OG29 Laparoscopic Subtotal Hysterectomy

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Huddersfield Royal Infirmary

- Main switchboard, who can connect you to the relevant department, on 01484 342 000
- Patient Advice and Liaison Service (PALS) on 01484 342 128

Calderdale Royal Hospital

- Main switchboard, who can connect you to the relevant department, on 01422 357 171
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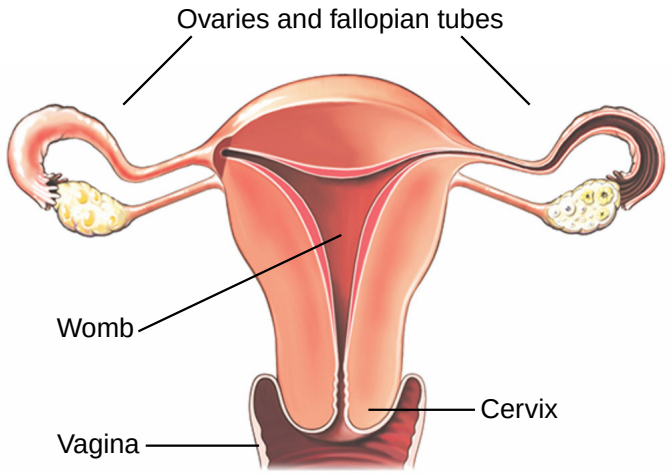
What is a subtotal hysterectomy?

A subtotal hysterectomy is an operation to remove part of your uterus (womb), leaving your cervix (neck of your womb) in place. Your ovaries may need to be removed at the same time.



The womb and surrounding structures

Your gynaecologist has suggested a subtotal hysterectomy. 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, it is important that you ask your gynaecologist or the healthcare team. Once all your questions have been answered and you feel ready to go ahead with the procedure, you will be asked to sign the informed consent form. This is the final step in the decision-making process. However, you can still change your mind at any point.

What are the benefits of surgery?

There are common reasons for having a subtotal hysterectomy.

- Heavy or painful periods not controlled by other treatments.
- Fibroids, where the muscle of your womb becomes overgrown.

The following problems may be better treated by a total hysterectomy, which includes removing your cervix.

- Problems with your cervix.
- Problems with the lining of your womb.
- 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, often, heavy periods.

Your gynaecologist will discuss with you why they have recommended a subtotal hysterectomy.

A subtotal hysterectomy may cure or improve your symptoms. More than 18 in 20 women will no longer have periods. Others may get a little blood-stained discharge.

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 a subtotal hysterectomy?

A subtotal 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’ where only the lining of your womb is removed (endometrial resection).

- 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 uterine artery embolisation to reduce the blood flow to the fibroids.

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 or the operation is delayed?

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.

If you experience any of the following symptoms, contact your healthcare team.

- Unusual bleeding.
- The prolapse becoming more prominent.
- A change in your bladder or bowel control.

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.

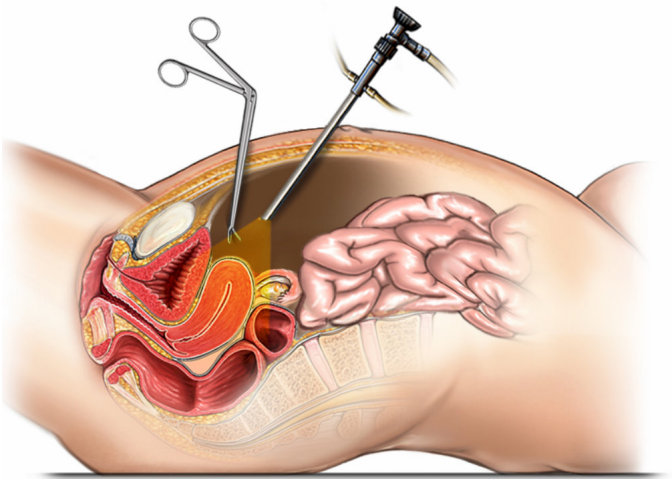
Your gynaecologist may ask you to have a pregnancy test. Sometimes the test does not show an early-stage pregnancy so let your gynaecologist know if you could be pregnant.

Your gynaecologist will check that your smear tests are up to date and they may perform an endometrial biopsy (removing small pieces of tissue from the lining of your womb).

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.



Laparoscopic surgery

The operation usually takes about 90 minutes. Your gynaecologist will use laparoscopic (keyhole) surgery as this is associated with less pain, less scarring and a faster return to normal activities.

