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**Patient Information**

# Day Case Laparoscopic Hysterectomy

## Introduction

A day-case laparoscopic hysterectomy is also known as a same-day discharge hysterectomy, performed via the keyhole route. This leaflet is for people who have made the decision to have a keyhole hysterectomy with a plan to go home on the same day as their surgery.

You will be given information regarding the surgery, benefits of going home on the same day and arrangements in place for your follow-up. This is to make sure that your surgical journey is safe and satisfactory.

If you are not suitable for day case, ie same day discharge hysterectomy, then your operation will be planned as an inpatient procedure. This will mean that you will need to stay in overnight. Your consultant will inform you of this when planning for your surgery in the clinic.

Same-day discharge hysterectomy is a package of care and is designed to inform you about what to expect before, during and after your operation by providing you with both written and verbal information.

## What is a Total Laparoscopic Hysterectomy (TLH)?

TLH is a major gynaecological surgical procedure performed under general anaesthetic (while you are asleep). It involves removing the womb (uterus) and the neck of the womb (cervix) using keyhole (laparoscopic) surgery. This involves introducing keyhole instruments through the belly button and the tummy wall.

Your surgeon may discuss the option of sub-total hysterectomy, where indicated, which means the removal of the womb (uterus) but not the neck of the womb (cervix).

The ovaries and fallopian tubes may or may not be removed, depending on the reason for your surgery. This should have been discussed with you when the decision for surgery was made.

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If the ovaries are removed before your natural menopause, you will start the menopause (change of life) immediately after surgery and depending on your age and medical conditions. You will be given advice about taking hormone replacement therapy (HRT) after surgery. HRT may not be suitable for all patients; this will depend on your medical condition(s) and risk factors.

TLH may be combined with other additional procedures. These additional procedures, if indicated and planned, will have been discussed in detail with you by the surgeon during the decision-making process.

As compared to open or abdominal route surgery, TLH is associated with less pain and discomfort you will experience after the surgery, but can have a slightly higher risk of complications, particularly urinary tract injury, which may need further investigations and treatment as necessary.

## Why am I having a TLH?

Hysterectomy is usually considered a last resort, usually after other treatments have failed, unless performed for certain lifesaving conditions such as cancer. Common benign indications for TLH surgery include, painful or heavy periods not responding to medical treatments (such as the hormone pill, hormone releasing coil or ablation treatment (burning of the lining of the womb), pelvic pain secondary to conditions such as endometriosis or adenomyosis or fibroids. Your doctor will explain why you are having this surgery, and a shared decision will be made between you and your doctor.

## Benefits of same-day discharge keyhole hysterectomy

- Going home sooner.
- Reduces the risk of catching hospital acquired infections.
- Fewer wound complications.
- Less disruption to your bowel and bladder function.
- Lower risk of Deep Vein Thrombosis (DVT).
- Shorter recovery period and hospital stay compared to other routes of hysterectomy surgery.

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# Risks and complications following surgery

Most of the risks relate to the surgical procedure rather than the same day discharge package for the day case TLH. These risks are not increased by going home the same day after your surgery. However, in case of any complications, you will be kept in the hospital after surgery. We advise you to bring an overnight bag with you when you come for planned day case surgery.

- Inflammation, infections and bruising to any wound on the abdomen or in the vagina.
- Haematoma (blood collecting in the wound).
- Return to the theatre because of bleeding.
- Chest infection.
- Urinary tract infections, such as cystitis.
- Vaginal discharge.
- Vaginal vault dehiscence ie separation of the cut at the top of the vagina which was previously closed at the time of hysterectomy.
- Feeling of a bloated tummy.
- Hernia at the site of insertion of the keyhole instruments.
- Adhesion (tissue sticking together).
- Post-operative nausea.

## More serious risks

- Injuries to the bladder, ureters (narrow tubes between the bladder and the kidneys), bowel or blood vessels, requiring further investigations or surgery, blood transfusion or longer admission.
- Blood loss can sometimes be heavy during the surgery, and this may mean that you need a blood transfusion or the use of cell salvage, which uses your own blood lost at the surgery and is given back to you after being filtered and washed.
- Anaesthetics carry a risk, and you will be asked by your doctors, before the surgery, about any medical problems that might increase those risks.

- Thrombosis (blood clots in the leg or chest) are uncommon after this surgery. Preventative treatment will be discussed, and you will be given blood-thinning injections if indicated in your case. Your doctor will discuss with you if blood thinners are needed for a longer period.

## Before surgery

You should carry on taking your usual medications, unless told otherwise. We strongly advise that you stop smoking before your surgery. If you are taking HRT or the combined pill, you may be advised to stop 4 weeks before the surgery. This is to reduce the risk of developing blood clots in the legs or lungs.

