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HYSTERECTOMY

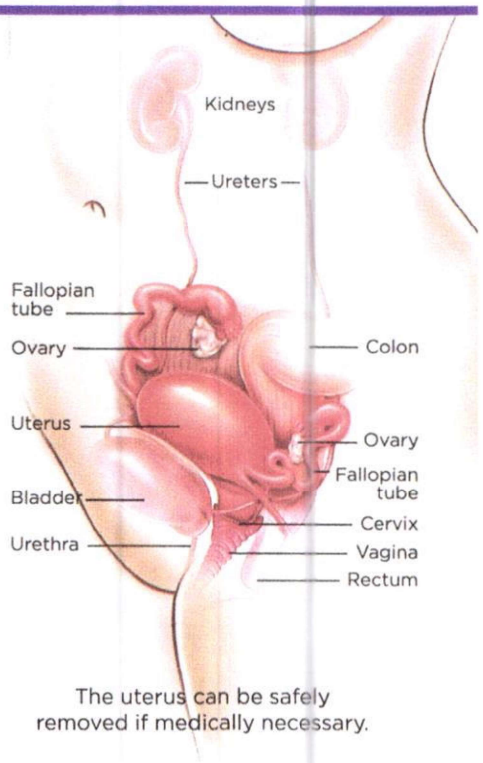
Patient information to assist informed consent

Hysterectomy is the removal of the uterus. It is conducted under anaesthesia. In consultation with her gynaecologist, a woman may consider having a hysterectomy for a number of reasons. The operation is performed when other treatments are unsuitable or have been tried without success. The uterus has its most important role during pregnancy when it provides protection and nourishment for the growing baby. The flow of menstrual blood occurs when the lining of the uterus (endometrium) is shed during the monthly periods. After the uterus is removed:

- no more periods occur
- pregnancy is not possible
- pain associated with periods may be reduced.

As the uterus does not produce female hormones, its removal does not change the level of female hormones in the blood. However, if the ovaries are removed during a hysterectomy in a premenopausal woman, the level of female hormones in the blood will decrease quickly. This will cause symptoms of menopause and the absence of periods.

After the uterus is removed, other organs in the abdomen take up the space.



The uterus can be safely removed if medically necessary.

REASONS FOR HYSTERECTOMY

Most hysterectomies are performed to treat diseases that are causing pain, discomfort, uterine bleeding or emotional distress.

Common reasons for a hysterectomy include:

- Uterine fibroids. These are non-cancerous growths of the uterus. They can cause pressure, pain and discomfort, or produce heavy periods.
- Unexplained heavy or irregular menstrual bleeding. It is not always possible to know why very heavy periods occur, despite investigations by your doctor. Hysterectomy may be an option.
- Prolapse of the uterus. This is a condition where the uterus and cervix protrude into the vagina. It is due to a weakness in the vaginal walls or in the support structures of the cervix, uterus, bladder and lower bowel.
- Endometriosis (and adenomyosis). Endometriosis is a condition where the cells that line the inside of the uterus grow outside the uterus and within the abdomen or pelvis. This can cause chronic pelvic pain, pain during sex, and prolonged or heavy periods. Adenomyosis refers to abnormal glandular tissue that is present within the thick, muscular walls of the uterus; the uterus has become enlarged, resulting in heavy, painful periods.
- Chronic pain not relieved by other treatments.
- Pelvic inflammatory disease (PID). This is a chronic infection in the reproductive organs that may cause permanent scarring and chronic pain.
- Cancer of the endometrium (uterine lining) or uterus.
- Cancer of the cervix (neck of the uterus).
- Cancer of one or both ovaries. A hysterectomy may be required when surgery for ovarian cancer is performed.

IMPORTANT: FILL IN ALL DETAILS ON THE STICKER BELOW

DEAR SURGEON: When you discuss this pamphlet with your patient, remove this sticker, and put it on the patient's medical history or card. This will remind you and the patient that this pamphlet has been provided. Some surgeons ask their patients to sign the sticker to confirm receipt of the pamphlet.

