HYSTERECTOMY STEP BY STEP

A Practical Guide to Surgery and Healing after Uterine Cancer

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INTRODUCTION

Facing a hysterectomy? You're not the only one.

Your doctor will explain the procedure and the medical details. But some of the most helpful information, what it actually feels like, what surprised me, what helped, what didn't, can only come from someone who has lived through it.

I've spent time in several hysterectomy support groups, and one thing became clear quickly: the surgery may have the same name, but the reasons behind it, and the recovery afterward, can be quite different. What was removed, how it was done, whether cancer was involved, whether ovaries were taken, all of that changes the experience.

I also realized that online chat groups can give a skewed picture of recovery. When someone is having a hard time, she posts, people respond, and the thread grows. When things go smoothly, there often isn't much to say; a few congratulations, and the topic fades away. Those conversations stay short, and Facebook often gives priority to longer threads. That can make positive recovery stories much less visible. Over time, this imbalance can make recovery look more negative than it really is, because the longest discussions are usually about problems.

I had surgery because of endometrial cancer. While preparing for it, I wanted something practical. Not just medical explanations. Not just scary stories. I needed a straightforward, actionable guide: what to do to prepare and what to anticipate.

The internet offered fragments. Bits and pieces of stories. Very

few distinctions exist between different diagnoses and different surgical paths. So I started paying attention. I kept notes. I asked questions. I kept a diary of what helped and what mattered.

This book shares what I would have found helpful. I wrote the book I wish I'd had before my surgery. Whether your surgery is related to cancer or to another condition, you'll find preparation ideas, recovery details, and the parts of healing that often go unspoken.

This is one woman's experience. It won't match everyone's exactly. But I hope what I learned will help you feel more prepared. Fear and worry are normal before a major surgery. You are not alone in having them. I had them too.

We'll walk through it step by step.

THE CANCER THAT TALKS

What makes uterine cancer, also called endometrial cancer, different from many other cancers is that it often gives an early warning that something is wrong. If you are fully menopausal and notice bloody discharge, you need to contact a doctor as soon as possible. Even though this cancer usually grows slowly, it is still better to catch it early.

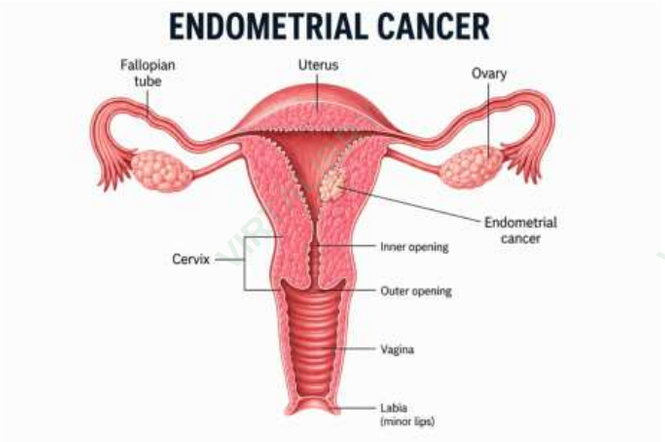
In my case, I had bloody discharge for one day, but no pain. The next day, the bleeding stopped, as if it had never happened. I was doing well both physically and mentally.

Still, when I mentioned it to my primary care doctor, she was immediately alarmed. She told me I needed to see a gynecologist as soon as possible for further testing.

I was sure they would find nothing. After all, I felt great. I had just retired after a 42-year career in high tech. For the first time in my life, I could throw myself into my hobbies without worrying about deadlines or work problems that demanded my attention even on weekends.

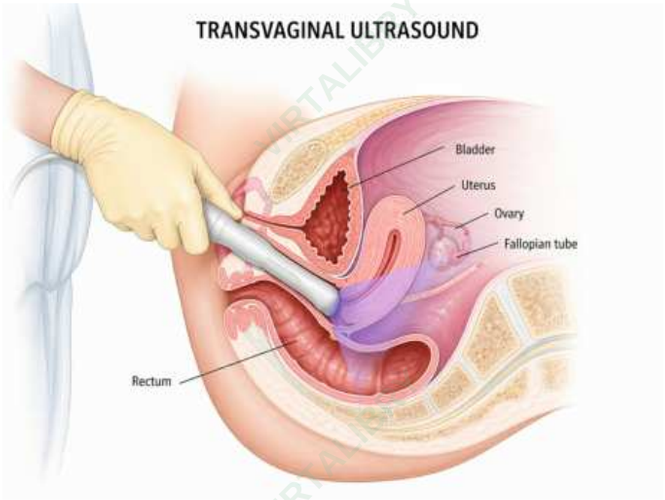
Then came the word cancer.

Cancer is a scary diagnosis. It is completely normal to be terrified. I was too. My mind went into a whirlpool.



PELVIC ULTRASOUND

The first test I had was a transvaginal ultrasound to examine the uterus, ovaries, and cervix.



I was told to drink 32 ounces of water one hour before the exam and to finish drinking within 30 minutes. I needed to arrive with a full bladder because this helps shift the organs slightly and allows for clearer images of the uterus. Having a full bladder was the most unpleasant part of the test.

I had a 45-minute drive to the doctor's office in heavy traffic, and I was worried my bladder might not hold during the ride. I wore a diaper so I wouldn't have to worry about ruining my car. I made it safely to the office, but wearing it eased my anxiety.

The technician first performed the external abdominal ultrasound with my bladder full. After that, she told me to empty it before the second part of the test.

Then she moved on to the internal ultrasound. I was positioned on an exam table on my back, with my knees bent and feet in stirrups. The technician handed me the wand-like probe, covered in a lubricated sheath, and asked me to insert it into my vagina myself.

The probe emitted sound waves that bounced off internal organs and created images on a monitor. The technician gently adjusted the probe to get different views of the uterus, cervix, and ovaries. I could feel slight movement, but nothing else. There was no pain and no cramping. The internal portion lasted about ten minutes.

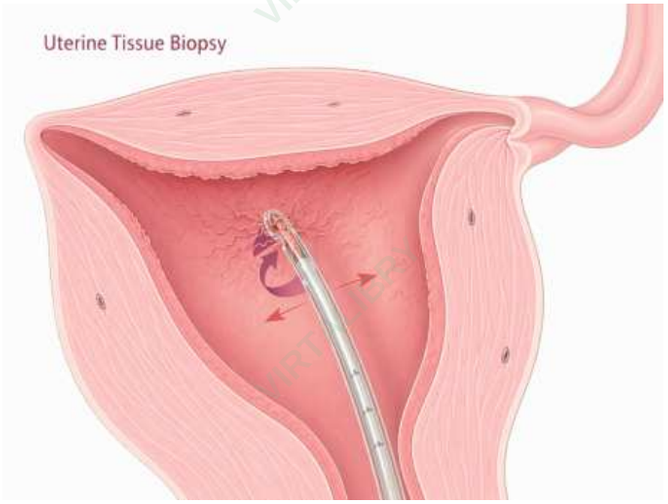
About an hour later, I met with the doctor. The ultrasound had been reviewed immediately, so the results were available during my appointment.

