Laparoscopic Hysterectomy - Your operation explained

Introduction

This booklet is designed to give you information about having a laparoscopic hysterectomy and the care you will receive before, during and after your operation. We hope it will answer some of the questions that you, or those who care for you, may have at this time. It is not meant to replace the discussion between you and your surgeon but it helps you understand more about what is discussed.

If you have recently been told that you need a hysterectomy, it is normal to feel a wide range of emotions. For some women it can be a frightening and unsettling time. If you have any questions regarding the information or any aspect of your treatment there are doctors, specialist nurses and nursing staff to listen and answer any of your questions. Some useful contact numbers and support agencies are listed at the back of the booklet.

What is a laparoscopic hysterectomy?

A laparoscopic hysterectomy is an operation using 'keyhole' surgery. A narrow telescope called a laparoscope is inserted through a small cut in the belly button. Keyhole surgery instruments are inserted into the abdomen (tummy) through other small cuts in the abdominal wall.

The laparoscope is used to perform the hysterectomy. The uterus (womb), usually with the cervix (neck of womb) is removed and passed through the vagina to leave the body. In some operations (known as bilateral salpingo-oopherectomy) both the ovaries and fallopian tubes are also removed at the same time .

What are the benefits of laparoscopic hysterectomy?

The benefits of having a laparoscopic hysterectomy over an abdominal hysterectomy (removal of the uterus through an larger surgical incision) are:

- Less pain after the operation
- Smaller, less noticeable scars
- A shorter stay in hospital (generally two to three days)
- Wounds are quicker to heal and less likely to become infected
- Being able to return to normal activities and work faster than after open surgery
- A smaller risk of serious complications (eg blood clots in the large veins of your legs or lungs).

How is a laparoscopic total hysterectomy performed?

You will have the surgery under general anaesthetic – you are asleep and do not feel any pain for the entire operation. We will give you more information about having an anaesthetic. For more details, please ask for a copy of our leaflet Having an anaesthetic. A catheter is put into your bladder when you are asleep to drain urine from your bladder and reduce the risk of injury to it during the operation.

Gas is put into your abdomen to lift the wall of your abdomen, so the surgeon has a clear view of your internal organs with a lighted telescopic camera (laparoscope). The laparoscope magnifies the view of your abdomen so the surgeon can see your organs clearly on a screen.

The surgical instruments needed for the operation are put through the small cuts in your abdomen. The womb is taken away from its surrounding structures and removed through your vagina. The top of the vagina is then closed afterwards with dissolvable sutures (stitches).

What are the risks?

There are risks associated with any surgical procedure. Your surgeon will explain these risks to you once during your clinic appointment and again before the operation. Please talk to your surgeon about any concerns you have.

Risks may include:

- Bleeding during or after your operation – this may need to be treated with a blood transfusion
- Infections – you will be given antibiotics during the operation to help prevent this
- Blood clots – after surgery there is a risk of blood clots in the large veins of your legs or lungs. You will receive a leaflet on preventing hospital-acquired blood clots.
- Injuring your bowel, bladder or blood vessels (3 in 1,000 patients) – injury to your bladder may require a urinary catheter to be left in place for 1-2 weeks, an injury to your bowel may require a surgical repair, or removal of the affected part of bowel and either re-joining of the bowel back together or diverting the bowel to the surface of your tummy attached to a bag, known as a stoma.
- Injury to the ureters - tubes draining urine from kidneys to bladder (1 in 100 patients)
- It may be necessary to perform open surgery (make a larger cut through the abdomen) either because the keyhole surgery was technically not possible, or to repair any of the injuries mentioned above.
- Other risks are bruising, shoulder tip pain (pain where your shoulder and arm meet), infection or re-opening of the wound, or a hernia (where tissue comes through the wound as it has not fully healed).
- Problems caused by having a general anaesthetic – please read our leaflet Having an anaesthetic for information about the risks. It is possible to have an allergic reaction to anaesthetic – this is rare, but tell your doctor about any allergies you have well before your operation.
- As with any operation, there is a very rare risk of death (1 per 10,000).

These complication rates are taken from national statistics; they are rare but you should be aware of them. Occasionally complications are not noticeable at the time of surgery. Therefore if you start feeling increasingly unwell after the surgery please see your GP or go to your local Emergency Department (A&E). Please talk to your doctor about any concerns you have before your operation.

Why do I need a laparoscopic hysterectomy?

The common reasons for having a laparoscopic hysterectomy are:

Benign conditions

These include heavy, sometimes painful menstruation (periods),or pain caused by conditions such as endometriosis...

Cancer

A laparoscopic hysterectomy can be performed as a treatment for cancer of the cervix or the lining of the womb (endometrium), and also for some types of ovarian cysts. Surgery for cancer of the ovary, peritoneum or fallopian tube is discussed in a separate booklet called ‘Ovarian Debulking Surgery’.

Atypical endometrial hyperplasia

This is a condition where there are changes in the cells lining the womb (endometrium). It can indicate an increased chance of developing cancer or can have areas of cancer around it. When atypical endometrial hyperplasia is diagnosed following endometrial biopsy, a hysterectomy is usually recommended as the treatment.