TREATMENT INFORMATION PAMPHLET

PEEL HERE

PROCEDURE: _____

PATIENT'S NAME: _____

DOCTOR'S NAME: _____

EDITION NUMBER: _____ DATE: D D / M M / Y Y Y Y

TALK TO YOUR GYNAECOLOGIST

The aim of this pamphlet is to provide you with general information. It is not a substitute for advice from your gynaecologist and does not contain all known facts about hysterectomy. Hysterectomy may have other risks not discussed in this pamphlet.

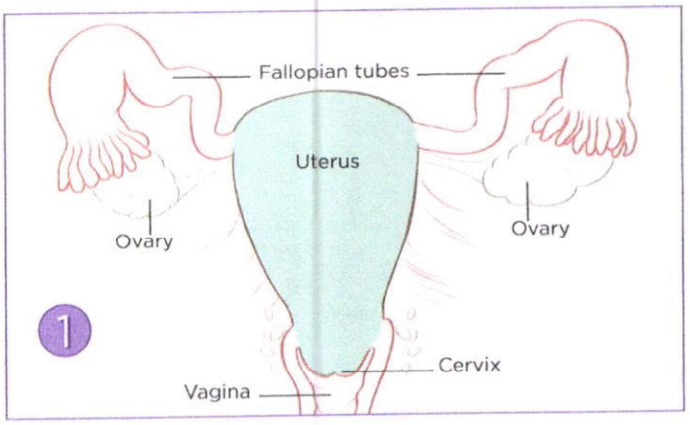
If you are not sure about the benefits, risks and limitations of treatment, ask your gynaecologist. Read this pamphlet carefully, and save it for reference. Technical terms are used that may require further explanation by your doctor. Write down questions you want to ask. Your gynaecologist will be pleased to answer them. Seek the opinion of another gynaecologist if you are uncertain about the advice you are given. Use this pamphlet only in consultation with your gynaecologist.

Making a decision: The decision whether to have surgery is always yours and should not be made in a rush. Make a decision only when you are satisfied with the information you have received and believe you have been well informed.

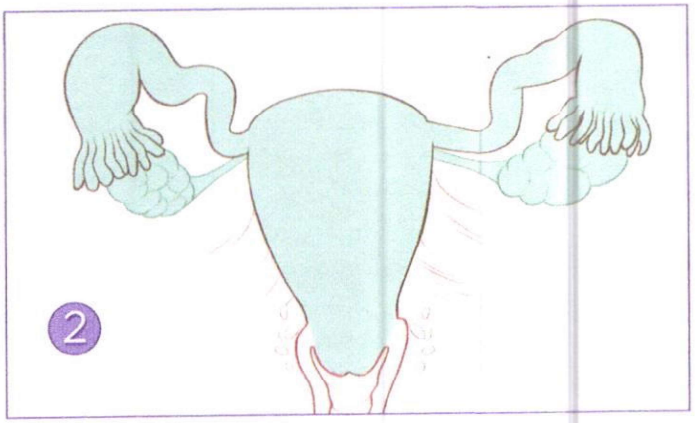
Consent form: If you decide to have the procedure, your gynaecologist will ask you to sign a consent form. Before signing, read it carefully. If you have any questions about it, ask your gynaecologist.

