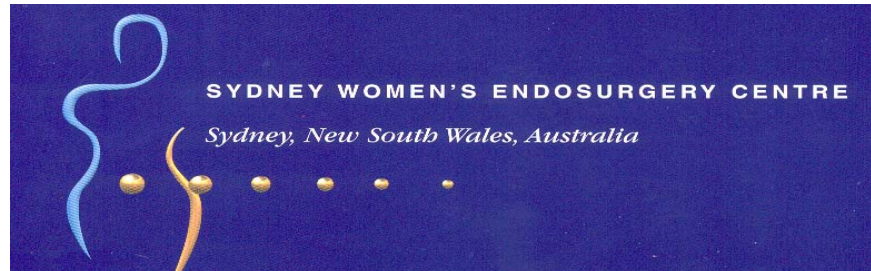


LAPAROSCOPIC HYSTERECTOMY



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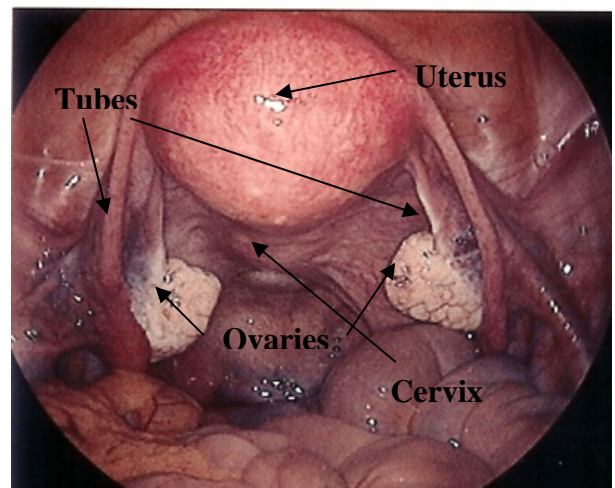
Director of the Sydney Women's Endosurgery Centre (**SWEC**), Australia's leading Centre for the development and training in Advanced Laparoscopic Surgery for women.

This information sheet has been produced for women who want to find out about hysterectomy and in particular the use of laparoscopic surgery in hysterectomy.

Hysterectomy is one of the most common operations performed in Australia and New Zealand and in fact is the second commonest major surgical operation after Caesarean Section being performed in around 33% of women under the age of 60. It is commonly recommended for women who have heavy vaginal bleeding or pelvic pain. The hysterectomy can offer a welcome cure for these very common, unpleasant symptoms and the opportunity for improved health.

WHAT IS A HYSTERECTOMY?

A hysterectomy involves the removal of the womb (**uterus**) as well as the neck of the uterus, which is called the **cervix**. In some situations the fallopian tubes may need to be removed (**salpingectomy**) and the ovaries may need to be removed (**oophorectomy**). After a hysterectomy there will be no more periods and it is not possible to become pregnant. A total hysterectomy involves removal of the cervix and the body of the uterus only. If a woman is premenopausal and the ovaries are free from disease, they are usually preserved and the patient will not require hormone replacement therapy following surgery. Cyclical symptoms such as sore breasts and mood swings may continue. If the ovaries are diseased or after the menopause, the tubes and ovaries may be removed. This is referred to as a **total hysterectomy and salpingo-oophorectomy**.



WHY DO I NEED A HYSTERECTOMY?

There are a number of reasons why a woman may require a hysterectomy. The commonest of these reasons include troublesome vaginal bleeding and uterine pain not relieved by other treatments. Fibroids may be causing pain, bleeding or pressure effects. Hysterectomy may be performed for symptoms related to endometriosis, as part of an operation for vaginal prolapse and for precancerous changes and cancerous changes in the uterus and/or the cervix.



ARE THERE ALTERNATIVES TO HAVING A HYSTERECTOMY?