Are there any alternatives to this operation?

Yes, but they vary from patient to patient. The team will discuss the options available to you.

What about losing my fertility?

At any age having to have your womb and/or ovaries removed can affect the way you feel about yourself. A hysterectomy will prevent you from having children in future. The loss of fertility can have a significant impact on you if you have not started or completed your family. You may want to make sure you have explored all your options with your team, who can also seek more specialist fertility advice if this is required.

Will my ovaries continue to produce eggs?

If your operation has not involved removing your ovaries then they will continue to produce eggs. As you have had a hysterectomy, you will not menstruate (have periods) each month and so your body will absorb the eggs harmlessly.

Will I need hormone replacement therapy (HRT)?

If your ovaries have been removed as part of your surgery and you have not already been through the menopause you may start having menopausal symptoms. These can include hot flushes, dry skin, and dryness of the vagina, feeling low and anxious and being less interested in sex for a time. Many of these symptoms can be eased by hormone replacement therapy (HRT). HRT is available in many forms – as implants, patches, tablets, gels, sprays and vaginal creams. Not all patients can have hormone replacement therapy and your doctor will discuss your options with you. There are alternative ways of managing the potential symptoms.

Is there anything I should do to prepare for the operation?

Yes, make sure that all your questions have been answered to your satisfaction and that you fully understand what is going to happen to you. You are more than welcome to visit the hospital before you are admitted.

If you smoke, it would benefit you greatly to stop smoking or cut down before you have your operation. This will reduce the risk of chest troubles, as smoking makes your lungs sensitive to the anaesthetic.

You should also eat a well balanced diet and if you feel well enough, take some gentle exercise before your operation, as this will also help your recovery afterwards. Your GP, the practice nurse at his/her surgery or the doctors and nurses at the hospital will be able to give you further advice about this.

Before you come into hospital for your operation, try to organise things for when you get home. If you have a freezer, stock it with easy to prepare food. Arrange for relatives and friends to do your heavy work (such as changing your bed sheets, vacuuming and gardening) and to look after your children, if necessary.

What tests will I need before my operation?

You will be asked to attend the pre-admission clinic about one or two weeks before your operation. Tests will be arranged to ensure you are physically fit for surgery. Recordings of your heart (ECG) may be taken as well as a chest X-ray. A blood sample will also be taken to check your blood counts. The nurses on the ward will take some details and ask some questions about your general health. Your temperature, pulse, blood pressure, breathing rate, weight and will be measured and a urine sample tested.

The nurses will explain to you about the post-operative care following your operation. You will have the opportunity to ask any questions that you or your family may have. It may help to write them down before you come to the clinic.

When will I come in for my operation?

You will be admitted the day before, or the day of your operation. You will be informed of where to arrive and at what time. On your arrival the ward clerk or one of the nurses will greet you and show you to your bed.

You will meet the ward nurses and doctors involved in your care. If you have not signed a consent form in the clinic, you will be asked to sign a consent form on admission to confirm that you understand and agree to the operation. The anaesthetist will visit you to discuss the anaesthetic and to decide whether you will have a 'pre-med' (tablet to relax you) before you go to the operating theatre.

You will not be allowed to have anything to eat or drink (including chewing gum or sweets) for at least 6 hours before your operation. If you are on any medication, you may need to take your tablets in the morning with a little water. The nurses on the ward will tell you which medication you need to take.

What will happen the day of the operation?

Before going to the operating theatre, you will be asked to take a bath or shower and change into a theatre gown. All make-up, nail varnish, jewellery (except wedding rings which can be taped over), contact lenses, wigs and scarves must be removed.

What will happen after the operation?

One of the nurses will collect you from the 'recovery' area (where you wake up after your surgery) and escort you back to the ward.

When you return from theatre please tell us if you are in pain or feel sick. We have tablets/injections that we can give you to relieve these symptoms as and when required.

Above all, we want you to remain comfortable and pain free. You may have a device that you use to control your pain yourself. This is known as a PCA (patient controlled analgesia) and how to use it will be explained to you.

You may still be very sleepy and be given oxygen through a clear mask to help you breathe comfortably immediately after your operation. A drip will be attached to your arm or hand to give you fluids to prevent dehydration until you are eating and drinking well.

You will have four very small wounds that will be covered with dressings. These will be removed two days after your operation and the wounds left exposed. You will be asked to take a shower to help keep your wound clean. Avoid highly scented soaps and do not rub the wound area. When

drying pat the area dry and avoid rubbing the wounds. Your wounds will be looked at daily to ensure they are healing. The stitches are dissolvable and will dissolve as the wound heals.

A catheter (tube) will be inserted into your bladder in theatre to drain urine away. As the bladder is positioned close to the cervix, uterus and vagina, where the surgery has taken place, the catheter will allow the area to recover and heal. The catheter will need to stay in for approximately one to two days. When the catheter is removed, the nurses will monitor how much urine you are passing to ensure you are emptying your bladder properly.

You may also have trouble opening your bowels as it takes a few days before they start to work properly. You may have discomfort due to the build up of wind for the first few weeks following surgery. This is temporary and we can give laxatives if needed and hot peppermint water to help relieve wind pain.