They may empty your bladder using a catheter (tube). They may also examine your vagina.

An instrument called a manipulator might be inserted through the neck of the womb (cervix) and into your womb by your gynaecologist to help them perform the surgery. The manipulator allows them to move your womb during the laparoscopy so that they can get a good view of your pelvic area.

Your gynaecologist will make a small cut, usually on or near your belly button, so they can insert an instrument in your abdominal cavity to inflate it with gas (carbon dioxide). They will make several small cuts on your abdomen so they can insert tubes (ports) into your abdomen. Your gynaecologist will insert surgical instruments through the ports along with a telescope so they

can see inside your abdomen and perform the operation.

Your gynaecologist will separate your womb from the neck of your womb with instruments, leaving your cervix in place. They may also separate your fallopian tubes and ovaries (if they need to) from surrounding structures, if they have become stuck together. Your gynaecologist will usually remove your womb through one of the small cuts on your abdomen.

They may need to use a special device called a morcellator to reduce the size of fibroids or your womb before removing them. Sometimes your gynaecologist will remove your womb through a cut near the top of your vagina (colpotomy).

Your gynaecologist may use diathermy (heat) to treat the lining of your cervix to reduce the risk of bleeding or having a period. Your gynaecologist may remove your ovaries even if this was not originally planned. This will happen only if it becomes necessary during the operation.

Sometimes it will not be possible to complete the operation using keyhole surgery. The operation will be changed (converted) to open surgery, which involves a larger cut usually on your 'bikini' line or downwards from your belly button (and in some cases from above your belly button).

Your gynaecologist will remove the instruments and close the cuts. They may place a catheter 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?

Make sure your healthcare team knows 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.

How can I prepare myself for the operation?

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.
- If you are diabetic, keep your blood sugar levels under control around the time of your procedure.

If you have not had the coronavirus (Covid-19) vaccine, you may be at an increased risk of serious illness related to Covid-19 while you recover. Speak to your doctor or healthcare team if you would like to have the vaccine.

What complications can happen?

The healthcare team will try to reduce the risk of complications.

Any numbers which relate to risk are from studies of people 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. Some risks are higher if you are older, obese, you are a smoker or have other health problems. These health problems include diabetes, heart disease or lung disease.

Some complications can be serious and can even cause death (risk: 4 in 10,000).

Using keyhole surgery means it may be more difficult for your gynaecologist to notice some complications that may happen during the operation. When you are recovering, you need to be aware of the symptoms that may show that you have a serious complication. You should ask

your doctor if there is anything you do not understand.

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

General complications of any operation

- 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 one if you need one (risk: less than 1 in 100).
- Infection of the surgical site (wound). 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 special dressings and your wound may take some time to heal. In some cases another operation might be needed. Do not take antibiotics unless you are told you need them.
- Allergic reaction to the equipment, materials or medication. The healthcare team is trained to detect and treat any reactions that might happen. Let your healthcare team know if you have any allergies or if you have reacted to any medication or tests in the past.
- Developing a hernia in the scar. This appears as a bulge or rupture called an incisional hernia. If this causes problems, 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 straight away 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. Let the healthcare team know straight away 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.
- Chest infection. If you have the operation within 6 weeks of catching Covid-19, your risk of a chest infection is increased (see the 'Covid-19' section for more information).

Specific complications of this operation

Keyhole surgery complications

- Surgical emphysema (a crackling sensation in your skin caused by trapped carbon dioxide), which settles quickly and is not serious.
- Damage to structures such as your bowel, bladder or blood vessels when inserting instruments into your abdomen (risk: less than 3 in 1,000). The risk is higher if you have had previous surgery to your abdomen. If an injury does happen, you may need open surgery. About 1 in 3 of these injuries is not obvious until after the operation.
- Making a hole in your womb or cervix with possible damage to a nearby structure during placement of the manipulator (risk: less than 8 in 1,000). You may need to stay overnight for close observation in case you develop complications. You may need another operation (risk: less than 1 in 1,000).
- Developing a hernia near one of the cuts used to insert the ports (risk: 1 in 100). Your gynaecologist will try to reduce this risk by using small ports (less than a centimetre in diameter) where possible or, if they need to use larger ports, using deeper stitching to close the cuts.
- Conversion to an abdominal hysterectomy. Your gynaecologist may need to make a cut on your abdomen if surrounding structures are damaged or if the operation is difficult to perform (risk: 4 in 100).
- Gas embolism. This is when gas (carbon dioxide) gets into the bloodstream and blocks

a blood vessel. This is very rare but can be serious.

