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## Enhanced Recovery Programme

# How to Recover Quickly from a Vaginal Hysterectomy



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### **Further Information**

We endeavour to provide an excellent service at all times, but should you have any concerns please, in the first instance, raise these with the Matron, Senior Nurse or Manager on duty. If they cannot resolve your concern, please contact our Patient Advice and Liaison Service (PALS) on 01932 723553 or email [pals@asph.nhs.uk](mailto:pals@asph.nhs.uk). If you remain concerned, PALS can also advise upon how to make a formal complaint.

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## Introduction

We look forward to welcoming you to Ashford and St. Peter's Hospitals for your operation.

Our mission is for you to come into hospital as strong as possible, ready for your surgery, and to make a quick recovery. To achieve this, we use an Enhanced Recovery Programme to optimise your nutrition, mobility and pain relief around the time of your operation. There is strong evidence that by following an Enhanced Recovery Programme you will recover faster from your operation, with fewer complications.

Enhanced Recovery involves staff caring for you (anaesthetists, nurses, dieticians, physiotherapists and surgeons), helping you to follow a clearly defined programme and most importantly requires your participation to make it work.

Together we will use as many parts of the programme suitable for you to achieve the best recovery.

The key parts are:

- Having nutritional high energy drinks before and soon after your operation leading to an early return to a normal diet.
- Having good pain relief.
- Getting out of bed and having assistance to walk soon after your operation.
- Getting home as soon as possible. Your Consultant should have already discussed this with you, or you should ask how long you will be in hospital at pre-assessment.

You may find a video on the website of the Royal College of Obstetricians and Gynaecologists useful. It explains how to recover well from a Vaginal Hysterectomy. To access the video, go to [www.rcog.org.uk](http://www.rcog.org.uk) and click on "patients" at the top right. Under "patient

information” click on “recovering after and operation” and find the video on vaginal hysterectomy. You can also find many other useful resources within the “patient information” section of the RCOG website.

## Useful Telephone Numbers

GP: \_\_\_\_\_

District Nurse: \_\_\_\_\_

Social Services: \_\_\_\_\_

Kingfisher Ward                   **01932 722380**

Ashford Hospital                   **01784 884488**

St. Peter's Hospital               **01932 872000**

## Vaginal Hysterectomy

### Why do I need a vaginal hysterectomy?

Vaginal hysterectomy is most commonly used in the treatment of uterine (womb) prolapse. A prolapse of the uterus occurs due to a weakness in the supporting tissues to the vagina. This weakness can cause symptoms of a bulge that appears from the vagina. It is usually worse on straining, walking and lifting. Commonly symptoms are worse in the evening.

Vaginal hysterectomy is also used in the treatment of women with menorrhagia (heavy bleeding) and/or dysmenorrhoea (painful periods) and small benign fibroids (non-cancerous growths) that grow in the wall of the uterus.

### What are my options?

#### ***No treatment***

Whilst vaginal prolapse can be uncomfortable and unpleasant, it is not life-threatening and having no treatment is a perfectly reasonable option, especially if you are not particularly aware of it and it is not causing you any problems.

#### ***Vaginal oestrogens***

These will not cure a prolapse, but if the tissues lack oestrogen it can help to reduce the symptoms.

#### ***Physiotherapy***

If a prolapse is mild, physiotherapy (pelvic floor exercises) can help to reduce the symptoms. It will not cure the prolapse, but can help to reduce the symptoms. In many cases, surgery can be avoided.

#### ***Vaginal support pessaries***

There are a large variety of pessaries which hold the prolapse in place. The pessary will need to be changed every 3-6 months but they can

avoid the need for surgery altogether or be used temporarily should you wish to defer surgery.

### **Medication**

For women with heavy bleeding, some medications have been shown to reduce the amount of bleeding women experience. A hormone regulating intra-uterine device (mirena coil) may be recommended to reduce symptoms of bleeding and pain.

