Shared Decision Making
A process of open communication. The physician offers the patient personalized information about treatment options and their associated risks and benefits. The patient then communicates to the physician her values, preferences and concerns regarding these variables. The goal is to arrive at a joint decision regarding the best nonemergency surgical procedure.

Both parties benefit. Physicians are better able to manage patient expectations and develop higher patient trust. Patients are better informed, more likely to comply with the treatment plan and more likely to be satisfied with their outcome.

When the Physician and the Patient use this guide together, they will make 

A Mutually Acceptable Decision.
THIS GUIDE will walk the physician and the patient through a discussion on hysterectomy. The guide outlines questions and points for the physician to discuss with the patient and provides information for the patient to review at home.

Together, the physician and the patient will make a mutually acceptable decision.
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For the **PHYSICIAN/GYNECOLOGIST**

- Put your patient’s mind at ease
- Explain the diagnosis
- Describe the procedure
- Potential benefits of minimally invasive hysterectomy
- Address possible complications
- Discuss quality-of-life implications
- Prepare your patient for surgery and recovery

For the **PATIENT**

- Feel good about your decision
- Understand your diagnosis
- Prevalence
- Reasons to have a hysterectomy
- Definitions
- Reasons not to have a hysterectomy
- Types of hysterectomies
- What surgical approach should you consider
- Surgical technique options
- Recovery after surgery
- Know the complications
- Healthcare costs

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- Informational websites
- Ask your surgeon questions
- References

The information contained in this material is for educational purposes only and is not a substitute for medical advice. Please review the entire document and talk to your physician to discuss which type of procedure may be most appropriate for you.
For the **PHYSICIAN**

**Physician and Patient Conversation Checklist**

The checklist provided on the following two pages will help guide your discussion with patients about the risks and potential health benefits of having a hysterectomy.

- **Put your patient’s mind at ease**
  
  Hysterectomy is one of the most common surgeries among women, second only to C-sections.1 Still, because of the intimate nature of the procedure and the conflicting emotions it may raise, many women feel uncomfortable talking about it.
  
  - You can put your patient’s mind at ease by inviting her to participate in the decision-making process and objectively describing her options based on her personal concerns.
  
  - Patient education materials and decision aids, many of which are available online, can help facilitate the process.

- **Explain the diagnosis**
  
  - Does your patient understand her diagnosis
    - Explain what is causing her symptoms and why she may be a candidate for hysterectomy.
  
  - Have you considered all less invasive options, such as hysteroscopic, robotic or laparoscopic myomectomy, uterine fibroid embolization, endometrial ablation, pelvic floor repair or medical management.
  
  - If there is an option, explain its benefits, risks and success rates. If there isn’t an option, explain why.

- **Describe the procedure**
  
  - Describe the types of hysterectomy:
    - Supracervical (subtotal) Hysterectomy — removes the uterus only, leaving the cervix attached to the top of the vagina
    - Total Hysterectomy — removes the uterus and the cervix
    - Radical Hysterectomy — removes the uterus, cervix and upper part of the vagina with supporting tissues and lymph nodes
    - Oophorectomy — combined with a hysterectomy to remove one or both ovaries and one or both fallopian tubes2

  Indicate which type you recommend for this patient and why. Discuss the potential impact on the patient’s current and future quality of life (e.g., Will hysterectomy invoke menopause? Will the cervix remain or not, and what are the implications?).

  Patients may not understand that a hysterectomy can be performed using different surgical techniques.
  
  - Explain the different approaches:
    - **Total Abdominal Hysterectomy** (Open) — a 6-inch incision made in the abdomen and underlying tissue to access the organs
    - **Minimally Invasive Procedures (MIP)**
      - **Vaginal Hysterectomy** — access is through the vagina.
      - **Laparoscopic Hysterectomy** — access is through 1–3 small incisions in the abdomen and surgery is done using laparoscopic instruments operated directly by the physician or by using a robot to assist in the operation2

  Explain to your patient why she may or may not be a good candidate for a minimally invasive procedure (MIP). In general, minimally invasive surgery is preferable unless there are other factors present that may interfere with its safety and efficacy, such as obesity, adhesions from earlier pelvic surgery or underlying medical conditions. Sometimes an MIP may have to be converted to a total abdominal hysterectomy due to these or other factors, such as an inability to visualize organs adequately or bleeding problems during the procedure.

