Hysterectomy
Patient Information
Even if your surgeon has explained to you what your operation entails many of us do not take in everything mentioned in the clinic, so this booklet is to help you understand your condition and the reason for the intended treatment.

As we are all different, it is not possible to personalise this information, so there may be differences between your individual case and the information given here.

If you have any queries regarding the information please discuss them with the consultant or a member of his / her team (doctors or nursing staff).

What is a hysterectomy?
A hysterectomy is an operation to remove the uterus (womb) often with removal of the cervix (neck of the womb).

One or both of your ovaries and fallopian tubes may also be removed at the time of hysterectomy. This should have been discussed with your consultant or a member of his / her team and is further described later in this booklet.

Why do I need a hysterectomy?
Although you will have discussed your own symptoms with your consultant, the most common reasons for a hysterectomy are:

- Prolonged or heavy periods (menstrual bleeding) not controlled by other treatments such as the use of a hormone-releasing intrauterine system (Mirena IUS) or an Endometrial Ablation procedure.
- Pain related to the uterus (womb) that has not been controlled by other treatments.

- As part of a repair operation for prolapse.
- Fibroids which are increasing in size, causing pressure symptoms, pain or bleeding (page three).
- Severe endometriosis, not controlled by other treatments (pages four and five).
- Cancerous changes of the cervix or the lining of the uterus or the ovaries.

Are there any alternatives to a hysterectomy?
Women who are having hysterectomy for fibroids could be treated by a procedure known as Fibroid Embolisation. Your consultant will be able to advise you further.

What are fibroids?
Fibroids are lumps of muscle that grow in the wall of the womb. They are not cancerous and are no more likely to become cancerous than any other part of the womb.
They are relatively common and the chances of them developing increases with age. Fibroids can vary in size from a small pea to a large melon. No-one really knows what causes them to develop but clinical evidence suggests they are related to the female sex hormones, mainly oestrogen. They usually develop during a woman’s reproductive years, although they rarely give rise to symptoms before the age of twenty-five.

Fibroids are rarely seen before puberty and tend to shrink in size after the menopause. A womb with large fibroids may be removed using a midline incision (this can be seen pictured on page six).

What is endometriosis?

Endometriosis is a condition usually affecting women between the ages of twenty and fifty. However, it can affect young women in their teens and can occur at any time between the onset of menstruation (periods) and the end of the menopause.

The inside of the uterus (womb) is lined with tissue called endometrium which thickens every month under the influence of hormones, to prepare for pregnancy.

If no pregnancy occurs, the endometrium is shed, passes through the cervix (neck of the womb) then out through the vagina. This is recognised as a woman’s period.

Endometriosis occurs when endometrium is found outside its normal place in the uterus and grows in other places in the body.

The most common place for endometriosis to occur is in the surrounding pelvic tissue where deposits can attach themselves to various organs and structures such as the ovaries, fallopian tubes, bladder and bowel.

These deposits respond to hormones in the same way as normal endometrium, and bleed each month at period time. However, the blood is released directly into the surrounding area and has no way to escape.

Pain is caused because the bleeding irritates other tissues in the pelvic area and occasionally because some of the blood and tissue develop into cysts.

The continual release of blood into the pelvic cavity each month also contributes to the formation of adhesions (scar tissue).

What causes endometriosis?

Despite extensive research worldwide, no-one really knows why some women develop endometriosis while others do not, but there are various theories.

The most widely accepted theory is that some tissue and blood may pass backwards, up the fallopian tubes and into the pelvis during menstruation (periods).

Another theory is that some women may have an abnormality of the immune system, or genetic factors which make them more open to the disease.

[Diagram of common and less common sites of endometriosis]
How is a hysterectomy performed?

**Abdominal hysterectomy:**
This means the operation is performed through either a ‘bikini line’ incision (a cut across the bottom of your abdomen) or by a ‘midline’ incision (a cut down towards your bikini line). Your cervix may be removed, known as a total hysterectomy or it may remain intact known as a sub-total hysterectomy.

For advice on sub-total hysterectomy, please see page 26.

**Laparoscopic hysterectomy or laparoscopically assisted vaginal hysterectomy (LAVH):**
This means the operation is performed using three to five tiny ‘keyhole’ cuts in the abdomen (tummy), so that a laparoscope (a long, pencil-slim telescope connected to a camera and television system) can be used to show the inside of the pelvis very clearly on screen. The uterus is then removed through the keyhole cuts or through a cut in the roof of the vagina.

The cervix is usually removed (known as a total hysterectomy) it may be possible to leave it intact if you wish, providing there are no medical reasons for its removal. Leaving the cervix intact is known as a sub-total hysterectomy. Your consultant will need to know in advance if you are requesting this so please contact his / her secretary as soon as possible.