Edition number: 10

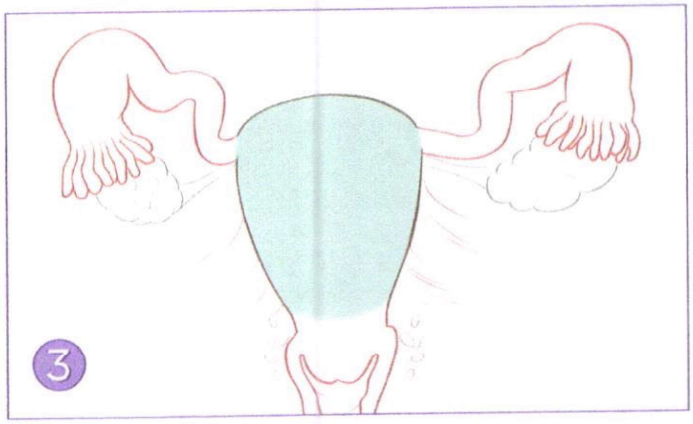
Four main types of hysterectomy



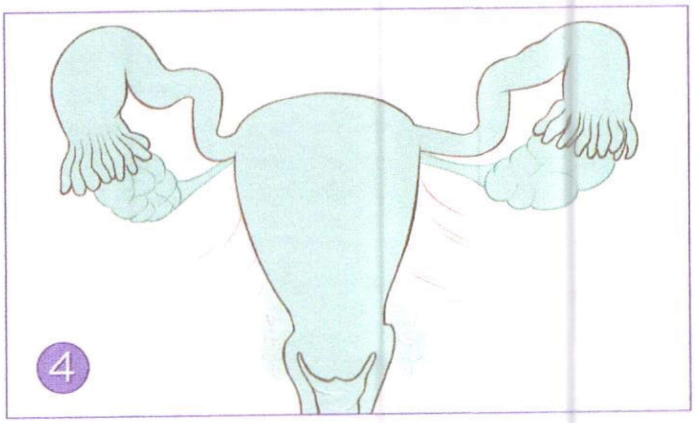
A total hysterectomy involves the removal of the entire uterus including the cervix, but not the ovaries or the fallopian tubes



A total hysterectomy with bilateral "salpingo-oophorectomy" includes complete removal of the cervix, uterus, ovaries and fallopian tubes.



Subtotal hysterectomy is the removal of the upper portion of the uterus, leaving the cervix in place. The fallopian tubes and ovaries may be left or removed, depending on the woman's case.



A radical hysterectomy includes the removal of the uterus, cervix, the top portion of the vagina and most of the tissue that surrounds the cervix in the pelvic cavity. The fallopian tubes, ovaries and pelvic lymph nodes may be left in place or removed, depending on the woman's case.

Note: Medical opinions and advice about the removal or retention of ovaries and fallopian tubes depend on the woman's age, general health and medical history. Make sure that you understand which type of hysterectomy is being recommended for your own individual case.

Principles of treatment

Your gynaecologist can discuss the diagnosis and treatment options with you. Women who have non-cancerous conditions that affect the uterus may have tried other surgical or non-surgical treatments, perhaps over many months or years.

A hysterectomy is not performed if a woman wishes to have more children or if medical or psychological reasons would make it dangerous for her to have the operation. Sometimes, a hysterectomy can be a life-saving procedure.

Your complete medical history

Your gynaecologist and anaesthetist need to know your medical history. Tell your gynaecologist about health problems you may have had because some may interfere with the surgery, anaesthesia or recovery. This information is confidential.

Tell your gynaecologist if you have or have had:

- allergy or bad reaction to antibiotics, anaesthetic drugs or other medicines
- prolonged bleeding or excessive bruising when injured
- recent or long-term illness, and any previous surgery.

Give your gynaecologist a list of ALL medicines you are taking or have recently taken. Include medicines prescribed by your family doctor and those bought "over the counter" without prescription, including vitamins and naturopathic preparations. Include long-term treatments such as blood thinners, aspirin (including that contained in cough syrups), arthritis medication or insulin.

Your gynaecologist may ask you to stop taking blood thinners or other medications before your procedure. As blood thinners can increase the risk of excessive bleeding during and after surgery, you may have to stop taking the drug or take an alternative dose for a week or more. Discuss this carefully with your gynaecologist.

If you are taking the contraceptive pill, you may be advised to stop taking it for one month before the surgery. During this time, use another contraceptive method. It is best to stop smoking completely, but at least in the weeks before and after the procedure.