- **Potential benefits of minimally invasive hysterectomy**
  
  Minimally invasive hysterectomy (VH, LAVH, TLH and LSH) is the preferred approach because of its proven benefits when compared to an open procedure.
  
  - Less major bleeding3
  
  - Fewer post-op infections3, 4
  
  - Fewer complications3, 4
For the physician

Discuss the procedure among women, second only to C-section. Still, hysterectomy is one of the most common surgeries, because of the intimate nature of the procedure and conflicting emotions it may raise, many women prefer to avoid the procedure even if they know they may be a candidate for hysterectomy.

Physician and Conversation Checklist

- Describe the procedure
- Explain the diagnosis
- Explain to your patient why she may or may not be a good candidate for a minimally invasive procedure
- Discuss possible complications
- Discuss quality-of-life implications
- Prepare your patient for surgery and recovery

Minimally invasive hysterectomy (VH, LAVH, TLH and LSH) is the preferred approach because of its proven benefits when compared to an open procedure.

- Shrinker length of stay
- Quicker return to normal activities
- Quicker return to work
- Less scarring
- Comparable or lower cost

Address possible complications

- Make sure your patient is aware of the potential for complications during surgery, such as adverse reactions to medications, problems with anesthesia or breathing, bleeding, blood clots, inadvertent injury to organs and vessels near the uterus and even death.
- Put these complications into perspective for your patient based on the type of surgery, her medical condition and age, as well as the surgeon’s and anesthesiologist’s experience and skill.

Discuss quality-of-life implications

- Ask about your patient’s lifestyle, occupation, normal activities, family, childbearing status, medical coverage and any other nonmedical factors that may influence the decision.
- Ask about personal concerns regarding the hysterectomy procedure: feelings about recovery time, cosmesis, returning to work and caring for family and other obligations.
- Address any personal concerns regarding the hysterectomy procedure:
  - Effects on sexuality and sexual activity
  - Effects on bladder or bowel function
  - Psychological effects
  - Menopausal symptoms following surgery
  - Other quality-of-life questions

Prepare your patient for surgery and recovery

- Explain what your patient can expect after the surgery in terms of:
  - Recovery time
  - Pain
  - Limitations on activity
  - Resumption of normal activities, including work and intercourse

Talk to your patient about options, concerns and expectations. An informed patient is a better patient.
Feel good about your decision
The prospect of having a hysterectomy can be daunting, but knowing you are not alone may help. One in three American women will have had a hysterectomy by the age of 60. The best way to prepare for this surgery is to learn as much as you can and discuss your questions and concerns with your doctor. You should feel confident that you and your doctor have explored all your options, that you understand everything fully and that together you are making the decision that is best for you.

Understand your diagnosis
Hysterectomies are performed to treat many medical conditions. Be sure you understand the nature of your condition and how a hysterectomy would treat it. Hysterectomy is a surgical procedure that removes the uterus. The term is based on the Greek word for uterus, “hyster,” plus the suffix that means removal, “ectomy.” In everyday usage, hysterectomy may refer to removal of not only the uterus but also the cervix, and does not necessarily mean removal of the ovaries.

Prevalence
Approximately 600,000 American women per year have hysterectomies, making it the second most common surgical procedure in the United States. Overall rates of hysterectomy were highest among women aged 40–44 years.

Reasons to have a hysterectomy
A study found that 44% of all hysterectomies performed in the U.S. in 2005 were for women with a primary diagnosis of either uterine fibroids or abnormal bleeding. Other leading reasons for hysterectomy, in descending order of prevalence, are endometriosis; prolapse; precancer of the uterine lining cells (atypical endometrial hyperplasia); and cancer of the cervix, uterus, fallopian tubes or ovaries.

Today, more and more women and their doctors are questioning whether a hysterectomy is really needed for some of these conditions. Newer, minimally invasive techniques have been developed to treat fibroids, abnormal bleeding and endometriosis while leaving the female reproductive organs in place. These new procedures are appropriate for many women, depending on the problem, and should be frankly discussed between a woman and her doctor.