She explained that the ultrasound showed thickening of my endometrium measuring more than 5 mm. When I asked what looked suspicious, she said that normal tissue looks smooth and even. In my case, she saw a lesion with irregular borders. It looked thicker, darker, and had an overall uneven appearance.

In postmenopausal women, an endometrial thickness of 5 mm or greater warrants further evaluation with an endometrial biopsy. Ultrasound can identify suspicious areas and help guide where the sample should be taken.

ENDOMETRIAL BIOPSY

She gave me a choice: proceed with an endometrial biopsy right away in the office, or schedule a hysteroscopy with biopsy at the hospital.



An endometrial biopsy is performed without anesthesia using a thin plastic tube called a pipelle. The pipelle is inserted through the cervix into the uterus to gently suction a small sample of the uterine lining. She warned me that it might cause discomfort similar to menstrual cramps.

A hysteroscopy is done at the hospital as a day procedure under general anesthesia. During this procedure, the doctor inserts a thin tube with a small light and camera (a hysteroscope) through the vagina into the uterus to look directly inside. The cervix is gently dilated, and tissue is removed from the uterine lining. This procedure is often referred to as dilation and curettage, or D&C. After a few hours in the hospital, I would be discharged. It can result in period-like cramps and light bleeding for a few days afterward.

She told me that if the biopsy results were positive for cancer, I would need a hysterectomy to remove the uterus and the cancerous lining.

I asked if doing a biopsy might spread cancer cells. She explained that during an endometrial biopsy, a very thin, flexible tube is passed through the cervix into the uterus. A small sample of the lining is then gently suctioned out. The instrument goes in and out through the same path, and the sample stays inside the tube as it is removed.

There is no cutting through layers of healthy tissue and no path being created through the abdomen where cells could be dragged along. Everything happens inside the uterus and takes just a few minutes.

She also said that this type of sampling does not cause cancer to spread. Biopsies are done routinely and are necessary to understand what is going on and plan the right treatment.

I decided to go ahead with the immediate endometrial biopsy. The doctor also performed a Pap smear at the same time.

The biopsy was not painful. Twice, I felt a cramp similar to a mild menstrual cramp. I had expected it to be more uncomfortable based on her warning, but it turned out to be better than I imagined. Afterward, I experienced light bleeding for about two weeks. She had told me this was likely to happen, so I was not alarmed.

After having my own biopsy, I read accounts from other women

about the procedure. Some reported significant pain, while many described an experience similar to mine. The level of discomfort likely depends on individual factors, including underlying conditions such as adenomyosis or inflammation.

I noticed that some women mentioned bringing someone with them so they could squeeze that person's hand during the biopsy. I can see why this helps mentally, but squeezing a hand tends to make the body tense up. When the hand tightens, the rest of the body tightens too, and that can make the procedure more uncomfortable. Relaxing as much as possible and keeping the body loose makes it more likely that the procedure will be easier.

If you know in advance that you will be having this biopsy, you may want to take a dose of acetaminophen (Tylenol) beforehand, just in case you fall into the group that experiences more discomfort.

If you need to have this done, it is easy to get worried after reading other people's experiences. But it does not mean it will be painful for you. My experience was much easier than I expected.

You might wonder why the biopsy is important, especially after hearing that it can be uncomfortable. If the uterus is going to be removed anyway, why do it?

The biopsy gives the doctors critical information that guides the type of surgery needed. If cancer is confirmed, the surgical plan changes. For example, lymph nodes may be removed and tested to check whether the cancer has spread. A positive biopsy also helps prioritize surgery so it can be scheduled promptly, while the disease is still in its early stages.

A few days after the biopsy, I received the results. To my complete surprise, it was positive for Grade 1 endometrial cancer.

GRADES AND STAGES

At that point in my cancer education, I was a little confused about the difference between grade and stage. When I was told I had Grade 1 endometrial cancer, I assumed it meant the cancer had not spread in my body. That confused me. How could they possibly know that from a biopsy taken from just one small area? So I want to take a moment to explain the difference between the cancer grade and the cancer stage.

The grade of the cancer cells describes their appearance under a microscope. The stage describes how far the cancer has spread in the body.

A biopsy like the one I had can only determine the grade because it looks at a small sample of cells. It cannot determine the stage, because staging requires knowing how far the cancer has spread, and that is only clear after surgery, when the uterus and lymph nodes are removed and examined by pathology.

A lower grade means the cancer cells are closer to normal cells in shape, while a higher grade means the cells look more abnormal and may grow or spread more aggressively.

Grade 1: Cancer cells resemble normal cells and are usually slower growing.

Grade 2: Cancer cells look more abnormal and grow at a moderate rate.

Grade 3: Cancer cells look very abnormal and are more likely to grow or spread quickly.

When my biopsy came back as Grade 1, it meant the cells did not look aggressive.

Staging describes how much cancer is present and where it is located.

Stage 0: Cancer cells are found only in the very top layer of the endometrium. This is sometimes called carcinoma in situ or a precancerous lesion.

Stage 1: The cancer is found only in the uterus.

Stage IA: The tumor has grown less than halfway into the muscle wall of the uterus.

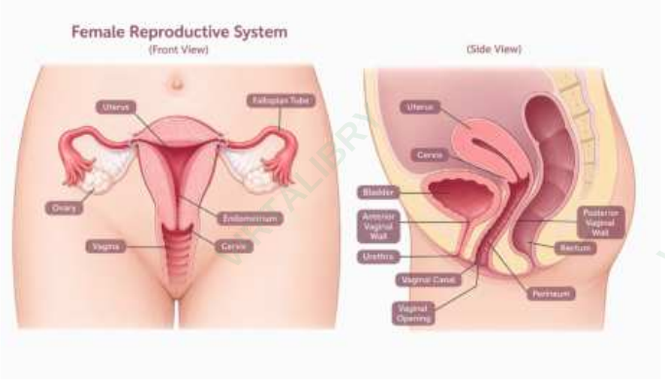
Stage IB: The tumor has grown halfway or more into the muscle wall.

Stage 2: The cancer has spread from the uterus into the cervical tissue but has not gone beyond the uterus.

Stage 3: The cancer has spread outside the uterus but remains within the pelvic or abdominal area. This stage is divided further depending on where it has spread, including possible spread to nearby lymph nodes.

Stage 4: The cancer has spread to distant organs, such as the bladder, rectum, or other parts of the body.

At the time of my biopsy, I knew only the grade. When the biopsy came back positive for cancer, a hysterectomy was next. I would have to wait until after surgery to learn the stage of my cancer.



COPING WITH FEAR THROUGH PREPARATION

People deal with fear and worry in different ways. When something scares me, I deal with it by learning as much as I can. That is how I handled technical problems at work, and it is how I approached this new health problem.

I started reading everything I could about hysterectomy and recovery. I wanted clear, practical information, especially about facing surgery because of endometrial cancer. I was not looking for medical textbooks. I was looking for everyday guidance on how to prepare and what to expect.

