Royal United Hospitals Bath
NHS Foundation Trust

DAY CASE HYSTERECTOMY

What to expect and how to prepare

Day Case Hysterectomy is carried out routinely in many hospital trusts in the UK and has been proven safe and acceptable to patients without increase in complications or readmission rates.

Going home early allows you to recover in your own surroundings and return to normal function sooner while also reducing the risk of complications such as hospital acquired infections and blood clots.

Before the day of surgery

In preparation for your operation you will be asked to complete an online assessment called 'My Pre-Op', this should take approximately an hour and you should be as accurate with your answers as possible. A Specialist Nurse or Anaesthetist will review your answers to assess your fitness and decide on any investigations that may be needed before your surgery such as bloods tests or electrocardiogram (ECG), you may be asked to attend the pre-operative department at the hospital.

Preparing for surgery

It is expected that your surgery will be performed as a Day Case procedure and you will be discharged on the same day as surgery, or early in the morning of the following day. Please bring an overnight bag with lose fitting night clothes, slippers and toiletries in case the surgeon recommends you are admitted overnight, or you do not feel comfortable to go home on the same day as your operation.

You may experience some pain and discomfort for the first few days after surgery, please ensure you have paracetamol and ibuprofen (if you are able to take it) at home, as well as over the counter laxatives in case of constipation. You will also be provided with some stronger prescription painkillers. Do not worry if you are having a period on the day of surgery as it does not affect the procedure.

You should have a responsible adult to accompany you home and be with you for the first 24 hours after your operation. If you live alone please make arrangements to have someone stay with you. You will also need a means of transport available in the unlikely event of any complications requiring you to return to hospital. If you live more than an hour's journey from the hospital by car it may be more appropriate for you to stay in hospital overnight.

The day of surgery

You will be asked to attend the Day Surgery Unit on the morning of your operation, you will see the surgeon, who will confirm your consent; and the anaesthetist will see you to explain what sort of anaesthetic you will need. While you are on the Day Surgery Unit, before you are taken to theatre you may be given some pre-medication to help reduce any post-operative pain and nausea and you will be given support stockings to minimise the rare risk of thrombosis after surgery

The operation

The surgeon will discuss with you the most suitable approach for your surgery.

- vaginal hysterectomy - surgery is performed through the vagina and all the scars are out of sight. The advantage of this method is that you do not need an additional cut in your abdomen.

- Laparoscopic (keyhole) hysterectomy – a camera is inserted through the bellybutton and a further 2 small (1cm) incisions will be made in the abdomen. Instruments pass through these incisions and the womb is disconnected from the pelvis and 'delivered' through the vagina. The top of the vagina is then sutured closed.

- Open abdominal hysterectomy - an incision going up and down the middle of the abdomen or (more commonly) an incision across the lower abdomen near the pubic hairline (bikini scar incision). This is NOT a daycase procedure but sometimes the womb is too big to come out through the vagina and or the surgery is unexpectedly complex and a vaginal or laparoscopic hysterectomy may be converted to an open procedure.

What is removed?

A hysterectomy involves removing the uterus (womb), cervix and fallopian tubes. Removal of the cervix means you cannot get cervix cancer and do not normally require cervical smears. The cervix will be examined under the microscope and your previous smears reviewed. In a minority of women with abnormal smears in the run up to surgery, or if pre- cancerous cells are found in the cervix then a smear test of the top of the vagina may need to be performed a few months post operatively.

Removing the uterus means that you will not have periods and cannot become pregnant. Removing the fallopian tubes does not make the operation bigger or affect recovery, however it reduces the risk of fallopian tube cancer. Removing your uterus and tubes does not change your hormones in any way and cannot make you lose or put on weight. The vagina is not usually made any shorter by the operation so sex after the operation is not affected.

If you are close to the menopause you will need to decide if you want your ovaries removing. Generally it involves minimal extra surgery and will greatly reduce the risk of ovary cancer. Ovary cancer kills 1% of women (1 woman in 100) and usually occurs late in life. If it is necessary to remove the ovaries before the menopause, hormone replacement therapy (HRT) may be recommended. Once you have had a hysterectomy, you cannot get uterine cancer and therefore you only need to take oestrogen HRT. You will not need progesterone HRT unless you have a history of severe endometriosis.

The ovaries continue to produce testosterone for 20 years after the menopause. Therefore, removing the ovaries, even in post-menopausal women can negatively impact libido. Testosterone can be replaced with testosterone gels but these can be difficult to dose and require monitoring.

Possible complications

Following is the list of complications quoted by the Royal College of Obstetricians and Gynaecologists (RCOG) (2009) which may not be all inclusive. If you have any particular concerns, do ask the surgeon.

