King's College Hospital
NHS Foundation Trust

Abdominal hysterectomy
Information for patients

The doctor who you saw in the outpatient clinic has recommended that you have an abdominal hysterectomy. This booklet explains the operation, as well as the risks, the benefits and any alternatives. It is a guide only and you will be able to discuss the procedure and any concerns you may have with a doctor and/or nurse at the pre-assessment clinic and during your admission to hospital.

If you have any queries or concerns before you come to the pre-assessment clinic, please call the pre-assessment clinic nurse:

- King's College Hospital, Denmark Hill, tel: **020 3299 3025**
- Princess Royal University Hospital (PRUH), Orpington, tel: **01689 866355**

You can also contact the doctor you saw in the outpatient clinic for more advice.

What is a hysterectomy?

It is an operation to remove your womb (uterus) and the neck of your womb (cervix). You can have this as:

- **keyhole surgery (laparoscopy),** where small cuts are made in your tummy (abdomen), around your belly button, and a laparoscope – a long, thin tube with a light and a camera at the tip – is inserted into one of them. Small surgical instruments are put into the other cuts
- **open surgery (laparotomy),** where a horizontal cut is made along your bikini line or a vertical cut is made from your belly button to your bikini line.

You can also have your womb removed through your vagina as vaginal surgery. This is explained in our leaflet, Vaginal Hysterectomy.

You may also have the following surgery at the same time:

- **Salpingectomy:** your fallopian tubes – which are attached to your womb – are usually removed as well when you have a hysterectomy.
- **Oophorectomy:** you may have one or both of your ovaries taken out during the hysterectomy surgery. Whether this happens depends on your age, and tour doctor will discuss this with you. Your ovaries make female hormones such as oestrogens, so if you have yours removed before your natural age of menopause then you should consider using hormone replacement therapy (HRT). Your doctor will discuss this with you so you can start taking HRT after the operation.

Why do I need a hysterectomy?

You may be offered this operation for a number of reasons.
The most common are:

- **painful, heavy or frequent periods** which are not improved with medical treatments
- **non-cancerous growths in the muscle of your uterus called fibroids**, which can cause painful and heavy periods or put pressure on other pelvic organs
- **prolapsed womb**, which is caused by your uterus dropping down
- **endometriosis**, a condition where tissue from the lining of your womb attaches and grows in the wrong place, causing pain
- **adenomyosis**, a condition where tissue from the lining of your womb grows into the muscular wall of your womb
- severe, recurrent or untreatable **pelvic infections**
- **cancer or precancerous changes** in your vagina, cervix, uterus, fallopian tubes or ovaries.

How long will I be in hospital?

You usually stay in hospital for one – five days. This depends on whether you had keyhole or open surgery and how complex the operation was. Duration of stay will also depend on where you had your operation. For example your doctor may decide that you are suitable to have your operation in our Day Surgery Unit (DSU), which means you may be able to go home within 24 hours of your operation.

What is removed during a hysterectomy?

Total hysterectomy

- Your periods should stop immediately.
- You no longer need cervical smear tests unless your gynaecologist asks you to have them because of previous abnormalities in your cervix.
- You will still have your ovaries if your doctor thinks they will be of benefit to you. They will discuss this with you before your operation.
- The type of surgery you have – keyhole (laparoscopy), open (laparotomy), vaginal, or a combination of keyhole and vaginal called vNOTES (vaginal natural orifice transluminal endoscopic surgery) – depends on why you are having the hysterectomy. Please see our leaflets about Vaginal Hysterectomy and vNOTES.

Total hysterectomy and bilateral salpingo-oophorectomy

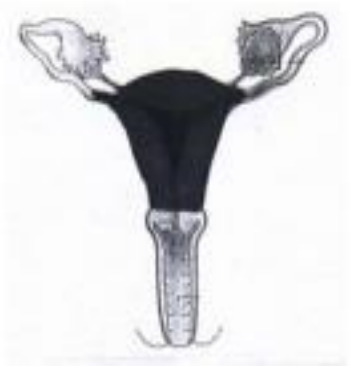
What is removed?