Anaesthesia

Hysterectomy is usually performed under general anaesthesia. In some cases, either spinal or epidural anaesthesia may be recommended.

Modern anaesthesia is safe and effective but does have risks. Rarely, side effects from an anaesthetic can be life threatening. Ask your anaesthetist or gynaecologist for more information.

SURGICAL REMOVAL OF THE UTERUS

A hysterectomy may be performed in several different ways. With your gynaecologist, you can discuss the most suitable operation for your condition, based on your medical history, diagnosis and previous treatment. The extent of the operation will depend on the condition being treated.

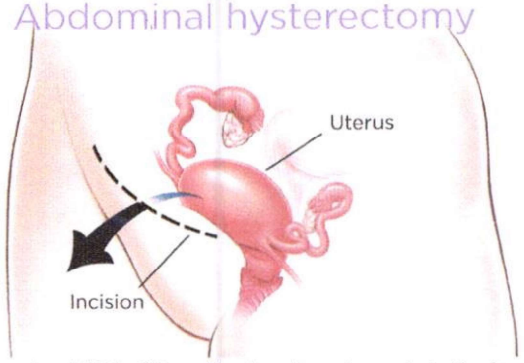
Shave: Excess abdominal and labial hair may be removed.

Urinary catheter: After the woman is anaesthetised, a catheter is passed into the urethra, and the bladder is emptied. This reduces the risk of surgical injury to the bladder. The catheter is left in place during the operation. In some cases, the catheter may be left in place for a day or two during recovery.

Vaginal examination: During the procedure, vaginal examination is usually performed to help assess the pelvic organs.

Antiseptic preparation: The vagina may be washed with an antiseptic solution which is usually iodine based.

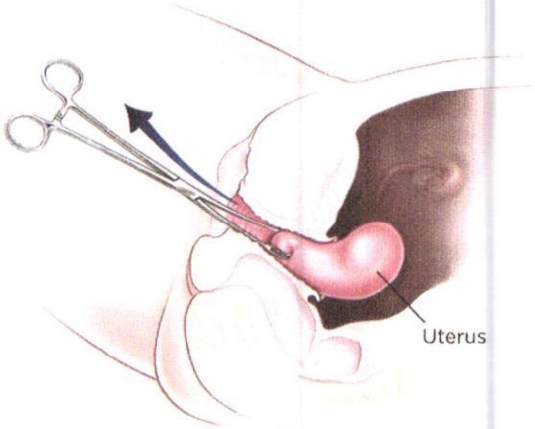
Abdominal hysterectomy



An incision about 10 to 20 centimetres long is made in the lower abdomen. This may be a horizontal cut quite low on the abdomen ("bikini line") or a vertical cut from the navel to the pubic bone.

This type of operation may be recommended if more extensive surgery must be performed, such as the removal of both ovaries and fallopian tubes and the uterus. It may be necessary if large fibroids or extensive areas of endometriosis exist or if a lot of scar tissue is present due to previous infection or surgery. If the gynaecologist needs to inspect other organs more closely, or believes the operation will take a long time, an abdominal hysterectomy may be the operation of choice.

Vaginal hysterectomy



This operation is performed entirely through the vagina. No incisions are made in the abdomen. In most cases, a hysterectomy can be performed vaginally. For a vaginal hysterectomy, only dissolving sutures (stitches) are used and do not need to be removed.

