Hysterectomy — laparoscopy

01 What is it?

Your doctor has suggested a hysterectomy. This sheet adds to the information your doctor gave you orally: it explains the principles, benefits and possible drawbacks of the operation that has been recommended to you.

A hysterectomy is the removal of the uterus. Here, it is performed by laparoscopy (keyhole surgery): the surgeon operates through a few small incisions in the abdomen, following the procedure on a screen.

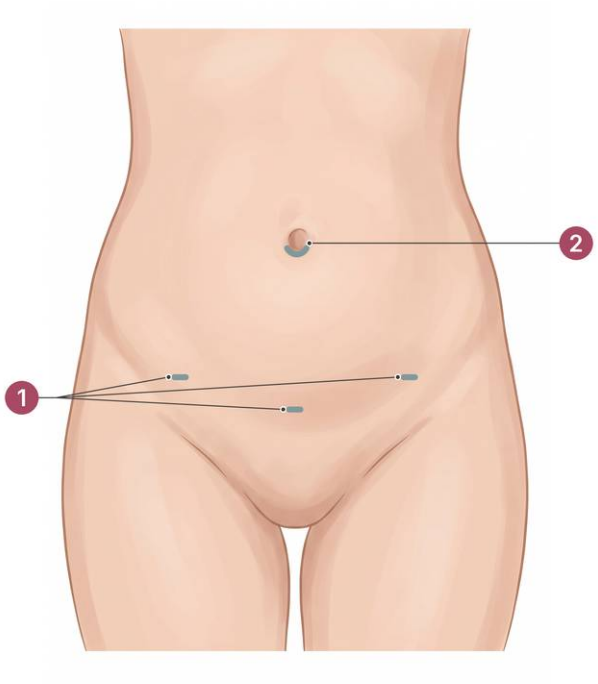


FIGURE 1 — The incisions for laparoscopy (diagram, front view).

1. Two or three other small incisions in the abdomen, usually 5 mm, sometimes 10 or 12 mm
2. Optical instrument: small incision, most often at the navel

Front view: the right of the image is the patient's left side.

Diagram Wagram Clinic, 2026.

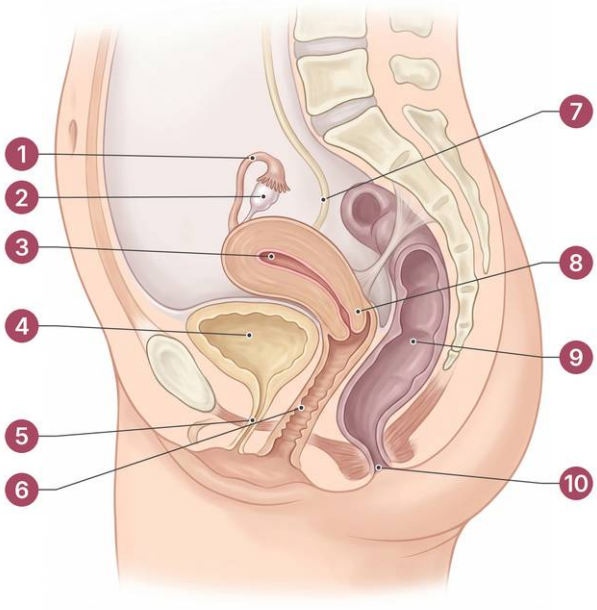


FIGURE 2 — The uterus and the neighbouring organs (diagram, side view).

1. Fallopian tube
2. Ovary
3. Uterus (removed)
4. Bladder
5. Urethra
6. Vagina
7. Ureter
8. Cervix
9. Rectum
10. Anus

Side view: the belly is on the left of the image, the back on the right.

Diagram Wagram Clinic, 2026.

There are several types of hysterectomy: total (the body of the uterus and the cervix are removed), subtotal (the uterus is removed, the cervix is left in place), or with adnexectomy (the ovaries and fallopian tubes, on one side or both, are removed at the same time).