For advice on sub-total hysterectomy, please see page 26.

**Vaginal hysterectomy**
This means the uterus is removed through the vagina and the operation involves no abdominal incisions. The cervix is removed (total hysterectomy).

The end result of the three approaches is the same but it is just a question of which method is most suitable in different circumstances.

**Hysterectomy with removal of ovaries**
If there is a problem with one or both of your ovaries, it makes sense to have them removed during your operation and it is possible to remove the ovaries during any type of hysterectomy.

Also, if you have already reached the menopause and your periods have stopped naturally, it is likely your ovaries are serving no useful function. Since there is a very small risk of cancer developing in them, it is wise to have them removed.

The removal of your ovaries should have been discussed with your consultant or a member of his / her team and you may need information about hormone replacement therapy (HRT). Information about HRT is available from both your GP practice and the hospital.
Where do I get HRT from?
If you start HRT tablets or skin applications before leaving hospital, you will be instructed how to use them and be given a supply to take home. Your GP will then take over the care of your HRT therapy and will continue to monitor your general health so if you have any problems or have any questions about your HRT, always contact your GP first.

Hysterectomy without removal of ovaries
After any type of hysterectomy, if you do not have your ovaries removed, they will go on producing hormones. They will continue to do so until you reach your normal menopause. However there is some evidence this may come a year or two earlier.

You will still experience a hormonal cycle and if you previously experienced pre-menstrual symptoms such as breast tenderness, pain, bloatedness and mood swings, these may continue but are likely to be less intense.

Any pre-menstrual symptoms will end with the natural menopause which may be signalled by the onset of hot flushes, sweats, mood changes etc.

Please note: The overall result of any style of hysterectomy is that your uterus (womb) will be removed, your periods will stop and there will be no possibility of any future pregnancy. This means if you are planning to have more children you cannot have a hysterectomy.

Are there any complications or risks associated with a hysterectomy?
We know there may be complications following various gynaecological operations or procedures, that are not particularly serious but do happen more often.

These frequently occurring risks include:
- Pain, bruising, delayed wound healing, scarring of the skin or scar tissue inside (adhesions).
- Numbness, tingling or burning sensation around the scar and some women will find there will always be numbness above a bikini-line scar.
- Anaemia, fatigue / tiredness. Ovarian failure, causing an early menopause. Urinary frequency or loss of control.
- Wound infection, urinary tract infection or chest infection which is usually easily treated with antibiotics. Patients are encouraged to follow the recommended post-operative breathing exercises and to reduce or stop smoking if possible.

Are there any ‘more serious’ risks?
The overall risk of serious complications from abdominal hysterectomy is approximately four women in every 100 (common). It is also known some risks are increased if you already have underlying medical problems or if there are very
large fibroids, lots of endometriosis and/or scar tissue (from previous operations or disease) which makes the hysterectomy more difficult. The risks are also increased if you are obese or if you smoke. **The more serious risks include:**

1) **Pelvic Abscess/Infection.** Two women in every 1,000 (uncommon) develop an abscess which may require surgical drainage under an anaesthetic. All ladies having hysterectomy are given antibiotics during the operation to help prevent occurrence of infection.

2) **Bleeding.** This may occur during the operation or, rarely, afterwards and may be enough to need a blood transfusion. This happens to 23 women in every 1,000 (common). If you have had some internal bleeding and we find blood has collected in your pelvis, we call this a haematoma. A haematoma can usually be easily treated with antibiotics, to encourage the blood to drain out through your vagina, but occasionally it may need to be drained surgically under anaesthetic. A haematoma is often described as a blood clot, and this is quite a good description but must not be confused with the blood clots described in sections four and five.

3) **Visceral injury.** This means injury to the bowel which would happen to four women in every 10,000 (rare). Or damage to the bladder and/or or ureters, the two tubes coming from the kidneys into the bladder, which happens to seven women in every 1,000. There may also be long-term disturbance to the bladder function but this is uncommon.

If there is an injury, it may need to be repaired by laparotomy. This involves a much larger abdominal incision (tummy cut) and a longer stay in hospital.

These complications would usually be found during the operation and dealt with immediately. In rare cases the problem may not become apparent for a few days after the hysterectomy and this may require a second operation to resolve the problem. Seven women in every 1,000 return to theatre (uncommon).