Laparoscopic hysterectomy (key-hole surgery)

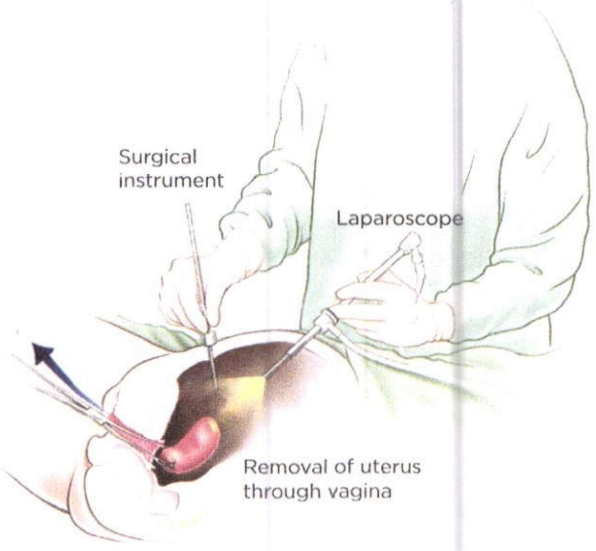
Hysterectomy can be performed using a laparoscope, a thin telescope-like tube that allows the gynaecologist to see the uterus and other organs. The laparoscope and other instruments are inserted through small incisions in the abdomen.

Carbon dioxide gas is blown into the abdominal cavity to lift the abdominal wall clear of the uterus, bowel and bladder. This is done to give a clear view of the uterus and ovaries. The uterus is usually removed through the vagina.

This procedure often takes longer to perform than an abdominal or vaginal hysterectomy. No large external cut is made, so little scarring is seen on the skin.

Conversion to open surgery: In some cases, the gynaecologist may find that it is not safe to continue the laparoscopic or vaginal hysterectomy due to unexpected or life-threatening problems. The gynaecologist may have to remove the uterus as described above under "Abdominal hysterectomy". A woman may be disappointed that she has had open surgery instead of laparoscopic or vaginal hysterectomy, but open surgery is done in the interests of her safety and well-being. It is best to discuss the possibility of conversion to open surgery with your gynaecologist.

Robotic-assisted laparoscopy: An important new technology is robotic-assisted laparoscopy. In the operating room, the surgeon sits near the patient at a computer console that precisely controls delicate movements of the surgical instruments. This technology is not an option for all patients and is not available at every hospital.



RECOVERY AFTER HYSTERECTOMY

Recovery times after a hysterectomy depend on factors such as your age, general health, and the type of operation you have had. Recovery after an abdominal hysterectomy generally requires two to three days in hospital. To recover fully may take four to six weeks.

Women who have a vaginal hysterectomy may have a shorter stay in hospital (often one to two days) and may recover more quickly. A laparoscopic hysterectomy may result in a shorter hospital stay (from one to two days) and sometimes a faster recovery at home.

Pain or discomfort may occur in the abdomen and pelvis, which may require a painkiller. If you have had a laparoscopy, you may notice some discomfort in your neck and one or both shoulders while recovering in hospital. This is thought to be referred pain caused by the gas used during the procedure.

Some women have a catheter inserted in the bladder to drain urine. This will be removed as soon as possible. If you have had a general anaesthetic, breathe deeply (and cough if you need to) after the

Continued on page 4

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operation to keep your lungs clear. Walking (with assistance) after surgery improves circulation in your legs and reduces the risk of a blood clot forming in a vein (deep venous thrombosis, DVT).

Vaginal bleeding (similar to a light period) may occur one to two weeks following the operation. If bleeding occurs, use sanitary pads rather than tampons to reduce the risk of infection.

During recovery, many women need assistance around the house. You can help yourself to recover quickly and comfortably by observing the following:

- no heavy lifting or vigorous exercise
- follow your gynaecologist's advice on showering, driving and returning to work
- pain medication can cause temporary changes in bowel habits.

While you are in hospital, your gynaecologist will check your progress, answer questions, and arrange follow-up to remove skin sutures or staples, if required.

POSSIBLE COMPLICATIONS OF HYSTERECTOMY

As with all surgical procedures, hysterectomy does have risks, despite the highest standards of surgical practice. While your gynaecologist makes every attempt to minimise risks, complications may occur that uncommonly may have permanent effects.

It is not usual for a surgeon to outline every possible side effect or rare complication of a surgical procedure. However, it is important that you have enough information about possible complications to fully weigh up the benefits and risks of surgery.