- your womb, cervix and ovaries

What is left behind?

- your vagina

- Your periods should stop immediately.
- You no longer need cervical smear tests unless your gynaecologist asks you to have them because of previous abnormalities in your cervix.
- If you have this operation before your natural age of expected menopause, your doctor will discuss using hormone replacement therapy (HRT) afterwards.
- You will have this operation by keyhole (laparoscopy) or open (laparotomy) surgery or a combination of keyhole and vaginal surgery called vNOTES (vaginal natural orifice transluminal endoscopic surgery). Please see our leaflets about Vaginal Hysterectomy and vNOTES.



What is removed?

- your womb (shown in black)

What is left behind?

- ovaries, cervix and vagina

Subtotal hysterectomy

- Your periods will stop but you may sometimes have bleeding or discharge from your cervix if you are premenopausal.
- You must continue to have cervical smear tests until your 65 as part of the National Cervical Screening Programme.
- You have less risk of bladder injury and blood loss during the operation.
- You will have this operation by keyhole (laparoscopy) or open (laparotomy) surgery. If you have keyhole surgery, your uterus will be taken out in small pieces through the small cuts made in your tummy (morcellation). The doctor will give you an information leaflet which explains this procedure in more detail.
- This type of hysterectomy is not suitable if you have had cervical smear abnormalities or you have cervical cancer.
- If you need to have your cervix removed at a later date, it may be more difficult and you risk bladder or bowel injury.

What happens during a hysterectomy?

Keyhole/Laparoscopy	**Open/Laparotomy**	**Vaginal**	**vNOTES**
Three or four small cuts are made in your tummy about 5-10mm long. Carbon dioxide gas is then pumped in to inflate your tummy so your surgeon can see your organs more clearly. A laparoscope is put into one of the cuts and this sends pictures of inside your tummy to a monitor in the operating theatre so your surgeon has a full view of the area. Small surgical instruments are put through the other cuts. You usually have this type of surgery if you have a normal sized to moderately enlarged womb. It can be used to treat other pelvic conditions such as endometriosis and abnormal ovaries at the same time. **Benefits** Your recovery time is quicker and you may be sent home the same day. You are likely to have less bleeding.	A moderate-size cut about 10cm long is made along your bikini line or vertically in your tummy. You usually have this type of surgery if you have a larger womb with fibroids. It takes you longer to recover from this type of surgery. **Benefits** This route is used if you have big and many fibroids.	Your surgeon does your surgery through your vagina if you have not had gynaecological abdominal surgery before. You usually have this type of surgery if you have a prolapse and have a normal size womb. It may not be possible to remove your ovaries at the same time. **Benefits** This has the fastest recovery time of all four types of surgery. You have less risk of bleeding and organ injury.	Your surgeon does your surgery through your vagina and also uses laparoscopic instruments. This type of surgery may not be suitable if you need treatment for other conditions such as endometriosis at the same time. **Benefits** Faster recovery time. Your ovaries and fallopian tubes can be taken out at the same time.

What are the risks of a total abdominal hysterectomy?

As with all operations there are always some risks. These will be explained to you after considering your individual circumstances.

The risks for the serious or common complications listed here are greater if you:

- are overweight (BMI of more than 25)
- have significant abnormalities such as large fibroids or severe endometriosis
- have had previous surgery
- have pre-existing medical conditions.
- are anaemic (Low iron or low haemoglobin).

We can find some of these complications and correct them during the operation. But some may not be recognised until after you have gone home. The overall risk of serious complications from a hysterectomy is 4 in 100 (common).

Risks during surgery

Bleeding: There is a risk of bleeding with all surgery. If you have excess bleeding you may need a blood transfusion. Your risk of needing a transfusion is 23 in 1,000 (common). This risk if higher if you are anaemic.