4) **Venous Thromboembolism.** This happens to four women in every 1000 (uncommon). This is broken down into two types:

- **Deep vein thrombosis (DVT)** … following a hysterectomy, it is possible for clots of blood to form in the deep veins of the legs and pelvis. If this does occur, a deep vein thrombosis would cause pain and swelling in a leg and can be treated relatively simply with drugs. The risk of developing a DVT is minimal, as many precautions are taken to help prevent and minimise the risks such as: recommending you reduce your smoking in the weeks before your operation, the use of support stockings and/or medication to ‘thin the blood’, the use of special equipment in the operating theatre and also the recommended post-operative leg exercises.

- **Pulmonary embolism** … in rare cases, it is possible for a clot to break away and be deposited in the lungs or heart and if this occurs it is a serious situation and will need immediate treatment with drugs. The precautions against pulmonary embolism are the same as for DVT.

A patient information leaflet has now been published by the Thrombosis Patient Safety Committee of the South Tees Hospitals NHS Foundation Trust.

5) **The risk of death** within six weeks is 32 women in every 10,000 (rare). The main causes of death are pulmonary embolism and cardiac (heart) disease.

If you do have any concerns about the risk of complications, please discuss them with the consultant or a member of his/her team (doctors or nursing staff) and your questions will be answered as clearly and as honestly as possible.
What happens before I am admitted into hospital?

At your clinic appointment you will have filled in some medical forms and had your weight, height, pulse, and blood pressure recorded. You will then be invited back to the hospital for your preadmission appointment. Some blood samples will probably be taken and, depending on your general health and age, you may also need a heart tracing (ECG - electocardiogram), a chest x-ray or a lung function test. We may want to listen to your chest or take a more detailed history of your medical problems for the anaesthetist. You will already have had your operation explained to you by your consultant so he/she is not usually involved in preadmission and there is not usually any need for an internal examination. You will have the opportunity to ask the nurse any questions you might have.

Shortly before your operation, we usually phone you to make sure your general health has not changed since you were seen by the preadmission team and you have understood the information you have been given. An appointment will be made for the telephone call. The nurse or healthcare assistant calling you will complete your hospital paperwork and also make sure the arrangement we have made for your discharge day is still right for you.

Your anaesthetist would prefer you to stop, or at least reduce, cigarette (and cannabis) smoking in the weeks before your operation, as this is known to increase the risk of anaesthetic complications, e.g. breathing difficulties, coughing, nausea and sickness and chest infection. Please avoid drinking alcohol on the evening before your operation as this may lead to dehydration.

To reduce the possibility of skin infection, we request you do not shave your bikini-line or your legs during the week before your operation but some ‘trimming back’ of excess pubic hair may be required, you can do this yourself at home or the nursing staff will help you after you are admitted.

Admission into hospital

Do not have anything to eat or drink as instructed in your admission letter. Do not suck sweets or chew gum. As you will be admitted on the day of your operation, you will need to take a bath or shower at home and take off as much of your jewellery as possible although we are able to cover wedding rings/bangles if you are unable to remove them. To reduce the possibility of any damage to your eyes, it is very important you remove all mascara and wear glasses instead of any type of contact lenses. Please wear comfortable clothes that are not tight around the waist.

You will need to bring a packet of sanitary towels into hospital with you, toiletries, dressing gown, nightgown and slippers, plus any medications that you are currently taking. You may also choose to bring in a book or magazine.

Please be aware that South Tees Hospitals NHS Trust cannot be held responsible for any personal belongings, valuables or money you bring in with you.

Please read your admission letter carefully to see where you are being admitted to. If you are unsure, you may phone the nursing staff:

- Allerton Ward at The Friarage Hospital: 01609 764404
- Women’s Health Unit / Ward 27 at The James Cook University Hospital: 01642 854527
What can I expect before the operation?
You should normally have signed a consent form before your admission day but if you have not done this, you will be seen by your consultant or a member of his/her team who will explain your operation in detail and answer any questions you may have before you sign the consent form. You will also have the chance to speak to your anaesthetist before your operation. The nurses will give you ‘support socks’ and a small injection may be given to thin the blood, helping to reduce the risk of a blood clot developing in your legs during the operation. You will then go to the theatre area with a nurse and/or porter.

What can I expect after the operation?
When the operation is completed you will be woken by the anaesthetist and transferred, on your trolley, to the recovery area in theatre. Your recovery nurse will look after you and stay with you until he/she is satisfied with your condition. You will be transferred to the ward on your trolley and the ward staff, with the help of the theatre porter, will transfer you into your bed. You will probably feel drowsy for a few hours afterwards.

You are likely to have a ‘drip’ (also known as an I.V.) to give you intravenous fluids until the next morning when you should be able to start drinking.