Some women elect to have a hysterectomy as a means of preventing cancer. After all, if the organs are not there, no cancer can develop. However, uterine cancer is rare. It is usually detected early and is one of the most easily cured cancers. Cervical cancer can be avoided through regular checkups and Pap smears. Of all the female reproductive system cancers, ovarian cancer is the most aggressive and usually requires removal of the ovaries, the fallopian tubes and the uterus because of its tendency to spread.

The choice of approach depends on your diagnosis, prior pelvic surgeries, uterine size and the preference and skill of the surgeon.

Definitions
- Endometriosis — growth of the uterine lining cells outside the uterus, in or on the ovaries or in the fallopian tubes, or involving the bowel and bladder; causes pain, cysts, scarring and infertility
- Uterine fibroids — benign tumors that grow in the walls of the uterus; cause excessive pressure, pain and bleeding, menstrual cramps
Text:

- Hysterectomy is a surgical procedure that removes the uterus. The term is based on the Greek word for uterus, "hyster, " plus the suffix that means removal, "ectomy."

- Approximately 600,000 American women per year have hysterectomies, making it the second most common surgical procedure in the United States.

- Uterine prolapse — the uterus is normally held in place by a web of muscles and connective tissues that act like a hammock; when this tissue is weakened, the uterus may descend into the vagina.

- Ovarian, uterine, cervical or endometrial cancer — abnormal cell growth in one of these organs; removal is the typical treatment.

**Reasons not to have a hysterectomy**

- Pelvic pain. Studies have shown that hysterectomy may not be the best means of providing long-term relief for pelvic pain, unless there is an underlying uterine problem that is causing it. In one study of women who were thoroughly evaluated for causes of their pelvic pain, only 5% actually needed a hysterectomy. Another study found that 20% of women who had a hysterectomy for pelvic pain had no improvement afterwards, and 5% said their pain was even worse.

- Sterilization. Hysterectomy as a means of birth control is unwarranted. Traditionally, a quicker and less costly method has been to have the fallopian tubes blocked using laparoscopic techniques. Newer techniques of hysteroscopic sterilization procedure offer less risk and may be performed in the office. Male sterilization, or vasectomy, is safe and fast, and its cost to the individual is usually less than a female office hysteroscopic sterilization procedure.

- Conditions that can be treated effectively in other ways. Most fibroids, abnormal bleeding and endometriosis can now be effectively treated using minimally invasive techniques that preserve the uterus. These new procedures are appropriate for many women.

**Types of hysterectomies**

There are several different types of hysterectomies. The names describe what is being removed and how the procedure is performed.

<table>
<thead>
<tr>
<th>Type of Hysterectomy ²</th>
<th>What Is Removed ²</th>
<th>How It Is Performed ²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subtotal or “Supracervical” Hysterectomy</td>
<td>Removal of uterus only, leaving the cervix attached to the top of the vagina</td>
<td>Laparoscopic Hysterectomy, Robotic-assisted laparoscopic surgery, Abdominal Hysterectomy, Mini Laparotomy (removal of uterus)</td>
</tr>
<tr>
<td>Total Hysterectomy (Open or MIP)</td>
<td>Removal of uterus and cervix</td>
<td>Vaginal Hysterectomy, Abdominal Hysterectomy, Mini Laparotomy (removal of uterus), Laparoscopic Hysterectomy, Robotic-assisted laparoscopic surgery, Laparoscopically Assisted Vaginal Hysterectomy</td>
</tr>
<tr>
<td>Radical Hysterectomy (Cancer)</td>
<td>Removal of uterus, cervix, surrounding lymph nodes and omentum for cancer. Lymph nodes are part of the lymphatic system, which parallel the blood vessels in the body and wash away abnormal cells and cellular waste products. Removing the lymph nodes around the uterus and cervix helps ensure that any stray cancer cells are also removed.</td>
<td>Abdominal Hysterectomy, Laparoscopic Hysterectomy, Robotic-assisted laparoscopic surgery</td>
</tr>
</tbody>
</table>
Know the complications
All surgical procedures have risks, but the risk for serious complications depends on the type of surgery, uterine size, pelvic adhesions, your medical condition and age, as well as the surgeon's and anesthesiologist's experience and skill.

