

Having a laparoscopic hysterectomy

Total laparoscopic hysterectomy (TLH)

*Laparoscopic assisted vaginal
hysterectomy (LAVH)*

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Who is this information for?

This information is for you if you are about to have, or you are recovering from total laparoscopic hysterectomy. You might also find it useful to share this information with your family and friends.

What is a hysterectomy?

A removal of the womb/uterus. The uterus can be removed in one of four ways:

1. A big cut on the abdomen (bikini-line or vertical).
2. Vaginally.
3. A combination of laparoscopic and vaginal operating.
4. Totally laparoscopic (key hole surgery).

Option 1 is the most commonly used approach to remove the uterus. While it is a safe technique overall, its disadvantages include longer hospital stay (usually 3 to 5 days), longer recovery and longer time to return to work (usually 6 -12 weeks), need for more pain medication and a relatively high rate of wound complications (especially in overweight/obese and cancer patients).

A vaginal hysterectomy or a combination of a laparoscopic operation with a vaginal hysterectomy (options 2 and 3) mean the hospital stay and recovery time are shorter and less pain medication is required than with the first option. This technique is often not feasible for patients who are very overweight or who have not had vaginal childbirths.

Option 4 - a Total Laparoscopic Hysterectomy (TLH) - this means the whole operation is performed by keyhole. After TLH, if there are no complications, patients usually stay in hospital for 24-48 hours and they are back to work after 2-6 weeks. Obviously, this would depend on the type of job. The overall complication rate is one third when compared to the first option, and the need for painkillers is reduced by 90% when compared to a major cut on the abdomen

and 50% when compared to a vaginal hysterectomy. This technique is often not feasible for patients with a large uterus. In about 5% of patients where a TLH is planned, the operation has to be converted to a laparotomy (a major cut on the abdomen). The reasons for this could be intraoperative complications (which are rare) or extremely difficult surgery where the continuation of a laparoscopic technique would increase the risk of complications.

What is a laparoscopic hysterectomy and how is it performed?

The skin on your abdomen will be cleansed. A catheter (a fine tube that is inserted into your bladder through your urethra, the opening where your urine normally comes out of) is used to empty your bladder. A small instrument is fitted into the womb to allow your gynaecologist to view behind your womb. The laparoscope is introduced into the abdomen through a small incision in the skin directly below or inside the belly button. The gynaecologist will do further small cuts at the left and right side of your abdomen and bikini line. After the procedure these wounds will be either glued or stitched and a small dressing applied.

Harmless carbon dioxide gas is used to lift the abdominal wall so that the pelvic organs can be seen more easily.

There are several different types of hysterectomy, including:

- Total hysterectomy, where both the uterus and cervix (neck of the womb) are removed.
- Subtotal hysterectomy, where just the uterus is removed and the cervix is not.
- Hysterectomy with salpingo-oophorectomy (removal of one or both of your ovaries and your fallopian tubes) at the same time.

Some laparoscopic hysterectomies are done entirely by keyhole surgery using four tiny abdominal incisions between 0.5cm and 1cm in length. The uterus and related organs are all removed via the small abdominal incisions. This is called a Total laparoscopic hysterectomy (TLH).

Others are done partially through your vagina sometimes called a laparoscopic assisted vaginal hysterectomy (LAVH). This procedure requires an incision deep within the vagina, through which the uterus and related organs are removed. The LAVH still involves a transvaginal (through the vagina) approach but still has decreased healing time, similar to a total vaginal hysterectomy.

During the procedure the vessels supplying your womb with blood will be sealed by heat and then cut. Other structures such as ligaments will also be sealed and cut to allow removal of your womb.

The type of hysterectomy will depend on your personal circumstances and will be discussed with you by your gynaecologist before your operation. You will need an anaesthetic for a laparoscopic hysterectomy. This will be a general anaesthetic +/- a regional anaesthetic (spinal or epidural).

About this information

You should read this information together with any other information you have been given about your choices and the operation itself. This information gives general advice based on women's experiences and expert opinion. Every woman has different needs and recovers in different ways.

Your own recovery will depend on:

- how fit and well you are before your operation
- the reason you are having a hysterectomy
- the exact type of hysterectomy that you have
- how smoothly the operation goes and whether there are any complications.

What are the intended benefits of having this procedure?

The aim is to improve your symptoms based on your clinical condition. Most commonly a hysterectomy is performed for

- Heavy periods – menorrhagia
- Painful periods - dysmenorrhea

Sometimes the procedure is done to treat

- Severe premenstrual symptoms (PMS)
- Endometriosis (a condition making periods painful)

It is also performed for

- Cancer or pre-cancer of the lining of the womb.

What are the risks?

This procedure is usually uncomplicated. However, all surgeries involve risks. Complications tend to be more frequent if you have had previous abdominal surgery, if you are overweight and suffer with chronic medical conditions such as diabetes, cardiac or breathing problems.

High body mass index (BMI)

An elevated BMI increases your risks of surgical complications, if you are overweight, it can take longer to recover from the effects of the anaesthetic and there is a higher risk of complications such as infection and thrombosis. BMI is based on your height and weight. This is one way to see if you're at a healthy weight.

- Underweight your BMI is less than 18.5
- Healthy weight your BMI is 18.9 to 24.9
- Overweight your BMI is above 25.

Infection

Surgery is covered with antibiotics, but infection can occur in the chest, urine, scars (umbilical wound) or internal infections of the pelvis or the wound at the top of your vagina. These are usually easily treated with antibiotics. Sometimes an abscess may have to be drained.

Refer to the sections on vaginal bleeding, stitches and dressings for advice on reducing your risk of infection.