I did not find what I was looking for. I bought about a dozen books on Amazon. They either repeated the same general information or were written for medical professionals and went into surgical technique details that were not helpful for someone trying to prepare for recovery at home. Facebook groups offered scattered pieces of information, but rarely a full picture. The longer discussions often focused on complications unrelated to my condition.

My surgeon gave me useful information about the procedure and general restrictions for after the surgery. But the day-to-day details were missing. What might make my recovery easier? What would I actually feel like the day after surgery? What

about a week later? Would I be able to get out of bed in the morning? Would I be able to walk up the stairs? Get in and out of the car? Would I need handrails to push myself up from the toilet? Would I be able to do laundry? Pick up something that fell on the floor?

What could I realistically do? What should I buy ahead of time? What would actually make recovery easier?

Some answers came from forums. But most things I had to learn by going through all of it myself. That is why I kept notes. This book grew out of those notes.

I hope the preparation, the practical tips, and the day-by-day realities can help anyone walking into this surgery, whether for cancer or another reason.

For me, knowing what to expect reduced fear. Preparation gave me a sense of control. And that made it easier to stay calm and believe in a positive outcome.

FINDING A DOCTOR

After my cancer diagnosis, the next step was to schedule a consultation with a gynecologic oncologist, followed by surgery.

The local gynecologic office recommended by my primary doctor performed my biopsy, but they did not have any consultation openings for several months. The first available appointment was two months away. I scheduled it, but that night I had trouble falling asleep. Could I really wait two months while my cancer was growing?

The next day, I looked up the doctor on Healthgrades.com. I saw she had only two years of experience. Practically fresh out of training. I also learned that she did not specialize in hysterectomies, and her experience with the procedure was rated below average. I decided to find a different oncologist on my own.

I used several doctor rating websites to evaluate physicians based on their specialty, the hospital where they operated, and patient feedback about surgical outcomes. To narrow down the list, I also checked which doctors took my insurance.

Later, I learned that whether the doctor is in-network matters less than whether the hospital is in-network, since insurance typically processes surgical coverage through the hospital. The doctor I ultimately chose was in-network, but his hospital was not. Fortunately, my PPO plan allowed me to use an out-of-network hospital for surgery.

Healthgrades.com provided the most detailed information. Reviewing and comparing hundreds of doctors took time, but it was worth it. I built a ranked list of surgeons at the best-ranked

hospitals in my area.

The next day, I called the top-ranked doctor on my list. I contacted his office without a referral, explained my diagnosis, and asked for the earliest available appointment. To my relief, I scheduled a consultation within a couple of weeks. The receptionist asked me to bring the CD of my ultrasound and the biopsy results.

I called the local gynecologist's office to cancel my original appointment and requested a copy of my biopsy report. It felt slightly uncomfortable to cancel, but the receptionist was understanding when I explained that I got an earlier appointment. When I mentioned the name of my new doctor, she said, “Oh. He is known as the best. He will take good care of you.” Hearing that reassured me. The hours of research had paid off.

That moment confirmed something important for me. No one else would manage this process on my behalf. My primary doctor had done her part. The local office had done theirs. But it was up to me to decide who would perform my surgery. This was my body and my future. Waiting two months did not sit right with me, so I did something about it.

Even before meeting the oncologist, I had a sense of what he would recommend. When I received my biopsy results, I learned that, for a postmenopausal woman with endometrial cancer, the surgery that offered the best long-term outcome was a hysterectomy, which would remove the uterus and cervix, along with the ovaries, fallopian tubes, and nearby lymph nodes. The removed tissues would be sent to pathology to determine whether the cancer had spread beyond the uterus. If it has not, surgery alone is often sufficient treatment, with no need for chemotherapy or radiation.

I hoped that would be my case.

Looking back, I give a great deal of credit to my surgeon for how smoothly my surgery and recovery went. I often think about what might have happened if I had simply waited two months

for the consultation with the first less experienced doctor. Advocating for myself did not feel bold at the time. It felt necessary. I am glad I did it.

CONSULTATION WITH ONCOLOGIST

In the two weeks before my appointment with the oncologist, I immersed myself in learning about endometrial cancer and recovery after a hysterectomy. I joined Facebook groups for women who had undergone this procedure and bought several books on the topic.

This research did not give me all the answers, but it helped me come up with a list of 57 questions that I include below.

When I selected my new oncologist, I paid close attention to patient ratings, especially comments about whether the doctor took time to answer questions. I knew that figuring out what to ask and getting clear answers was what helped me feel calm and in control.

The ratings were spot on. He patiently answered every question on my list. At the end of our meeting, he even complimented me on being so prepared. I had worried he might be impatient with such a long list, so it was a relief that he welcomed it.

57 QUESTIONS I ASKED MY SURGEON

I walked into the appointment with a printed list in one hand and a pen and notepad in the other, ready to write down the answers so I would not forget them, because I was nervous and stressed.
Below are my questions and the doctor's answers, grouped by topic.

UNDERSTANDING THE DIAGNOSIS

1. What are the treatment options?

The doctor explained three main treatment options: surgery, radiation, or chemotherapy.
Because I had no symptoms, no pain, and no weight loss, he believed there was a good chance the cancer was caught early and that surgery alone might be enough.

There are several types of hysterectomy. For premenopausal women, it may be possible to preserve the ovaries or the cervix. For a postmenopausal woman like me, removing the uterus, ovaries, cervix, and fallopian tubes offered the best possible outcome.

He also explained that the lymph nodes closest to the uterus would be removed and examined to determine whether the cancer had spread.

2. Should I remove or keep my ovaries?

The answer varies for each woman based on the many factors that go into the decision. Some of the main ones are age, whether she has a BRCA gene, family history of uterine, ovarian, or breast cancers, and whether there is pelvic pain involving the ovaries.

The oncologist explained how some studies show removing the ovaries may slightly increase the risk of heart disease and stroke. But this risk is higher for women who have their ovaries removed at a younger age. As a woman gets older, the benefits of keeping the ovaries become smaller. These risks need to be weighed against the risk of ovarian cancer, so the decision is very specific to each person.

For me, he said, given my cancer diagnosis, age, family history, and that I was already postmenopausal, he had no hesitation in recommending removing the ovaries.

3. What causes endometrial cancer?

What fuels endometrial cancer is excess estrogen. Fat cells act like little factories that make extra estrogen. So the more fat tissue you have, the more estrogen your body produces.

That extra estrogen causes the uterine lining to thicken. Sometimes it grows out of control and becomes cancerous. This is why overweight women are at a higher risk of uterine cancer.

After menopause, the ovaries stop producing large amounts of estrogen, but fat tissue continues to make it. At the same time, the body no longer produces progesterone, which normally balances estrogen and keeps the uterine lining in check. Without that balance, even small amounts of estrogen can keep stimulating it.

This helps explain why uterine cancer is more common after menopause. The average age of menopause in the U.S. is 51, and most cases occur after this age, with the highest incidence in women aged 55–74.