Bladder or ureter damage. If your bladder or ureter (the tube connecting your kidneys to your bladder) are damaged, we will repair this immediately, if possible. Depending on the damage, you will then need to have a small plastic tube (temporary catheter) in your bladder or ureter to drain the urine for the next few weeks. Your overall risk is 7 in 1,000 (uncommon).

Bowel damage: If this happens we will repair it immediately. Depending on the extent of the injury and which part of your bowel is damaged, you may then have a plastic bag attached to your lower abdomen to collect your bowel movements while your bowel heals. This is usually a temporary colostomy and you would probably only need it for a few months. You would also not be able to eat and drink for a longer time than usual after the operation. Your overall risk is 4 in 10,000 (rare).

General anaesthetic: There is always a small risk of a serious reaction or complication when you have a general anaesthetic.

Extra procedures: You might need to have an extra procedure during your operation which your surgeon may or may not have anticipated beforehand. For example, they might need to convert your operation from keyhole to open surgery, repair injuries (as mentioned above), or remove your ovaries because of problems they have found during the operation.

Risks after surgery

Infection: This includes wound infection, a urine infection, infected collection of blood in your pelvis (your risk of this is 2 in every 1,000 – uncommon) or an infection you picked up in hospital. If this happens we will give you antibiotics to treat the infection, so it is important that you tell your nurse or doctor if you are allergic to any antibiotics. Very occasionally you made need an investigation or an operation to drain the infection.

Urinary problems: Urine infections can be treated with antibiotics. You may also have some short-term difficulties in passing urine (peeing). If so, you may need to go home with a temporary catheter which will be taken out at a clinic a few days later. You very rarely need this long term. There is also a risk of urinary frequency, where you need to go to the loo often, which can be caused by the surgery damaging the nerves supplying your bladder.

Thrombosis (blood clots): A thrombosis is a blood clot that forms inside a vein and interferes with your normal circulation. This commonly affects your lungs, causing breathing difficulties, or your legs, causing swelling. To help prevent blood clots we will give you a blood-thinning drug called enoxaparin. We will also encourage and help you to start moving around as soon as possible after your operation and to keep drinking plenty of fluids. Your overall risk is 4 in 1,000 (uncommon).

Scar issues: You might feel numbness, tingling or a burning sensation near or on your scar(s). This usually takes a few weeks or months to go away completely.

More surgery: You may have some complications such as bleeding, infection, bowel or urinary tract injury, or wound breakdown while you are recovering in hospital or at home. This may mean you need more surgery or other treatment. Your overall risk is 7 in 1,000 (uncommon).

What are the benefits of a total abdominal hysterectomy?

The main benefits of this operation is relief from your symptoms like heavy periods, post-menopausal bleeding, pressure on bowel/bladder, pain etc.

Are there any alternatives?

Your doctor will discuss with you before your operation whether there any other suitable treatments for your problems. Here we list the possible alternative treatments for a range of conditions. Some or all might be considered in your case.

	Medication	**Long-acting progestogens**	**Endometrial ablation**	**Myomectomy**	**Do nothing**
Description	You can take tablets (hormonal or non-hormonal) such as the combined/mini Pill, tranexamic acid, mefanemic acid or GnRH analogues for heavy menstrual bleeding or painful periods	Depo-injection or implant Mirena coil	Day case procedure under general anaesthetic which destroys the lining of your womb and reduces heavy periods. This procedure is not suitable for all patients	Surgery to remove fibroids but not your womb. You can have this as keyhole or open surgery.	You do not have to have any treatment, especially if you are coping well with the symptoms