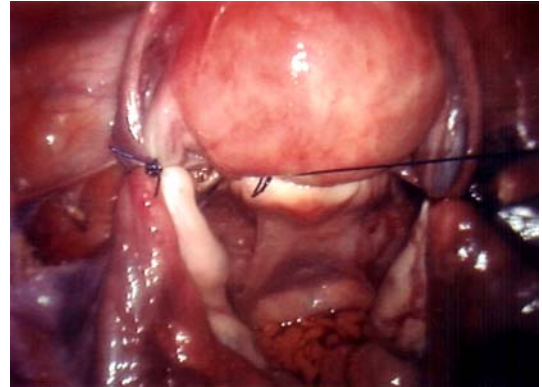
1. **D & C** and hysteroscopy (endoscopic examination of the uterine cavity) is a diagnostic procedure and has very little value in the treatment of the above disorder.
2. **Medical Treatment.** This includes non-steroidal anti-inflammatory drugs, the oral contraceptive pill, oral progestogens, tranexamic acid (Cyklokapron), Danazol, the progesterone intrauterine device and iron therapy for anaemia. Your doctor will discuss these alternatives in some detail.
3. **Endometrial Ablation.** In this surgical procedure (which is carried out under general anaesthetic), the endometrium or lining of the uterus is destroyed down to the level of the muscle coat, essentially removing the entire lining of the uterus. This destruction can be done using a number of different energy sources but all the results are similar. This procedure has a very high success rate in the first 12 months and a satisfaction rate above 90% with approximately 30-60% of patients having no periods at all. Over the next five years 20-25% of patients will require further intervention, which usually means a hysterectomy.
4. **Myomectomy**, which is the surgical removal of uterine fibroids that can be done at open surgery (particularly for large fibroids) and at laparoscopic surgery. It's effectiveness in reducing heavy menstrual bleeding and pelvic pain has been a matter of debate. It is usually reserved for patients who want to preserve their fertility as the operation may have a higher morbidity than hysterectomy with a higher transfusion rate and a higher incidence of postoperative adhesions.

HYSTERECTOMY MAY BE PERFORMED IN 4 WAYS:

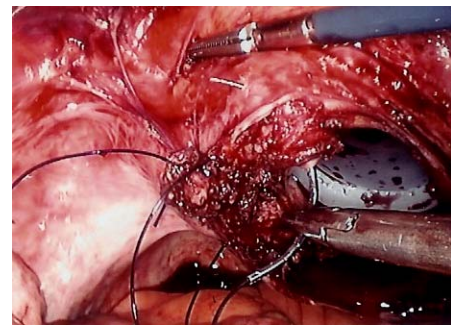
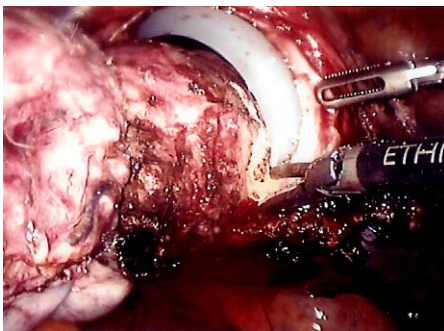
1. The uterus may be removed using an **abdominal** incision, which is either horizontal or vertical. This is performed in most developed countries in over **60%** of cases.
2. The uterus may be removed **vaginally**. Here the uterus is removed with the surgeon operating through the vagina. The vagina is sutured from below and there are no scars in the abdomen. (**30%**) This is usually done for women with significant prolapse of the uterus with no other major pelvic pathology.
3. **Laparoscopically assisted vaginal hysterectomy** where the upper part of the uterus is removed using the keyhole technique and the operation completed using the traditional vaginal approach. (**8%**)
4. **Total laparoscopic hysterectomy.** The uterus is removed entirely using the keyhole technique and the vaginal vault is stitched from above. There is no vaginal surgery with this technique. This is the newest technique. (**2%**)

WHAT IS LAPAROSCOPIC HYSTERECTOMY?

This is the newest technique for removal of the uterus and involves the introduction of a laparoscope or telescope which has a powerful light source attached to a miniature video camera which projects a clear image from inside the body on to a TV screen. The surgeon operates using the TV monitor and manipulates surgical instruments from outside the patient's body to carry out this advanced surgical procedure. Because the image is magnified the surgeon can more clearly identify the anatomy and more easily prevents bleeding during surgery to maintain a perfect picture.



These days laparoscopic surgery is used to diagnose most gynaecological problems. It has been used successfully for 30 years as a diagnostic tool and over the last 10 years has become the major instrument for performing pelvic surgery in women.



Laparoscopic hysterectomy was first performed in 1989 in the USA and was first performed by Dr Cario in 1991 and is now very commonly performed by a number of surgeons throughout Australia

ARE THERE ADVANTAGES TO LAPAROSCOPIC SURGERY?

Laparoscopic surgery is a less traumatic way of removing the uterus and is associated with a dramatic decrease in pain, minimal scarring, less blood loss, faster recovery and a quicker return to normal activities and work.

IS THIS PROCEDURE SAFE?

All types of surgery carry a risk. This risk includes the risk of general anaesthesia and the risk related to the procedure. It appears that laparoscopic hysterectomy has exactly the same major complication rate as abdominal or vaginal surgery. It would appear however that laparoscopic surgery has a significant decrease in the minor complication rate because there are less incisions and the recovery time is decreased.

