Hysterectomy

Hysterectomy is one of the most commonly performed abdominal surgical procedures. The majority of patients referred to our practice for care of a gynecologic malignancy, pre-cancerous condition, or complicated benign pelvic problem will require a hysterectomy as part of a treatment plan.

What is a hysterectomy?

Let's start with some terminology:

Hysterectomy = removal of the uterus alone

Trachelectomy = removal of the cervix

Oophorectomy = removal of an ovary

Salpingectomy = removal of a fallopian tube

Although not strictly correct the term "hysterectomy" generally implies removal of both the uterus and the cervix.

When both ovary and fallopian tube are removed the operation is referred to as a "salpingoophorectomy".

In the popular lexicon removal of the uterus alone is often referred to incorrectly as a "partial hysterectomy". Likewise, removal of both the uterus and the ovaries/fallopian tubes is often referred to incorrectly as a "total hysterectomy". Think of it this way, we do not describe an expectant mother as "partially pregnant" or "totally pregnant". In the same way removal of the uterus is always just a "hysterectomy".

What are the different types of hysterectomy?

Hysterectomies can be categorized by the route of removal and by the extent of surrounding tissue removed.

Routes of removal:

1. Trans-abdominal approach (an "abdominal hysterectomy"). The uterus is removed through an incision made on the abdomen.

2. Trans-vaginal approach (a vaginal hysterectomy). The uterus is removed completely through the vagina.

3. Combined laparoscopic and trans-vaginal approach (a "laparoscopic-assisted vaginal hysterectomy or LAVH). Part of the surgery is performed via several small (1 cm) incisions on the abdomen and part of the surgery is performed through the vagina.

Extent of surrounding tissue removed:

Type I. None of the tissue surrounding the uterus or cervix is included in the operative specimen. The ureters and bladder are not mobilized.

Type II ("modified radical" hysterectomy). A small margin of tissue surrounding the uterus and cervix (parametria and uterosacral ligaments) is removed with the operative specimen. The ureters and bladder are not mobilized.

Type III ("radical" hysterectomy). The amount of parametria and uterosacral ligament removed with the uterus is greater than a Type II procedure. The ureters are mobilized. The bladder is minimally mobilized.

Type IV. The parametria and uterosacral ligaments are completely removed. Portions of the bladder/ureter/rectum are included in the operative specimen.

What kind of hysterectomy do I need?

With rare exceptions the Type II, III and IV procedures described above are reserved for treatment of cancers of the cervix and (occasionally) ovary. Most hysterectomies for benign conditions as well as early cancers of the uterus and ovary will be Type I procedures.

<u>Vaginal hysterectomies</u> can be appropriately performed only when, 1) there is no evidence of malignancy, 2) the uterus is small enough to fit through the vagina, 3) there is no ovarian mass present and, 4) there is enough relaxation of the supporting structures of the uterus (descensus) to allow it to be "pulled down" through the vagina during surgery (this is usually seen only in women who have had a prior vaginal delivery).

Pros:

1. Very little post-operative discomfort
2. Short hospital stay
3. No visible incisions
4. Little associated morbidity

Cons:

1. Abdominal/pelvic contents cannot be visualized or palpated
2. Ovaries cannot always be removed
3. Not appropriate if significant benign pathology or malignancy is present

A laparoscopic-assisted vaginal hysterectomy (LAVH) can often be performed when a vaginal hysterectomy would otherwise be contra-indicated. For instance, the presence of a benign ovarian mass, early cancer of the uterus or lack of descensus may not preclude performance of a LAVH.

Pros:

1. Very little post-operative discomfort (less than a vaginal hysterectomy)
2. Short hospital stay
3. Little associated morbidity
4. Pelvic contents can be visualized
5. Ovaries can always be successfully removed if necessary

Cons:

1. Abdominal contents cannot be visualized
2. Abdominal/pelvic contents cannot be palpated
3. Several small (1 cm) incisions on abdomen
4. Inappropriate if significant benign pathology malignancy is present

An abdominal hysterectomy is performed whenever a vaginal hysterectomy or LAVH is contra-indicated. A known or suspected malignancy of the ovary, cervix or uterus (with some exceptions) requires an abdominal approach to hysterectomy. Large ovarian masses, significant suspected benign abnormalities (e.g. endometriosis, adhesions from prior surgeries, etc) and lack of any descensus all must be managed through an abdominal approach.

Pros:

1. Abdominal/pelvic contents can be completely visualized and palpated
2. Used when significant benign pathology or malignancy is present

Cons:

1. Post-operative discomfort
2. Longer hospital stay than a vaginal hysterectomy or LAVH
3. Abdominal scar
4. Greater morbidity than vaginal hysterectomy or LAVH

Can I have a “bikini” incision?

The fact that you are a patient in our practice means that you probably have either a gynecologic malignancy or a complicated benign gynecologic problem. For reasons noted above your hysterectomy will probably require an abdominal rather than a vaginal approach.

An abdominal hysterectomy is performed through either a low transverse (bikini) or a midline incision.

Most surgeries for benign indications and many surgeries for treatment of pelvic malignancies can be performed through a low transverse incision.

Pros:

1. Cosmetically more acceptable than a midline incision
2. Low incidence of hernia formation

Cons:

1. Upper abdomen cannot be visualized

A hysterectomy for any benign or malignant indication can be performed through a midline incision.

Pros:

1. The entire abdomen can be visualized
2. Surgery can be performed in the upper abdomen if necessary

Cons:

1. More post-operative discomfort than low transverse incision
2. Higher risk of post-operative hernia than low transverse incision

So, a low transverse incision is nicer looking and hurts less than a midline incision. For these reasons it is usually preferable to a midline incision. There are times, however, when a midline incision simply must be used so that your surgical outcome or adequate treatment of a malignancy is not compromised.

Will my bladder fall down after a hysterectomy?

The bladder is not held in position by the uterus. However, the supporting structures of the bladder, rectum, uterus and vagina can all be damaged with childbirth. This damage can eventually lead to descensus of the uterus and prolapse of the vagina,

bladder and rectum. Removing the uterus does not further weaken the supporting structures of the bladder, vagina or rectum.

When my uterus is removed is there an empty space in my pelvis?

No. Think of the pelvic contents being analogous to a bowel of spaghetti and meatballs (your intestine is the “spaghetti” and the uterus is a “meatball”). If you were to remove one meatball from the middle of the bowel you are not left with a “hole” – everything just “flops” together. The same thing happens in the pelvis when the uterus is removed.

What is at the top of my vagina after a hysterectomy?

After the uterus and cervix are removed the top of the vagina is sewn closed.

Will intercourse be different after a hysterectomy?

If you had a satisfying sexual life prior to hysterectomy then the same will be true after surgery.

If you are premenopausal you may notice a decrease in vaginal secretions after a hysterectomy since cervical mucous will no longer be produced.