### **Surgery**

Surgical procedures will be offered if clinically indicated. The type of surgery and the need for it will depend on the type of prolapse, whether you have had previous gynaecological surgery and whether you have other presenting symptoms such as large fibroids or the need to remove the ovaries.

An abdominal uterosacropexy (surgical support of the uterus without removal) can be performed in certain women, although this is largely done in women who have not completed their family. This is a larger operation performed through a cut in the abdomen.

### **What is vaginal hysterectomy?**

A vaginal hysterectomy is removal of the uterus (womb) through the vagina, with or without additional repair to the vaginal walls. The ovaries are not commonly removed by this route of surgery.

Repair to the vaginal walls can be either the front wall and/or the back wall. Front wall prolapse can cause bladder symptoms including frequency, urgency, incontinence and difficulty with bladder emptying. Urodynamic (bladder function) tests may be performed prior to surgery to determine the potential impact on bladder function, even if you have no symptoms. Back wall prolapse may cause bowel symptoms including constipation and difficulty in passing stool. For some women ano-rectal studies may be performed before 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 2 to 4 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.

### **Return to work**

You should be able to return to work within 4-6 weeks of surgery. This will depend on what your work entails and whether it involves heavy manual work.

### **If you become ill**

If you have any illness after your return home, please contact your GP.

### **Follow Up**

Routine follow up is not always done within the hospital setting and can be carried out by your GP. If you have follow-up arranged at the hospital this will be approximately 3 months after the operation by either one of our specialist nurses or doctors.

### **Personal hygiene**

It is better to shower than to bath for the first couple of weeks.

### **Bowels**

Avoid constipation and straining when opening your bowels as this puts unnecessary pressure on the repair. A good fluid intake (1.5-2 litres in 24 hours) and increase in fibre in your diet will minimise the risk of constipation.

### **Stitches**

All stitches are dissolvable so do not need to be removed. If they are bothersome they can be trimmed by your GP or practice nurse. Do not pull the stitches.

### **Medication**

Please finish the course of any antibiotics you may have been prescribed and continue with your normal prescribed medication.

Any topical oestrogen cream or pessary (vagifem) should be continued as prescribed once you are comfortable to insert the applicator.

### **Sexual intercourse**

Avoid penetrative intercourse for 4-6 weeks or until the bleeding subsides. It may feel superficially tender to start, but this should settle down with time.

### **Lifting**

You should avoid heavy lifting as long term as a lifestyle change if you have had prolapse surgery.

### **Exercise**

For the first couple of weeks you should rest, relax and take gentle exercise. Start by taking a short walk every day and then gradually introduce further exercise into your daily routine after 4 weeks. Avoid vigorous sports and swimming for around 6 weeks. Pelvic floor exercise should resume once you feel comfortable.

## **Risks and complications**

No surgery is without its risks and whilst vaginal surgery is safe, there are some risks associated with this particular kind of surgery.

### **Pain**

It's quite normal to experience pain or discomfort, but this can be controlled effectively with painkillers. These will be offered on a regular basis, but please let the nurse or doctor know if they are not controlling any discomfort.

Some women may have painkillers administered through a small pump attached to the arm or hand. A Patient controlled analgesia (PCA) allows you to release painkillers directly into the bloodstream. The machine is set so you can only get a safe dose.

Painkillers can also be administered through an epidural immediately after surgery. This is a small tube inserted into the space just outside the membranes surrounding your spinal cord in your back.

### **Bleeding**

This can occur during or after surgery. Major bleeding requiring blood transfusion is uncommon (less than 3 in 100).

### **Infection**

This can occur in the wound (15 in 100), urine or chest. If an infection occurs you will be given antibiotics

### **Clots in your legs (DVT) or lungs**

The risk of blood clots in the leg (deep vein thrombosis - 1 in 100) or lung (pulmonary embolus - 4 in 1000) is increased by immobility and if you are overweight.