Post-operative pain is controlled with a PCA (Patient Controlled Analgesia) device that allows you to control the amount of pain relief that you receive and should result in a comfortable post-operative recovery. The PCA is usually removed when both you and your nurse feel you are ready to progress onto painkillers that are given by mouth or in suppository form. This is quite often during the first day after your operation.

You may have had a catheter inserted into the bladder. This is a very slim rubber tube which drains urine from the bladder so that:

a) you do not have to get up to go to the toilet when you may still be feeling a bit drowsy and sore
b) we can make sure that the bladder is working well.

The catheter is usually removed the night after your operation. Its removal is a simple and painless procedure.

You may be visited by the physiotherapist the day after your operation, who will give you advice on gentle post-operative exercise.

You will be encouraged to increase your mobility gradually during the day after your operation until you can be fully mobile making it possible for you to have a shower or to go in the bath, with some assistance from the staff.

You may feel much more tired than usual after your operation as your body is using a lot of energy to heal itself. You may need to take a nap for the first few days. A hysterectomy can also be emotionally stressful and many women feel tearful and emotional at first – when you are tired these feelings can seem worse. For many women this is often the last symptom to improve.

It usually takes a few days before your bowels start to work normally and you may experience discomfort associated with a build-up of wind. This usually resolves itself, but if it becomes a problem the nursing staff may provide some peppermint water to drink and encourage taking gentle exercise. You may want to bring a bottle of baby’s gripe water into hospital with you as many women feel that this is effective in relieving wind pain.
It is important to keep your genital area and any abdominal wounds clean. A daily bath or shower is advisable paying particular attention to these areas. Avoid the use of highly scented soaps, bubble bath and vaginal deodorants, etc. We will provide a separate sterile towel to dry the wound and a sterile dressing to cover the wound after bathing. If dressings are still needed on discharge they will be provided by the nursing staff. You may have dissolving stitches in your wound, in which case you will be advised by the nursing staff how to care for them. If you have clips, staples or stitches (sutures) which need to be removed, the nursing staff will explain how to care for your wound and advise you when they will be removed.

You should expect to have some vaginal bleeding in the first few days after the operation. The bleeding normally turns into a red/brownish discharge before stopping completely and can last anything from a few days to a few weeks. If bleeding becomes heavier than a period or smells very offensive, let the doctor or nursing staff know as it may mean that you have an infection. We advise you to use sanitary towels in preference to tampons whilst the bleeding persists, as this will help you to keep a check on the amount you are losing and will help to reduce the risk of infection associated with tampon use. Some further, slight, bleeding may occur about four to six weeks after your operation. This can happen because your internal stitches are dissolving. As long as this bleeding only lasts for a day or two do not worry, but if it becomes very heavy and you are worried, please contact your GP.

How long can I expect to be in hospital after the operation?
Many patients feel well enough to leave hospital one to three days after the operation but you must tell your nurse how you are feeling and she will help you to decide whether you are ready.

What happens when I go home?
‘Support stockings’, should be worn day and night for two weeks. You then need to wear them only during the night for a further four weeks (or until you are back to your full mobility). ‘Blood-thinning injections’ should be continued until your prescribed course is finished.

The following information is from the publication, “Recovering Well”, produced by the Royal College of Obstetricians and Gynaecologists:

What can help me recover?
It takes time for your body to heal and for you to get fit and well again after any type of hysterectomy. There are a number of positive steps you can take at this time.

Rest: Rest as much as you can for the first few days after you get home. It is good to relax, but avoid crossing your legs for too long when you are lying down. Rest doesn’t mean doing nothing at all throughout the day, as it is important to start exercising and doing light activities around the house within the first few days.

A pelvic-floor muscle exercise programme: Your pelvic-floor muscles span the base of your pelvis. They work to keep your pelvic organs in the correct position (prevent prolapse), tightly close your bladder and bowel (stop urinary or anal incontinence) and improve sexual satisfaction.
It is important for you to get these muscles working properly after your operation, even if you have stitches.

To identify your pelvic-floor muscles, imagine you are trying to stop yourself from passing wind or you could think of yourself squeezing tightly inside your vagina. When you do this you should feel your muscles ‘lift and squeeze’.

It is important to breathe normally while you are doing pelvic-floor muscle exercises. You may also feel some gentle tightening in your lower abdominal muscles. This is normal. Women used to be told to practise their pelvic-floor muscle exercises by stopping the flow of urine midstream. This is no longer recommended, as your bladder function could be affected in the longer term.

