GOLD COAST **GYNAECOLOGY**

HYSTERECTOMY

THE HYSTERECTOMY PROCEDURE IN AUSTRALIA - HYSTERECTOMY RECOVERY AND SIDE EFFECTS

The decision to have a hysterectomy is an important one, and should not be undertaken lightly. While many women think that removing their uterus will be an end to their problems, in reality, it can be the start of other problems. The long-term complications caused by hysterectomy include:

- Adhesion formation causing pain and bowel obstruction, requiring major surgery to try to correct
- Residual ovary syndrome, causing pain and cyst formation of the ovaries, requiring difficult major surgery to correct
- Increased risk of vaginal prolapse and incontinence, requiring major surgery to correct
- Premature menopause, requiring the use of HRT, with the increased risk of breast cancer, heart attacks, strokes and DVT

Of course, in some cases, hysterectomy is the only answer, but it should be reserved for major pathology, not just for period problems or prolapse.

INDICATIONS FOR HYSTERECTOMY

Cancer of the cervix, uterus or ovaries will necessitate a hysterectomy in most cases.. Benign fibroids usually will stop growing once the menopause is reached. If large and causing pressure, hysterectomy may be indicated:

Adenomyosis a condition similar to endometriosis, causing very painful periods

Vaginal Prolapse there is no indication to remove the uterus for prolapse alone. The repair is stronger keeping the ligaments intact.

Chronic disabling pelvic pain and not responding to other treatments may require hysterectomy. In many cases, this will be due to adenomyosis or chronic pelvic infection

DEFINITIONS

- Total Hysterectomy the removal of the body of the uterus and cervix, but not the ovaries or fallopian tubes
- Supracervical or Sub-total Hysterectomy the removal of the body of the uterus, but not the cervix. See separate article regarding total and supracervical hysterectomy below
- Salpingo-oophorectomy the removal of the ovaries and fallopian tubes
- Radical Hysterectomy the removal of the whole of the uterus, cervix, fallopian tubes and ovaries, with dissection of the pelvic lymph glands.

TYPES OF HYSTERECTOMY

1. Abdominal Hysterectomy a horizontal or vertical incision is made in the abdomen, and the uterus removed through this incision. This approach is necessary for major conditions such as cancer, large fibroids, adhesions and endometriosis.
2. Vaginal Hysterectomy the uterus is removed through the vagina, with no external incision. Recovery is quicker with this procedure.
3. Laparoscopic or Key-Hole Hysterectomy (LAVH) this is a misnomer, as there is no such thing as a key-hole hysterectomy. Three abdominal incisions are made and the laparoscopic instruments used to help the operator perform a vaginal hysterectomy (see above).

Removal of the ovaries or cervix is a separate issue, and should be decided on an individual basis.

COMPLICATIONS OF HYSTERECTOMY

Up to 40% may have some complications, although in most cases, these are minor. There are general risks of surgery, including cardiovascular risks such as heart attack and stroke, but the main risks are:

- Infection
- Haemorrhage
- Injury to Other Organs, such as bladder, ureter or bowel
- Thrombosis of the veins, e.g. DVT, pulmonary embolus

TOTAL AND SUPRACERVICAL (SUB-TOTAL) HYSTERECTOMY

History

Charles Clay performed the first recorded hysterectomy in 1843. From then on until 1927, only supracervical hysterectomies were performed. In that year

E.H. Richardson performed a total abdominal hysterectomy. Gradually, improvements in anaesthesia, antibiotics and blood transfusions, the numbers of total hysterectomies increased.

The main reason for performing total hysterectomy was that 0.4% of women after supracervical hysterectomy, developed cancer of the cervix, and the cervix was removed to prevent this complication. By the 1950s, total hysterectomy became almost universal.

However, this was before the introduction of Pap smears, whereby abnormal cells can be picked up and treated before the development of cancer of the cervix. For this reason, some gynaecologists have started to question whether it is still appropriate to remove the cervix for benign conditions, in view of the extra complications associated with total hysterectomy.

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Arguments in Favour of Supracervical (Sub-Total) Hysterectomy

a) The cervix is a normal organ, with pelvic support functions, and should be retained unless diseased. One important surgical principle is: first do no harm

b) Supracervical hysterectomy is a quicker, simpler, easier operation to perform, with more rapid recuperation and a shorter hospital stay.

c) There is less risk of infection, as the vagina is not opened. The vagina is a potential source of infection leading to peritonitis.

d) There is less risk of complications, especially injury to bladder and ureter, as the body of the uterus is removed from the cervix above these organs.

e) Removal of the cervix interferes with the nerve supply to the bladder and bowel, and this may cause problems with bladder and bowel function.

f) There is some evidence that removal of the cervix may interfere with sexual response in some women, although this has not been absolutely proven.

g) The cervix is the cornerstone of the pelvic support structures, and removal can lead to weakening and atrophy of the pelvic ligaments, which leads to an increased risk of prolapse. These types of vaginal vault prolapse are particularly difficult to repair, as there is no solid structure to which to attach the cervix, whereas if prolapse occurs with the cervix intact, repair is relatively simple.

h) Pap smear is still necessary, which means that you will have a general checkup at least every two years.

Arguments in Favour of Total Hysterectomy

a) You do not normally need to have a hysterectomy, unless you have had a previous abnormal pap smear, although abnormalities can still occur in the vaginal vault.

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