Hysterectomy complications

- 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.
- 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 such as your bladder or ureters (tubes that carry urine from your kidneys to your bladder), bowel and blood vessels (risk: less than 1 in 100). 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: less than 4 in 100).
- Developing a collection of blood (haematoma) inside your abdomen where your womb used to be (risk: less 1 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.
- Implantation of fibroid seedlings, if your gynaecologist needed to use a morcellator. A small piece of fibroid or muscle from your womb (myometrium) can implant in your abdominal cavity (risk: 1 in 200).
- Spread of endometrial cancer, if your gynaecologist needed to use a morcellator to help remove your womb and cancer cells were later found in the tissue when it is examined under a microscope. Your gynaecologist will usually have recommended a scan or an endometrial biopsy to check the lining of your womb.
- Spread of cancer, if your gynaecologist needed to use a morcellator to help remove a fibroid and cancer cells were later found in the tissue when it is examined under a microscope (risk of a fibroid having cancer cells: less than 3 in 1,000). Your gynaecologist will try to assess your risk before the operation.

Long-term problems

Most women who have a subtotal 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.

Covid-19

A recent Covid-19 infection increases your risk of lung complications or death if you have an operation under general anaesthetic. This risk

reduces the longer it is since the infection. After 7 weeks the risk is no higher than someone who has not had Covid-19. However, if you still have symptoms the risk remains high. The risk also depends on your age, overall health and the type of surgery you are having.

You must follow instructions to self-isolate and take a Covid-19 test before your operation. If you have had Covid-19 up to 7 weeks before the operation you should discuss the risks and benefits of delaying it with your surgeon.

Consequences of this procedure

- 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. After keyhole surgery, it is common to have some pain in your shoulders because a small amount of carbon dioxide gas may be left under your diaphragm. Your body will usually absorb the gas naturally over the next 24 hours, which will ease the symptoms.
- Unsightly scarring of your skin.

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 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.

If you have a drip, or a catheter or drain, they are usually removed the same day or the next morning. The healthcare team will allow you to start drinking and to eat light meals. 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.

You may get a slight discharge or bleeding from your vagina. Use sanitary pads, not tampons.

You will be able to go home when your gynaecologist decides you are medically fit enough, which is usually the same day or after 1 to 2 days.

You need to be aware of the following symptoms as they may show that you have a serious complication.

- Pain that gets worse over time or is severe when you move, breathe or cough.
- A heavy discharge or bleeding from your vagina.
- A high temperature or fever.
- Dizziness, feeling faint or shortness of breath.
- Feeling sick or not having any appetite (and this gets worse after the first 1 to 2 days).
- Not opening your bowels and not passing wind.
- Swelling of your abdomen.
- Difficulty passing urine.

If you do not continue to improve over the first few days, or if you have any of these symptoms, let the healthcare team know straight away. If you are at home, contact your gynaecologist or GP. In an emergency, call an ambulance or go immediately to your nearest Emergency department.

Returning to normal activities

If you had sedation or a general anaesthetic and you do go home the same day:

- a responsible adult should take you home in a car or taxi and stay with you for at least 24 hours;
- you should be near a telephone in case of an emergency;
- do not drive, operate machinery or do any potentially dangerous activities (this includes cooking) for at least 24 hours and not until you have fully recovered feeling, movement and co-ordination; and
- do not sign legal documents or drink alcohol for at least 24 hours.

To reduce the risk of a blood clot, make sure you carefully follow 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.

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

Do not have sex for at least 4 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 4 weeks, depending on your type of work). You should be feeling more or less back to normal after 2 to 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 can control your vehicle, including in an emergency, and always check your insurance policy and with the healthcare team.

The future

As your cervix has not been removed, 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, it is likely 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.

After a subtotal hysterectomy your doctor may want you to have HRT. You may be offered an oestrogen-only HRT or HRT that contains oestrogen and progesterone (although this is usually given to women who still have their womb). Your gynaecologist will explain why they have recommended a particular type of HRT for 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 subtotal 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.

Some information, such as risk and complication statistics, is taken from global studies and/or databases. Please ask your surgeon or doctor for more information about the risks that are specific to you, and they may be able to tell you about any other suitable treatments options.

This document is intended for information purposes only and should not replace advice that your relevant healthcare team would give you.

Acknowledgements

Reviewers

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Illustrator