You can begin these exercises gently once your catheter has been removed and you are able to pass urine on your own. You need to practise short squeezes as well as long squeezes: Short squeezes are when you tighten your pelvic-floor muscles for one second and then relax. Long squeezes are when you tighten your pelvic-floor muscles, hold for several seconds and then relax. Start with what is comfortable and then gradually increase – aiming for ten long squeezes, up to ten seconds each, followed by ten short squeezes.

You should do pelvic-floor muscle exercises at least three times a day. At first you may find it easier to do them when you are lying down or sitting. As your muscles improve, aim to do your exercises when you are standing up. It is very important to tighten your pelvic-floor muscles before you do anything that may put them under pressure, such as lifting, coughing or sneezing.

Make these exercises part of your daily routine for the rest of your life. Some women use triggers to remind themselves such as, brushing their teeth, washing up or commercial breaks on television.

Straining to empty your bowels (constipation) may also weaken your pelvic-floor muscles and should be avoided. If you suffer from constipation or find the pelvic-floor muscle exercises difficult, you may benefit from seeing a specialist women’s health physiotherapist.

A daily routine: Establish a daily routine and keep it up. For example, try to get up at your usual time, have a wash and get dressed, move about and so on. Sleeping in and staying in bed can make you feel depressed. Try to complete your routine and rest later if you need to.

Eat a healthy balanced diet: Ensure that your body has all the nutrients it needs by eating a healthy balanced diet. A healthy diet is a high-fibre diet (fruit, vegetables, wholegrain bread and cereal) with up to 2 litres a day of fluid intake, mainly water. Remember to eat at least five portions of fruit and vegetables each day. You will only gain weight if you eat more than you need to and you are not exercising enough.

Keep your bowels working: Your bowels may take time to return to normal after your operation. Your motions should be soft and easy to pass. You may initially need to take laxatives to avoid straining and constipation. You may find it more comfortable to hold your abdomen (provide support) the first one or two times your bowels move.

If you do have problems opening your bowels, it may help to place a small footstool under your feet when you are sitting on the toilet so your knees are higher than your hips. If possible, lean forwards and rest your arms on top of your legs to avoid straining.
Stop smoking: Stopping smoking will benefit your health in all sorts of ways such as lessening the risk of a wound infection or chest problems after your anaesthetic. By not smoking – even if it is just while you are recovering – you will bring immediate benefits to your health. If you are unable to stop smoking before your operation, you may need to bring nicotine replacements for use during your hospital stay. You will not be able to smoke in hospital. If you would like information about a smoking cessation clinic in your area speak with the nurse in your GP surgery.

Support from your family and friends: You may be offered support from your family and friends in lots of different ways. It could be practical support with things like shopping, housework or preparing meals. Most people are only too happy to help – even if it means you having to ask them! Having company when you are recovering gives you a chance to say how you are feeling after your operation and can help to lift your mood. If you live alone, plan in advance to have someone stay with you for the first few days when you are at home.

A positive outlook: Your attitude towards how you are recovering is an important factor in determining how your body heals and how you feel in yourself. You may want to use your recovery time as a chance to make some longer term positive lifestyle choices such as starting to exercise regularly if you are not doing so already and gradually building up the levels of exercise that you take.

Eating a healthy diet: if you are overweight it is best to eat healthily without trying to lose weight for the first couple of weeks after the operation. After that you may want to lose weight by combining a healthy diet with exercise. Whatever your situation and however you are feeling, try to continue to do the things that are helpful to your long-term recovery.

What can slow down my recovery?
It can take longer to recover from a hysterectomy if you had health problems before your operation; for example, women with diabetes may heal more slowly and may be more prone to infection. If you smoke; some women who smoke are at increased risk of getting a chest or wound infection during their recovery: smoking can delay the healing process.

If you were overweight at the time of your operation it can take longer to recover from the effects of anaesthesia and there can be a higher risk of complications such as infection and thrombosis. It can also take longer to recover if there were any complications during your operation.

Recovering after an operation is a very personal experience. If you are following all the advice you have been given but do not think you are at the stage you ought to be, talk with your GP.

When should I seek medical advice after an abdominal hysterectomy?
While most women recover well after a hysterectomy, complications can occur – as with any operation. You should seek medical advice from your GP, the hospital where you had your operation, NHS Direct or NHS 24 if you experience:

- burning and stinging when you pass urine or pass urine frequently: this may be due to a urine infection. Treatment is with a course of antibiotics.
- heavy or smelly vaginal bleeding or bleeding which starts again: if you are also feeling unwell and have a temperature (fever), this may be because of an infection or a small collection of blood at the top of the vagina, called a vault haematoma. Treatment is usually with a course of antibiotics.
Occasionally you may need to be admitted to hospital for the antibiotics to be administered intravenously (into a vein). Rarely, this may need to be drained.