Advantages	Avoids surgery Avoids general anaesthetic Also a contraceptive You keep your fertility	Avoids surgery Avoids general anaesthetic 70% of patients have less bleeding Also a contraceptive You keep your fertility	You keep your womb Day case procedure with fast recovery 90% success rate for patient with heavy bleeding	Mainly a treatment for fibroids You keep your fertility	No side effects of medication No risks of surgery or anaesthesia
Disadvantages	You may have side effects from the medication You need to take the tablets regularly You may still have some symptoms	You may have side effects from the progesterone The coil needs to be replaced every three – five years You may still have some symptoms	Does not treat painful periods Your family must be complete as you may not be able to have children after this procedure. Risks of general anaesthesia You may still have some symptoms	Risks of bleeding and morcellation Risks of hysterectomy Risks of major surgery and general anaesthesia You may still have some symptoms	May not be enough to deal with your symptoms

Consent

We must by law obtain your written consent to any operation and some other procedures beforehand. Staff will explain all the risks, benefits and alternatives before they ask you to sign a consent form. It is very important that you understand all the information provided to you. If you are unsure about any aspect of the treatment proposed, please do not hesitate to speak with a senior member of staff again. You may also ask to receive a copy of your consent form along with any other relevant information regarding different aspects of the operation.

Pre-admission clinic and date for your operation

The doctor in the outpatient clinic will fill in an electronic admission card to put you on the waiting list. All patients referred for any operation are discussed by the gynaecology admissions team and /or team of other gyanecologists (MDT-multidisciplinary) to confirm the appropriateness of your procedure. time scales and place of surgery. This is reassure that you are being offered the most suitable and effective treatment.

Once you have a date for your surgery, the pre-admissions nurse will contact you to arrange for you to have a pre-admissions appointment for some tests and checks. This usually happens a few weeks before your operation. The appointment will be either at a hospital clinic or over the phone.

The nurse will explain the operation to you and answer any questions you may have. They will send you a letter with the name of the ward and the direct phone number and give you information about our pre-operation support group.

They will also discuss with you the amount of support that you will need when you go home after your operation. If you have any concerns about this, please discuss them with the nurse at this appointment so they can arrange extra support for you.

The nurse will arrange any checks you need before surgery, such as a chest x-ray, ECG (heart check) and blood tests. They will also discuss with you pain relief after the operation (see page 11 for details), any other medications you need to take before your operation such as laxatives, and whether you need to alter the dose or stop taking any of your medications you usually take, such as blood thinners. You might also need injections before your operation and the nurse will arrange this with your GP.

Depending on the type of procedure, you will meet the surgeon to discuss your operation and to give consent either prior to the surgery date or on the day of the surgery. If you are going to have your surgery in our Day Surgery Unit (DSU) – where you could have your operation and be discharge within 24 hours – we will give you the Day Surgery Information leaflet.

How do I prepare for my operation?

In the weeks or months leading up to your operation, there are a number of things you can do to help you to recover well from your operation and to reduce your risk of some complications:

- cut down or give up smoking
- eat a healthy diet
- exercise
- lose weight if you are overweight
- ensure any medical problems you have such as anaemia, diabetes, high blood pressure and asthma are well controlled. Please discuss this with your GP.

If you would like any information about any of these issues, please ask the nurse at the pre-admission clinic.

Where will I have my surgery?

King's College Hospital, Denmark Hill

- Women's Surgical Unit, Level 3, Golden Jubilee Wing
- Day Surgery Centre, next to the Dental Institute

Princess Royal University Hospital (PRUH), Orpington

- Level 2, Surgical Lounge, North Wing – before the operation
- Level 2, Surgical Ward 8, North Wing (next to the Surgical Lounge) – after the operation.

Admission to hospital

You may be admitted the day before your operation. Otherwise, you will be asked to come in on the day of the operation.

We may ask you to phone the ward or the admissions officer on the day you are due to be admitted to check that a bed is available. Sometimes you have to wait for a bed because these wards also take emergency admissions.

Once you are admitted, a nurse will come to see you who will be responsible for your care and who will assist you, your family and friends to plan your recovery and discharge.