Wound bruising and gaping

These are frequent risks but will usually resolve without any intervention.

Bleeding

Heavy bleeding (haemorrhage) at the time of surgery is rare. This is more likely to happen when the operation is done for fibroids. Blood loss is usually less than 200 mls, however, blood loss requiring a blood transfusion or return to theatre within the first 24 hours of the operation because of internal bleeding or bleeding through the vagina occurs in 3% of patients.

Haematoma

A collection of blood (haematoma) at the top of the vagina in place of your womb may occur. This is called a vault haematoma. Most patients do not require treatment, although antibiotics are sometimes needed or follow up ultra sound scans to ensure the blood gets absorbed by your body. Very rarely these collections of blood require surgical drainage. When you are at home after the operation the loss should be light, like the end of a period, and getting less and less each day. If it becomes very heavy or smelly, please contact either the hospital or your GP.

Retention of urine

Sometimes it may be difficult to pass urine once your catheter is removed and occasionally it is necessary to catheterise you and send

you home with a catheter in to return in 1 week to have it removed and try to pass urine independently. During the following weeks or months you may need to pass urine more frequently. This will usually settle. Drinking 1.5-2.0 litres of fluid each day and converting on to decaffeinated drinks can help to resolve this.

Anaesthetic

Your anaesthetist will be able to discuss with you the risks of having an anaesthetic. Please read “You and your Anaesthetic” patient information leaflet.

Deep vein thrombosis (DVT)A blood clot including pulmonary embolus (a blood clot in the lung) is also a potential risk. Blood clots in the legs and lungs can occur after surgery, though the risk is small (less than 1%). Specific steps are taken to minimize this risk such as use of compression stockings and blood thinning injections. By staying active and well hydrated you can further reduce the risk of clots.

Refer to the section on “Formation of blood clots - how to reduce the risk”.

Hernia Ref 1

This is when tissue pushes through a surgical wound in the abdomen that has not completely healed.

Damage to organs

The operation is safe but in rare instances damage to internal organs can occur. Many of these complications will be identified during the procedure but sometimes can go unrecognised and only become apparent once you go back to the ward hence it is sometimes necessary for you to return back to theatre to repair any damage.

Once recognised the injury will be repaired, usually by keyhole surgery. A laparotomy- open operation through a larger incision (cut) may have to be carried out to explore and repair the injury when for

technical reasons it is not possible to complete the procedure by keyhole surgery. These complications once corrected do not usually lead to any long term problems.

Damage to the bowel (<1 in 100). The lowest part of your bowel can sometimes get injured during the procedure. Depending on the size of the injury a simple repair by keyhole may be sufficient but sometimes a laparotomy with a colostomy (stoolbag to the skin) may be required for several months.

Damage to the uterus/womb (1 in 100) Trauma to the womb or perforation is also a small risk but this usually heals easily on its own.

Damage to the bladder (<1 in 50) A catheter will be left in your bladder for 10-14 days to allow the repaired area to heal. An Xray will be done 10 days after the operation to exclude any leakage from the bladder and the catheter will finally be removed.

Damage to the ureter(<1 in 100) s – Ureters are the tubes that connect your kidneys to the bladder on each side of your pelvis, they lie immediately below and behind your ovary and they are frequently found near where the scars of endometriosis are, hence the risk of them becoming injured. If this happens, a laparotomy will usually be required and you will have to stay in hospital for several days following the procedure.

Haemorrhage (excessive bleeding) during or after surgery due to damage to the larger blood vessels (<1 in 100) may require a blood transfusion or a second open operation to stop the bleeding.

Some women may be more at risk of complications. For example:

- previous major abdominal surgery, particularly if a long midline incision has been made (between the belly button and the pubic line)
- Caesarean section via the bikini line incision
- Previous peritonitis or inflammatory bowel disease.

If your gynaecologist thinks you are at high risk of complications from laparoscopic surgery then they may advise that you have your surgery done through an open operation (through a larger cut) instead, known as a laparotomy.

Refer to the section on “what can slow down my recovery”

Are there any alternatives?

Alternative treatment options will vary based on your specific clinical condition, which will be discussed with you by your gynaecologist.

Hysterectomy is required when most other methods have not been successful. These include methods such as tablets (tranexamic acid and hormonal ones), the Mirena device (a device coated with a thin layer of the hormone progesterone which is placed inside your womb) and endometrial ablation (destruction or removal of the lining of the womb) So Laparoscopic Hysterectomy is one of the treatment options for your clinical condition.

Alternatives to hysterectomy when done for heavy periods include uterine artery embolization (ref1). This procedure is done by radiologists and involves blocking the blood supply to your womb by placing fine wire through a blood vessel in your groin. Another way is monthly injections of GnRh agonists, which involves monthly injections that will cause you to go into the menopause. This method is not a long term treatment and mainly used for patients close to the menopause or patients for whom surgery is considered too dangerous.

Specific issues

Does my cervix have to be removed?

Many women are concerned that removing their cervix will lead to a loss of sexual function, but there is no evidence that this is the case (ref 2). Some women are reluctant to have their cervix removed because they want to retain as much of their reproductive system as possible. If you feel this way, you should talk to your gynaecologist about possible risks of keeping your cervix. 5% of women who keep their cervix will require an operation at a later date to address problems related to the retained cervix (on going bleeding etc.)

What about my ovaries?

Your gynaecologist may recommend removal of your ovaries (oophorectomy) This is particularly appropriate in women with a family history (mother or sibling) of ovarian cancer or breast cancer or they are found to carry a genetic fault (BRCA1 BRCA2) Ref 3, to prevent cancer from occurring in the future.

