Having a Hysterectomy

A hysterectomy is the removal of your womb (uterus). When considering a hysterectomy, it's important to spend plenty of time beforehand weighing up the pros and cons so you can decide whether or not it's the right choice for you. A hysterectomy is not something that can be reversed and is not a cure for endometriosis, as endometriosis by definition is outside the womb. As a hysterectomy cannot guarantee total loss of pain and symptoms, you will want to know what relief you may experience.

It's important to remember that the final choice is yours – it is your body. However, you don't have to do it all on your own. Discuss your options of treatment with your gynaecologist, and whether they think a hysterectomy is the right choice for you. You may wish to talk to family or friends who may be able to support you through your decision making.

Undergoing a hysterectomy means that you will be unable to get pregnant. It's important that you have considered your wishes and options surrounding fertility before making this decision. If you are wishing to have children and have been having difficulties getting pregnant, speak to your gynaecologist or endometriosis nurse specialist, as a referral to a fertility specialist may be appropriate. Endometriosis UK has a range of services that enable you to talk to others who may be (or have been) in the same situation as you and provide the chance to discuss your concerns with others who understand. https://www.endometriosis-uk.org/get-support

If you are experiencing pain or debilitating symptoms, it may feel like a hysterectomy is the only answer. If possible, work with your, GP, gynaecologist or endometriosis nurse to and understand all the treatments that could reduce your pain.

What exactly is a hysterectomy?

A hysterectomy is an operation to remove the womb. If the cervix (entrance to the womb) is removed, it is a total hysterectomy. If the cervix is kept, it is a subtotal hysterectomy. If the ovaries are removed at the same time as the womb, it is referred to as a hysterectomy with oophorectomy – oophorectomy meaning removal of either one or both ovaries.

Will a hysterectomy cure endometriosis?

Unfortunately, there is no cure for endometriosis. For some, a hysterectomy may be a positive step, and it is a definitive way to stop periods. But a hysterectomy is not guaranteed to put an end to symptoms such as pain, because endometriosis is outside the womb and so having the womb removed may not help alleviate all symptoms. Those who have adenomyosis and heavy periods as well as endometriosis are more likely to

benefit from having a hysterectomy as adenomyosis affects the wall of the womb. The likelihood of endometriosis recurring following hysterectomy depends on factors such as whether or not you also have your ovaries removed, whether any endometriosis is left behind and how severe your disease is. As surgery is not curative it's possible for some to experience a return in symptoms or further growth of endometriosis even when both ovaries have been removed. These factors, along with statistics, are discussed in this factsheet.

A useful way of gauging whether a hysterectomy and having your ovaries removed will be successful for you is by trialling Gonadatrophin releasing hormone analogues (GnRHa). This treatment temporarily switches off the ovaries, causing a medical induced menopause, stopping periods and suppressing oestrogen to treat endometriosis and relieve symptoms. This can be reversed once the medication is stopped.

Is a hysterectomy an option after menopause?

Endometriosis symptoms can continue after menopause. This may be due to adhesions (scar tissue) or remaining endometriosis. If symptoms persist, your gynaecologist may consider a hysterectomy, usually alongside removal of the ovaries, adhesions and any remaining endometriosis. Pain is complex, and surgery, including a hysterectomy, cannot guarantee that symptoms will go away.

What's the difference between a subtotal or total hysterectomy?

If after careful consideration you decide to have a hysterectomy, the type of hysterectomy you have will usually depend on your own medical history and where the endometriosis is. As long as your womb tubes and ovaries look healthy at the time of the operation, and you've always had normal smears, you have the option to keep your cervix. However, a total hysterectomy is usually the preferred option, as by removing the cervix there is no risk of developing cervical cancer at a later date. It may be a case of personal preference; some may opt for subtotal hysterectomy because they want the 'least amount possible' removed.