- red and painful skin around your scars: this may be caused by a wound infection. Treatment is with a course of antibiotics.

- increasing abdominal pain: if you also have a temperature (fever), have lost your appetite and are vomiting, this may be because of damage to your bowel or bladder, in which case you will need to be admitted to hospital.

- a painful, red, swollen, hot leg or difficulty bearing weight on your legs: this may be caused by a deep vein thrombosis (DVT). If you have shortness of breath, chest pain or cough up blood, it could be a sign that a blood clot has travelled to the lungs (pulmonary embolus). If you have these symptoms, you should seek medical help immediately.

Getting back to normal

**Around the house:** While it is important to take enough rest, you should start some of your normal daily activities when you get home and build up slowly. You will find you are able to do more as the days and weeks pass. It is helpful to break jobs up into smaller parts, such as ironing a couple of items of clothing at a time and taking rests regularly. You can also try sitting down while preparing food or sorting laundry. For the first one to two weeks you should restrict lifting to light loads such as a one litre bottle of water, kettles or small saucepans. You should not lift heavy objects, such as full shopping bags or children, or do any strenuous housework like vacuuming, until three to four weeks after your operation, as this may affect how you heal internally. Try getting down to your children rather than lifting them up to you. If you feel pain you should try doing a little less for another few days. Remember to lift correctly by having your feet slightly apart, bending your knees, keeping your back straight and bracing (tightening or strengthening) your pelvic floor and stomach muscles as you lift. Hold the object close to you and lift by straightening your knees.

**Exercise:** While everyone will recover at a different rate, there is no reason why you should not start walking on the day you return home. You should be able to increase your activity levels quite rapidly over the first few weeks. There is no evidence that normal physical activity levels are in any way harmful and a regular and gradual build-up of activity will assist your recovery. If you are unsure, start with short steady walks close to your home a couple of times a day for the first few days. When this is comfortable you can gradually increase the time while walking at a relaxed steady pace. Many women should be able to walk for 30 to 60 minutes after two or three weeks.

Swimming is an ideal exercise that can usually be resumed within two to three weeks as long as vaginal bleeding and discharge has stopped. If you build up gradually the majority of women should be back to previous activity levels within four to six weeks.

Contact sports and power sports should be avoided for at least six weeks, although this will depend on your level of fitness before your surgery.

**Driving:** You should not drive for 24 hours after a general anaesthetic. Each insurance company will have its own conditions for when you are insured to start driving again. Check your policy.
Before you drive you should be:

• free from the sedative effects of any painkillers
• able to sit in the car comfortably and work the controls
• able to wear the seatbelt comfortably
• able to make an emergency stop
• able to comfortably look over your shoulder to manoeuvre.

In general, it can take three to six weeks before you are able to do all of the above. It is a good idea to practise without the keys in the ignition. See if you can do the movements you would need for an emergency stop and a three-point turn without causing yourself any discomfort or pain. When you are ready to start driving again, build up gradually, starting with a short journey.

Travel plans: If you are considering travelling during your recovery, it is helpful to think about:

• The length of your journey: journeys over four hours where you are not able to move around (in a car, coach, train or plane) can increase your risk of deep vein thrombosis (DVT). This is especially so if you are travelling soon after your operation.
• How comfortable you will be during your journey, particularly if you are wearing a seatbelt.

Overseas travel:

• Would you have access to appropriate medical advice at your destination if you were to have a problem after your operation?
• Does your travel insurance policy cover any necessary medical treatment in the event of a problem after your operation?

• Are your plans in line with the levels of activity recommended in this information?

If you have concerns about your travel plans, it is important to discuss these with your GP or the hospital where you have your operation before travelling.

Having sex: You should usually allow four to six weeks after your operation to allow your scar to heal. It is then safe to have sex – as long as you feel comfortable. If you experience any discomfort or dryness (which is more common if your ovaries have been removed at the time of the hysterectomy) you may wish to try a vaginal lubricant. You can buy this from your local pharmacy.

Returning to work: Everyone recovers at a different rate, so when you are ready to return to work will depend on the type of work you do, the number of hours you work and how you get to and from work. You may experience more tiredness than normal after any operation, so your return to work should be like your return to physical activity, with a gradual increase in the hours and activities at work. If you have an occupational health department they will advise on this.

Some women are fit to work after three to four weeks and will not be harmed by this if there are no complications from surgery. Many women are able to go back to normal work after six to eight weeks if they have been building up their levels of physical activity at home.