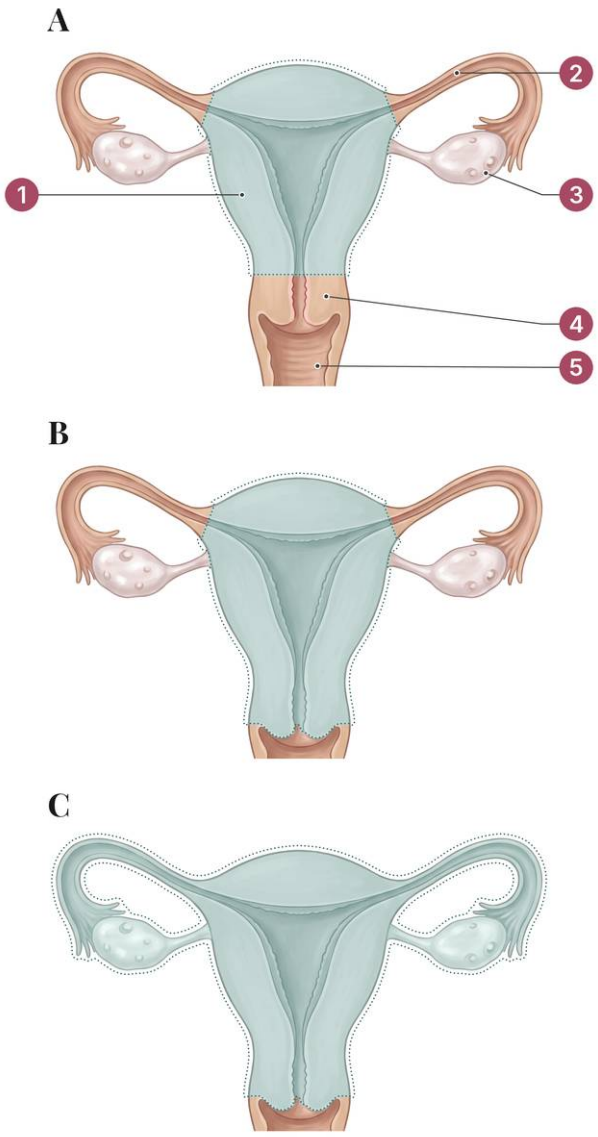


FIGURE 3 — The different types of hysterectomy: A, subtotal; B, total; C, with adnexectomy (diagram, front view).

A — subtotal: the uterus is removed, the cervix is left in place

1. Body of the uterus
2. Fallopian tube
3. Ovary
4. Cervix
5. Vagina

B — total: the body of the uterus and the cervix are removed

C — with adnexectomy: the ovaries and fallopian tubes, on one side or both

In blue-green, outlined with dots: the part removed during the operation.

Front view: the right of the image is the patient's left side.

Diagram Wagram Clinic, 2026.

This sheet is based on the patient information sheet of the CNGOF "Hystérectomie par voie laparoscopique" (2017, updated 2025), adapted to the practice of the clinic.

02 Why this procedure?

Your doctor explained to you during the consultation why this procedure is being suggested.

The type of hysterectomy depends on your personal situation; it is discussed with your surgeon before the operation.

03 How does the procedure take place?

The procedure is performed under general anaesthetic and lasts about 1 hour 30 minutes to 2 hours.

An optical instrument a few millimetres in diameter, connected to a camera, is inserted through a small incision, most often at the navel. Two or three other incisions, usually 5 mm and sometimes up to 10 or 12 mm, allow the instruments to be passed through (forceps, scissors, equipment for coagulation and washing). A gas (carbon dioxide) is introduced into the abdomen to give a clear view.

The hysterectomy is then carried out as it would be through an opening of the abdomen, but with these instruments.

For a total hysterectomy, the uterus is removed through the vagina, then the top of the vagina is closed with dissolvable stitches; this scar needs no particular care.

For a subtotal hysterectomy (the cervix is left in place) and if there is any doubt that a fibroid is benign, the uterus may be broken up after being placed in a sealed bag, so that no fragment is spread in the abdomen; this bag is removed through one of the small incisions, which may be enlarged.

The small incisions in the abdomen are each closed with a dissolvable stitch and are soon left open to the air.

Exceptionally, a small drain coming out through the abdomen may be left in place for 24 to 48 hours. Some surgeons leave a gauze vaginal pack in place for 24 hours to reduce the risk of bleeding.

04 What the procedure does not guarantee

A hysterectomy is a common, well-established procedure that is straightforward in most cases. The planned approach may nevertheless be changed: in the event of difficulties during the operation, particular anatomical features or a complication, the surgeon may have to open the abdomen through a suitable incision, although the procedure was planned by laparoscopy.