Age Group	Percentage of Uterine Cancer Cases
<45	15–25%
45–54	10–15%
55–64	35–40%
65–74	25–30%
75+	10–15%

4. Should I do genetic testing? If it is positive, what will be different?

Given my family history of breast and ovarian cancer, I asked the doctor if I should do genetic testing. He said he would give me a referral to speak with a specialist who could evaluate whether I would be a good candidate for it.

He explained that nothing during the surgery would depend on the results of genetic testing. However, the care after surgery, combined with the stage of my cancer, could be influenced by a positive result. The follow-up care would likely be more aggressive.

Since the surgery itself would not be affected by the test results, there was no need to rush the testing or delay surgery while waiting for the results, which normally take about three weeks.

5. Should I have an MRI prior to surgery?

Several people I knew had an MRI before their hysterectomy, so I asked whether I would need one as well.

My surgeon said that because I had no symptoms such as pain or weight loss, and because the biopsy showed Grade 1 cells, he did not think an MRI was necessary before surgery.

He reassured me that we would discuss any additional tests or treatment after the pathology results came back, which usually take about ten days after surgery.

6. What should postmenopausal women expect? Do they get a second round of hot flashes?

I wanted to know what happens if the ovaries are removed. Would menopause start all over again?

His explanation was simple: removing ovaries in premenopausal women starts symptoms immediately after surgery. The ovaries produce estrogen and progesterone, and without those hormones, symptoms such as hot flashes start right away.

For women who are already postmenopausal, he told me in most cases there are no additional menopausal symptoms after surgery.

I brought up this question because a friend of mine shared her experience of another round of hot flashes after her hysterectomy, even though she had gone through menopause ten years earlier. I wondered how that was possible.

He reassured me that this only happens in rare cases. One ovary may still be producing small amounts of hormones even after menopause. If that ovary is removed, the sudden drop in hormones can trigger temporary symptoms again. According to him, my friend was likely one of those rare cases.

He was right. I did not experience any additional hot flashes after surgery.

UNDERSTANDING THE SURGERY

7. Will the surgery be laparoscopic or abdominal?

The doctor said he planned to perform the surgery laparoscopically. He explained that this approach uses four small incisions in the abdomen for the instruments and camera. At the time, I did not understand what "small" really meant. After surgery, I saw each incision was a quarter of an inch.

He also described how, in a laparoscopic hysterectomy, the uterus, fallopian tubes, cervix, ovaries, and lymph nodes are removed through the vagina. To do this, he would make an incision at the top of the vagina, where it connects to the cervix and uterus. The small abdominal incisions are only for the surgical instruments, not for removing the organs.

Before surgery, the cervix sits at the top of the vaginal canal, essentially closing it off. When the organs, including the cervix, are removed through the vagina, an opening is left at the top of the vaginal canal. To close the opening, the surgeon stitches the upper edges of the vagina together. This closed area is called the vaginal cuff. Once healed, the cuff is strong and flexible. It prevents abdominal organs, such as the intestines, from dropping into the vaginal canal.

He then warned me that while the plan was laparoscopic, there was always a possibility of needing to switch to an open procedure if something unexpected happened.

I asked what could require such a switch.

He told me that my ultrasound showed a fibroid. It had never caused symptoms, so I did not even realize it was there. However, if it turned out to be too large to remove vaginally, he would need to make an abdominal incision to remove it safely.

He also mentioned how, in the past, surgeons sometimes cut fibroids into smaller pieces inside the body, a technique called morcellation. Today, most surgeons avoid that approach because

of the risk of spreading cancer cells if any are present. Sometimes cancer is not suspected before surgery, but pathology later finds malignant cells. For this reason, he preferred to remove all organs intact.

As he spoke, I grew reassured. He never tried to minimize the risks. He explained them clearly. I knew I was in experienced hands.

8. Will the surgery be robot-assisted?

My surgeon explained he typically uses robotic assistance only for patients who are severely obese, generally with a BMI over 40. In those cases, the robotic system can offer better visualization and access.

He told me robotic-assisted laparoscopic surgery usually takes longer than manual laparoscopic surgery, often around four hours compared to two hours for a standard laparoscopic procedure. The longer a patient is under anesthesia, the higher the surgical risk. For me, he felt a manual laparoscopic procedure would be the better choice.

My family received a text message saying I was in the recovery room one hour and twenty minutes after the surgery began. It likely means the procedure lasted even less time, since I do not know how much time passed between the end of surgery and when the message was sent.

I believe the surgeon's experience made a difference in how smoothly and efficiently the surgery went. I was glad I had chosen a surgeon with the experience to do it manually.

9. Where are the incisions located?

My main reason for asking this question was not cosmetic. I was concerned that the incisions might fall where I have skin creases from abdominal fat. I am not rail-thin, and I know that creases can get sweaty and create a good environment for infection.

The doctor smiled and said they are well aware of different body shapes and take that into account when making incisions.

He explained he uses three incisions slightly below the level of the belly button on the sides, and one incision inside the belly button. He also said they do not make any incisions on the lower abdomen to avoid areas where skin folds may generate moisture and increase the risk of infection.

During the surgery, the surgeon decided that the angle of my belly button was not ideal, so instead of making an incision inside the belly button, he made the incision just below it. He later apologized for adding another visible scar. I found his apology endearing. However, it turned out to be unnecessary. My incisions healed flat and invisible. A year later, I could not see where any of them had been.

10. What can be done to prevent prolapse?

Before answering this question, the doctor asked me how many vaginal births I had. When I told him none, he said my chances of developing prolapse were very small.

He explained that prolapse is strongly associated with vaginal births because childbirth stretches the pelvic ligaments and support structures. He also said prolapse can occur in women who have never had children if they do repetitive heavy lifting or struggle with chronic constipation or a chronic cough, all of which put ongoing pressure on the pelvic floor.

For women at higher risk, suturing supportive ligaments to the vaginal cuff at the time of hysterectomy can serve as a preventive measure.

In my case, with a desk job and no history of vaginal childbirth, chronic constipation, or chronic cough, he said additional preventive steps were not necessary.

That answer put my mind at ease.

11. How long does the surgery take?

The doctor expected the surgery to last about two hours.

The hospital kept my family informed with text messages throughout the process. They received updates as I moved from the pre-operative area to the operating room, then from the operating room to the recovery room, and finally to the observation bay.

As planned, my surgery started at 3 pm. My family received a message at 4:20 pm notifying them I was already in the recovery room. The message also reported everything had gone smoothly and I was recovering comfortably.

12. If the surgery had to be switched to open, how long would I stay in the hospital?

The surgeon reassured me that the likelihood of switching to open surgery was low. If it did happen, I would stay in the hospital for one to three days, depending on my recovery progress.

