Hysterectomy:

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Introduction:

Hysterectomy is one of the commonest operations performed in gynaecology. It involves removal of the uterus, and commonly the cervix, fallopian tubes and sometimes the ovaries. The exact historical origin of the operation is not clear, however, one should be aware that it is a major operation since it is associated with surgical and anaesthetic risk. Once the uterus is removed you will be unable to bear children.

What are the different types of hysterectomy?

- Total abdominal hysterectomy (TAH) - removal of the uterus and cervix. If the ovaries are removed at the same time then it is referred to as a total abdominal hysterectomy and oophorectomy (which refers to the ovaries). One or both of the ovaries might be removed.

- Subtotal hysterectomy – In this case only the uterus is removed but the cervix is left behind. It is usually done when it is difficult to remove the cervix or in cases when there is a lot of bleeding at the time of hysterectomy. In this case you will need to continue to have papsmears since your cervix is left behind.

- Vaginal hysterectomy – removal of the uterus through the vagina. Usually done when the uterus is small, moves easily and when the gynaecologist does not suspect cancer.

- Radical hysterectomy – done in cases of early cervix cancer. The uterus, cervix and upper part of the vagina as well as the tissue around the cervix is removed. The ovaries, lymph nodes and fallopian tubes are usually removed during this operation.

The type of hysterectomy chosen will depend on the on your diagnosis and a discussion between yourself and the gynaecologist. All of the above procedures involve a cut through the abdominal skin (abdominal approach) except the vaginal hysterectomy (vaginal approach). In some cases the uterus might be removed with laparoscopic surgery-which means that there is no ‘big cut’ but 3 small cuts through which the operation is performed.

What should you know before a hysterectomy?

- What is the reason for the hysterectomy?
- Were other options explored or discussed?
- Will the ovaries be removed, and if so will you need hormone replacement therapy?
- What does the procedure involve?
- What will the post operative recovery entail?

What are the indications for hysterectomy?

There are several reasons why your doctor will recommend a hysterectomy. In some cases it is not recommended as first line treatment if other least invasive options are available. Indications include:

- Fibroids - one of the commonest reasons for hysterectomy. Common in middle age and reproductive age group. It is also referred to as ‘myoma’, ‘fibroma’ and ‘leiomyoma’. It is most times a non-cancerous growth from the smooth muscle of the uterus. In cases when it is very small and does not cause you any problems (such as excessive bleeding and lower abdominal pain) you may not need any treatment after discussion with the doctor. When they are bigger and symptomatic then depending on the size, your doctor might recommend other lesser invasive treatment such as pills to control the bleeding and pain, or uterine artery embolization (covered in a separate section below). If this does not work, or if the fibroids are quite big, then a hysterectomy will be recommended.

They can be located at different areas of the uterus and are then called different names such as ‘intramural’ (in the uterine muscle), ‘subserosal’ (beneath the

surface of the uterus), ‘submucosal’ (in the lining of the uterus). The submucosal form may be associated with difficulty in falling pregnant since it might interfere with the normal cavity of the uterus. Cervical fibroids are located in the cervix.

- Menorrhagia - refers to heavy and prolonged menstrual bleeding which may occur on a regular basis. It is not a diagnosis since there are many causes of ‘heavy bleeding’. When it occurs irregularly (no cycle control) then it is referred to as ‘menometrorrhagia’. It may be associated with pain as well. The usual menstrual cycle is between 25-35 days, and most times you will bleed for an average of 5-7 days (losing an average of about 25-80 mls per cycle). There are several reasons why this can happen such as problems with the blood clotting system. You will need to consult a gynaecologist to make a diagnosis so that appropriate treatment can be suggested. When this is mild and no definitive cause is found, treatment with the contraceptive pill, iron tablets, and pain medication maybe first recommended by your doctor.

- Cancer – early cancer of the cervix, uterus and ovaries.

- Chronic pelvic pain – this diagnosis is made after you have consulted a gynaecologist and other pathology has been excluded. At first your pain will be controlled medically but only if you are non-responsive then a hysterectomy might be discussed. In some cases the pain does not disappear after the hysterectomy.

- Vaginal prolapse- a vaginal hysterectomy might be suggested by your doctor in cases of uterine prolapse. Other operations also exist such as sacrohysteropexy, and bilateral Richter’s procedure. Please discuss this with the gynaecologist.

Complications of hysterectomy:

This is dependent on the indication for the hysterectomy and any other medical problems that you might have such as obesity, hypertension, diabetes etc. You should be briefed about these potential complications before the surgery. Also intraoperative (e.g. bleeding, injury to other organs, need for blood transfusion

and postoperative problems (e.g. wound healing, blood clots, urinary tract infections etc.) should be discussed before the procedure.

What to expect after a hysterectomy?

In hospital: Once your drip and catheter are removed you will be encouraged to walk around. A physiotherapist might assist you with this. Adequate pain medication will be prescribed and sometimes blood-thinning injections to prevent clotting in the calf muscle (i.e deep vein thrombosis which can be fatal). Antibiotics and stool softeners may be also prescribed. Your doctor will advise you when it is safe to begin eating again, as well as discuss the issue of hormone replacement therapy.

When you are discharged you might experience the following:

- Mild vaginal spotting (reddish or brownish). This should clear up soon. Note that there might be a sudden gush of blood of fluid at about 7-10 days later and it is best to then revisit your doctor.
- Pain and discomfort- this is also expected since you had an organ removed from your body! Pain medication is prescribed upon discharge to make you more comfortable.
- Tiredness-this is usually due to the effects of the general anaesthetic drugs and the stress of surgery. You will begin to feel better each day and if not discuss this at your postoperative consultation.

General advise:

- Keep your stools soft,
- stop smoking (if you’re a smoker)
- get help at home,
- stay positive,
- establish a daily routine,
- discuss the histological findings with your doctor- usually 4-6 weeks later

- You should be able to resume sexual intercourse and work 6 weeks after the procedure
- Consult your doctor again should you have any concern!!!