prevent it from growing back (endometrial ablation).
- Fibroids – Depending on the size and position of fibroids, you can take medication to try to control the symptoms. Other treatments include surgery to remove the fibroids only (myomectomy) or to shrink the fibroids by reducing their blood supply (uterine artery embolization).

For the less common reasons for recommending a hysterectomy, your gynaecologist will be able to discuss the alternative treatments with you.

What will happen if I decide not to have the operation?

Your doctor will monitor your condition and try to control your symptoms.

You may feel that you would prefer to put up with your symptoms rather than have an operation. Your gynaecologist will tell you the risks of not having an operation.

What happens before the operation?

Your gynaecologist may arrange for you to have a pre-admission assessment. They will carry out several tests and checks to find out if you are fit enough for the operation. If you have any questions about the operation, you should ask the healthcare team at this visit.

Your gynaecologist may ask you to have a pregnancy test. Sometimes the test does not show an early-stage pregnancy so let your gynaecologist know if you could be pregnant.

What does the operation involve?

The healthcare team will carry out a number of checks to make sure you have the operation you came in for. You can help by confirming to your gynaecologist and the healthcare team your name and the operation you are having.

The operation is usually performed under a general anaesthetic but various anaesthetic techniques are possible. Your anaesthetist will discuss the options with you. You may also have injections of local anaesthetic to help with the pain after the operation. You may be given antibiotics during the operation to reduce the risk of infection. The operation usually takes about an hour.

Your gynaecologist may examine your vagina. They will make a cut on your abdomen, usually on your 'bikini' line or sometimes on your midline. Check with your gynaecologist which cut will be made.

Your gynaecologist will remove your womb and fallopian tubes, usually along with your cervix, through the cut. To remove your cervix, they will also need to make a cut at the top of your vagina.

Your gynaecologist may be able to remove only your womb due to technical reasons (subtotal hysterectomy).

Your gynaecologist may need to remove your ovaries even if this was not originally planned. The healthcare team will discuss the reasons with you before the operation.

Your gynaecologist will close the cuts with stitches. They may place a catheter (tube) in your bladder to help you to pass urine. Your gynaecologist may insert a drain (tube) in your abdomen to drain away fluid that can sometimes collect.

What should I do about my medication?

Let your doctor know about all the medication you take and follow their advice. This includes all blood-thinning medication as well as herbal and complementary remedies, dietary supplements, and medication you can buy over the counter.

What can I do to help make the operation a success?

If you smoke, stopping smoking now may reduce your risk of developing complications and will improve your long-term health.

Try to maintain a healthy weight. You have a higher risk of developing complications if you are overweight. Regular exercise should help to prepare you for the operation, help you to recover and improve your long-term health. Before you start exercising, ask the healthcare team or your GP for advice.

You can reduce your risk of infection in a surgical wound.

- In the week before the operation, do not shave or wax the area where a cut is likely to be made.
- Try to have a bath or shower either the day before or on the day of the operation.
- Keep warm around the time of the operation. Let the healthcare team know if you feel cold.

What complications can happen?

The healthcare team will try to make the operation as safe as possible but complications can happen. Some of these can be serious and can even cause death (risk: 3 in 10,000 in the first 6 weeks). You should ask your doctor if there is anything you do not understand.

Any numbers which relate to risk are from studies of women who have had this operation. Your doctor may be able to tell you if the risk of a complication is higher or lower for you.

Your anaesthetist will be able to discuss with you the possible complications of having an anaesthetic.

General complications of any operation

- Pain. The healthcare team will give you medication to control the pain and it is important that you take it as you are told so you can move about and cough freely.
- Feeling or being sick. Most women have only mild symptoms and feel better within 1 to 2 days without needing any medication.
- Bleeding during or after the operation. The healthcare team will try to avoid the need for you to have a blood transfusion but you will be given a blood transfusion if you need one (risk: less than 3 in 100).
- Unsightly scarring of your skin, although your wound usually heals neatly. Sometimes your wound may also open. This is more likely with a midline cut than a cut on the `bikini' line. It can usually be dealt with on the ward but you may need another operation to correct it.
- Developing a hernia in the scar caused by the deep muscle layers failing to heal. This appears as a bulge or rupture called an incisional hernia. If this causes problems, you may need another operation.
- Infection of the surgical site (wound) (risk: 15 in 100). It is usually safe to shower after 2 days but you should check with the healthcare team. Let the healthcare team know if you get a high temperature, notice pus in your wound, or if your wound becomes red, sore or painful. An infection usually settles with antibiotics but you may need another operation.
- Blood clot in your leg (deep-vein thrombosis – DVT) (risk: 1 in 100). This can cause pain, swelling or redness in your leg, or the veins near the surface of your leg to appear larger than normal. The healthcare team will assess your risk. They will encourage you to get out of bed soon after the operation and may give you injections, medication, or special stockings to wear. Let the healthcare team know straightaway if you think you might have a DVT.
- Blood clot in your lung (pulmonary embolus), if a blood clot moves through your bloodstream to your lungs (risk: 4 in 1,000). Let the healthcare team know straightaway if you become short of breath, feel pain in your chest or upper back, or if you cough up blood. If you are at home, call an ambulance or go immediately to your nearest Emergency department.