Sometimes it is advisable to have the ovaries removed to increase the success of the operation. This applies particularly to patients who have a condition called endometriosis, patients with severe premenstrual symptoms and patients with cancer/pre-cancer of the lining of the womb. Your gynaecologist will be able to discuss the benefits and disadvantages of removing your ovaries with you. If your ovaries are removed your fallopian tubes will also be removed (salpingectomy)

If you have already gone through, or are close to the menopause, some gynaecologists will recommend removing ovaries regardless of the reason for your hysterectomy. This is because it is a good way to protect against the possibility of ovarian cancer developing in the future.

Other gynaecologists feel it is best to leave the ovaries in place if the risk of ovarian cancer is small, for example, if there is no family history. This is because the ovaries produce several hormones that are beneficial to women. They can help protect against such

conditions as osteoporosis and they play a part in feelings of desire and pleasure.

If you would prefer to keep your ovaries, make sure that you have discussed with your gynaecologist and make it clear before your operation. You may still be asked to give your consent for your ovaries to be removed if an abnormality is found during the operation. Think carefully about this and discuss any fears or concerns you have with your gynaecologist.

Refer to the section on Starting HRT (hormone replacement therapy).

How successful is the operation?

The procedure is always successful when it is done to treat heavy periods (menorrhagia) because you will no longer have periods. Occasionally when the neck of the womb (cervix) is not removed a small cyclical bleed can still occur. In most situations both the neck of the womb and the womb itself are removed.

When a hysterectomy is done to treat pain, the ovaries are sometimes removed at the same time and the likelihood of the pain persisting in this situation is less than 1 in 20.

Irrespective of the reason for doing the hysterectomy about 1 in 20 will need another gynaecological operation in the following 10 years.

Do I need to do anything before I come in to hospital?

To help you recover from your operation and reduce your risks of complications it helps if you are fit as fit as possible beforehand. As soon as you know you are going to have a hysterectomy operation, try to:

- Stop smoking
- Eat a healthy diet
- Do regular exercise
- Lose weight if you are over weight.

Pre-assessment

You will have to attend a pre-assessment appointment. This will involve having a general health check, anaesthetic assessment, blood tests and heart monitoring (ECG) to make sure that you are fit for surgery.

Fasting

Please follow the fasting instructions either sent out to you by the waiting list office or pre assessment. This includes not being able to suck sweets, chew gum or have a drink. It is important that you fast to ensure you have an empty stomach. If not you may vomit whilst you are anaesthetised and inhale vomit into your lungs and become seriously ill. If you do not adhere to the fasting instructions your operation will be cancelled.

Bowel preparation

If there is an increased risk of injury to your bowel your gynaecologist may prescribe you medication to empty your bowel before your surgery. Please follow the instructions given to you by your consultant on when to take this, it will be written on the box the medication is provided in. You will also need to have a low residue diet the day before your procedure. Information on what this is, can be found on pages 36-38.

Medication

Unless you have been advised otherwise please take your tablets and medication as normal. Medications that increase your risk of bleeding after surgery (asprin, warfarin, clopidogrel, ticagrelor, rivaroxaban, apixaban, dabigatran, diprydamole sometimes called persantin) you will be advised at pre assessment what you need to do about them.

Arrange help and prepare your home.

Organise for a friend or relative to help you at home after you leave hospital. Sort out transport to take you to hospital and home from hospital. Prepare your home. Before you go into hospital put your TV remote control, radio, telephone and medication close to where you will spend most of your time. Stock up on food that is easy to prepare during your recovery. Precook and freeze meals that can be warmed up.

Comfort and security

To reduce the risk of infection, please have a bath or a shower before you arrive. It is advisable to wear loose fitting clothing and underwear as your abdomen will be bloated and tender after your operation.

Bring a change of night clothes, toiletries, antiseptic hand wipes or gel, a book, magazine, ipad or other things to help pass time during your recovery.

Do not wear any makeup especially foundation, mascara and lipstick. Foundation and lipstick mask the true colour of your skin which the anaesthetist will want to see. Flakes of mascara could get into your eyes during the anaesthetic causing irritation. You will also need to remove any nail polish and jewellery, other than your wedding ring.

Remember to write down or store in your phone important phone numbers.

Please bring a supply of sanitary towels with you, the use of tampons is not advisable.

Do not take any unnecessary money and valuables into hospital with you.

Please refer to the section on 'what can help me to recover'. What can slow down my recovery?

What can I expect after a laparoscopic hysterectomy?

Usual length of stay in hospital

In most instances, you will be admitted to hospital on the day of your operation. You may be able to go home within 24 hours or, depending on your circumstances, you may need to stay in hospital for one to three days.

After-effects of general anaesthesia

You will wake up in the operating theatre or the recovery room where a nurse will monitor your observations (blood pressure, pulse and oxygen saturations along with your pain score). You may have an oxygen mask over your face to help you breathe. Nausea is a common side effect with anaesthetic, if you feel sick, tell the nurse. If you have had an anaesthetic in the past and have had side effects mention this to the anaesthetist. Most modern anaesthetics are short lasting. You should not have, or suffer from, any after-effects for more than a day after your operation. You are likely to be in hospital during the first 24 hours but, if not, you need to make arrangements for someone to look after you and any dependent children in the first 24 hours and you should not drive or make any important decisions. During the first 24 hours you may feel more sleepy than usual and your judgement may be impaired. If you drink any alcohol, it will affect you more than normal. Please read "You and your Anaesthetic" patient information leaflet.

Catheter

You will have a catheter (tube) in your bladder to allow drainage of your urine. This is usually for up to 24 hours after your operation until you are easily able to walk to the toilet to empty your bladder. If you have problems passing urine, you may need to have a catheter for a few days.