If you have a subtotal hysterectomy, then you will need to continue having smear tests. If you have not had your ovaries removed then you may continue to have light periods from the lining inside the cervix. These can be regular or irregular.

Successful relief of symptoms relies on removing all of the endometriosis; if you have endometriosis on your cervix, a subtotal hysterectomy may not be the right option for you. Discuss this with your gynaecologist before you make the decision.

How could a hysterectomy affect having sex?

The cervix produces a slippery discharge, so without it, intercourse may be slightly drier. However, the vagina itself produces a lubricating discharge. Contrary to popular belief, the cervix does not contain the 'G spot.' There are some studies that suggest that orgasm is less satisfying after the cervix is removed, whilst other studies suggest that removal of the cervix makes no difference to sexual satisfaction. There is also data that suggests that orgasm and sex drive is better after hysterectomy.

How could a hysterectomy affect the bladder?

Some of the pelvic floor ligaments insert into the cervix. If the cervix is removed, these ligaments remain attached to the top of your vagina where they will continue to give lift and support. Some studies suggest that urinary incontinence is more common after hysterectomy, but the greatest risk of problems afterwards seems to be for those who have urinary incontinence before hysterectomy.

What about keeping or removing ovaries?

This is an important question to consider, especially for someone with endometriosis. The ovaries produce the hormone oestrogen, which stimulates endometriosis and causes it to grow. So, if the ovaries are left in place, it could cause endometriosis to remain active or reoccur. This would be more likely if any traces of endometriosis were left behind after the operation.

If you opt to keep your ovaries, there is a higher chance of needing further treatment or surgery for endometriosis, this is usually because symptoms have returned.

A study by Salmanpour et al. (2026) involving 990 confirmed cases of endometriosis examined rates of further surgery over 15 years in the following groups:

- hysterectomy keeping both ovaries
- hysterectomy with one ovary removed
- hysterectomy with both ovaries removed.

After hysterectomy, further surgery was less common when ovaries were removed: 19.2% when both ovaries were kept, 13.2% when one ovary was removed and 4.9% when both ovaries were removed.

A useful treatment method to find out if a hysterectomy and removal of the ovaries (oophorectomy) will be successful for you, is a three to six month trial of a Gonadotrophin releasing hormone analogue (GnRHa) medication. This produces a temporary menopause and will give you a good idea as to whether hysterectomy and oophorectomy will improve your symptoms.

Salmanpour A, Kaur P, Long A et al. Reoperation Rates and Pain-Related Outcomes Following Hysterectomy in Pathologically Confirmed Endometriosis: Impact of Oophorectomy Status. Journal of Obstetrics and Gynaecology Canada, 2026

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If you do keep your ovaries, there is research that suggests that menopause may occur earlier than normal with as many as one in six patients going through the menopause within two years of the hysterectomy. If you suspect that you are going through the menopause, a blood test can show if your ovaries are working normally.

Undergoing an oophorectomy at a younger age, such as before 45, may increase the risks related to early menopause, because the body is deprived of oestrogen. Oestrogen helps maintain bone density as well as providing cardiovascular (heart) protection. Early menopause can increase the risk of developing osteoporosis (weak bones) and heart disease, there is also research that identifies an increased risk of developing dementia with early menopause. HRT can help minimise these health risks and are discussed further within this document.

How is a hysterectomy procedure done?

A hysterectomy can be carried out in three different ways:

Vaginal hysterectomy

This is the removal of the womb and cervix through the vagina – there are no abdominal cuts. The surgeon would be unable to surgically treat any pelvic endometriosis or remove the ovaries via this route of surgery.

Laparoscopic hysterectomy

A thin camera (laparoscope) is inserted into a small cut (key hole) in or near the belly button so the surgeon can see inside. 2-3 other small cuts will be made so surgical instruments can enter the abdomen to carry out the surgery. The womb, and sometimes the ovaries, are freed, and along with the cervix, are removed through the vagina.

