Total Laparoscopic Hysterectomy (TLH)

Definition and purpose

This means removing the uterus (womb) using an operating telescope (laparoscope) inserted through the abdominal wall. This avoids having a large abdominal wound so your recovery is much faster. The vast majority of straightforward hysterectomies can be done in this fashion, and many more challenging ones too. The cervix (neck of the womb) is also removed so you generally will not need Pap smears any longer. The ovaries may or may not be removed depending on your wishes and condition; i.e. *the term TLH refers to removing the uterus and cervix only, entirely using the telescope*.

Under general anaesthetic carbon dioxide gas is used to inflate the abdomen and to create space for me to work. I will perform the operation using the laparoscope inserted through the umbilicus (belly button). Several other instruments are inserted through three or so small cuts in the abdomen. The uterus is freed from the tubes, ligaments and blood vessels on each side. A cut is made around the cervix, into the vagina to enable the uterus to be removed through the vagina. This cut is then closed with absorbable stitches, inserted from within.

If the ovaries and tubes are being removed at the same time their attachments are freed and these are also removed through the vagina.

The pelvic cavity is then washed out with a sterile solution, as much gas as possible is removed, and the wounds closed with sutures or glue. Local anaesthetic is instilled into the abdomen and pelvis.

Sometimes a small drain tube is inserted through one of the wounds; this will drain some blood stained fluid and gas after the operation and is removed the following day.

The operation takes around one hour.

© Dr Philip Thomas Gynaescope PL 2018

After the operation

You can expect to wake up with a tube in the bladder (catheter), an IV drip to replace lost fluids, a drain tube as described above and an oxygen mask. After four hours you will be offered something to drink. You will probably be able to eat breakfast the following day, when you will also be able to shower and have the drip and catheter removed. Patients are discharged after one to two days. If your operation is early in the day and you recover well you may be able to go home the following day.

Complications

All operations have a small risk of complications, and there may be specific risks related to any particular operation on any particular person. Your risks may be higher if you smoke, have heart disease, have diabetes or are overweight. You should write down any questions you may have. Overall, if you are offered an operation it is because I believe the benefits far outweigh the potential for harm.

General risks

- Infection of wound- antibiotics are given into the drip whilst you are asleep to lessen the chance of this
- Bleeding- a small percentage of women may require a blood transfusion during or after the procedure. Rarely post operative bleeding may occur a while after the operation, requiring a further operation. My average blood loss for this procedure is less than 50 ml, and I've never had to transfuse a patient. For this reason prior donation of blood is considered unnecessary.
- Blood clots in legs (deep venous thrombosis) which may rarely break off and travel to the lungs (pulmonary embolism). You will be given medication to reduce this risk.
- As tissues heal inside the abdomen loops of bowel or other tissues may become stuck together (adhesions), which occasionally causes pain and may warrant further surgery. Measures are taken to reduce this possibility, including meticulous surgical technique and use of adhesion barriers where appropriate.

Specific risks

- Urine infection which may require antibiotics
- Damage to the bladder or ureters. No greater risk of this in my hands than with any other kind of hysterectomy (eg abdominal) During the early days of developing this operation this was thought to be a potential concern but this is no longer the case.
- Bowel damage (1/1000) or major blood vessel damage (1/3000 for all laparoscopies)

© Dr Philip Thomas Gynaescope PL 2018

which may require a large cut on the abdomen (laparotomy) in order to correct, and rarely remains unrecognized for some time. Very unlikely! Many such issues can be dealt with laparoscopically at the time of the procedure.

- If the operation cannot successfully and safely be carried out via the laparoscope the operation may be converted to a conventional abdominal hysterectomy, which may require a longer hospital stay of around three days.
- If you have the ovaries removed and you were not already menopausal, you will begin to experience hot flushes. Around 2% of patients, in my experience, actually enter the menopause after a TLH, the reasons for this are not clear however may involve alteration in blood supply to the ovaries and already diminished "ovarian reserve".
- A hysterectomy is irreversible, pregnancy is impossible, and you will no longer need contraception or Pap smears.

The recovery phase

Pain/bloating

Some pain is usual. You may also experience a period-like cramping sensation or pain in the shoulders. This is thought to be due the Carbon Dioxide gas used to inflate the abdomen. This and a sensation of bloating usually last 1-2 days but in some people last weeks. Try simple analgesics such as paracetomol/Panadeine or Naprogesic. Please see my website www.philipthomas.com.au for detailed notes on pain relief.

Wound care and dressings

Leave dressings intact 24hrs unless soiled or wet. After that you may remove them, and either leave the wounds open, or preferably cover with a Band-Aid if you wish, as it has been shown that keeping wounds slightly moist and warm enhances healing. Do **NOT** apply antiseptic creams, Dettol, Betadine, methylated spirits etc to the wounds. These are unnecessary and in most cases harmful to healing tissue.
The best way to achieve a good scar is to leave the wounds alone until healed. Sutures will need to be removed by me preferably no later than five days from the date of operation. After that you may massage the wounds with a moisturizer containing Vit E.

Some **redness or 'flare'** is usual especially around the umbilical port site, but if the redness is spreading, the wound is discharging or if you feel unwell/feverish then seek advice.

© Dr Philip Thomas Gynaescope PL 2018

Showering

You can get the wounds wet the day after the operation, but avoid spas/baths/swimming pools until the sutures are out. Pat dry afterwards.

Sore throat and nausea

These are common; the former is due to the endotracheal (breathing) tube used whilst you are anaesthetised. Analgesics & small quantities of fluids will help. Nausea and drowsiness is due to the anaesthetic itself.

Dizziness/loss of concentration

This may be due to the anaesthetic or analgesics (especially ones such as Panadeine or morphine). Avoid operating machinery or dangerous household appliances or making important decisions for at least 48hrs. You should take at least 2 weeks off work, longer if your work involves strenuous activity or using machinery. Avoid strenuous exercise for about five days.

Driving a car

Generally, avoid driving for around one week. Once you can comfortably sit in the car, do not feel inhibited in your movements by pain and feel that your concentration has returned (eg can easily read a newspaper without mind wandering) it is probably safe to drive.

Post-operative review

You will need to see ME / YOUR GP in around 5-7 days to have the stitches removed.
I will then see you around six weeks after your surgery.

© Dr Philip Thomas Gynaescope PL 2018