Vaginal Hysterectomy

Introduction

A vaginal hysterectomy (VH) is a procedure in which the uterus is surgically removed through the vagina.

Occasionally one or both ovaries and fallopian tubes may be removed during the procedure as well. The cervix is also removed, as it represents the bottom part of the uterus. Vaginal hysterectomy has traditionally fewer complications and a faster recovery time than abdominal hysterectomy (AH). AH should only used as a last resort, if VH and total laparoscopic hysterectomy (TLH, see separate document) are not appropriate although these situations should be unusual. It is possible that a TLH has a faster recovery time than a vaginal hysterectomy.

FEMALE ANATOMY

The uterus is a hollow, pear shaped, muscular organ located within the pelvis. The fallopian tubes are part of the uterus, however the ovaries are not. The ovaries represent different organs; they have their own blood supply, although they do happen to lie quite close to the uterus within the pelvis. At its lower end the uterus becomes continuous with the cervix or mouth of the womb. The uterus is generally suspended in the pelvis by several sets of ligaments, and blood vessels. All of these need to be cut and tied off for the uterus to be removed and this process is not possible, without some degree of uterine prolapse. This means that when traction is gently applied to the cervix, whilst the patient is asleep, the cervix passes down into the lower vagina in order to provide access to these ligaments and blood vessels. If there is no descent, or insufficient descent, a TLH is usually required.

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REASONS FOR VAGINAL HYSTERECTOMY

The main reason for vaginal hysterectomy is utero-vaginal prolapse. This occurs due to stretching and weakening of the pelvic muscles, ligaments and walls of the vagina.

This may occur spontaneously, or after childbirth. Prolapse is generally graded one to four. It is usual to have approximately grade two prolapse after having had a couple of vaginal deliveries. Genetic factors, chronic constipation, chronic cough or lifestyle factors such as repeated heavy lifting or exercise may also play a part in the genesis of prolapse.

In order to completely correct utero-vaginal prolapse, a vaginal hysterectomy is often required as the uterus sits at the very top of the vagina, and the vagina must at this point be repaired or a less satisfactory long-term result for the prolapse repair may result. In this setting, a vaginal hysterectomy adds very little to the extent of the operation, hospital stay and recovery time.

Other reasons for vaginal hysterectomy may include abnormal uterine bleeding, pelvic mass effect due to fibroids, and endometrial abnormalities such as precancerous changes, abnormal Pap smears or chronic pelvic pain.

PRE-OPERATIVE PREPARATION

You should get a good night's sleep and take all your routine medication. You will be advised from when to fast. The operation will be carried out either a general (sleeping) or spinal anesthetic and this general requires a six-hour fasting period. If you are unsure when to fast from please contact my rooms. It is important that you provide me with a comprehensive list of the medications including herbal remedies and alternative remedies. Herbal remedies, aspirin and fish oil tablets can prolong postoperative bleeding in an unpredictable way and should all be brought to my attention. It is important that you stop aspirin and tablets such as clopridogrel (Plavix) for at least one week prior to the operation. Stop medications such as Jardiance at least a week before.

If you have any concerns regarding the applicability of this to your individual circumstances then please seek advice from me or another specialist physician.

Often special arrangements need to be made for patients taking Warfarin especially in the setting of an abnormal heart rhythm or an artificial heart valve.

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Please shower carefully prior to the procedure and pay special attention to the umbilicus (belly button), removing all traces of fluff and debris. You might like to use an antibacterial soap (such Gamophen) for this purpose.

Please make sure that you use any topical oestrogen medications such as oestriol or Vagifem pessaries up until the night prior to your procedure.

If you have any concerns or questions at all regarding the conduct of your procedure and what is to be carried out you should bring this to my attention before the day of the operation.

WHAT HAPPENS IN THEATRE?

The anaesthetist will decide the most appropriate type of anaesthetic for you based on a detailed preoperative discussion of your requirements.

When arriving in the operating theatre, you will be taken to a pre-anaesthetic area, where the anaesthetist will interview you. Hospital paperwork will be checked. You will then be taken to theatre, where an intravenous line will be sited and the anesthetic will be commenced. The uterus is removed through the vagina. The procedure will take between one to two hours, depending on whether or not a vaginal repair is also performed. Examination of the lining of the bladder (cystoscopy) and ureters is usually performed.

It is unlikely that you will have any recollection of the anesthetic having been given and will wake up in the recovery area where a specialist member of nursing staff will care for you. You will then be transferred to the post-operative ward, for an average two-night stay.

You will have an intravenous line on returning to the ward, and most likely a urinary catheter.

Occasionally I also insert a gauze vaginal pack into the vagina, which will be removed on the first post-operative morning.