If you are overweight, losing weight before your surgery will also help with your recovery and reduce the risks of problems during surgery and recovery.

If TLH is being performed due to fibroids, then your doctor may discuss some medications to be taken for a few months before the surgery. This will help shrink the size of the fibroids before your surgery date.

If you develop an illness before your surgery date or have any questions about the surgery, please contact the admissions team.

## Pre-operative assessment

You will be invited to the hospital any time up to 4 weeks before your surgery date for a pre-operative assessment. During this assessment, we will check your fitness for general anaesthetic and the surgery to be performed as a day case /same day discharge TLH. This will include recording a full medical history, any current medication and arranging any investigations required. Please tell the nurse practitioner or doctor if you have had problems with any previous surgery, anaesthetic, or if you have any allergies – **this is very important**. This may require a formal anaesthetic review before the surgery.

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## Will I have to sign a consent form?

We want you to fully understand why you are having the surgery and be aware of the possible risks. These should have already been discussed with you in the clinic when the decision for surgery was made.

Once you have read the information leaflet provided to you from the clinic, you will be asked to sign a form on the day of your surgery, giving your consent to have surgery. The consent form gives your gynaecologist the right to do only what is written on this form.

The only exception to this is if, during the surgery, there is an unforeseen problem. You have then consented to have this corrected, for example, the repair of any injuries, a blood transfusion, and the need to convert the keyhole procedure into an open procedure.

Please feel free to ask any questions or discuss any concerns you have about the surgery that you do not understand before signing the consent form.

The medical terms commonly used on the consent form are:

- Total Laparoscopic Hysterectomy (TLH) - removal of the womb which includes the cervix (neck of the womb).
- Sub-total Hysterectomy – removal of womb without removing the neck of womb (cervix).
- Oophorectomy - removal of one ovary.
- Bilateral oophorectomy - removal of both ovaries.
- Salpingectomy - removal of one fallopian tube.
- Bilateral salpingectomy - removal of both fallopian tubes.
- Salpingo-oophorectomy - removal of one ovary and fallopian tube.
- Bilateral salpingo-oophorectomy - removal of both ovaries and fallopian tubes.

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## When should I stop eating and drinking?

Detailed instructions will be included in your admission letter about when to stop eating and drinking. It is very important that you follow the instructions otherwise your surgery may need to be cancelled on the day and another date arranged.

## Day of your surgery

Following your admission to the day surgery ward, a member of the nursing staff will check your pulse, blood pressure and temperature. You will then be asked to provide a urine (wee) sample.

An anaesthetist and your surgeon (or a senior member of the team) will see you and go through the consent form. When they are sure that you understand why you are having this procedure and what it involves, you will be asked to sign the consent form, if it has not already been signed. They will inform you of the likely timing of your operation. The anaesthetist and surgeon will also answer any questions or concerns you may have.

You will be given a hospital gown to change into and anti-embolism stockings to wear during your stay in the hospital. You are advised to wear these stockings after your surgery and at home until you are fully mobile (up to 2 weeks). This will help to reduce the risk of blood clots in your legs or lungs.

When it is time for your operation, a nurse will take you to the theatre. You will meet the theatre team in the anaesthetic room.

## During the surgery

TLH is normally carried out under a general anaesthetic (while you are asleep). Sometimes the anaesthetist may discuss with you the option of spinal or epidural anaesthetic, in addition to general anaesthetic.

A narrow plastic tube (called a cannula) will be inserted into a vein in your arm or hand using a needle. This is used to give you fluids and medications.

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After you have been given a general anaesthetic and you are asleep, your bladder will be emptied by inserting a urinary catheter. The urinary catheter is usually removed straight after your surgery and while you are still under anaesthesia.

An instrument will then be inserted through your vagina into the cavity of the womb to help the uterine manipulation required for the laparoscopic hysterectomy.

A small cut (about 1 cm) will be made which is usually around your navel (belly button). The abdomen is then filled with gas and an optical instrument, called a laparoscope, will be inserted to allow the internal organs to be viewed before 2 to 3 further small cuts, about 0.5 to 1 cm each, are made on your abdomen. These cuts are used for other instruments to be inserted to perform the surgery. The location of these cuts is decided by the type of procedure and preference of the surgeon so as to increase the safety and efficiency of your surgery.

Your ovaries and fallopian tubes may or may not be removed depending on the reason for your surgery. In most cases the uterus and cervix are removed through the vagina. If the uterus is too large to remove vaginally, or the vagina is too narrow, a slightly larger cut will be made on your abdomen for it to be taken out.