Scars

You will have between two and four small scars/port sites (the holes through which the surgical instruments have been inserted) on different parts of your abdomen. Each scar will be between 0.5cm and 1cm long. You will feel sore around these port sites. If you have had your cervix removed, you will also have a scar at the top of your vagina.

Stitches and dressings

Cuts on your abdomen will be closed by stitches or glue. Glue and some stitches dissolve by themselves. Other stitches may need to be removed. This is usually done by the practice nurse at your GP surgery about five to seven days after your operation. You will be given information about this. Your cuts will initially be covered with a dressing. You should be able to take this off about 24 hours after your operation and have a wash or shower (see section on washing and showering). Wound bruising and gaping are frequent risks but will usually resolve without any intervention. Any stitches in your vagina will not need to be removed, as they are dissolvable. You may notice a stitch, or part of a stitch, coming away after a few days or maybe after a few weeks. This is normal and nothing to worry about.

Drains

Occasionally a drain may be placed inside your abdomen. This is usually removed after 24 hours. This is so that any fluid inside the abdomen after the surgery can drain away.

Packs

Very occasionally you may have a pack (a length of gauze like a large tampon) in your vagina after the operation to reduce the risk of bleeding. A nurse will remove this after your operation while you are still in hospital. Check with your nurse that this has been done before you go home.

Vaginal bleeding

You can expect to have some vaginal bleeding for one to two weeks after your operation. This is like a light period and is red or brown in colour. Some women have little or no bleeding initially, and then have a sudden gush of old blood or fluid about 10 days later. This usually stops quickly. You should use sanitary towels rather than tampons as using tampons could increase the risk of infection.

Pain and discomfort

You can expect pain and discomfort in your lower abdomen for at least the first few days after your operation. You may also have some pain in your shoulder. This is a common side effect of laparoscopic surgery. When leaving hospital, you should be provided with painkillers for the pain you are experiencing. Sometimes painkillers that contain codeine or dihydrocodeine can make you sleepy, slightly sick and constipated. If you do need to take these medications, try to eat extra fruit and fibre to reduce the chances of becoming constipated. Taking painkillers as prescribed to reduce your pain will enable you to get out of bed sooner, stand up straight and move around - all of which will speed up your recovery and help to prevent the formation of blood clots in your legs or your lungs.

Trapped wind

Following your operation your bowel may temporarily slow down, causing air or 'wind' to be trapped. This can cause some pain or discomfort until it is passed. Getting out of bed and walking around will help. Peppermint water or peppermint capsules may also ease your discomfort. Once your bowels start to move, the trapped wind will ease.

Starting to eat and drink

After your operation, you will have a drip in your arm to provide you with fluids. When you are able to drink again, the drip will be removed. You will be offered a drink of water or cup of tea and something light to eat. If you are not hungry initially, you should drink fluid. Try eating something later on.

Constipation

You may experience constipation following your surgery; this can be caused by the effects of the anaesthetic, your reduced mobility, reduced appetite and food intake, low fluid intake, and the effects of some types of analgesia (pain relief tablet) in particular codeine and tramadol. It is advisable to drink 1.5-2.0 litres of fluid a day and increase fruit, vegetables and fibre in your diet. If this doesn't help speak to your general practitioner.

Washing and showering

You should be able to have a shower or bath and remove any dressings the day after your operation. Don't worry about getting your scars wet – just ensure that you pat them dry with clean disposable tissues or let them dry in the air. Keeping scars clean and dry helps healing.

Formation of blood clots – how to reduce the risk

You can reduce the risk of clots by:

- being as mobile as you can as early as you can after your operation
- doing exercises when you are resting, for example:
 - pump each foot up and down briskly for 30 seconds by moving your ankle, move each foot in a circular motion for 30 seconds, bend and straighten your legs - one leg at a time, three times for each leg.

You may also be given other measures to reduce the risk of a clot developing, particularly if you are overweight or have other health issues.

These may include:

- Daily heparin injections (a blood thinning agent) - you may need to continue having these injections daily when you go home; your doctor will advise you on the length of time you should have these for.
- Graduated compression stockings, which should be worn day and night until your movement has improved and your mobility is no longer significantly reduced.
- Special boots that inflate and deflate to wear while in hospital.

Physiotherapy

You will be given advice and information about exercises to help you recover and about ways to move easily and rest comfortably. You should be given written information on this. The ward physiotherapist may also visit you after your operation to show you some exercises and have a discussion with you about how to progress with getting out of bed and mobilising. The physiotherapist will also advise you on how to do pelvic floor muscle exercises.

Starting HRT (hormone replacement therapy)

If you have had both your ovaries removed or have no ovaries left at the end of the procedure then you will go into the menopause immediately following your operation regardless of your age. This is known as surgical menopause. Menopausal symptoms include hot flushes, sweating, disturbed sleep and tiredness. You will be offered hormone replacement therapy (HRT) to replace the hormones of your ovaries, namely oestrogen, if you are less than 50 at the time of your surgery. Oestrogens are recommended to protect your bones, blood vessels, hair and skin. If your hysterectomy leaves one

or both your ovaries intact, there is a chance that you will go through the menopause a little earlier than you would otherwise have done. (up to 4 years earlier)

Recent evidence and the National Institute for Health and Care Excellence's (NICE) 2015 say that the risks of HRT are small and are usually outweighed by the benefits.

Breast cancer

NICE says: taking combined HRT (oestrogen **AND** progestogen) is associated with a small increased risk of breast cancer – some studies have suggested that for every 1,000 women taking combined HRT, there will be around five extra cases of breast cancer (from a normal risk of 22 cases of breast cancer per 1,000 menopausal women to 27)

- The risk of breast cancer decreases when you stop taking HRT – estimates suggest the level of risk returns to normal after about five years.
- Oestrogen-only HRT is associated with little or no change in the risk of breast cancer.