This risk will decrease by quick mobilisation after the operation and weight loss and smoking cessation prior to your operation.

You will be given support stockings to wear to help prevent clots and given a blood thinning injection. Please inform your doctor or nurse if you experience any swelling or pain in your legs or sudden shortness of breath.

### ***Developing a haematoma***

This is a collection of blood where the uterus used to be (5 in 100). Most haematomas are small and resolve by themselves. Antibiotics may be given to minimise any further problems and in rare circumstances they are drained under anaesthetic.

### ***Damage to internal organs***

The bladder; ureters (tubes that pass from the kidneys to the bladder); bowel; and blood vessels lie close to the uterus and may possibly be damaged during the operation.

These potential but rare complications (ureters/bladder - less than 1 in 100; bowel – 2 in 1000; blood vessels - 1 in 10,000) would be dealt with and repaired when they are identified, usually at the time of operation. However, damage may not be obvious until after the operation and may result in a further operation (1 in 100).

Please inform your doctor/nurse if you experience severe abdominal pain and/or a temperature.

### ***Developing a fistula***

This is an abnormal connection that forms between the bladder; ureters or bowel and vagina and although rare (1 in 1000) may require a further procedure to correct.

### ***Difficulty in passing urine***

If difficulty emptying your bladder persists, a urinary catheter may be inserted to rest the bladder for a longer period of time. Occasionally a few women are taught self-catheterisation. If you have any difficulty passing urine before the operation, you may need to be taught this before going on the waiting list.

If you have a urinary catheter (tube to drain urine) this is also usually removed the following morning after your operation.

If you don't pass urine after the catheter is removed, which is not uncommon and is normally temporary, you will have a new urinary catheter inserted to rest your bladder. This can stay in for several days, and you will be taught how to use it and empty the bags when at home. You will be seen back on the ward a week later to remove the catheter and try to pass urine again.

Getting out of bed as soon as you are able and walking is an important part of enhanced recovery. Performing simple breathing and leg exercises will reduce your risk of complications such as blood clots and chest infections.

You will be able to go home once you are comfortable and passing urine normally and will be given some medication to take home including painkillers.

You can expect to be in hospital for 1-3 days. Occasionally, some women may need to stay a bit longer.

## **Recovery at Home**

### ***Vaginal bleeding***

You should expect some bleeding for a couple of weeks. The initial bleeding should gradually tail off and become like a light period after a few days. If it becomes painful and/or heavy, you may have an infection and should go to see your GP straight away.

You may also have some vaginal discharge for a few weeks. Providing this is not excessive, it is a normal part of the healing process.

You should initially avoid using tampons and use sanitary towels instead.

### ***The operation***

The operation takes about 70 minutes, but longer if there is additional incontinence or vaginal wall prolapse surgery. Your legs will be raised into stirrups (please let us know if you have any hip or back problems). Local anaesthetic and weak adrenaline (to reduce any bleeding) is injected into the skin of the vagina. The vagina is opened at the back and then the front. The bladder and bowel are gently removed away from the uterus. The blood supply to the uterus is tied off and the uterus is removed through the vagina. The supports to the uterus are then shortened and attached to the top of the vagina. The skin at the top of the vagina is then closed with dissolvable stitches. Any further vaginal repairs or continence procedures are done after.

### ***After the operation***

Once your operation is over, you will be taken first to theatre's recovery unit and then on to the ward. You may wake up with an oxygen mask over your face to help disperse the anaesthetic gases.

Painkillers will be provided but please tell the nurse or doctor if any pain is not relieved by the painkillers you are given.

You may be given fluids through a drip in your arm for the first 12-24 hours. Once you are able to take fluids you will be encouraged to start drinking and eat light meals. Good nutrition is important to your recovery. A good fluid intake (1.5-2 litres in 24 hours) and increase in fibre in your diet will minimise the risk of constipation.