Major complications include damage to the bladder, bowel, ureters, major blood vessels, haemorrhage, infection, blood clots. The total rate of these major complications appears to be less than **5-10 per 1000** regardless of whether abdominal, vaginal or laparoscopic approach is taken. In my recent

published review of 200 consecutive cases of Total Laparoscopic Hysterectomy there were no cases of damage to bladder, bowel, ureters or major blood vessels or conversion to open operation (Australian & New Zealand Journal of Obstetrics & Gynaecology 2001;41:3:307 Cario GM and Carlton MA). Occasionally however during an operation the surgeon may discover an additional problem which complicates the procedure. In this situation he may need to make a number of decisions which might include converting from a laparoscopic operation to an open operation. If this is a great area of concern for you, you must discuss this with your surgeon. This operation usually takes 60-90 minutes.

POSTOPERATIVE CARE.

HOW LONG WILL IT TAKE ME TO RECOVER FROM THE SURGERY?

The external incisions are very minor and heal quickly. This is a major operation and the internal healing process may take considerably longer. In our recent review article we showed that the average time in hospital was a little over **2 days** with return to normal home activities in around **9 days** and return to full time work in around **15 days**. A certain amount of discomfort should be expected in the first few days following the operation. During surgery carbon dioxide is used to inflate the abdomen and this may give rise to a dull ache, abdominal bloating and some shoulder tip pain. This discomfort usually passes in **24-48 hours**. There may be mild discomfort over the incision sites.



Generally speaking, the patient may begin a normal diet almost immediately after surgery and should ambulate very quickly within the first 24 hours. The patient can start driving again immediately after discharge from hospital. The patient must not start having intercourse until the postoperative visit in 4-6 weeks after the surgery. The very nature of laparoscopic surgery encourages patients to mobilise as quickly as they feel comfortable. Most patients will not require hormone replacement therapy following surgery.

You should call your doctor if you develop a fever over 38.5.C., heavy vaginal bleeding or offensive vaginal discharge, difficulty emptying your bladder, significant abdominal pain, bloating, nausea, vomiting or, pain, redness and swelling in one of your legs which may indicate a thrombosis.

Post Hysterectomy bleeding and discharge

Following your hysterectomy, you may experience some very light spotting or discharge for **4-6 weeks** after the operation. With laparoscopic hysterectomy all the sutures are tied internally above the suture line at the top of the vagina or the vault. As these sutures dissolve, you may see a slight increase in discharge or even some spotting. **This is completely normal.**



The 2nd week is often the time that secondary infection of this suture site can occur. In this condition bugs within the vagina or lower anal canal can migrate up to the suture line and cause an infection or some bleeding or result in a clot or **haematoma** which can also become infected. If this happens you may see increased bleeding which is either heavier or associated with offensive discharge. You may also become toxic which means that you develop a fever or hot and cold chills and become generally unwell. This needs to be treated with antibiotics and you need to notify Dr Cario on the next working day or if the symptoms are very severe you can notify Sister DelPin or the private hospital where you were operated on. If your temperature is above 38.5 C you may well need to be readmitted for 24—72 hours of intravenous antibiotics.

Usually after treatment of this condition which can occur to some degree in 15—20% of cases, you will return to a completely normal recovery profile. It is merely a small hiccup in your recovery phase and should not delay your return to normal activities and work significantly. It is impossible to predict which patients will infect themselves in this manner but as a rule there are absolutely no long term consequences from this condition.

Please remember that you cannot resume intercourse until the discharge and bleeding has completely settled and this usually occurs from 4-6 weeks after surgery.

WHAT IS THE COST OF THE PROCEDURE ?

This practice charges the fees set by the **AMA**. The Medicare schedule does not reflect the difficulty or complexity of ground breaking operations like this and in fact have not even gone to the trouble of providing an item number for this operation despite the fact that we have been doing them for over 10 years. Advanced laparoscopic surgery requires many years to master and is only performed by a small group of surgeons in Australia who are certified to perform this operation in particular. It takes up to 2 times longer than the open operation yet only attracts the same Medicare rebate. The Medicare system considers operations like this in a similar fashion to plastic surgery where there is a very poor rebate. They feel that the great cosmetic advantage and early release from hospital as well as early return to work are a *luxury* that people should pay for. There is therefore a considerable gap to pay despite our attempts to lobby the government for a review.

The exact fees and gaps can be easily obtained from my secretary prior to the operation and from the anaesthetist and hospital in a similar fashion. Obviously the big decrease in hospital bed days and the early return to family and work do offset the gap considerably. Please discuss this with me if you have a problem.