You will also have another chance to meet the operating team and ask any questions you have about the operation.

What do I need to bring with me?

Comfortable clothes for after the operation – you do not have to wear nightclothes – a dressing gown, toiletries, slippers and sanitary towels.

Valuables

Please do not bring in valuables, jewellery, large sums of money or bank cards. If you cannot avoid bringing in valuables, please ask a relative or friend to take them home for you.

What happens the day before my operation?

We will let you know what to do the day before you operation at your pre-operative assessment appointment. This usually includes what to eat and drink and when to stop.

If you take any regular medicines, such as drugs for diabetes or for high blood pressure, we will tell you how and when to take these.

You may be given a mild laxative to ensure your bowel is empty for surgery.

What happens on day of my operation?

On the morning of your operation, please:

- have a bath or shower and clean your tummy and belly button with soap and water
- remove all make-up, jewellery(including body piercings), nail varnish or false nails, contact lenses, wigs and false teeth (dentures).

You may keep your wedding ring on if you wish and we will cover it with tape.

Your nurse will ask you about your teeth and whether you have any dental caps or crowns and give this information to your anaesthetist.

You will then be asked to put on a hospital gown that ties at the back and to take off your underwear.

We may give you a pre-medication injection or tablet one – two hours before you go to the operating theatre. This should make you feel more relaxed and less likely to feel sick after the operation. Go to the toilet before having it because it can make you feel dizzy and you should not try to get out of bed once you have had it.

You will either walk or be taken on your bed/chair to the anaesthetic room and operating theatre. Your anaesthetist will give you a general anaesthetic injection into the back of your hand, through a small plastic tube, to send you to sleep.

How long will my operation take?

It usually takes about one – two hours.

What happens after my operation?

You will wake up in the recovery room with an oxygen mask over your face. You will stay here for about 30 – 60 minutes until you are fully awake and can be safely taken back to the ward.

You may have:

- a thin plastic tube in your arm (intravenous/IV infusion drip) through which you are given fluids and painkilling medication. You usually have this for 24 – 48 hours until you are drinking normally again
- a plastic tube (drain) under your skin near the wound to remove any excess blood. You will have this for 24 – 48 hours
- a thin plastic tube (urinary catheter) in your bladder to drain urine for 24 – 48 hours
- a dressing covering your wound
- padding in your vagina (vaginal pack) to soak up blood, depending on the type of hysterectomy you have had.

When you are back on the ward your nurse will check your blood pressure, wound and sanitary towel regularly. They will also assess your pain and give you painkillers as you need them (see page 11 for more details). If you have an analgesia pump (PCA) that you control yourself, they will explain how to use it.

You may feel sick after the anaesthetic and your nurse can give you medication to ease this.

Your stay on the ward

On the morning after your operation you should have a wash. Your nurse will encourage you to sit out of bed and/or get up and move around. They will also give you exercises you can do in bed.

Moving about is very important because it encourages a normal blood flow around your body and it can help to prevent problems such as blood clots in your legs (deep vein thrombosis/ DVT). It also helps prevent chest infections, because it allows you to breathe more deeply and efficiently.

Once your urinary catheter has been taken out you should be able to pass urine (pee) normally. You will need to measure how much urine you pass the first three times and tell the nurse. This is to make sure that your bladder has not been damaged during your operation.

Your bowels will also slowly get back to normal, although you may have some constipation. Your nurse can give you laxatives or suppositories, so please let them know if you are finding it hard to go.

You may also feel tired and a little weepy. This is normal.

Please do not hesitate to ask the nurses and doctors looking after you any questions you may have.

Pain relief after surgery

The pre-admission nurse will discuss pain relief with you at the pre-admission clinic, before your operation. Strong painkillers can often make you feel and be sick. We can give you regular injections to prevent this, if needed.