You may have some vaginal bleeding for the first few days following surgery. The bleeding normally turns to a red/brownish discharge before disappearing after a few days to a few weeks.

When can I go home?

You will be in hospital between 1 to 2 days, depending on your individual recovery, how you feel physically and emotionally, and the support available at home. This will be discussed with you before you have your operation and again whilst you are recovering.

When can I get back to normal?

It is usual to continue to feel tired when you go home. It can take up to four weeks to fully recover from this operation. However, your energy levels and what you feel able to do will usually increase with time. For the first 4 weeks avoid lifting or carrying anything heavy (including children and shopping).

When can I return to work?

If you work then this will depend on the type of work that you do, how well you are recovering and how you feel physically and emotionally. Any job requiring heavy lifting may take a bit longer to return to, but you are the best judge as to how you feel.

Most women need approximately 4-6 weeks away from work to recover fully before returning to work or their usual routine. However, this will depend upon your recovery, and you can discuss it further with your doctor, specialist nurse or GP.

When can I start driving again?

We advise you not to drive for at least 4 weeks after your operation or until you have had your check up at the hospital. You can normally resume driving when you can stamp your feet hard on the ground without causing any pain or discomfort, as this movement is required in an emergency stop. Most important of all is that you should feel comfortable during driving and not distracted by the pain during the manoeuvres. It is advisable to check the details of your car insurance policy, as some contain clauses about driving following an operation.

What about exercise?

You will be shown some exercises in the hospital by the physiotherapists, and it is important that you continue to do these for at least 6 weeks after your operation. These should include exercises to build and maintain strength in the muscles of the pelvic floor. It is important to get these muscles working properly after your surgery, and these exercises help to prevent prolapse, and urinary or faecal incontinence, in future if they are continued lifelong. Aerobic exercise, such as jogging, will need to be built up slowly over a period of weeks after your surgery.

When can I have sex?

You may resume sexual activity when you feel fit and able to do so but it is advisable to give your stitches time to heal (usually about 6 weeks).

Many women find it reassuring to know that following a laparoscopic hysterectomy there should be little change to their sexual response as the vagina is essentially unaltered. If an orgasm is a normal experience for you during sexual activity then this should continue.

During this time, it may feel important for you and your partner to maintain intimacy, despite refraining from sexual intercourse. However, some couples are both physically and emotionally ready to resume having sex much sooner and this can feel like a positive step.

It can be a worrying time for your partner. He or she should be encouraged to be involved in discussions about the operation and how it is likely to affect your relationship afterwards.

Will I need to visit the hospital again after my operation?

Your follow up will be planned with either your GP or the Gynaecologist at around 6 weeks after the operation. Sometimes no follow up appointment is required. It is common practice for the womb to be send for examination under a microscope in the laboratory after the surgery, and, if no follow up has been planned, a letter will be sent to you with the results of this examination. .

Do I need to have cervical smears?

Before you are discharged the doctor or nurse specialist will let you know if this applies to you.

It is important that you make a list of all medicines you are taking and bring it with you to all your follow-up clinic appointments. If you have any questions at all, please ask your surgeon, oncologist or nurse. It may help to write down questions as you think of them so that you have them ready. It may also help to bring someone with you when you attend your outpatient's appointments.

When to seek medical advice

Burning or stinging when passing urine, or going to the toilet more frequently – this may indicate a urinary infection

Heavy or smelly vaginal bleeding – this may be a sign of an infection

Redness, pain, swelling or discharge from the wounds on your tummy – this may be a sign of an infection

Increasing pain in your tummy or feeling shivery/feverish – this may be a sign of a serious complication or infection

A red, hot, swollen or painful leg – this may be a sign of a blood clot in the large veins of the leg

Pain in the chest or difficulty breathing – this may be a sign of a chest infection or a blood clot of the large veins of the lung

If you experience any of these symptoms, please seek advice from your GP or The Gynaecology Assessment Unit (Good Hope Hospital – 0121 424 7747, Heartlands Hospital – 0121 424 3505/3506). For urgent or emergency treatment, go to A&E.

Glossary of medical terms used in this information:

Catheter: a flexible tube used to drain fluid from the bladder.

Cervix: the narrow outer end of the uterus or womb.

ECG: also known as an electrocardiogram is a test which measures the electrical activity of the heart.

Fallopian tubes: one of a pair of long, slender tubes that transport eggs released from the ovary to the womb.

Ovary: one of two small oval bodies in which eggs and hormones are developed.

Physiotherapist: a therapist who treats injury or dysfunction with exercises and other physical treatments.

Uterus: Also known as the womb. A hollow muscular organ in the female pelvis, which a fertilised egg develops into an embryo.

This leaflet was originally developed by a range of health care professionals and the copyright was through the former Pan Birmingham Cancer Network. The leaflet has now been adopted by University Hospitals Birmingham NHSFoundation Trust and reviewed and revised in line with trust policy.

If you require this information in another format, such as a different language, large print, braille or audio version please ask a member of staff or email interpreting.service@uhb.nhs.uk.