13. What accommodations are possible for someone with a fused spinal disk?

One of my big concerns was that this surgery might aggravate my back, since I had a spinal disk fusion a few years earlier. I brought this up during the consultation. The doctor said he would make a note in my chart and that his team would position me before I went under anesthesia so I could confirm that the position did not put pressure on the fusion area. Normally, patients are positioned after anesthesia starts, but he said they would make this part of the presurgical check for me.

My second concern was my dry eyes. I cannot open my eyes in the morning without putting moisturizing eye drops in first, otherwise the dryness scratches my cornea. He told me to mention this to the anesthesiologist and to bring a bottle of my eye drops. He said they would put drops in my eyes before bringing me out of anesthesia.

The takeaway from this is simple: if there is something that worries you, bring it up before surgery. The surgical team can often adjust things to fit your specific needs. Both of the issues that worried me were handled perfectly. My back and my eyes both came through the surgery without any problems.

14. How will my external incisions be closed? What is the aftercare?

My doctor said the incisions would be closed with surgical glue. He said that for the best cosmetic result, I should try to keep the glue on as long as possible.

He told me not to put any cream or oil on the incisions. When I take a shower, he said not to wash the incisions with soap. Simply let the water run over them and do not rub. After showering, gently pat the incisions dry with a towel, touching and lifting rather than rubbing the skin.

Later, when the glue starts to peel, he suggested trimming the loose edges with small scissors and trying to keep the middle part that sits over the incision for as long as possible.

My incisions never hurt or itched. The last bits of glue came off after about three and a half weeks. At that point, the incisions were healed, flat, and light pink. About a year after the surgery, they became flesh-toned and invisible.

I cannot feel them with the tip of my finger. The skin is completely smooth. I know roughly where they were, but I cannot point to the exact spot anymore.

So his advice about keeping the glue on as long as possible turned out to be very helpful. I read in support groups that some women put cream on the glue, which makes it dissolve sooner. It turns out that this is not a good idea.

15. How many lymph nodes will be tested, and when?

He went over how one lymph node on each side, the ones closest to the uterus, would be removed and examined to determine whether the cancer had spread. The pathology on the nodes would not be done during the surgery, but later, when all the organs are sent to the lab.

He also shared that in the past, surgeons used to remove a larger number of lymph nodes. Research later showed that removing the first draining node provides the same information without the potential side effects of removing many nodes.

Of course, I immediately asked what those side effects might be.

He explained how removing a large number of lymph nodes is strongly linked to lymphedema, which is a painful swelling of the leg. It usually affects just one leg and typically appears a few months after surgery, not right away.

16. How long will it take for me to know the stage of my cancer?

The doctor said the pathology results typically take about ten days. His prediction was exactly right. The pathology report took about ten days to appear.

I was able to find information about my surgery by logging into the hospital portal. A lot of other information in the portal became visible before the pathology report did. For example, I could read the details of my surgery, including what was done, what the surgeon observed, the amount of blood I lost, and other things I found interesting.

One number surprised me. The report said I lost only 20 milliliters of blood. Twenty milliliters is about four teaspoons!

I looked up that a "normal" menstrual period is usually about 30 to 40 milliliters of blood loss. My surgeon removed several major organs with even less blood loss than that. That really floored me.

17. Will a catheter be used?

Yes. The doctor explained that a catheter would be used.

The surgical team inserted the catheter while I was under anesthesia. It stayed in overnight, and a nurse removed it the next morning, after the bladder test, while I was still in the observation bay. I will describe this procedure in more detail later in The Surgery day: after surgery.

18. Will vaginal packing be used?

No. Vaginal packing is not always used. My surgeon said he prefers not to use it unless there is significant bleeding.

Vaginal packing is a long strip of sterile gauze placed into the vaginal canal at the end of surgery. Its main job is to act like a bandage, applying constant pressure to the vaginal cuff to stop the bleeding.

The doctor said he does not use packing if the vaginal cuff is dry and the stitches are secure with no oozing.

Packing can be uncomfortable to remove and can sometimes trap bacteria if left in too long. He said he feels the first few hours of recovery are easier for the patient if the packing does not have to be pulled out later. And indeed, a few women who described the packing being pulled out made it sound rather unpleasant, saying it keeps coming and coming like some kind of magic trick with no end, and that it can scrape against the operated area.

I did not have vaginal packing. Instead, I had a large pad in my underwear with only a small amount of spotting.

19. Does being overweight create any special challenges?

I asked my surgeon if being overweight creates any special challenges during this surgery. He said it was not a problem at all. He reassured me that they look at the patient's natural body shape and place the incisions above any skin folds so they stay away from any areas where sweat might collect.

He also added that even if they have to switch from laparoscopic surgery to an open procedure, the incision would still be placed above the fold lines to keep it from getting sweaty.

He shared that for severely obese patients, he sometimes uses robotic surgery. However, my BMI was below 40, so there was no need for robotic assistance in my case. As I mentioned earlier, manual laparoscopic surgery has some advantages, so he prefers this approach when possible.

My laparoscopic incisions were all below the waist and above the skin folds. During the surgery, he decided to place one incision just above the belly button rather than inside it because, he said, my belly button was at the wrong angle for the area he needed to reach.

For about six months, I had a small pink dot above my belly button. After that, it became invisible. In the end, having the incision above the belly button turned out to be easier to keep clean and dry than if it had been inside the belly button.

20. What is a frozen section test for a large fibroid?

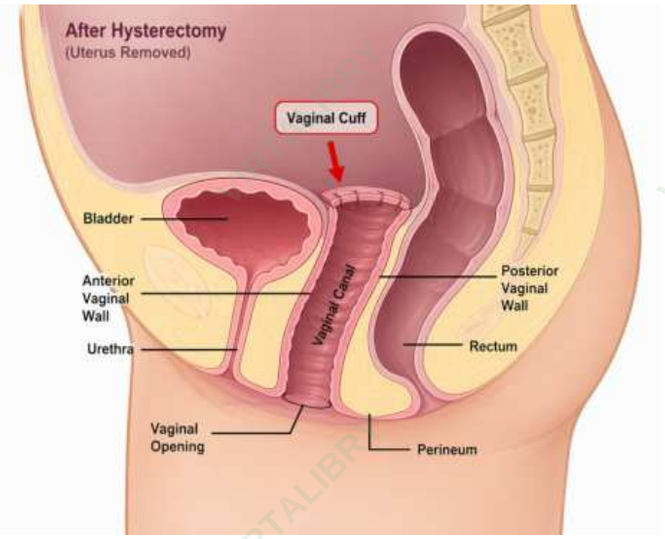
I heard about a test called a frozen section for fibroids done during surgery. Since the doctor mentioned my ultrasound scan showed a fibroid, I wanted to know if he was planning to do this test.

My surgeon explained that this is a test done in the middle of the surgery to determine if the fibroid is cancerous. This test is done when the doctor is considering cutting a large fibroid into smaller parts so it can be removed vaginally. Otherwise, the surgeon would need to make an abdominal incision because a fibroid of that size is too large to remove through the vagina in one piece. The test reduces the risk of accidentally spreading cancer cells by cutting a cancerous fibroid, which might cause the cancer cells to escape during surgery. If the test shows that the fibroid is cancerous, the surgeon would not cut it into smaller pieces and would make an abdominal incision instead. He said he does not think this test will be needed during my surgery, as my fibroid was fairly small.