Though uncommon, if there are unexpected complications, the surgeon may change to open surgery and make an abdominal incision to complete the operation.

Abdominal hysterectomy

This is when the womb is removed through an abdominal incision, it'll either be made horizontally along your bikini line, or vertically from your bikini line to you belly button. You would have the option to either keep or remove your ovaries and cervix.

Will I need HRT?

If your ovaries are removed at the time of the hysterectomy, you will start the menopause, so hormone replacement therapy (HRT) is usually recommended (depending on your age) until you are around 50, which is the average age for natural menopause. You can discuss this with your surgeon or GP and review the situation when you reach 50. HRT prevents premature menopause symptoms and longer-term problems such as thinning of the bones (osteoporosis). HRT, in this instance, is

replacing the hormones that your ovaries would have produced if they had not been removed (generally it's not associated with the risks of taking HRT after the natural menopause age of around 50). However, with some medical conditions, it may not be recommended you have HRT, or used with caution due to other risk factors. Sometimes HRT can cause endometriosis symptoms to return, in which case, the type of HRT can be reviewed, the dose can be reduced or even stopped.

A good way to find out if HRT would cause your symptoms to return after an oophorectomy (ovary removal) would be to combine HRT with GnRHa medication (mentioned above). If your symptoms are reduced and the HRT does not bring them back, it suggests that HRT would be a good option for you following hysterectomy and oophorectomy.

You may need additional HRT if you are still getting symptoms of the menopause, and there are also treatments to improve your libido, so do mention this to your doctor or nurse if it is a problem.

The type of HRT you choose should be discussed with your surgeon.

More information about menopause and endometriosis can be found here.

What are the risks?

As with any operation, there are some risks involved in having a hysterectomy. More common problems are not serious and could include a bruise around the wound, wound infection or minor bleeding. Your surgeon may discuss prophylactic (i.e. preventative) antibiotics at the time of the operation to reduce the risk of infection. More serious complications are less common and include severe bleeding inside the tummy or damage to other structures, such as bowel, bladder or the ureters (tubes connecting the kidneys to the bladder). These are rare complications that may make a further operation necessary.

Thrombosis (blood clots) in deep veins (DVT) and in the lungs (pulmonary embolism – PE) can occur infrequently after surgery. Specific steps are taken to minimise this risk, you will be asked to wear pressure (TED) stockings and may be given injections that prevent clots developing called low molecular weight heparin, early mobilisation (ie starting to move about) after the operation is also recommended.

The precise risks depend on your individual situation, current and past medical health. The risks of surgery are increased by previous operations, presence of adhesions and being overweight. Before your surgery, talk to your surgeon about the possible risks involved.

What should I do if symptoms continue following hysterectomy

A hysterectomy is not a cure for endometriosis. Symptoms and endometriosis can return after surgery. Keeping your ovaries and taking HRT can increase the risk of endometriosis returning, but symptoms can also return if both ovaries have been removed and you are not taking HRT. Ongoing symptoms do not always mean that endometriosis has grown back. Other causes of returning symptoms may include:

Pelvic adhesions – when scar tissue causes organs to stick together, causing pulling and pain.

Pain sensitisation - when your nervous system becomes more sensitive to pain signals.

Ovarian remnant syndrome – when some ovarian tissue is left behind unintentionally after surgery to remove the ovaries.

Pelvic floor dysfunction – when tight pelvic floor muscles or muscle spasms cause pelvic pain.

Other conditions, such as bladder or bowel problems.

Speak to your healthcare practitioner or surgeon if symptoms continue or return. You may need a new referral to the hospital. Keeping a pain and symptom diary can also be helpful.

More information on pain relief for endometriosis can be found here.

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Feedback:

If you have any comments about this leaflet, please contact us at admin@endometriosis-uk.org

Support:

If you'd like to find out more about Endometriosis UK support services, please visit our website.

www.endometriosis-uk.org

Helpline: 0808 808 2227

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