Hysterectomy — The operation

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You have had all the relevant tests, weighed up your options and decided that having a hysterectomy is the best solution for you. Now you must come to an agreement with your doctor as to how the operation is to be performed - either vaginally or abdominally - and how much of your reproductive organs are to be removed.

Through the vagina or the abdomen?

When the hysterectomy is performed through the vagina there is no visible external scar. Vaginal hysterectomy has fewer complications and involves a shorter hospital stay and more rapid recovery. In this country about one quarter of all hysterectomies are performed vaginally. The greater frequency of abdominal hysterectomy is mainly due to doctors' preference for this procedure, but in some cases, such as where the uterus is very large because of fibroids, a vaginal hysterectomy is impossible.

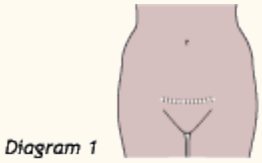


Diagram 1

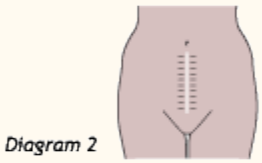


Diagram 2

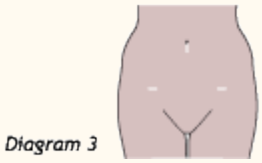


Diagram 3

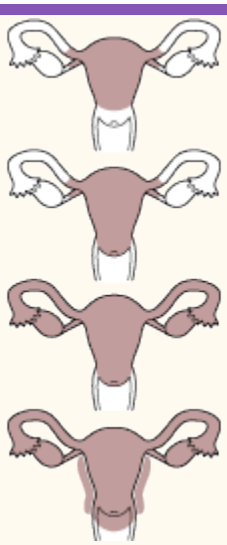
Most surgeons have their own personal preferences based on their experience and skills, so if a surgeon rarely performs vaginal hysterectomies, it will probably not be in your best interests to ask for one. If there are no medical reasons why you shouldn't have this type of operation, you may want to seek a consultant who prefers the vaginal method.

If you are having an abdominal hysterectomy, you can request that your surgeon makes a cut at the bikini line if possible. This is a horizontal cut just above your pubic hair, as shown in Diagram 1. It heals well and leaves an almost invisible scar . If your uterus is very large, you have large fibroids or your ovary has a large swelling on it, this incision may not be possible and a vertical cut may be made instead, as in Diagram 2.

Laparoscopic hysterectomy

A laparoscope is a viewing instrument like a telescope which is inserted into the abdomen to enable the doctor to see the pelvic organs. This avoids the need for a large abdominal incision. A small (1/4 inch) incision is made just below the belly button for the laparascope to be put through.

Two additional small incisions are made on either side of the abdomen for insertion of instruments used to carry out the operation, see Diagram 3. The uterus is usually removed through the vagina although sometimes the small incisions for the laparascope are used if the uterus is not too large. The advantage of laparascopic hysterectomy is that it is a less



invasive operation than abdominal hysterectomy, so recovery times are shorter. However, there is a potential for complications because the surgeon's view is limited and inadvertent damage to other organs may occur.

Types of hysterectomy

These vary according to your condition and how much can safely be left in place. You and your doctor should aim to leave in as much as is possible considering the implications for your subsequent health.

1. **Subtotal hysterectomy**
   the body of the uterus is removed, leaving the cervix in place. This is rarely performed. If it is, the woman must continue to have cervical smear tests afterwards. The most common reason given for removing the cervix is to avoid any possibility of subsequent cervical cancer. But it is more likely that doctors simply think that the cervix is superfluous and therefore can be routinely removed. In fact subtotal hysterectomy appears to have several advantages: less disruption to the pelvic floor, less damage to the urinary tract, and fewer infections. The cervix may play a role in sexual pleasure, so leaving it in place reduces any possibility of loss of sexual function.

2. **Total hysterectomy**
   both the body of uterus and cervix removed. This is the operation most often performed.

3. **Total hysterectomy with bilateral or unilateral salpingo-oophorectomy**
   body of uterus, cervix, fallopian tube(s) and ovary(ies) removed.

   The decision to either remove or retain the ovaries should be made according to the individual woman's medical history and personal feelings. A minority of doctors routinely remove ovaries on the grounds that they are superfluous, and to eliminate the risk of ovarian cancer. Women who have a family history of ovarian cancer should discuss with their doctor whether they are at increased risk and if ovarian removal is justified. In women not at particular risk of developing ovarian cancer it has been estimated that about 200 oophorectomies would have to be carried out to avoid one case of ovarian cancer.

   Removal of the ovaries brings on a sudden menopause because of the loss of ovarian hormones. However, as mentioned earlier, hysterectomy may bring on an earlier menopause even if the ovaries are retained, because of disruption to the blood supply to the ovaries.

   Oophorectomy is usually not a straigthforward decision, and the pros and cons may need to be talked through carefully.

4. **Wertheim's hysterectomy**
   body of uterus and cervix, part of the vagina, fallopian tubes, usually the ovaries, parametrium (the broad ligament below the fallopian tubes) and lymph glands and fatty tissue in the pelvis removed. Usually performed to remove cancer. This type of hysterectomy is also called a radical hysterectomy.

The operation

Preparation for both vaginal and abdominal hysterectomy is similar. If you are having an abdominal hysterectomy, you will have a strip at the top of your pubic hair shaved the night before your operation. On the day, you may be given a suppository to empty your bowels, and you will not be allowed to eat or drink anything except perhaps a cup of tea early in the morning if you are to be operated on late in the day. Before going to the theatre, you will be given pre-medication drugs to dry up your saliva and make you relax.

Once you are in the small room just outside the operating theatre, you will be given the anaesthetic. This is done either by an injection that puts you to sleep and then having a "drip" containing the anaesthetic attached to you, usually in the back of your hand, via a thin plastic tube, or by having the drip put in while you are awake. In some special circumstances, a general anaesthetic is not given, and an epidural or spinal anaesthetic is used instead. This is an injection of anaesthetic around or in the spinal cord which numbs all the nerves below it.

Once you are asleep, a catheter (a narrow tube) will be inserted into your bladder to empty it. The inside of your vagina may be painted with Bonney's blue, an antiseptic dye that makes lining up the vaginal walls easier.

The abdominal approach: after the skin of your abdomen has been cleaned with antiseptic, the incision will be made and the uterus removed by clamping and cutting large blood vessels and then tying them off. The top of the vagina is then closed and each layer of tissue of your abdomen is individually stitched shut until the wound is completely closed, either with dissolving stitches or metal clips. The latter must be removed six to eight days later. After about six to eight weeks the scar is usually barely noticeable.

The vaginal approach: this procedure is very similar except that the necessary cuts are made internally, through the vagina. Each operation takes about an hour, depending on which type of surgery you are having.