UNDERSTANDING BODY CHANGES AFTER SURGERY

21. What is a vaginal cuff and why is it necessary?

When both the uterus and the cervix are removed, the top of the vaginal canal is left open. This is because the cervix is located at the top of the vaginal canal, and removing it leaves an opening. That opening has to be closed by stitching the edges together, so the abdominal cavity is sealed off from the outside.



If it were left open, it would create a direct pathway from the outside into the pelvic cavity. That could lead to infection, bleeding, or even allow internal organs, like the intestines, to slip out and cause prolapse.

The cuff is simply the way the surgeon closes this opening. It seals the vaginal canal, protects the pelvic organs, and helps everything heal in a stable position. The cuff is necessary in both laparoscopic and open surgery when the cervix is removed.

If this gap is not closed, serious complications are likely, because the body needs that barrier to keep everything secure.

22. Will creating the vaginal cuff shrink my vagina?

The doctor explained that a small portion of the very top of the vaginal canal is used to create the vaginal cuff. Since only a small amount of tissue is involved, most women and their partners never notice a difference in length.

I wanted to get a more precise idea of what "small" meant. The doctor told me that creating the cuff typically uses about 5 to 10 millimeters of tissue. In inches, the amount is roughly 1/5 to 3/8 of an inch.

He also explained that the vaginal canal is extremely stretchy. It is designed to allow a baby to pass through during childbirth. Even though the resting length of the vaginal canal is usually about 3 to 4 inches, it expands and lengthens significantly during arousal. Losing a small amount of tissue at the top does not change its ability to stretch.

He said the canal might feel shorter or tighter right after surgery, but that is usually temporary. Healing tissue is stiffer than fully healed tissue, and the muscles around the canal can tighten after surgery. Some swelling and inflammation can also contribute to this feeling.

These effects usually improve as healing progresses.

23. After a total hysterectomy, is the vaginal canal attached to something?

I wondered about this. If the top of the vagina used to be attached to the cervix, and the cervix is removed, what happens once it's gone? Is the vagina attached to something else, or is it just floating around?

The surgeon nodded and explained that when he disconnects the ligaments from the cervix, he reattaches them to the corners of the vaginal cuff. Another set of ligaments is stitched to the sides of the cuff to provide side-to-side support.

In addition, the vagina is surrounded by connective tissue, called fascia, which continues to provide support whether the cervix is present or not.

In other words, the vagina ends up anchored to the same support structures as before. Once the scar tissue heals, these attachments become strong and permanent.

24. What is the likelihood of the vaginal cuff ripping during sex?

This question is a big fear for many women, including me. So I wanted to know if this medical complication is common, because it always gets a lot of attention in the discussion groups.

The doctor said that the good news is that this condition is rare. It is called vaginal cuff dehiscence, a fancy way of saying the seam opened. The likelihood of the cuff ripping is estimated between 0.1% and 4%. This means that for 96% to 99.9% of women, the cuff heals without any issues.

The surgeon said that the risk varies slightly depending on the type of surgery. He reassured me that manually performed laparoscopic surgery is extremely safe in this respect, because he can “feel” the tension of the stitches through the instruments. He told me he has a lot of experience and knows what the right tension feels like.

Then he shared some statistics with me to make the answer more specific.

Open abdominal:
0.1% to 0.3% estimated risk of dehiscence
Lowest risk. The surgeon uses traditional sutures and can feel the tissue tension perfectly.

Vaginal:
0.1% to 0.3% estimated risk of dehiscence
Very low risk. The cuff is stitched directly through the vaginal opening.

Manual laparoscopic:
0.6% to 0.8% estimated risk of dehiscence
Very safe. The surgeon uses instruments held by hand to stitch the seam. The cuff is closed from the inside (laparoscopically), which is currently considered one of the strongest ways to se-

cure the seam. The surgeon can feel the tension of the stitches through the instruments.

Robot-assisted:
1.1% to 4.0% estimated risk of dehiscence
Higher end of the range. Some specific studies found a 4% rate, though most modern hospitals see closer to 1.5%. With the robot, there is no physical touch, called haptic feedback, so the doctors rely entirely on their eyes.

Then the doctor shifted the conversation to when rips typically occur. He said it almost always happens during the first six to twelve weeks of recovery. This is the "danger zone" because the internal stitches are dissolving, but the new tissue has not reached full strength yet.

Once you are past the twelve-week mark, the tissue has usually scarred over and become quite tough. After six months, the risk drops very low.

I asked him to list what situations are most likely to cause a rip. Intercourse too soon is the obvious one, but what else?

He said straining is another situation I should be aware of. Straining can occur when lifting heavy items or bearing down during constipation. Both of these things put intense pressure on the pelvic floor and, therefore, on the cuff.

Another potential danger is infection. If the cuff becomes infected, the tissue becomes soft and the stitches can pull through while the cuff is still healing.

I decided that while cuff tears are a very scary situation, the odds were overwhelmingly in my favor.

25. If my cervix is removed, will my partner feel the difference?

When the vaginal cuff heals, your partner should not feel any difference. "The vagina is built to stretch," he explained. "Remember, it needs to expand to let out a newborn. A newborn is a lot bigger than a human penis."

He also mentioned that shortly after the surgery, there is still some swelling in the area, and some stitches may not have dissolved yet. So there might be some difference early on, but that would be due to swelling or stitches and would be temporary.

26. What happens to ejaculate during sex when there is a vaginal cuff?

It simply comes right back out. The cuff seals everything off, leaving no “way in” anymore, so gravity just does its thing like it always has.

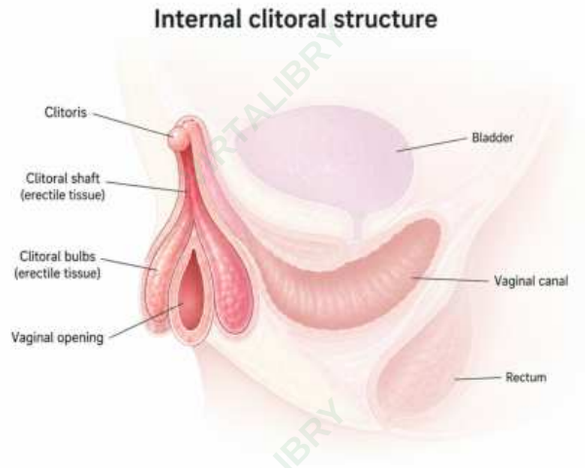
Afterward, using a peri bottle with warm water for a quick rinse or wearing a panty liner for a little while helps keep things clean and takes care of any leftover leaking.

In very rare cases, if the cuff didn't seal perfectly due to slow healing and the ovaries were left intact, there is a small chance of an ectopic pregnancy because the ovaries still release an egg every month. But for the most part, because the cuff acts as a solid wall, the “swimmers” stay trapped on the outside and eventually dissolve or get washed away.