Minimally invasive hysterectomies have been associated with a lower risk of postoperative infection, less pain and a faster recovery.3–5

Possible complications include:2
- Adverse reactions to medications
- Infection at the site of the operation
- Breathing problems (infection of the lungs)
- Infection of the bladder
- Blood clots
- Problems with anesthesia
- Bleeding that may require a blood transfusion
- Injury to bowel, bladder and blood vessels
- Internal scarring with creation of adhesions
- Failure to remove all the diseased tissue
- Death

Sometimes a procedure can start out as minimally invasive, but may have to be converted to conventional surgery based on factors such as: obesity, a history of prior abdominal surgery causing dense scar tissue, inability to visualize organs, bleeding problems during the operation and other underlying medical conditions. This decision is made by the surgeon and is based on what is best for you.

Healthcare costs
Check your benefit plan and know your co-insurance rates (the amount you are required to pay of the total bill) and your deductible. It is advisable to call your insurance company and inquire about the costs of the procedures. Ask specifically about the cost differences in the various procedures so you can determine what your co-insurance payments will be.

What surgical approach should you consider
If a hysterectomy has been recommended by your gynecologist, ask if you are a candidate for a minimally invasive approach to your surgery. In most instances, hysterectomies can be accomplished minimally invasively with a vaginal, laparoscopic, robotic or single port approach. Seek a second opinion if a minimally invasive option is not offered.2

Surgical technique options
Minimally Invasive Surgery
- **Laparoscopic hysterectomy** is a minimally invasive type of surgery to remove the uterus. The surgeon makes tiny incisions through which instruments and the laparoscope are inserted. The laparoscope is a miniature camera attached to a slender telescope and is inserted through an incision in the navel. What it sees inside the body is projected onto a video screen, giving the surgeon a close-up view of the female reproductive organs.

  The uterus is detached by laparoscopic instruments and then removed through a small incision at the top of the vagina or through the umbilicus if a supracervical hysterectomy is performed. Because the procedure is minimally invasive, recovery time is shorter than with open abdominal procedures.

  - **Robotic or robotic-assisted laparoscopic surgery** is a variant of laparoscopic surgery using special remotely controlled instruments that allow the surgeon finer control as well as three-dimensional magnified vision.

  - In **vaginal hysterectomy**, the entire procedure is performed through an incision at the top of the vagina. First the uterus is pulled down into the vagina; then the ligaments and cervix and blood vessels that connect it to the body are cut and sutured. This procedure is most appropriate for women who have delivered children vaginally, because the ligaments have been stretched and the uterus is attached more loosely.

Open Surgery
- **Abdominal hysterectomy** is the most invasive type of surgery because it involves a large incision in the abdominal wall (laparotomy). This may be either horizontal — the “bikini incision”— or vertical from just below the navel down to the pubic bone.

Recovery after surgery
Your recovery will be dependent on the type of hysterectomy procedure you have.

<table>
<thead>
<tr>
<th></th>
<th>Vaginal Hysterectomy</th>
<th>Total Laparoscopic Hysterectomy</th>
<th>Abdominal Hysterectomy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Average Days in the Hospital</strong></td>
<td>2.2&lt;sup&gt;3&lt;/sup&gt;</td>
<td>1.6&lt;sup&gt;3&lt;/sup&gt;</td>
<td>1.37&lt;sup&gt;6&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Average Weeks of Recovery</strong></td>
<td>5–6&lt;sup&gt;5&lt;/sup&gt;</td>
<td>3.4&lt;sup&gt;5&lt;/sup&gt;</td>
<td>Most similar to Laparoscopic although not cited</td>
</tr>
<tr>
<td><strong>Scarring</strong></td>
<td>No external scar</td>
<td>Minimal scarring</td>
<td>Minimal scarring</td>
</tr>
<tr>
<td><strong>Operative Time (inpatient)</strong></td>
<td>2.82 hours&lt;sup&gt;6&lt;/sup&gt;</td>
<td>2.82 hours&lt;sup&gt;6&lt;/sup&gt;</td>
<td>3.22 hours&lt;sup&gt;6&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Operative Time (outpatient)</strong></td>
<td>2.46 hours&lt;sup&gt;6&lt;/sup&gt;</td>
<td>2.46 hours&lt;sup&gt;6&lt;/sup&gt;</td>
<td>2.99 hours&lt;sup&gt;6&lt;/sup&gt;</td>
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Talk to your physician/gynecologist. Become an active partner to develop the surgical plan that’s right for you.
HYSTERECTOMY