Sometimes a narrow tube or a drain may be left inside your tummy during the surgery. This is usually used for observation to detect any ongoing bleeding. The drain will be secured using a stitch and is usually taken out after a medical review on the ward.

Sometimes, a vaginal pack may be required for a few hours following hysterectomy, in case of any bleeding from the vaginal wall. The pack helps by applying pressure to bleeding points and stops the bleeding.

It is likely then that you may need to stay in hospital for overnight observation if a drain or a vaginal pack is inserted during your operation.

The wounds will be closed with dissolvable stitches and a waterproof dressing or tissue glue. Stitches usually fall out in about 2 weeks following the healing of the surgical wound.

The operative procedure takes about 60 to 90 minutes, but you can expect to be in theatre and the recovery area for 3 to 4 hours.

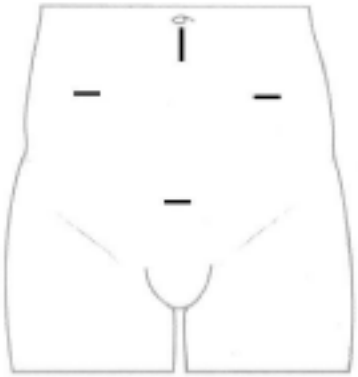

**Figure 1: Image of typical incision sites but these may vary.**

## After the surgery

You will normally wake up in the operating theatres recovery area, but you may not remember much until you are back on the ward in your own bed.

You will be given a variety of medications that work in different ways to make sure that you are comfortable when you wake and that you feel like eating and drinking soon after waking. If there are any issues, then please let the nurses know; they will do their best to help.

As the operation is performed by keyhole with tiny cuts in your tummy, pain is usually managed with simple pain relief such as paracetamol and ibuprofen. You will also be given anti-sickness medication.

The nursing staff will encourage you to drink water to keep hydrated and encourage you to mobilise as soon as possible after your surgery.

Early mobilisation will help your recovery, reduces the risk of developing blood clots in your legs or lungs and help you to regain your bowel and bladder function.

Gradually, you will be assisted to sit out in a chair beside your bed. You should be able to walk to the bathroom within 4 to 6 hours after your surgery.

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## Will I need a catheter (tube for urinary drainage)?

The catheter is usually removed after the surgery. The ward team will check that you are able to pass urine satisfactorily before your discharge from the hospital.

## Going home

You will be ready to go home in the evening following your surgery. This will be ensured by various checks made by the nurse looking after you on the ward. They will make sure that you are eating and drinking, taking regular pain relief and staying comfortable, able to move around on the ward comfortably and can pass urine normally before you are discharged home. However, we understand that you may need a longer time to recover, or your doctor may advise you to stay longer after your surgery.

Please make sure that you have a supply of paracetamol and ibuprofen at home which you should take regularly for the next 1 to 2 weeks as advised. We will also give you a supply of additional pain relief to take home to help keep you comfortable. This may be medication such as codeine and some laxatives to avoid constipation.

After the surgery, you may experience ‘wind pains’ from having medical air inside your abdomen, these should stop within a few days. Drinking a small amount of peppermint oil in warm water can help. Peppermint oil can be bought in supermarkets and health shops.

You may notice some weight gain during the first few weeks following surgery because you are less active. Hysterectomy itself does not cause weight gain.

You may have some light vaginal bleeding (spotting) for up to 6 weeks after the surgery, this is normal. If the bleeding becomes heavy, has a bad smell or if you are concerned, please seek advice. We advise you not to use tampons but to wear sanitary pads.

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If you have any concerns about the healing of your skin, such as signs of inflammation or infection, please seek medical advice. You may need antibiotics if the infection is understood to be the cause. It is advised that you keep your wounds clean and dry until healed.

## When can I resume my normal diet?

You will be encouraged to drink fluids soon after the surgery. You will usually be eating a light diet within a day of the surgery.

## Recovery and returning to normal

We encourage you to be as mobile as possible at home to help with the healing process. You should take regular pain relief as advised so as to allow you to remain comfortable. Most women are able to resume light activities within the first few days after TLH.

It is advisable not to carry out any high impact activities and exercises or lift heavy weights for 6 to 8 weeks.

Swimming should be avoided until all the external wounds have healed and any vaginal discharge has cleared up.

It is also advised that you do gentle pelvic floor exercises to support and strengthen your pelvic floor muscles and to prevent prolapse.

## When can I go back to work?

We suggest that you stay off work for 4 to 8 weeks; this depends on the nature of your job. We are able to give you a sick note for 4 weeks but if you need any longer off work, then you will need to see your GP.

## What about my sex life?

The area at the top of the vagina, where the cervix was, will have dissolvable stitches which will need about 6 to 12 weeks to heal fully before intercourse can be resumed. You will tend to know when you feel ready to resume intercourse.