It is not uncommon to experience griping "wind-pain" on the second or third day after your operation. This is your bowel just settling down and can be eased with medication.

You may have a vaginal swab in the vagina to reduce any bleeding. It will be removed once any bleeding has subsided usually the following morning.

### ***Long-term problems***

Most women do not have long term problems; however a small number of women may experience the following:

- Recurrence of prolapse. This can be as high as 30%. The aim of any surgery is to repair the prolapse, but we cannot cure the inherent weakness that resulted in the prolapse in the first place. Avoidance of heavy lifting and constipation may reduce this risk.
- Development or worsening of bladder symptoms including an increase in frequency and urgency, urge incontinence and stress incontinence. In some women this risk can be predicted by performing urodynamic studies (bladder function tests) prior to surgery.
- Onset of menopause even when your ovaries are not removed. You may need to consider taking hormone replacement therapy (HRT) at least until the age of 50 to prevent your bones from becoming weak and fragile (osteoporosis) and to help control mood swings and hot flushes. The need for HRT, its benefits and risks should be discussed with your medical team prior to leaving hospital. It may be advisable to delay the start of HRT until a few weeks after your operation (as you may have an increased risk of developing a blood clot immediately following surgery). However, you should be made aware which type of HRT you need and when to start taking it prior to leaving hospital.

### ***Before Your Operation***

Having seen your consultant and agreed to surgery, you will need to think ahead and plan your life whilst waiting for the operation and for your recovery afterwards.

### ***Investigations***

An internal ultrasound scan is performed to check the overall size of the uterus, presence and size of any fibroids and for any ovarian abnormality.

### **Medications**

You will be asked to stop any blood thinning medications such as aspirin, ibuprofen, diclofenac or clopidogrel 2 weeks before the operation. If you are on Warfarin or heparin we will liaise with both you and the haematology department about a regime to come off these medications.

You may need to stop oral contraception or hormone replacement therapy (HRT) before your operation.

Please bring all your medications with you when you attend the hospital and only stop those medications you have been advised to.

### **Consent**

You will be asked to sign a consent form which confirms you have agreed to the procedure. If you do not understand anything or would like someone with you, please let the consenting doctor know before you sign.

### **Eating and drinking**

You will be advised when you need to stop eating and drinking prior to the procedure depending on the type of anaesthetic.

### **Bowel preparation**

It is not routine for bowel preparation medication to be given to women undergoing this procedure, but in some circumstances it is most appropriate. If you do require bowel preparation medication, you will be given information about it when it is prescribed for you.

## **Pre-Assessment Clinic**

The purpose of this clinic is to prepare you for your admission and discharge from hospital. You will be sent a date for your pre-assessment clinic. At this clinic we will have a chance to discuss with you your home circumstances for safe discharge, assess your fitness

for anaesthesia and give you a chance to ask any questions you may have.

## **Preparing for Admission**

It is important for you to be thinking about planning your discharge now, before you go into hospital. You can help yourself by arranging help and support before you come into hospital such as:

- Make sure you know who can come and collect you from hospital, please bring their contact details with you.
- Ask friends and relatives if they can come to stay or visit to help around the house when you get home.
- Arrange for a friend or relative to do some shopping for you or make extra portions of food to freeze, or purchase ready meals and convenience foods that you can freeze for use in the first couple of weeks.
- Get up to date on your housework before you come into hospital, this will help reduce the load when you get home.
- Arrange additional childcare or help with the school runs where necessary.
- Arrange care for your pets, if necessary.

If you have any requirement that needs to be put in place before you go home, or any concerns or queries, please talk to your clinical nurse specialist, key worker, pre-assessment nurse or doctor before you come into hospital.

## **Your Operation**

### **The anaesthetic**

The operation can be done under either a spinal anaesthetic (awake but numb from the waist down) or general anaesthetic (asleep). A general anaesthetic is not generally used if you are having a mid-urethral tape procedure for urinary leakage done at the same time.