Specific complications of this operation

- Pelvic infection or abscess (risk: 2 in 1,000). You will need further treatment. Let your gynaecologist know if you get an unpleasant-smelling vaginal discharge.
- Vaginal cuff dehiscence, where the cut at the top of your vagina opens (risk: less than 4 in 1,000). You will need another operation.
- Developing an abnormal connection (fistula) between your bowel, bladder or ureters and your vagina (risk: less than 1 in 1,000). You will need another operation.
- Damage to structures close to your womb (risk: less than 3 in 100) such as your bladder or ureters (tubes that carry urine from your kidneys to your bladder) (risk: 1 in 100), bowel (risk: 4 in 10,000) and blood vessels. Your gynaecologist will usually notice any damage and repair it during the operation. However, damage may not be obvious until after the operation and you may need another operation (risk: 1 in 100).
- Developing a collection of blood (haematoma) inside your abdomen where your womb used to be (risk: 5 in 100). Most haematomas are small and may cause only a mildly high temperature that may need treatment with antibiotics. If the haematoma is large and causing symptoms, it may need to be drained under an anaesthetic. Sometimes a haematoma will drain through your vagina, usually causing bleeding similar to a period for up to 6 weeks.

Long-term problems

Most women who have a hysterectomy do not have any long-term problems. A small number of women may get the following problems.

- Developing a prolapse (a bulge of your vagina caused by internal structures dropping down) as a hysterectomy can weaken the supports of your vagina. The risk of a prolapse increases if you had a degree of prolapse before the operation.

- Continued bleeding from your cervix (risk: less than 2 in 10). Your surgeon can use diathermy to try to stop the bleeding. If the bleeding does not stop, your cervix might need to be removed (risk: less than 2 in 100).
- Your pain may continue.
- Difficulty or pain having sex.
- Tissues can join together in an abnormal way (adhesions) when scar tissue develops inside your abdomen. The risk is higher if you get a pelvic infection or haematoma. Adhesions do not usually cause any serious problems but can lead to complications such as bowel obstruction and pelvic pain. You may need another operation.
- Passing urine more often, having uncontrolled urges to pass urine or urine leaking from your bladder when you exercise, laugh, cough or sneeze (stress incontinence).
- Feelings of loss as a hysterectomy will make you infertile (you cannot become pregnant). This may be more important for you if you have not had children.
- Going through menopause even if your ovaries are not removed. You should discuss hormone replacement therapy (HRT) with your doctor.

How soon will I recover?

In hospital

After the operation you will be transferred to the recovery area and then to the ward.

You may be given fluid for 12 to 24 hours through a drip (small tube) in a vein in your arm. You will probably feel some pain or discomfort when you wake and you may be given strong painkillers. Good pain relief is important to help you to recover. If you are in pain, let the healthcare team know.

The drip will usually be removed after 12 to 24 hours. If you had a catheter or drain, they are usually removed after 4 to 6 hours.

The healthcare team will allow you to start drinking and to eat light meals. Good nutrition is important in speeding up your recovery. Drink plenty of fluid and increase the amount of fibre in your diet to avoid constipation.

The healthcare team may recommend exercises to help you to recover. Getting out of bed and walking is an important part of your recovery. You may also be given breathing or other exercises to do. It is important that you do these even though you may not feel like it.

You should expect a slight discharge or bleeding from your vagina for the first 2 weeks. Let the healthcare team know if this becomes heavy. Use sanitary pads, not tampons. On the second or third day you may get wind pains. They can last for 1 to 2 days but can be relieved with medication.

You will be able to go home when your gynaecologist decides you are medically fit enough, which is usually after 3 to 5 days.

If you are worried about anything, in hospital or at home, contact the healthcare team. They should be able to reassure you or identify and treat any complications.

Returning to normal activities

To reduce the risk of a blood clot, make sure you follow carefully the instructions of the healthcare team if you have been given medication or need to wear special stockings.

Rest for 2 weeks and continue to do the exercises that you were shown in hospital. You should continue to improve.

It is important to let your doctor know if you have heavy bleeding, increasing pain or shortness of breath.

Try to take a short walk every day and increase this gradually. Eat healthily, drink plenty of fluid and rest when you need to.

Do not have sex for at least 6 weeks and until any bleeding or discharge has stopped. It is not unusual to have some discomfort at first or need to use a lubricant.

Do not stand for too long or lift anything heavy. You can return to work once your doctor has said you are well enough to do so (usually after 6 to 8 weeks, depending on your type of work). You should be feeling more or less back to normal after 3 months.

Regular exercise should help you to return to normal activities as soon as possible. Before you start exercising, ask the healthcare team or your GP for advice.

Do not drive until you are confident about controlling your vehicle and always check your insurance policy and with your doctor.

The future

Your doctor will tell you if you need to continue to have regular smear tests. Most women make a good recovery and return to normal activities.

Menopause and HRT

Will I need HRT?

If your hysterectomy is performed while you are still having periods and your ovaries are removed during the operation, you will have menopausal symptoms. These may include hot flushes, night sweats, passing urine more often, a dry vagina, dry skin and hair, mood swings and lack of sex drive. These symptoms can usually be treated with HRT.

It is common for your doctor to recommend that you take HRT until the time when you would have gone through menopause naturally (about age 50 to 52) but you can carry it on for longer if you want. You should discuss this with your doctor.

HRT is most often taken in tablet form but it is also available as patches, gels, nasal sprays, vaginal rings and implants. The healthcare team will be able to discuss the options with you.

What if my ovaries are not removed?

Your ovaries should continue to produce the hormones that you need until you have reached the normal age of menopause. However, there is some evidence to suggest that, in some women, menopause may start 2 to 3 years earlier after a hysterectomy.

It can be more difficult to know when you are in menopause, as your periods will have already stopped. You may need blood tests. If you develop flushes or sweats or other menopausal symptoms, you should discuss HRT with your doctor.

Summary

A hysterectomy is a major operation usually recommended after simpler treatments have failed. Your symptoms should improve.

Surgery is usually safe and effective but complications can happen. You need to know about them to help you to make an informed decision about surgery. Knowing about them will also help to detect and treat any problems early.

Keep this information document. Use it to help you if you need to talk to the healthcare team.

Acknowledgements
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