There are a number of ways in which we can ease your pain:

- Regular injections of painkillers.
- Patient-controlled analgesia (PCA): we put a plastic tube (catheter) in your vein and attach it to a pump that gives you a dose of painkiller when you press a button. This means you are in control of your pain relief but you cannot take too much.
- Epidural infusion/spinal anaesthesia: at the start of your operation you may be given pain medicine through a plastic tube (catheter) into your spine which gives you a continuous infusion of painkiller. Or you might have a single injection of painkillers into your spine to block the nerve endings that cause pain.
- Suppository: this is put in your rectum and gives you long-lasting pain relief.
- Standard painkilling tablets when you are able to eat and drink normally.

Getting back to normal

This is a guide only as your recovery will depend on the type of surgery you have had, why you have had it and your individual circumstances. Your nurse or doctor will be happy to answer any questions you may have.

Work

You are the best judge of when you feel able to go back to work. This is usually four – six weeks after going home, depending on the type of job you have and how you are feeling. If your job involves sitting down most of the time, you can start doing it again within one – two weeks of surgery.

Exercise and lifting

- We will give you an information sheet with some exercises that you can do.
- You can start swimming again once your wound has healed and you have no vaginal discharge.
- You are likely to feel more tired than normal so just try to do as much exercise as you feel able.
- Only lift light objects and ensure you always keep your knees bent and your back straight.

If you have any concerns or questions about lifting and exercising, please speak with your nurse.

Driving

- Do not drive until you feel comfortable wearing a seatbelt and can do an emergency stop.
- Check your insurance policy for cover after surgery.
- Contact the DVLA for advice if necessary.

Sex

It is your personal choice when you and your partner start having sex again. As a guide, wait until you have no vaginal discharge and you feel as comfortable and as relaxed as possible. It is normal to feel apprehensive about this. Please talk to your doctor about any concerns you may have.

Contraception

You do need to use contraception after a hysterectomy, whether or not your ovaries have been removed. But you still need to use condoms to protect yourself against sexually transmitted infections (STIs).

Hormone replacement therapy (HRT)

If you have had your ovaries removed at the same time as the hysterectomy you should consider using hormone replacement therapy (HRT). Please discuss this with your doctor because you can start using it straight after your operation.

Who can I contact with queries and concerns?

King's College Hospital, Denmark Hill
Women's Surgical Unit, tel: **020 3299 5936** or **020 3299 5933**

Princess Royal University Hospital (PRUH), Bromley
Surgical ward 8, **tel: 01689 863000, ext 64741** 01689864741/ 01689864132

More information

Women's Health Concern
www.womens-health-concern.org/

Womens Health London
www.womenshealthlondon.org.uk/

The Menopause Amarant Trust
British Menopause Society (BMS)
thebms.org.uk/

Family Planning Association (FPA)
www.fpa.org.uk/

NHS 111
Free telephone number for urgent healthcare

Some of the other documents you might find useful:
Vaginal Hysterectomy - for uterine prolapse BSUG Jan 2021

Patient information leaflets (rcog.org.uk):
Factsheet, Overview, recovering from Vaginal/Abdominal/ Laparoscopic Hysterectomy - Royal College of Obstetrics and Gynaecology.

PALS
The Patient Advice and Liaison Service (PALS) offers support, information and assistance to patients, relatives and visitors. They can also provide help and advice if you have a concern or complaint that staff have not been able to resolve for you.

PALS at King's College Hospital, Denmark Hill, London SE5 9RS
Tel: 020 3299 3601
Email: kch-tr.palsdh@nhs.net

PALS at Princess Royal University Hospital, Farnborough Common, Orpington, Kent BR6 8ND
Tel: 01689 863252
Email:kch-tr.palspruh@nhs.net

If you would like the information in this leaflet in a different language or format, please contact our Communications and Interpreting telephone line on 020 3299 4826 or email kch-tr.accessibility@nhs.net