PROCEDURE

Hysterectomy

A hysterectomy is surgery to remove the uterus.

PURPOSE
Remove the uterus to treat serious or persistent pelvic conditions

PROCEDURE TYPE
Therapeutic surgery; open, vaginal, laparoscopic, or robotic

WHERE IT IS DONE
Operating theatre

ANAESTHESIA
General; sometimes spinal or epidural anaesthesia

HOW LONG IT TAKES
Usually 1 to 3 hours; complex surgery may take longer

PREPARATION
Fasting, medication review, and arranging help and transport home

RECOVERY
Overnight or several days; no driving until safe and cleared

MAIN RISKS
Bleeding, infection, blood clots, and nearby organ injury

RESULTS
Surgical findings immediately; pathology results usually within several days

Overview

A hysterectomy is surgery to remove the uterus, also called the womb. After the operation, you cannot carry a pregnancy and will no longer have menstrual periods.

A total hysterectomy removes the uterus and cervix. A subtotal or supracervical hysterectomy leaves the cervix in place. A radical hysterectomy removes additional tissue around the uterus and is mainly used for certain cancers.

Removing the fallopian tubes or ovaries is a separate decision. If both ovaries are removed before natural menopause, menopause begins soon after surgery. If one or both ovaries remain, they may continue producing hormones even though periods stop.

The operation may be performed through an abdominal incision, through the vagina, or using small abdominal incisions with laparoscopic instruments. Robotic surgery is a type of

laparoscopic surgery in which the surgeon controls robotic instruments.

Why the procedure is performed

A hysterectomy may be considered when symptoms are severe, other treatments have not worked, or a condition cannot be treated safely while leaving the uterus in place.

Reasons include:

A hysterectomy does not always cure pelvic pain, particularly when pain comes from the bladder, bowel, pelvic floor muscles, nerves, or endometriosis outside the uterus.

- Fibroids causing heavy bleeding, pressure, or pain
- Heavy or persistent bleeding that has not responded to other treatments
- Adenomyosis, where tissue similar to the uterine lining grows into its muscle
- Endometriosis that remains severe despite other treatment
- Uterine prolapse, when the uterus drops into the vagina
- Cancer or precancer affecting the uterus, cervix, ovaries, or nearby tissues
- Uncontrolled bleeding or serious infection in an emergency

Who should and should not have it

A hysterectomy may be appropriate if a uterine condition is seriously affecting your health or daily life and less invasive options are unsuitable or have not helped. For cancer, the recommended operation is based on the cancer type and stage.

It is not the right choice if you want to become pregnant in the future. Pregnancy is impossible after the uterus is removed.

Surgery may be avoided or delayed if you have an untreated infection, a medical condition that makes anaesthesia unsafe, or a diagnosis that needs further investigation. Your team may first recommend improving anaemia, blood sugar control, breathing problems, or heart health.

If cancer could be present, you may need assessment by a gynaecologic cancer specialist. This can affect the surgical route and how tissue is removed.

Before consenting, ask which organs will be removed, why that route is recommended, and whether the operation might need to change during surgery.

How to prepare

Your treating facility's own instructions take priority because preparation differs by surgical route, anaesthetic plan, and your health.

Tell the team about all medicines, supplements, allergies, previous reactions to anaesthesia, and any possibility of pregnancy. Blood thinners and some medicines for diabetes or weight management may need special instructions. Do not stop a prescribed medicine unless your treating team tells you to.

You will usually be told when to stop eating and drinking. Bowel preparation is not routine for every hysterectomy but may be requested for some operations.

Preoperative testing may include blood tests, a pregnancy test when relevant, an electrocardiogram, or imaging. Anaemia may be treated before planned surgery.

Arrange for someone to take you home and help during the first part of recovery. Prepare loose clothing, sanitary pads, simple meals, and frequently used items that do not require bending or lifting.

What happens during the procedure

Most hysterectomies are performed under general anaesthesia, so you are unconscious. Spinal or epidural anaesthesia may be used for selected vaginal or open procedures, often with medicine to make you relaxed or sleepy.

The surgical route may be:

The surgeon separates the uterus from its supporting tissues and blood vessels, then removes it. The cervix, fallopian tubes, ovaries, or nearby tissue may also be removed if this was planned or becomes medically necessary.

A urinary catheter drains the bladder during surgery and may remain temporarily afterward. Removed tissue is usually sent to a laboratory for examination under a microscope.

- Abdominal: The uterus is removed through an incision in the lower abdomen
- Vaginal: The uterus is removed through the vagina, without an abdominal incision
- Laparoscopic or robotic: Instruments and a camera are placed through several small abdominal incisions

Recovery and what to expect afterward

Pain: Cramping, incision soreness, bloating, shoulder discomfort after laparoscopy, and mild vaginal bleeding are common early on. Pain usually improves gradually. Use pain medicine as instructed.

