Hysterectomy and Associated Risks

Possible After Effects of Total or Sub-Total Hysterectomy

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With great interest I have observed several online and real-time discussions regarding hysterectomy within the trans community, the wimmin's community and the health care community. I find only the wimmin's community to be realistic with regard to the short and long-term sequelae and their overall impact on the patient's post-operative quality of life. Now ... to translate that into English ... most of the F.T.M.s and S.O.s don't seem to have a clue about the negative possible after-effects of total or sub-total hysterectomy ... and the doctors gloss over them quickly, preferring instead to focus on the preventative aspects of this surgical procedure. I'll grant you that any organ that is surgically removed will no longer be a source of potential problems, but they fail to mention the problems that can come as a result of surgical intervention:

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Basic anatomical structures I will refer to include: uterus, cervix, vagina, ovaries, and Fallopian tubes.

A hysterectomy is the surgical removal of the uterus or womb. A total hysterectomy is the surgical removal of the uterus and cervix. Total hysterectomy with bilateral salpingo-oophorectomy includes the removal of the Fallopian tubes and ovaries in addition to the uterus and cervix. A radical hysterectomy is a procedure that includes uterus, cervix, tubes, ovaries, upper vagina, and some lymph nodes and is usually used in treating cancer and other pathological conditions. Vaginectomy (colpectomy) is not part of a hysterectomy of any type. It is a procedure that is normally performed only in 'bio-women' for conditions such as cancer or as treatment for vaginal prolapse. It can also be part of a sex reassignment surgery such as phalloplasty or metoidioplasty, but is not, repeat not, part of a 'normal' hysterectomy.

In addition, there are several types of surgical procedures used by gynaecologists/surgeons. An abdominal hysterectomy is performed through a horizontal incision in the lower abdomen. Most of the time the small resulting scar will be covered by pubic hair (after it grows back from the pre-op shave) and is not noticeable. You may know women whose incisions are vertical. Usually this type of incision is only used if the horizontal type cannot be used for some reason or if the woman has had previous abdominal surgery with a resulting vertical scar. In that case, the incision may be made in the same place as the existing scar to prevent further scarring.

Vaginal hysterectomy is the surgical removal of the uterus through the vagina. In addition, today's surgeons also perform this type with an assist from a laparoscope that enables them to see internal pelvic structures while using the vaginal approach. I have personally cared for a number of both abdominal and vaginal hysterectomy patients as the charge nurse on a peri-operative care hospital unit.

I will now address the risks associated with the procedures described. Of course, the risks that come with all surgery using general anaesthesia are quite serious and are always listed on surgical consent forms. These risks include such problems as infection, bleeding, drug reactions, blood clots, loss of sensation, loss of limb function, paralysis, stroke, brain damage, heart attack or death. While serious and worthy of much consideration, these risks are not the intended subject of this article.

If you have concerns regarding these risks or if you have had problems with anaesthesia in the past, you should definitely discuss this with both your surgeon and anaesthetist.

What I would like to address are the sequelae of hysterectomy. These include:

- Injury to the bowel or rectum;
- Injury to the bladder or urethra;
- Haemorrhage that may require a blood transfusion;
- Wound infection;
- Urinary tract infection;
- Incontinence;
- Urinary retention requiring continued use of a catheter;
- Bowel obstruction;
- Vaginal pain; and
- Fistula (abnormal communication) between the vagina and bladder or rectum

In addition, urinary frequency, stress incontinence, and nocturia are known post-operative complications of this surgery that are experienced by patients.

Some of these patients report that these complications persist indefinitely.

In fact, any surgical procedure that involves a female's reproductive system exposes that patient to risks of damage to the bladder and urinary system. Any damage to associated nerves and muscles can cause urinary incontinence.

Adhesions appear be another common problem in patients who have undergone this surgery. This internal scar tissue can attach itself to internal organs and cause major problems with anything to which they adhere. This will sometimes cause the need for additional surgeries including a common procedure called 'lysis of adhesions' which can in and of itself predispose the patient to further adhesions which can lead to the need for further surgery ... and on and on in a spiralling quagmire of expensive and painful medical intervention.

Rectocele is another problem directly caused by hysterectomy that patients may not be aware of. This condition, in which the front wall of the rectum bulges down into the vagina, sometimes causes faecal incontinence and other related problems. Medical treatment consists primarily of increasing dietary fibre and fluids, but troublesome cases require surgical repair.

While I realise that many F.T.M.s would like to have 'bottom surgery' or what is otherwise called sex reassignment (genital) surgery (S.R.S.), reality is such that few actually do this. The reasons include the poor outcome with regard to functionality inherent in the various techniques (i.e. phalloplasty, metoidioplasty, etc.) and the high financial burden of the cost of these procedures that usually falls on the patient without any assistance from insurance coverage.

So the argument that the vaginectomy will eliminate any risks associated with prolapse of either rectum or bladder into the vagina cannot happen to F.T.M.s as they will undergo vaginectomy is mostly wishful thinking. While I wish that every F.T.M. who desires S.R.S. could have this done, it is not going to happen any time soon. The medical resources in my country (U.S.A.) are stretched to the maximum as a result of budget cutbacks and other 'small government' schemes. Combine the shrinking health care budget with the virtual blank check given to our insurance companies and Health Maintenance organisations (H.M.O.s) with regard to selecting areas of coverage, and reality is such that most F.T.M.s will not be undergoing these surgical procedures. It is therefore important that the sequelae associated with female-bodied persons that have a vagina be understood before any consent to treatment is given.

These are not new ideas. Common sense and a practical knowledge of basic surgical technique and insight into human frailty mandate that there can and will be errors in the surgical suite. I am not suggesting that any or all of these complications can or will happen to all patients ... just that they are possibilities that every potential hysterectomy patient needs to be aware of in order to give fully informed consent to the procedure. For those who are not familiar with the term 'informed consent', let me point out that this is a legal term that has a specific meaning. I will just say here that it means that you have a right to fully informed choices with regard to your health care and any treatments or procedures given/done to you. This is your legal right. Do not sign it away without doing your homework.

I fully acknowledge the fact that many F.T.M.s want a hysterectomy for psychological reasons. I recognise that mental health needs are often as or more pressing than physical health concerns. It should be the right of every F.T.M. to have a hysterectomy with salpingo-oophorectomy if they so desire. I fervently believe that. I am just concerned at the flippant attitude with which the risks of this procedure are dismissed and the assumption that every F.T.M. wants/needs this done. Nothing is further from the truth. Most of the F.T.M.s I have known online and in real time who did not want the procedure done for one reason or another are afraid to voice their concerns with their 'brothers' because of possible ridicule, misunderstanding, or doubt as to the veracity of their status as F.T.M.s. Thus as a nurse I chose to articulate these concerns even though I am not an F.T.M., but am an S.O. of many years standing who shares hope, life, and dreams with my beloved Sam who is finally coming into his rightful place in the world after a successful transition with me by his side every step of the way.

Finally, let me just say that I am not in any way attempting to speak for any F.T.M.s, but rather I speak as a health caregiver who is concerned for the safety of those from within my community who choose this procedure as a part of their transition process. I wish them success and a trouble free transition unencumbered by any major problems. Transition is difficult enough even when you are armed with good information and plentiful resources. I hope I have contributed in some way to that by providing this information.

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