It is the position of the AAGL that most hysterectomies for benign disease should be performed either vaginally or laparoscopically and that continued efforts should be taken to facilitate these approaches. Surgeons without the requisite training and skills required for the safe performance of VH or LH should enlist the aid of colleagues who do, or should refer patients requiring hysterectomy to such individuals for their surgical care.

The American Congress of Obstetricians and Gynecologists (ACOG) issued a Committee Opinion in 2009 that examined evidence on the route of hysterectomy for benign (noncancerous) disease. The Committee recommended that vaginal hysterectomy surgery be considered the route of choice, with laparoscopic hysterectomy also considered a viable alternative to abdominal surgery. The Committee Opinion lists the strengths and weaknesses of each approach and cites evidence.

It is the position of the American Institute for Minimally Invasive Surgery (AIMIS) that patients should be aware of the expertise of their surgeon prior to a procedure being performed. We believe that every hysterectomy for benign disease should be planned secondary to the disease state not to a specific technique. Patients should seek surgeons that are accountable and transparent with surgical outcomes data and who provide hysterectomy options. AIMIS will support patient access to physicians that show outcomes and include the patient in the surgical decision process.

Informational websites:

www.aagl.org
www.acog.org
www.aimis.org
www.pelvichealthsolutions.com
www.smarterpatient.com/hysterectomy
www.surgeryoptions.info

Endorsed by:
AMERICAN ASSOCIATION of GYNECOLOGIC LAPAROSCOPISTS (AAGL)

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The AMERICAN CONGRESS of OBSTETRICIANS and GYNECOLOGISTS (ACOG)

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Take this page with you to your appointment with the surgeon. This will ensure you receive helpful information to make an informed decision.

Ask your surgeon questions

Never be afraid to ask questions if there is something you don’t understand. You should feel entirely comfortable asking questions of your doctor. The more you understand about your condition and its possible treatments, the better decision you will be able to make. You and your doctor are partners in your health, and an informed patient is the best candidate for success.

Bring a friend, partner or relative with you for your pre-operative discussion with the surgeon. If you are seeking a second opinion, it is helpful to bring your patient records, labs and image/ultrasound reports.

In addition to the topics covered here, you should know that minimally invasive surgery requires special training and expertise.

You should feel free to ask your surgeon:

- What is causing my problem? Although this may be clear in many cases, in others it is not so obvious. For example, pelvic pain may have a number of causes such as bladder or bowel problems that are unrelated to the uterus.
- Are there other tests available to help confirm this diagnosis? What are their side effects, risks and costs?
- Do you perform minimally invasive hysterectomies? If so, how many have you performed?
- How long have you been doing these surgeries? Would you refer me to another colleague if you cannot offer me a minimally invasive procedure?
- How long do you expect my hospital stay to be?
- How long do you expect my recovery to be?
- What symptoms are typical following a hysterectomy?
- Will my procedure cause menopausal symptoms?
- Should I continue to have annual Pap tests?

Use the opposite side to write down any additional questions or concerns you want to discuss with your surgeon.
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3. Do you perform minimally invasive hysterectomies? If so, how many have you performed?

4. How long have you been doing these surgeries? Would you refer me to another colleague if you cannot offer me a minimally invasive procedure?

5. How long do you expect my hospital stay to be?

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7. What symptoms are typical following a hysterectomy?

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References


2. American Association of Gynecologic Laparoscopists (AAGL) www.aagl.org/service/patients


If you and your physician have decided to explore a hysterectomy as a possible next step, please visit www.smarterpatient.com/hysterectomy or access it by scanning the QR code to the right.