The following possible complications are listed to inform and not to alarm you. There may be other complications that are not listed. Smoking, obesity and other significant medical problems can cause greater risks of complications.

General risks of surgery

- Cardiovascular risks such as heart attack, blood clots or stroke, which often depend on the patient's medical history. Your doctor may suggest a medication that reduces the risk of blood clots.
- Infection of the wounds, bladder, urinary tract, chest or bloodstream. Your doctor may suggest preventative "antibiotic prophylaxis" to reduce the risk of infection.
- Keloid or hypertrophic scar – a surgical scar that becomes inflamed, raised and itchy. Such a scar can be annoying but is not a threat to health.
- Risks related to anaesthesia.

Specific risks of hysterectomy

- Transfusion after large blood loss. Overall the risk of transfusion is about six patients in every 100 but can vary widely.
- Injury to organs near the uterus, such as the bladder, ureters or bowel, may be caused by instruments during laparoscopic and abdominal hysterectomy.
- Rarely, injury to major blood vessels.
- During laparoscopy, a bubble of carbon dioxide may get into the blood. Called a "gas embolism", it can travel to the heart and lungs, and be life threatening. A gas embolism can be quickly diagnosed and managed by the anaesthetist, surgeon and other medical staff. Although rare, it has caused deaths.
- If hysterectomy has been done to treat chronic pain, there is a risk that pain may persist after the operation.
- Rarely, an incisional hernia.

REPORT TO YOUR GYNAECOLOGIST

Notify your gynaecologist at once if you notice any of the following:

- Persistent bleeding from the vagina. It may be smelly or may become heavy and bright red.
- Persistent redness, pain, pus or swelling around the wounds or a fever more than 38ºC or chills, which may indicate infection.
- Pain or burning on passing urine or the need to pass it frequently. This may indicate a urinary tract infection.
- Dizziness, short of breath, feeling faint.
- Any other concerns about your surgery and recovery.

If your surgeon cannot be contacted, attend your family doctor or the Accident and Emergency department at your nearest hospital.

AFTER THE HYSTERECTOMY

- Feelings and emotions: While a woman may be pleased to have a hysterectomy to improve her condition, she may also feel sad or depressed afterwards. It is important to consider how a hysterectomy may make you feel. Before the operation, you may want to discuss this with a friend, family member or health care professional.
- It will be possible to return to normal sexual activity between three and eight weeks after surgery if there have been no complications. Some women prefer to wait until after the six-week check-up. Women who have had a vaginal repair may notice tightness to begin with but usually have little change in sensation.
- Cervical screening test (CST): A woman who has had the cervix removed will not usually need to have a CST unless she has a history of abnormal cervical cells or cancer of the cervix. A CST sample may be obtained from the top of the vagina, the vaginal vault. Discuss this with your gynaecologist. The CST has replaced the Pap smear.
- If the ovaries have been removed, a woman will not be at risk of ovarian cancer. However, in some women, retention of the ovaries may result in better overall health in the long run. Your doctor can advise you if you need pelvic examinations in the future.
- Women who have also had the ovaries removed may be advised to start hormone therapy (HT). HT may reduce the side effects of menopause and protect the bones from osteoporosis. Your doctor can discuss the risks and benefits of HT.
- Weight gain should not normally occur after a hysterectomy, although there may be some temporary gain due to inactivity. Watch your diet at this time. It is common for a woman's body shape to alter during menopause, regardless of whether she has had a hysterectomy.

Costs of Surgery

Your gynaecologist can advise you about coverage by public and private health insurance and out-of-pocket costs. You may want to ask for an estimate that lists the likely costs of medical and hospital fees, and other items. As the course of actual treatment may differ from the proposed treatment, the final account may vary from the estimate. It is best to discuss costs with your gynaecologist before surgery rather than afterwards.

Your Gynaecologist

This patient education has been reviewed by obstetricians and gynaecologists in Australia and New Zealand

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