Because of the risk of breast cancer, it's especially important to attend all your breast cancer screening appointments if you're taking combined HRT.

Blood clots

Blood clots can be serious if they become lodged in a blood vessel and block the flow of blood. NICE says:

- taking HRT tablets can increase your risk of blood clots
- the risk of blood clots from HRT patches or gels is lower when compared to that seen in patients taking HRT as tablets.

It's thought the risk of developing a blood clot is about two to four

times higher than normal for women taking HRT tablets. But as the risk of menopausal women developing blood clots is normally very low, the overall risk from HRT tablets is still small. It's estimated that for every 1,000 women taking HRT tablets for 7.5 years, less than two will develop a blood clot.

Heart disease and strokes

NICE says:

- HRT doesn't significantly increase the risk of cardiovascular disease (including heart disease and strokes) when started before 60 years of age.
- oestrogen-only HRT is associated with no, or reduced, risk of heart disease.
- combined HRT is associated with little or no increase in the risk of heart disease.
- taking oestrogen tablets is associated with a small increase in the risk of stroke, although the normal risk of women under 60 having a stroke is very low, so the overall risk is small.

This will be discussed with you by your gynaecologist and together you can decide the best way. Speak to your GP if you're taking HRT or are considering taking it and are worried about the risk.

Cervical screening (smears)

Some women who have had a laparoscopic hysterectomy will need to continue to have smears from the cervix if their cervix was not removed or sometimes from the top of the vagina when the cervix has been removed and abnormal cells are found in the cervix. Check with your GP or gynaecologist whether this applies to you.

Tiredness and feeling emotional

ou may feel much more tired than usual after your operation as your body is using a lot of energy to heal itself. You may need to take a nap during the day for the first few days. A hysterectomy can also be emotionally stressful and many women feel tearful and emotional at first - when you are tired, these feelings can seem worse. For many women this is the last symptom to improve.

It is common to feel a sense of loss and sadness after a hysterectomy. Some women who have not one through the menopause may feel a loss as they can no longer have children, other might have a sense that they are less 'womenly' than before. In some cases, having a hysterectomy can be a trigger for depression. You may find talking to other women who have had a hysterectomy can provide emotional support and reassurance. Your general practitioner (GP) may be able to recommend a local support group. Charities such as The hysterectomy Association (www.hysterectomy-association.org.uk) can put you in touch with other women through online forums. If feelings of depression persist, you should see your own GP, who will be able to advise you on available treatments options.

When will I be able to go home?

In most situations you will be able to go home within 48 hours of your surgery. Your individual needs will be considered and you will not be discharged from hospital until you are ready. This will be when you are mobile, able to eat and drink, and can control your pain by taking tablets. The team will make sure you get pain relief to allow you to do your activities comfortably. Before you leave hospital, you will be given instructions about who to contact if you have any worries.

What can help me recover?

It takes time for your body to heal and for you to get fit and well again after a laparoscopic hysterectomy. There are a number of positive steps you can take at this time. The following will help you recover.

Rest

Rest as much as you can for the first few days after you get home. It is important to relax, but avoid crossing your legs for too long when you are lying down. Rest does not mean doing nothing at all throughout the day, as it is important to start exercising and doing light activities around the house within the first few days.

A pelvic floor muscle exercise programme

Your pelvic floor muscles span the base of your pelvis. They work to keep your pelvic organs in the correct position (prevent prolapse), tightly close your bladder and bowel (stop urinary or anal incontinence) and improve sexual satisfaction.

It is important for you to get these muscles working properly after your operation, even if you have stitches. To identify your pelvic floor muscles, imagine you are trying to stop yourself from passing wind, or you could think of yourself squeezing tightly inside your vagina. When you do this you should feel your muscles 'lift and squeeze'. It is important to breathe normally while you are doing pelvic floor muscle exercises. You may also feel some gentle tightening in your lower abdominal muscles. This is normal. Women used to be told to practise their pelvic floor muscle exercises by stopping the flow of urine mid-stream. This is no longer recommended, as your bladder function could be affected in the longer term.

You can begin these exercises gently once your catheter has been removed and you are able to pass urine on your own.

You need to practise short squeezes as well as long squeezes:

- short squeezes are when you tighten your pelvic floor muscles for one second, and then relax
- long squeezes are when you tighten your pelvic floor muscles, hold for several seconds, and then relax.

Start with what is comfortable and then gradually increase, aiming for 10 long squeezes, up to 10 seconds each, followed by 10 short squeezes.

You should do pelvic floor muscle exercises at least three times a day. At first you may find it easier to do them when you are lying down or sitting. As your muscles improve, aim to do your exercises when you are standing up. It is very important to tighten your pelvic floor muscles before you do anything that may put them under pressure, such as lifting, coughing or sneezing. Make these exercises part of your daily routine for the rest of your life. Some women use triggers to remind themselves such as, brushing their teeth, washing up or commercial breaks on television.

Straining to empty your bowels (constipation) may also weaken your pelvic floor muscles and should be avoided. If you suffer from constipation or you find the pelvic floor muscle exercises difficult, you may benefit from seeing a specialist women's health physiotherapist.

A daily routine

Establish a daily routine and keep it up. For example, try to get up at your usual time, have a wash and get dressed, move about and so on. Sleeping in and staying in bed can make you feel depressed. Try to complete your routine and rest later if you need to.