05 Risks and complications

During the operation, exceptionally, an organ near the uterus may be injured (bowel, urinary tract, blood vessels), which requires specific surgical management. In the exceptional case of life-threatening bleeding, a transfusion of blood or blood products may be needed.

After the operation, in addition to the possible effects of the anaesthetic (nausea, vomiting, drowsiness), pain may occur, mainly in the abdomen; it may spread to the shoulders and is caused by the gas introduced into the abdomen. Current pain management tends to reduce it.

The small scars may become red and painful, sometimes with a fever: this may be due to a haematoma, or even an abscess, which most often needs only simple local care.

If you have not reached the menopause, you will no longer have periods and pregnancy will no longer be possible. This does not mean that you will be menopausal: if the ovaries are left in place, they continue to work until natural menopause, with no hot flushes or other signs of menopause; if the ovaries are removed, the operation brings on menopause, with for example hot flushes, and you can discuss hormone replacement therapy with your doctor. If you have already reached the menopause, nothing changes in this respect.

If the ovaries have been removed, vaginal dryness may occur; it can be eased with lubricants or with hormone replacement therapy prescribed by your doctor.

In all cases, a hysterectomy changes neither the possibility nor the quality of sexual intercourse.

As with any surgery, this procedure may, very exceptionally, involve a risk to life or serious after-effects.

06 Alternatives

The type of hysterectomy depends on your personal situation; it is discussed with your surgeon before the operation. Do not hesitate to ask your surgeon all your questions.

07 Contraindications

Certain risks may be increased by your state of health, your medical history or a treatment taken before the operation. It is essential to tell your doctor about your personal and family medical history and about all the treatments and medicines you take.

Smoking increases the risk of complications of any surgery; stopping smoking 6 to 8 weeks before the procedure removes this additional risk.

08 Before the procedure

A pre-anaesthetic consultation is compulsory before the operation.

You are usually admitted the day before or on the day of the procedure. After premedication, you are taken to the operating theatre; a drip is put in, then the general anaesthetic is given.

If you smoke, talk to your doctor, your surgeon and your anaesthetist, or call the Tabac Info Service helpline on 3989 for help.

09 After the procedure and your instructions

You go to the recovery room before returning to your room. During the first 24 hours, you may

feel more drowsy than usual and your judgement may be impaired.

A urinary catheter may be left in place for a few hours, or even 24 hours, but most often there is none.

Compression stockings are recommended for the first few days, as long as you are not moving about normally. While you are in bed, move your feet in circles for about 30 seconds, several times a day. Daily injections of an anticoagulant may be prescribed, for up to about ten days depending on the case; they are discussed with the anaesthetist.

As soon as you can drink and after passing some wind, the drip is removed and you can eat lightly. Your bowel movements may be slightly slowed, which may cause temporary discomfort or pain; eat fruit and fibre to avoid constipation.

Painkillers may be needed for the first few days, at the clinic and at home.

Your hospital stay lasts 1 to 2 days.

You can shower from the day after the operation. Baths should be avoided for three weeks.

Bleeding is expected for one to two weeks; passing small clots is not unusual and not serious if it does not last. Use sanitary towels rather than tampons, which increase the risk of infection.

You may feel tired for a few days, or even one to two weeks; recovery is quicker the more active you stay. Return to work or sport depends on your activity; with this approach, recovery is quick and convalescence rarely exceeds 15 days.

Sexual intercourse is allowed 4 to 6 weeks after the procedure, once the scar at the top of the vagina is strong enough.

A follow-up consultation usually takes place within three to four weeks after the procedure.

10 When to seek medical advice without delay

Burning when passing urine or a frequent need to pass urine may be due to a urinary infection: see your GP for a urine test.

Abnormal or foul-smelling vaginal bleeding, or a fever, may be a sign of an infection or an infected haematoma: consult your surgeon. The same applies if you have nausea or vomiting with a fever, or if the small scars become red and painful.

If you have pain in your calves or difficulty breathing, call your GP promptly.

11 Your questions for Dr Gatri

This information sheet probably cannot answer all your questions. In any case, do not hesitate to ask your doctor any question that comes to mind, either orally or in writing.