POST-DISCHARGE CARE

Most patients are out of bed and out of the house within a week post-procedure. After this time, if you are comfortable you can also drive a car. It is however most important that you refrain from heavy lifting for six weeks. Gym memberships etc should be suspended. There may be mild discomfort, which can be treated with non-steroidal anti-inflammatories such as Naprogesic or Nurofen in combination with Panadol, Panadeine 8/15 or Panadeine Forte.

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There may be a small amount of bleeding and whilst bleeding it is wise to avoid tampons and refrain from intercourse until after your six-week check. Bathing is allowed but swimming in public pools should be avoided until your six-week check. Excessive bleeding after the procedure is uncommon however I am unable to give you an exact figure as to how long the spotting may persist. You should notify me if you develop a fever (temperature greater and 37.5 degrees), pain or cramping that does not respond to regular doses of simple analgesics, or bleeding involving clots or foul smelling discharge. Please note that the dissolving stitches used during the hysterectomy and or repair will harbor a slightly different population of bacteria than the vagina is use to and this will create a watery discharge, which will disappear as the sutures dissolve. Post-operative review will be at around six weeks. Note that if a sacrospinous vault suspension is performed, this is generally on the right side and a small amount of buttock pain may be expected which generally resolves within a short period of time.

COMPLICATIONS SPECIFIC TO VAGINAL HYSTERECTOMY:

the following have been described (but are unlikely)

1. **Conversion to open or laparoscopic hysterectomy.** If operation cannot be safely performed vaginally, conversion to an open operation will be undertaken. This will involve a transverse incision, just above the hairline (incidence less than one in 50).
2. **Temporary difficultly in passing urine immediately following the surgery.** This may occur if you have also had a sling procedure for urinary incontinence carried out. Around one in 50 women may need to be discharged with a temporary catheter in situ, which is generally removed after one week.
3. **Rarely (less than one in 200) the dissection carried out to do the vaginal repair may create a small hole** in either bowel or bladder, which lie adjacent to the vagina. This will be repaired at the time of the operation although your bladder catheter may need to stay in for several days. No lasting effects. Very rarely a leak may persist or arise some weeks post-op, and may need further surgery.
4. **Pain during intercourse.** This is very unusual and in fact most women find intercourse much more satisfactory after a vaginal hysterectomy and repair.
5. **Long term recurrence of prolapse.** Recurrence of prolapse is related to the age of the patient, condition of the skin pre-operatively, physical activity after repair (especially heavy lifting) and most importantly patient genetics). There is no doubt that some people are more prone to developing vaginal prolapse or hernias due to the way their connective tissues are formed.

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6. **Unmasking other previous tendency to stress incontinence.** Sometimes, the vaginal prolapse hides the patient's tendency to leak from the bladder when coughing or sneezing. This may require further surgery. If you already have a tendency to leak, please make sure that we have discussed this prior to your operation.
7. **Infection in the operating site or urinary infection (around 5%).** Treated with antibiotics. If you are aware of a fowl smelling discharge or irritation on passing urine please bring this to my attention.
8. **A Cystoscopy (examination of the lining of the bladder, with a small fibrotic telescope)** if often carried out at the time of a vaginal hysterectomy. This cystoscopy and the postoperative catheter may sometimes cause temporary irritation when passing water for a short time. This is often confused with a urine infection.
9. **Blood clots (deep venous thrombosis)** Any pelvic surgery increases the risk of developing blood clots in the large veins of the legs or pelvis. The risk is increased for approximately six weeks after surgery. As routine I give medication during the surgery and post-operatively in order to reduce this risk although no medication can entirely eliminate it.
10. **Earlier menopause.** Women, who have undergone hysterectomy, may experience menopause one year prior to the average age of 52. This can occur even if the ovaries are left in situ. No one really knows why this happens; perhaps it is due to an alteration in the blood supply to the ovaries. Incidence is around 2% and tends to be more common in women who are at least in their late 40's and who may already, may be having the occasional hot flush, indicating decreased ovarian reserve.

ALERNATIVES TO HYSTERECTOMY

Many women regard a hysterectomy as the "last resort". However studies have found that hysterectomy has a very high satisfaction rate, when performed on the right women, for the right reason. I am happy to leave no stone unturned, in finding alternatives to a hysterectomy, if appropriate; these can include use of a Mirena IUCD, endometrial ablation, or simple correcting vaginal prolapse without a hysterectomy.

We will need to work together, to determine what the chances of a non-hysterectomy procedure have of adequately fixing your problem without risk of recurrence or need for further surgery. For some women, this decision process is very easy, others less so. However, with modern surgical techniques, instruments and approaches, a hysterectomy is not the onerous procedure perhaps it once was, has a surprisingly short recovery time, and is a very effective way of optimizing and maintaining a women's health and effectiveness.

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