27. Will a hysterectomy affect my ability to have an orgasm or enjoy sex?

This is one of the common concerns many women share. The doctor explained that even though experiences vary from person to person, the anatomy that causes orgasm remains intact.

The organ most responsible for sexual pleasure and orgasm is the clitoris. Even though most people think of it as a small external structure, it actually extends inside the body and is connected to the surrounding tissues and the vaginal walls.



A hysterectomy removes the uterus and sometimes the cervix, but it does not remove the clitoris or the nerve structures responsible for orgasm. This means the ability to feel pleasure and experience an orgasm remains.

Some women also talk about “vaginal orgasms” and the G-spot. It is part of the same nerve structure connected to the clitoris. The bottom line is that sexual pleasure is not removed during a hysterectomy.

28. Will I have thinning hair on top?

Hair loss after a hysterectomy happens for several different reasons. The first is stress-induced hair loss, which often occurs after any surgery. The stress of the surgery shocks hair follicles into a shedding state. In addition, long anesthesia contributes to the shedding cycle. This shedding is temporary, although it typically lasts several months. The second reason is hormonal: estrogen helps keep hair in the growth phase, so its absence can shrink hair follicles. Not every woman will notice hair thinning after surgery, and the amount can vary quite a bit from person to person. For women who are bothered by it, medical and cosmetic options can help.

Women who can take HRT can stabilize hair shedding through hormonal therapy. In addition, some cosmetic solutions could hide the thinning. One option is keratin powders, fibers that cling to existing hairs and make the hair appear denser. Another option is clip-on hairpieces, which can look good if their color matches the natural hair color. Alternatively, the natural hair can be colored to match the hairpiece. Clip-ons are less hot and more comfortable than full wigs.

Even though this issue still worried me, I was glad to hear that even if hair thinning happens, it does not mean it will be severe, and there are some ways to deal with it.

UNDERSTANDING RISKS AND COMPLICATIONS

29. What are the potential complications during surgery?

I knew all surgeries carry some risk, so I wanted to understand what the possible complications might be.

The surgeon told me complications in this type of surgery are rare. The surgery has about a 1 to 3% chance of accidentally damaging a nearby organ. If damage happens, the problem is usually repaired during the same operation.

As with any surgery, there is also a risk of infection. An infection would typically cause a rise in temperature, which is why patients are asked to monitor their temperature after the procedure.

I asked him which organs might be damaged.

He explained that the uterus sits in a very crowded space. It is surrounded by several neighboring organs. The bladder sits directly in front of the uterus. To remove the uterus, the surgeon often has to gently move the bladder out of the way. Because they are so close together, there is a small risk of a nick or tear in the bladder wall.

Also nearby are two thin tubes, called ureters, which carry urine from the kidneys to the bladder. They run extremely close to the uterine arteries that the surgeon must cut and tie off during the procedure.

If one of these structures were accidentally nicked, urine could leak into the abdomen. Urine does not belong there and can cause irritation or infection.

I was glad he explained this, because after my surgery the nurse performed a bladder test and I understood why she was doing it. I will write more about that test when I describe my immediate recovery after surgery.

30. What are the signs that something is wrong after a hysterectomy?

I asked what I should watch for after surgery.

He told me the main warning signs are fever and heavy bleeding.

If my temperature goes above about 101°F, it could be a sign of infection.

Heavy bleeding means soaking one sanitary pad per hour for several hours in a row.

He added, if either of these happens, I should call the phone number in my discharge papers to reach the doctor on call.

I was relieved the list of things to worry about was short and clear.

31. Will I bleed after the surgery?

The doctor said I might experience some bleeding after surgery. It can be brown, pink, or yellow in color. It might happen within the first eight weeks.

He explained that spotting often occurs when the stitches dissolve, leaving tiny openings which can bleed a little. He said only a small amount of bleeding is expected.

If I soak one pad an hour for several hours in a row, it is not normal and warrants a call to the hospital or a trip to the emergency room.

32. Is urine loss during coughing more likely after a hysterectomy?

I asked if a hysterectomy makes urine leakage during coughing more likely.
He said that a hysterectomy itself does not make leaking more likely, nor does the surgery reduce the chances of it happening.
I was kind of hoping for a two-for-one deal, but no luck.

33. What are the negative side effects of a hysterectomy?

I understood that when someone has cancer, the benefits of a hysterectomy outweigh any possible side effects. Still, I wanted to hear the doctor's opinion about potential negative effects.

He said there are studies suggesting some increased health risks after hysterectomy, but most of those studies focus on women under the age of 50. The risks tend to be higher when the ovaries are removed, because that causes a sudden loss of estrogen.

He explained that the exact risk varies depending on age, whether the ovaries are removed, and other factors such as overall health and lifestyle. Some studies suggest increased risks of heart disease, stroke, and possibly memory issues in younger women.

However, for older women, especially those who are already past natural menopause, these risks are much lower.

When weighing those potential risks against the danger of cancer, he said the benefits of a hysterectomy in my case are very clear.

34. Tell me about potential colonoscopy problems after a hysterectomy.

My doctor said this was a good question and that I should alert my GI doctor before the next colonoscopy that I had a hysterectomy so they would know what to expect.

A hysterectomy does not make a colonoscopy dangerous, but it can make it a bit more like driving on a road with extra curves and speed bumps. Most experienced GI doctors deal with this regularly and can adjust their technique.

My doctor highlighted a few changes that come with a colonoscopy after a hysterectomy.

The biggest factor is scar tissue, also called adhesions. Anytime you have surgery in the abdomen or pelvis, the body forms internal scar tissue as it heals. These thin bands of tissue can sometimes cause loops of the colon to stick to each other or to nearby structures, including the vaginal cuff.

During a colonoscopy, the doctor needs the colon to be flexible so the scope can slide through the turns easily. If adhesions have made the colon more fixed in place, it can make it harder for the doctor to guide the scope through the entire colon.

Another issue is that the uterus normally acts as a solid structure in the pelvis. When the GI doctor moves the scope through the sigmoid colon, the part closest to the rectum, the uterus helps keep the colon from shifting too much. Without the uterus, the colon has more room to move around. This can sometimes cause the colon to stretch or loop more while the doctor is advancing the scope.

Because of these factors, the procedure can be a bit more challenging.

So it is important to inform the GI doctor in advance that you have had a hysterectomy. This allows them to anticipate possible adhesions or looping. The doctor may also adjust sedation to

make sure the procedure does not cause pain.

35. Some people say that the rib cage drops after a hysterectomy because the uterine ligaments are cut. Is it true?

I had seen this claim in discussion groups and wanted to ask about it.

The doctor explained that the rib cage is not attached to the uterus. The uterine ligaments are located low in the body, deep in the pelvis. They support the uterus within the pelvic area, but they are not connected to the rib cage or the upper torso.

He said the idea of the uterus acting like a pillar holding up the body is anatomically wrong.