Women who are obese, who have had previous open surgery or who have pre-existing medical conditions are at a higher risk of having complications.

Serious Risks Include:
● The overall risk of serious complications from abdominal hysterectomy is approximately (4 in 100 - common)
● Damage to the bladder / ureter (7 in 1000 uncommon)
● Damage to the bowel (4 in 10 000 - rare)
● Heavy bleeding requiring blood transfusion (23 in1000 - common)
● Return to theatre because of bleeding/wound break down / organ damage (7 in 1000 - uncommon)
● Pelvic infection (2 in 1000 uncommon)
● Clots in the legs or lungs (4 in 1000 uncommon)
● Risk of death within 6 weeks (32 in 100 000 rare). The main causes of death are clots in the lungs and heart disease.

Frequent Risks Include:
● Wound infection, pain, bruising, delayed wound healing or keloid formation
● Numbness, tingling or burning sensation around the scar (usually this is self-limiting but can take weeks or months to resolve)
● Frequently passing urine and urine infection
● Earlier menopause

After the operation

When you wake up you may have a tube with fluid running into a vein in your arm. This will be removed when you are drinking fluids freely. You will be encouraged to drink and eat some light food and start to gently mobilise within a few hours of your operation. You will be given painkillers and anti-sickness medication as required.
You may have some pain in your lower abdomen, experience trapped wind or shoulder pain and feel bloated in the first few days after your operation. These symptoms can be eased with regular analgesia, over the counter laxatives and gentle walking.

Any incisions or abdominal wounds will be closed with dissolvable stitches that do not need to be removed, they will be covered with either skin glue which will peel away after 5-10 days, or a small dressing which can be removed after 1 or 2 days.
It is common and quite normal to feel a little ‘low’ or tearful after the operation.

If your surgery is uncomplicated then the nurses will continue to monitor you and if you remain well you should be able to go home later that day. Specifically you will have to have passed urine, be able to mobilise and have your pain controlled.

The following day you will be called in the morning by one of the gynaecology doctors who assess how you are getting on and address any questions / concerns you might have.

Getting back to normal

You can start to resume some normal activities at home within a few days when you feel ready and gradually increase over the next few days and weeks. Gentle activity encourages the muscles, particularly the back muscles, to get back to normal quickly. From about three weeks after the operation you may do more strenuous activity. Vacuuming, lifting heavy items and more energetic activities like sports may be uncomfortable or slightly painful but is safe and will do no harm. The back muscles are the most important part of the body to be concerned with. Too much, or too little activity can result in backache. A little gentle swimming is particularly good exercise, as it often causes no discomfort. Any exercise is better than none although it will be tiring and frequent rests will be necessary.

The operation may temporarily affect your ability to pass urine. During your operation, the muscles of your vagina and those that support your bladder may have been cut or stretched. The bladder may also be bruised and this may make it irritable. This means you may want to pass urine frequently and feel your bladder is not completely empty. This feeling settles quickly with time. The "Pelvic Floor Exercises" explained to you by the physiotherapist are important. They will help you retain and regain bladder tone and control. Practice them regularly when at home. If you experience any "burning" when you pass urine or feel that it looks cloudy and smells unpleasant, inform your doctor, you may have an infection which should be treated with antibiotics.

Work, driving, sex

You should be able to start work again around six to eight weeks after the operation but this does vary a lot between people. A doctor's certificate for time off work can be provided for you on the day of surgery, however, it is your G.P. who provides long-term sick notes.

You should not drive for 24 hours after a general anaesthetic and should check your car insurance to ensure you are covered. Do not drive if your concentration is not perfect or if you have any discomfort. You must feel able to perform an emergency stop when driving.

In most cases it is safe to have sexual intercourse after about four to six weeks and it should actually help your tissues become supple again, this should be gentle and if much discomfort is felt you should be prepared to wait a little longer, you may find a vaginal lubricant helpful at first.

More information

Well-meaning friends and relatives, or even other patients may tell you things that can be alarming and often inaccurate. Try instead to get your advice from the doctors, nurses or other people who have seen many women who have had this operation. A useful source of information is the ward. The nurses are very used to answering questions (01225 824664/4436).

More information is available on the Royal College of Obstetricians and Gynaecologists website: www.rcog.org.uk/for-the-public

Or by scanning the following QR codes with any smart device:

Hysterectomy	Vaginal Hysterectomy - Recovering well.	Laparoscopic Hysterectomy – Recovering well

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If you would like this leaflet in email form, large print, braille or another language, please contact the Patient Support and Complaints team on 01225 825656.

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