Returning to work can help your recovery by getting you back into your normal routine again. Some women who are off work for longer periods start to feel isolated and depressed. You do not have to be symptom free before you go back to work. It is normal to have some discomfort as you are adjusting to working life.
It might be possible for you to return to work by doing shorter hours or lighter duties and building up gradually over a period of time. Consider starting partway through your normal working week so you have a planned break quite soon.

You might also wish to see your GP or your occupational health department before you go back and do certain jobs – discuss this with them before your operation. You should not feel pressurised by family, friends or your employer to return to work before you feel ready. You do not need your GP’s permission to go back to work. The decision is yours.

Further advice

From The James Cook University Hospital and The Friarage Hospital’s Gynaecology Team

Sub-total hysterectomy: If you have had your cervix (neck of the womb) removed during the hysterectomy, there is usually no need for further smear tests unless you have had abnormal smears in the past, or you are advised otherwise. If the neck of the womb remains intact, please attend for your smears as usual. If you are not sure, please discuss this with one of the doctors or nurses or your own GP.

Breathing exercises

The recommended breathing exercises mentioned should help maintain a clear chest, tone up muscles and ease wind pain following surgery. Start this exercise as soon as you wake up from the anaesthetic and do regularly until you increase your walking.

Bend your knees up with feet flat on the bed, breathe in through your nose until your lungs are as full as possible, then relax as you breathe out through your mouth. Repeat five times every half hour or so, and follow with two huffs.

Huff: Position as above with hands or pillows supporting any area of discomfort. Take a medium breath in, then force the air out quickly through an open mouth, as though you are trying to mist up a large mirror. Follow this with a cough – take a big breath in first, and do not worry about this doing any damage in the area of your surgery.

Foot and knee exercises: These should help the circulation and help prevent clots from forming in your legs. Repeat every time you do your breathing exercises and until you are walking about. Bend feet up and down at the ankle firmly and quickly. Draw circles with your feet. Press back of the knees into the bed and tighten up the thigh muscles.
## Recovery tracker after abdominal hysterectomy

<table>
<thead>
<tr>
<th>Days after operation</th>
<th>How might I feel?</th>
<th>What is safe to do?</th>
<th>Fit to work?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1–4 days</td>
<td>You are likely to be in hospital during this time. You will have some pain and discomfort in your abdomen. You may feel sore moving in and out of bed. You may have some bleeding like a light period.</td>
<td>Get up and move about. Go to the toilet. Get yourself dressed. Start eating and drinking as usual. You will feel tired and perhaps feel like a sleep in the afternoon.</td>
<td>No</td>
</tr>
<tr>
<td>5–7 days</td>
<td>You should be at home by now. Your pains should be reducing in intensity now and you will be able to move about more comfortably. You will still tire easily and may require a nap during the day.</td>
<td>Continue as days 1–4. Go for short walks. Continue with exercises that have been recommended to you. Wash and shower as normal. Have a rest or sleep in the day if you need to.</td>
<td>No</td>
</tr>
<tr>
<td>1–2 weeks</td>
<td>There will be less pain as you move about and you will find your energy levels slowly returning. Bleeding should have settled or be very little.</td>
<td>Build up your activity slowly and steadily. Restrict lifting to light loads.</td>
<td>No</td>
</tr>
<tr>
<td>2–4 weeks</td>
<td>There will be even less pain now as you move about more and more. You will find your energy levels are returning to normal. You should feel stronger every day.</td>
<td>Continue to build up the amount of activity you are doing towards your normal levels. You can start to do low impact sport. Make a plan for going back to work.</td>
<td>Yes, possibly, on reduced hours or lighter duties.</td>
</tr>
<tr>
<td>4–6 weeks</td>
<td>Almost back to normal. You may still feel tired.</td>
<td>All daily activities including lifting. Usual exercise. Driving. Have sex if you feel ready.</td>
<td>Yes, but not heavy work.</td>
</tr>
<tr>
<td>6–8+ weeks</td>
<td>Back to normal.</td>
<td>Everything.</td>
<td>Yes, including heavy work. If you don’t feel ready to go to work, talk to your GP or employer about the reasons for this.</td>
</tr>
</tbody>
</table>