Eating: You may begin with fluids and light food, then return to your normal diet as nausea settles. Fluids, fibre, and gentle movement can help with constipation.

Activity: Short, regular walks lower the risk of blood clots and help bowel function. Increase activity gradually. Avoid heavy lifting, strenuous exercise, sex, tampons, and placing anything in the vagina until your surgical team says healing is adequate. Recovery is usually longer after open abdominal surgery.

Driving: Do not drive home. Resume driving only when you are no longer taking sedating pain medicine, can wear a seat belt comfortably, can turn and brake safely, and have been cleared under your team's instructions.

Work: Some people with desk-based work return within a few weeks. Open surgery, physically demanding work, or complications may require a longer absence. Fatigue can continue after pain has improved.

Light bleeding or brown discharge may continue for several weeks. Use pads rather than tampons while healing.

Risks and possible complications

Possible complications include bleeding that may require a transfusion, infection, blood clots in the legs or lungs, and reactions to anaesthesia.

The bladder, ureters-the tubes carrying urine from the kidneys-or bowel can be injured because these organs are close to the uterus. An injury may require repair during the operation or another procedure.

Other possible problems include difficulty urinating, wound complications, scar tissue, persistent pelvic pain, or separation of the healed area at the top of the vagina. An intended laparoscopic or vaginal operation may need to be changed to open surgery for safety.

Removing both ovaries causes surgical menopause if menopause has not already occurred. Symptoms can include hot flushes, sleep changes, and vaginal dryness. Even when the ovaries remain, menopause may occur earlier than expected.

Results and follow up

The surgeon can usually explain the main surgical findings after the operation. If you had general anaesthesia, it may help to have someone else listen because you may not remember every detail.

Laboratory examination of removed tissue usually takes several days, although complex testing can take longer. Your team will explain what was found and whether further treatment is needed.

Follow-up may include checking your incisions, reviewing bleeding and pain, discussing the pathology report, and advising when to resume work, exercise, driving, and sex.

If your cervix remains, you may still need cervical screening. If it was removed, future screening depends on why surgery was performed and your previous cervical test results.

Alternatives

The alternatives depend on what the hysterectomy is intended to treat. Each option has different benefits and limitations.

Ask what is likely to happen if you delay surgery and which alternatives preserve fertility, the cervix, or the ovaries.

- Monitoring: Mild or stable symptoms may be watched, but they can continue or worsen
- Medicines: Hormonal treatments, anti-inflammatory medicines, or medicines that reduce bleeding can control symptoms without surgery, but benefits may be temporary and side effects are possible
- Hormonal intrauterine system: This can reduce heavy bleeding while preserving the uterus, but it does not treat large fibroids, prolapse, or cancer
- Endometrial ablation: Destroying the uterine lining may reduce bleeding with a shorter recovery, but it is not suitable if future pregnancy is desired and does not treat pressure symptoms or cancer
- Myomectomy: Removing fibroids while leaving the uterus can preserve pregnancy options, but fibroids may return and another operation may be needed
- Uterine artery embolisation: Blocking blood flow to fibroids avoids major surgery, but it is not suitable for every fibroid and future pregnancy outcomes require careful discussion
- Pessary or prolapse repair: A vaginal support device or uterus-preserving repair may treat prolapse, but symptoms can recur

- Cancer-specific treatment: Selected cancers may have fertility-sparing surgery, radiation, or drug treatment options, depending on type and stage

When to call your healthcare team

Contact your surgical team promptly for increasing pain, fever, persistent vomiting, difficulty urinating, worsening wound redness, pus, foul-smelling discharge, or bleeding that is heavier than expected. New swelling or pain in one calf also needs urgent assessment.

Seek emergency help for chest pain, sudden shortness of breath, fainting, coughing blood, uncontrolled heavy bleeding, or severe rapidly worsening pain.

Questions about activity, pathology results, menopause symptoms, or return to work can usually wait for routine contact or your planned follow-up appointment.

Common questions

Will I be asleep?

Most hysterectomies use general anaesthesia, so you will be unconscious. Selected procedures may use spinal or epidural anaesthesia with sedation.

Can I drive home?

No. Arrange for someone to take you home. Do not drive again until you can control the vehicle safely and are no longer affected by sedating medicines.

How painful is it?

Pain is expected, especially after open abdominal surgery, but it should gradually improve. Your team will provide a pain-control plan.

When will I know the results?

The surgeon can discuss the operation soon afterward. Laboratory results from removed tissue usually take several days and sometimes longer.

Will I go into menopause?

Only removal of both ovaries causes immediate surgical menopause. If the ovaries remain, they may continue making hormones, although menopause can occur earlier.

Can I still have sex afterward?

Yes, after healing. Wait until your team confirms that vaginal tissues have healed. Many people report unchanged or improved comfort once the condition causing symptoms has been

treated.

Sources

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