Eat a healthy balanced diet

Ensure that your body has all the nutrients it needs by eating a healthy balanced diet. A healthy diet is a high fibre diet (fruit, vegetables, wholegrain bread and cereal) with up to two litres per day of fluid intake, mainly water. Remember to eat at least five portions of fruit and vegetables each day! As long as you are exercising enough and don't eat more than you need to, you don't need to worry about gaining weight.

Support from your family and friends

You may be offered support from your family and friends in lots of different ways. It could be practical support with things such as shopping, housework or preparing meals. Most people are only too happy to help - even if it means you having to ask them! Having company when you are recovering gives you a chance to say how you are feeling after your operation and can help to lift your mood. If you live alone, plan in advance to have someone stay with you for the first few days when you are at home.

A positive outlook

How your body heals and how you feel in yourself.

You may want to use your recovery time as a chance to make some longer term positive lifestyle choices such as:

- starting to exercise regularly if you are not doing so already and gradually building up the levels of exercise that you take
- eating a healthy diet - if you are overweight, it is best to eat healthily without trying to lose weight for the first couple of weeks after the operation; after that, you may want to lose weight by combining a healthy diet with exercise.

Whatever your situation and however you are feeling, try to continue to do the things that are helpful to your longterm recovery.

What can slow down my recovery?

It can take longer to recover from a hysterectomy if:

- you had health problems before your operation; for example, women with diabetes may heal more slowly and may be more prone to infection.
- you smoke - smokers are at increased risk of getting a chest or wound infection during their recovery, and smoking can delay the healing process.
- you were overweight at the time of your operation - if you are overweight, it can take longer to recover from the effects of the anaesthetic and there is a higher risk of complications such as infection and thrombosis.
- there were any complications during your operation.

Recovering after an operation is a very personal experience.

If you are following all the advice that you have been given but do not think that you are at the stage you ought to be, talk with your GP.

When should I seek medical advice after a laparoscopic hysterectomy?

While most women recover well after a laparoscopic hysterectomy, complications can occur - as with any operation. Before you telephone for advice please read through your information leaflet again carefully as this may answer your query.

You should seek medical advice from your GP, the hospital where you had your operation, NHS 111 or NHS 24, GAU gynaecology assessment unit 01924 541135, Endometriosis Clinical Nurse 07803 440236, if you experience:

- **Burning and stinging when you pass urine or pass urine frequently:** This may be due to a urine infection. Treatment is with a course of antibiotics.

- **Vaginal bleeding that becomes heavy or smelly:** If you are also feeling unwell and have a temperature (fever), this may be due to an infection or a small collection of blood at the top of the vagina called a vault haematoma. Treatment is usually with a course of antibiotics. Occasionally, you may need to be admitted to hospital for the antibiotics to be administered intravenously (into a vein). Rarely, this blood may need to be drained.
- **Red and painful skin around your scars:** This may be due to a wound infection. Treatment is with a course of antibiotics.
- **Increasing abdominal pain:** If you also have a temperature (fever), have lost your appetite and are vomiting, this may be due to damage to your bowel or bladder, in which case you will need to be admitted to hospital.
- **A painful, red, swollen, hot leg or difficulty bearing weight on your legs:** This may be due to a deep vein thrombosis (DVT). If you have shortness of breath or chest pain or cough up blood, it could be a sign that a blood clot has travelled to the lungs (pulmonary embolism). If you have these symptoms, you should seek medical help immediately.
- **There is no improvement in your symptoms:** You should expect a gradual improvement in your symptoms over time. If this is not the case, you should seek medical advice.

Getting back to normal

Around the house

While it is important to take enough rest, you should start some of your normal daily activities when you get home and build up slowly. You will find you are able to do more as the days and weeks pass. If you feel pain, you should try doing a little less for another few days.

It is helpful to break jobs up into smaller parts, such as ironing a couple of items of clothing at a time, and to take rests regularly. You can also try sitting down while preparing food or sorting laundry. For the first one to two weeks, you should restrict lifting to light loads such as a one litre bottle of water, kettles or small saucepans. You should not lift heavy objects such as full shopping bags or children, or do any strenuous housework such as vacuuming until three to four weeks after your operation as this may affect how you heal internally. Try getting down to your children rather than lifting them up to you.

Remember to lift correctly by having your feet slightly apart, bending your knees, keeping your back straight and bracing (tightening or strengthening) your pelvic floor and stomach muscles as you lift. Hold the object close to you and lift by straightening your knees.

Exercise

While everyone will recover at a different rate, there is no reason why you should not start walking on the day you return home. You should be able to increase your activity levels quite rapidly over the first few weeks. There is no evidence that normal physical activity levels are in any way harmful and a regular and gradual build-up of activity will assist your recovery. If you are unsure, start with short steady walks close to your home a couple of times a day for the first few days. When this is comfortable, you can gradually increase the time while walking at a relaxed steady pace. Many women should be able to walk for 30- 60 minutes after two or three weeks. Swimming is an ideal exercise that can usually be resumed within two to three weeks provided that vaginal bleeding and discharge

has stopped. If you build up gradually, the majority of women should be back to previous activity levels within four to six weeks.

Contact sports and power sports should be avoided for at least six weeks, although this will depend on your level of fitness before surgery.

Driving:

You should not drive for 24 hours after a general anaesthetic. Each insurance company will have its own conditions for when you are insured to start driving again. Check your policy.

Before you drive you should be:

- free from the sedative effects of any painkillers
- able to sit in the car comfortably and work the controls
- able to wear the seatbelt comfortably
- able to make an emergency stop
- able to comfortably look over your shoulder to manoeuvre.

In general, it can take two to four weeks before you are able to do all of the above. It is a good idea to practise without the keys in the ignition. See whether you can do the movements you would need for an emergency stop and a three-point turn without causing yourself any discomfort or pain. When you are ready to start driving again, build up gradually, starting with a short journey.