## Recovery tracker after vaginal or laparoscopic hysterectomy

<table>
<thead>
<tr>
<th>Days after operation</th>
<th>How might I feel?</th>
<th>What is safe to do?</th>
<th>Fit to work?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1–2 days</td>
<td>You are likely to be in hospital during this time. You will have some pain and discomfort in your abdomen. You may feel sore moving in and out of bed. You will feel tired and perhaps feel like a sleep in the afternoon.</td>
<td>Get up and move about. Go to the toilet. Get yourself dressed. Start eating and drinking as usual. You will feel tired and perhaps feel like a sleep in the afternoon.</td>
<td>No</td>
</tr>
<tr>
<td>3–7 days</td>
<td>You should be at home by now. Your pains should be reducing in intensity now and you will be able to move about more comfortably. You will still tire easily and may require a nap during the day.</td>
<td>Continue as days 1–2. Go for short walks. Continue with exercises that have been recommended to you. Wash and shower as normal. Have a rest or sleep in the day if you need to.</td>
<td>No</td>
</tr>
<tr>
<td>1–2 weeks</td>
<td>There will be less pain as you move about and you will find your energy levels slowly returning. Bleeding should have settled or be very little.</td>
<td>Build up your activity slowly and steadily. Restrict lifting to light loads.</td>
<td>No</td>
</tr>
<tr>
<td>2–4 weeks</td>
<td>There will be even less pain now as you move about more and more. You will find your energy levels are returning to normal. You should feel stronger every day.</td>
<td>Continue to build up the amount of activity you are doing towards your normal levels. You can start to do low impact sport. Make a plan for going back to work.</td>
<td>Yes, possibly, on reduced hours or lighter duties at first, some women will be fit for full-time work after 4 weeks.</td>
</tr>
<tr>
<td>4–6 weeks</td>
<td>Almost back to normal. You may still feel tired and need to rest more than usual.</td>
<td>All daily activities including lifting. Usual exercise. Driving. Have sex if you feel ready.</td>
<td>Yes, if you don’t feel ready to go to work, talk to your GP or employer about the reasons for this.</td>
</tr>
</tbody>
</table>

## Fit to work?

- **No**
- **Yes, including heavy work. If you don’t feel ready to go to work, talk to your GP or employer about the reasons for this.**
- **Yes, possibly, on reduced hours or lighter duties.**
- **Yes, possibly, on reduced hours or lighter duties at first, some women will be fit for full-time work after 4 weeks.**
- **Yes, including heavy work. If you don’t feel ready to go to work, talk to your GP or employer about the reasons for this.**
- **Yes, possibly, on reduced hours or lighter duties at first, some women will be fit for full-time work after 4 weeks.**
- **Yes, but not heavy work.**
- **Yes, if you don’t feel ready to go to work, talk to your GP or employer about the reasons for this.**
- **Yes, possibly, on reduced hours or lighter duties.**
- **Yes, including heavy work. If you don’t feel ready to go to work, talk to your GP or employer about the reasons for this.**
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- **Yes, including heavy work. If you don’t feel ready to go to work, talk to your GP or employer about the reasons for this.**
- **Yes, including heavy work. If you don’t feel ready to go to work, talk to your GP or employer about the reasons for this.**
We hope you have found this information helpful. Please remember our staff will be happy to answer any questions you have about any aspect of your care and welcome any comments about this leaflet.

### The James Cook University Hospital
- **Appointments Desk:** 01642 854861 / 282714 / 854883
- **Gynaecology Outpatients Dept. (Including Pre-admission Service):** 01642 854243
- **Surgical Admissions Unit:** 01642 854603
- **Women's Health Unit / Ward 27:** 01642 854527

### The Friarage Hospital
- **Appointments Desk:** 01609 764814
- **Gynaecology Outpatients Dept.:** 01609 764814
- **Pre-admission Service:** 01609 764845 / 01609 763769
- **Surgical Admissions Unit Reception:** 01609 764847
- **Nursing Staff:** 01609 764657
- **From 7am Mondays until 5pm Fridays, Allen POS.D.U.:** 01609 764405
- **From 5pm Fridays until 7am Mondays, Allerton Ward:** 01609 764404

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**Your notes**

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Comments, compliments, concerns or complaints

South Tees Hospitals NHS Foundation Trust is concerned about the quality of care you receive and strives to maintain high standards of health care.

However we do appreciate that there may be an occasion where you, or your family, feel dissatisfied with the standard of service you receive. Please do not hesitate to tell us about your concerns as this helps us to learn from your experience and to improve services for future patients.

Patient Advice and Liaison Service (PALS)

This service aims to advise and support patients, families and carers and help sort out problems quickly on your behalf.

This service is available, and based, at The James Cook University Hospital but also covers the Friarage Hospital in Northallerton, our community hospitals and community health services. Please ask a member of staff for further information.

Authors: The Gynaecology Medical and Nursing Team at The James Cook University and Friarage Hospitals.

Acknowledgements: The Royal College of Obstetricians and Gynaecologists, 27 Sussex Place, London NW1 4RG

More patient information is available on their website: www.rcog.org.uk/womens-health/patient-information

The James Cook University Hospital
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