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You should find that there is no alteration in the sensation but you may at first feel slight discomfort. If you experience any pain, please seek advice from your GP.

## When can I drive?

You should not drive until you feel able to perform an emergency stop comfortably and are not taking regular pain medication. This usually means about 6 to 8 weeks without driving. We recommend you discuss this with your insurance company.

## Smear test

If you had a total hysterectomy (removal of the womb and the neck of the womb ie cervix) and the detailed examination of tissues did not show any abnormality in the cervix, you will not need any cervical smears in the future. Your consultant will advise you after your hysterectomy if future smear tests are needed from the vaginal vault. However, if you did not have your cervix removed at the time of hysterectomy ie if you had a sub-total hysterectomy, then you will need to continue having cervical smears as you would have done without having had hysterectomy.

## Contact information and follow-up

At the time of your discharge from the hospital, a member of the nursing staff will give you the contact details for any concerns during the first 2 weeks after surgery.

After 2 weeks, you are advised to contact your GP directly.

For any acute problems such as heavy bleeding or acute pain you should attend the Accident & Emergency or call NHS 111.

A member of the team will contact you by telephone the day after your surgery. This is to check on your recovery and give any advice needed.

Your surgeon will write to you with the results of the detailed lab examination of any tissues removed at the time of your surgery. They will also advise if you need a follow-up appointment in the clinic or will arrange patient-initiated follow-up (PIFU) for 6 months.

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# Will I need hormone replacement therapy (HRT)?

HRT will have been discussed with you in the Outpatient Clinic before your surgery. Whether or not HRT is offered to you will depend on if your ovaries were removed during the surgery, your age at the time of removal, if you were already postmenopausal and other medical conditions and risk factors.

- If you have not yet reached menopause and your ovaries are left in place, there is a small possibility that they may stop working at an earlier age than normal. If you do develop hot flushes or other menopausal symptoms before the age of 45. You should seek advice from your GP about the possible need for HRT to prevent osteoporosis (premature thinning of the bones).
- If your ovaries are removed at the time of hysterectomy, before your natural menopause, this will bring forward permanent menopause. You will usually be offered an oestrogen replacement therapy until the age of natural menopause ie 50. However, this will depend on your diagnosis, your risk factors and any contraindications to HRT in your case. Your gynaecologist will advise you on the type and dose of HRT. This will be continued and reviewed by your GP.
  It is important to know that HRT may not address your menopausal symptoms completely, especially the symptoms of hot flushes, night sweats and sexual desire or lack of libido.
- If you have already reached the menopause before your surgery, your need for HRT will not change. If you were not taking it before the surgery, you should not need it afterwards.
- You may wish to have a discussion about the advantages and possible disadvantages of HRT with the gynaecology team or with your GP before or shortly after your surgery.
- If it has been decided that you will need HRT after your surgery, you will be given a month’s supply to take home. Further supplies can be obtained from your GP. Transdermal HRT preparations of oestrogen such as patches, gel or spray, carry minimal risks and can be started soon after your surgery, once you are mobile.

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- It is important to know that HRT may take time to show its full benefits. It is usually started on smaller doses and can be gradually increased to the maximum recommended dose so as to address your symptoms.

## Further information

We recommend that you read information about the menopause and HRT by visiting the following: (References from – NICE, British Menopause Society (BMS)

**Menopause Matters**
www.menopausematters.co.uk/menopause.php

**Menopause exchange**
www.menopause-exchange.co.uk

**The Menopause Charity**
https://themenopausecharity.org

**The Daisy Network**
www.daisynetwork.org

**Women's health concern**
www.womens-health-concern.org

**Menopause Mandate**
www.menopausemandate.com

**Health Talk**
Seeking information about people's experience of menopause, visit @healthtalk

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# Making a choice

## Shared Decision Making

If you are asked to make a choice, you may have lots of questions that you want to ask. You may also want to talk over your options with your family or friends. It can help to write a list of the questions you want answered and take it to your appointment.

## Ask 3 Questions

**To begin with, try to make sure you get the answers to three key questions if you are asked to make a choice about your healthcare.**

1. What are my options?
2. What are the pros and cons of each option for me?
3. How do I get support to help me make a decision that is right for me?

These resources have been adapted with kind permission from the MAGIC Programme, supported by the Health Foundation

* Ask 3 Questions is based on Shepherd HL, et al. Three questions that patients can ask to improve the quality of information physicians give about treatment options: A cross-over trial. Patient Education and Counselling, 2011;84: 379-85

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https://aqua.nhs.uk/resources/shared-decision-making-case-studies/