Travel plans

If you are considering travelling during your recovery, it is helpful to think about:

- the length of your journey - journeys over four hours where you are not able to move around (in a car, coach, train or plane) can increase your risk of deep vein thrombosis (DVT); this is especially so if you are travelling soon after your operation

- how comfortable you will be during your journey, particularly if you are wearing a seatbelt

Overseas travel:

- Would you have access to appropriate medical advice at your destination if you were to have a problem after your operation?
- Does your travel insurance cover any necessary medical treatment in the event of a problem after your operation?
- Whether your plans are in line with the levels of activity recommended in this information.

If you have concerns about your travel plans, it is important to discuss these with your GP or the hospital where you have your operation before travelling.

Having sex

You should usually allow four to six weeks after your operation to allow your scars to heal. It is then safe to have sex - as long as you feel comfortable. If you experience any discomfort or dryness (which is more common if your ovaries have been removed at the time of the hysterectomy), you may wish to try a vaginal lubricant. You can buy this from your local pharmacy or ask your Gp to prescribe something. Sylk, Replense and Yes, are non-hormonal lubricants, silicon or oil based lubricants last longer than water based. The use of Hormonal creams will need to be discussed with, and prescribed by your GP or consultant.

Sexual desire

Testosterone is produced by the ovaries in women. This hormone is linked to sexual desire. You may therefore note a drop in sexual desire even after removal of the ovaries you take oestrogens. You may be offered to use testosterone patches to reverse the effects.

Returning to work

Everyone recovers at a different rate, so when you are ready to return to work will depend on the type of work you do, the number of hours and how you get to and from work.

You may experience more tiredness than normal after any operation, so your return to work should be like your return to physical activity, with a gradual increase in the hours and activities at work. If you have an occupational health department, they will advise on this.

Some women are fit to work after two to three weeks and will not be harmed by this if there are no complications from surgery.

Many women are able to go back to normal work after four to six weeks if they have been building up their levels of physical activity at home.

Returning to work can help your recovery by getting you back into your normal routine again. Some women who are off work for longer periods start to feel isolated and depressed. You do not have to be symptom free before you go back to work. It is normal to have some discomfort as you are adjusting to working life. It might be possible for you to return to work by doing shorter hours or lighter duties and build up gradually over a period of time. Consider starting partway through your normal working week so you have a planned break quite soon.

You might also wish to see your GP or your occupational health department before you go back and do certain jobs - discuss this with them before your operation. You should not feel pressurised by family, friends or your employer to return to work before you feel ready. You do not need your GP's permission to go back to work. The decision is yours.

Sick note

If you are off work for less than one week, you will be able to complete a self-certification form for the time you have been off work. If it is longer than one week, a certificate can be obtained from the hospital where you have your operation. It might also be advisable to see your GP or your occupational health department before you go back and do certain jobs, - by discussing this with them before your operation it might be possible for you to go back on a phased return or lighter duties. You should not feel pressurised by family, friends or your employer to return to work before you feel ready. You do not need your GP's permission to go back to work. The decision is yours.

Follow up appointments

If your surgery is uncomplicated it is not uncommon for you to be discharged back into the care of your own general practitioner and not require a follow up appointment with the gynaecologist. Some gynaecologists require their patients to attend a follow up appointment anywhere between 6-12 weeks after surgery, sometimes this can be with a nurse.

Recovery tracker - Total laparoscopic hysterectomy (TLH), laparoscopic assisted vaginal hysterectomy (LAVH)

Time after op	How I might feel?	What is it safe to do?	Fit to work?
1-2 days	<p>You are likely to be in hospital during this time</p> <p>You will have some pain and discomfort</p> <p>You may feel sore moving in and out of bed</p> <p>You may have some bleeding like a light period</p>	<p>Get up and move about</p> <p>Go to the toilet</p> <p>Get yourself dressed</p> <p>Start eating and drinking as usual</p> <p>You may feel tired and perhaps feel like a sleep in the afternoon</p>	No
3-7 days	<p>You should be home by now</p> <p>Your pains will slowly be reducing in intensity and you will be able to move about more comfortable</p> <p>You will still tire easily</p>	<p>Continue as for days 1-2</p> <p>Go for short walks</p> <p>Continue with exercises that have been recommended to you</p> <p>Wash and shower as normal</p> <p>Have a sleep or rest in the afternoon if you need to.</p>	No

Time after op	How I might feel?	What is it safe to do?	Fit to work?
1-2 weeks	<p>There will be less pain as you move about and will find your energy levels slowly returning</p> <p>Bleeding should have settled or be very little</p>	<p>Build up your activity slowly and steadily</p> <p>You are encouraged to go for longer and more frequent walks</p> <p>Restrict lifting to light loads</p>	Not Just yet
2-4 weeks	<p>There will be even less pain now as you move more and more</p> <p>You will find your energy levels returning to normal</p> <p>You should feel stronger everyday</p>	<p>Continue to build up the amount of activity you are doing towards your normal levels</p> <p>You can start doing low impact sport</p> <p>Make a plan for going back to work</p>	Yes, possibly on lighter duties or reduced hours. Some women will be fit for full time work after 4 weeks.
4-6 weeks	<p>Almost back to normal</p> <p>You may still feel tired and need more rest than usual</p>	<p>All daily activities including lifting</p> <p>Usual exercise</p> <p>Driving</p> <p>Sex if you feel ready</p>	Yes, but if you don't feel ready to go to work, talk to your GP or employer about the reasons for this

Low residue diet

	Foods Allowed	Foods to Avoid
Starchy foods 	<ul style="list-style-type: none"> • White bread/flour • White pasta • White rice • Cous cous • Pastry (white flour) 	<ul style="list-style-type: none"> • Wholemeal or Granary bread/flour • Wholemeal pasta • Brown rice • Pearl barley • Quinoa
Breakfast cereals 	<ul style="list-style-type: none"> • Cornflakes • Rice krispies • Frosted Flakes 	<ul style="list-style-type: none"> • All wholewheat cereals (e.g., Branflakes, Weetabix, Shreddies etc) • Porridge & Muesli • All containing dried fruit/nuts
Dairy 	<ul style="list-style-type: none"> • Milk • Yoghurts (smooth) • Cheese 	<ul style="list-style-type: none"> • Yoghurts or cheeses containing fruit/nut pieces
Meat, fish & eggs 	<ul style="list-style-type: none"> • All tender meat, fish and poultry • All eggs 	<ul style="list-style-type: none"> • Tough, gristly meat • Skin and bones of fish • Pies/egg dishes containing vegetables as listed
Vegetables 	1-2 portions daily: <ul style="list-style-type: none"> • Peeled, well-cooked, soft/mashable vegetables • Potatoes (not skins) • Crisps 	<ul style="list-style-type: none"> • Raw vegetables/salad • Baked beans • Split peas/lentils • Peas, sweetcorn, celery • All seeds, pips, tough skins • Potato skins

Low residue diet

	Foods Allowed	Foods to Avoid
Fruit 	1-2 portions daily: • Soft/ripe <u>peeled</u> fruit <u>without pips or seeds</u> e.g. tinned fruit, peaches, plums, melon, apricots, nectarines, ripe bananas, apples, pears	<ul style="list-style-type: none"> • All dried fruit • Citrus fruit • Berries e.g. strawberries, raspberries, blackberries • Prunes • Smoothies & fruit juices with bits
Nuts 	<ul style="list-style-type: none"> • Nil 	<ul style="list-style-type: none"> • Avoid all, including coconut and almond
Desserts & sweets 	<ul style="list-style-type: none"> • Sponge cakes (without fruit/nuts) • Custard • Ice cream • Jelly • Semolina, rice pudding • Chocolate (without fruit/nuts) • Seedless jam • Plain biscuits 	<ul style="list-style-type: none"> • Puddings/cakes/biscuits made with wholemeal flour, dried fruit or nuts (e.g mince pies, fruit crumble etc) • Chocolate/toffee/fudge with dried fruit or nuts • Marmalade with peel and jam with seeds • Popcorn • Marzipan • Digestive biscuits
Fats 	<ul style="list-style-type: none"> • All ok in moderation 	<ul style="list-style-type: none"> • Nil
Other	<ul style="list-style-type: none"> • Clear soups • Spices, pepper • Stock cubes • Tea, coffee, squash 	<ul style="list-style-type: none"> • Lentil/vegetable soups • Pickles/Chutneys • Horseradish • Relish

Low residue diet

Example Meal Plan:

<u>Breakfast</u>	Fruit Juice (with no bits) Tea/Coffee Cornflakes/Rice Krispies with milk Egg – poached, boiled, scrambled White bread and butter, seedless jam
<u>Lunch & dinner</u>	Tender meat, poultry or fish Boiled/mashed potatoes or white pasta/rice 1 portion of soft cooked vegetables
<u>Desserts</u>	Plain cakes/jelly/custard/rice pudding/ tinned fruit, poached/stewed permitted fruit
<u>Suitable Snacks</u>	Plain biscuits or cakes, white bread, plain crackers & cheese, yoghurt

Charities and support groups

The Hysterectomy Association

60 Redwood House

Charlton Down

Dorchester

DT2 9UH

Tel: 0871 781 1141

Web: www.hysterectomy-association.org.uk

References

Online

www.cks.nhs.uk/patient_information_leaflet/Hysterectomy

[www.2womenshealth.com/Hysterectomy-Abdominal-Vaginal-](http://www.2womenshealth.com/Hysterectomy-Abdominal-Vaginal-Laparoscopic.htm)

[Laparoscopic.htmwww.patient.co.uk/health/Hysterectomy.htm](http://www.patient.co.uk/health/Hysterectomy.htm)

Publications

1. Bradley LD Uterine fibroid embolization: a viable alternative to hysterectomy *Am J Obstet Gynecol.* 2009 Aug;201(2):127-35.

2. Zobbe V et al. Sexuality after total vs. subtotal hysterectomy. *Acta Obstet Gynecol Scand.* 2004 Feb;83(2):191-6.

3. Anderson GL et al. Effects of conjugated equine estrogen in postmenopausal women with hysterectomy: the Women's Health Initiative randomized controlled trial. *JAMA* 2004 291:1701-12

4. Garry G et al. EVALUATE hysterectomy trial: a multicentre randomised trial comparing abdominal, vaginal and laparoscopic methods of hysterectomy *Health Technol Assess* 2004 Jun 8 (26) 1-154.

5. McPherson K et al. Severe complications of Hysterectomy Risks: the VALUE study. *BJOG.* 2004 Jul;111(7):688-94.

6. RCOG recovering well

7. www.cancerresearchuk.org

Contact details

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Short stay surgery unit at Pinderfields:
01924 541854 or 01924 541855

Mr Sharma's secretary: 01924 543842

Mr Kremer's secretary: 01924 543811

Joanne Pursglove, Endometriosis Clinical Nurse: 07803 440236
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We are committed to providing high quality care. If you have a suggestion, comment, complaint or appreciation about the care you have received, or if you need this leaflet in another format please contact the Patient Advice and Liaison Service on: **01924 542972** or email: myh-tr.palsmidyorks@nhs.net

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