36. Some people say that after a hysterectomy, the bladder drops and this causes incontinence. Is this true?

The surgeon explained what happens after the uterus is removed. When the uterus is removed, there is technically a new "empty space" in the pelvis. The bladder does not drop into a void because the bladder and uterus are neighbors. Other organs, primarily the small intestines, naturally shift to fill that space.

In a very small percentage of cases, if the pelvic floor was already weak before surgery, the absence of the uterus as a physical barrier can make it easier for a prolapsed bladder to develop later. This is a known potential complication that surgeons try to prevent.

Studies show bladder function stays the same for the vast majority of women. In fact, some women find that their bladder symptoms improve because a large or heavy uterus is no longer pressing down on the bladder.

If a woman develops incontinence after surgery, it is usually related to either nerve irritation or pelvic floor health. The nerves that control the bladder are located near the cervix. Temporary irritation of these nerves during surgery can sometimes cause bladder issues right afterward, but this usually resolves as healing progresses.

The surgery itself does not create pelvic floor weakness. However, if the pelvic floor muscles were already strained from age, weight, or childbirth, the surgery can sometimes act as a tipping point.

UNDERSTANDING AFTER-SURGERY PAIN

37. Will I be able to get up from bed the day after surgery?

My only previous experience with major surgery was a spinal fusion for a herniated disk. After that operation, I needed help getting out of bed for about a week. I felt as helpless as a baby. I even needed help using the bathroom. That was my mental picture of what any serious surgery would be like.

The surgeon said he did not expect any problems with me getting up from bed on my own the day after surgery. He explained that they would not discharge me if I was unable to get out of bed or go to the bathroom without help.

Normally, this surgery is done as day surgery, and women go home the same day. However, since I live alone, the surgeon suggested scheduling the operation in the afternoon rather than the morning. That way they could keep me overnight for observation and release me the next morning.

This arrangement would still fall under the day-surgery category because I would leave within 24 hours. I would not be assigned a hospital room, but would stay in the observation area overnight.

That sounded like a safer option to me, and this is what we agreed on.

His explanation and the suggestion to stay overnight for observation calmed my worries significantly.

38. How much pain should I expect?

The surgeon told me that he expected the level of pain to be low. He said most of his patients do not need anything stronger than Tylenol, although he would prescribe a small amount of stronger prescription pain medicine just in case.

I asked if he could write the prescription before the surgery. Since I live alone, I wanted to have the medication at home waiting for me when I got back from the hospital. I did not do that for my back surgery, and it was stressful trying to arrange for someone to pick it up afterward. He had no problem writing the prescription in advance.

As it turned out, I did not need any pain medication. The last time I took anything was on the way home from the hospital to help me handle the ride over potholes. After that, I never felt enough discomfort to need even Tylenol.

39. What can be done about surgical gas pain?

Before my surgery, I read many posts from women complaining about the excruciating pain from the carbon dioxide (CO2) gas used during laparoscopic surgery. The women described the sensation as sharp or stabbing pain in the shoulder or upper chest, especially during deep breaths.

The doctor explained how the abdomen is inflated with gas to give the surgeon room to operate on the uterus and other organs. The surgeon needs more room during laparoscopic surgery, whether manual or robotic. The gas is not used in open abdominal surgery because the surgeon already has room to work after the abdomen is opened. When some gas is left in the body after surgery, it can irritate the diaphragm, the muscle under the lungs, which helps with breathing. The nerves connected to the diaphragm send pain upward, which is why the pain often seems to come from the shoulder or upper chest rather than the lower abdomen. The gas used to inflate the abdomen stretches the abdominal tissues, and this can cause the sensation of bloating and general discomfort. This pressure can also contribute to pain around the incision sites.

I asked the doctor how to deal with this pain. He replied that he did not expect me to have gas pain because they use a machine which removes all the surgical gas at the end of the surgery.

I remained skeptical and asked how to manage gas pain if it did happen. He said the best remedy is walking because movement helps the body absorb and release the remaining gas. He said I should try to walk at least every three hours. Walking does not have to be fast or strenuous. What matters is moving rather than sitting or lying down.

I also learned that the timing and location of the pain can give a clue about what kind of gas pain it is. Surgical gas pain from laparoscopic surgery usually happens in the first few days after surgery and often causes discomfort around the shoulders or upper

chest. Gas pain that shows up later is more likely to be digestive gas in the stomach or bowels, especially while bowel movements are still getting back to normal after surgery.

The doctor added that using a heating pad often helps relieve the discomfort, and that drinking warm water might help as well.

I asked if heat might cause bleeding by dilating the blood vessels. He said I did not need to worry about that. The only caution he gave was not to burn the incision sites by using heat that was too strong. He explained that they apply a numbing solution around the external incisions, which means I might not notice heat quickly enough to realize it is too hot.

Again, the doctor was right. I had no gas pain. It seems that some hospitals have an effective way of removing all the gas at the end of the procedure. At the same time, it is clear that not every hospital uses the same equipment, since many women do experience this type of pain. It is a good question to ask during a pre-operative consultation.

40. Does Gas-X help with surgical gas pain?

One of the common suggestions people gave in Facebook hysterectomy support groups was to take Gas-X after a hysterectomy to reduce surgical gas pain. I asked my doctor if Gas-X could help, since I wanted to buy some before surgery.

He explained that Gas-X works on gas in the stomach and intestines. It works by reducing the surface tension of gas bubbles there, allowing them to combine and pass more easily. The gas used during laparoscopic surgery is different. Carbon dioxide (CO_2) is pumped into the abdominal cavity, not into the stomach. Because of that, Gas-X cannot reach or react with the surgical gas.

He said the gas used during surgery leaves the body on its own over time, even if nothing is done.

He added that people who feel that Gas-X helped them are experiencing a placebo effect from believing they are doing something helpful. Still, since Gas-X is not harmful, there is no real downside to taking it. Walking, however, is the more effective remedy because it helps the body absorb and release the gas faster.

UNDERSTANDING THE RECOVERY TIMELINE

41. How long is the recovery period?

The doctor explained that recovery time depends on whether the surgery is done laparoscopically or as an open abdominal procedure.

He set my expectations that recovery from laparoscopic surgery would take about two to three weeks. He said most women can return to normal activities after that, with two important restrictions.

The two main restrictions were no heavy lifting for eight weeks and nothing inserted into the vagina for twelve weeks.

Some women in hysterectomy support groups reported tearing their vaginal stitches during sex even after nine weeks. This is statistically rare, but if it does happen, it can be very painful and is usually accompanied by significant bleeding. It requires immediate medical attention and another surgical repair. Because of that, I think it makes sense to be cautious and wait longer.

My discharge notes also made a distinction between external stimulation and penetrative sex. External stimulation was considered safe after three weeks.

42. What are the restrictions after surgery, and for how long?

The surgeon said I would receive detailed discharge instructions after the surgery, but he gave me two main restrictions during the consultation.

First, no lifting anything heavier than about 10 pounds. To give me a visual reference, he said to think of my limit as a gallon of milk. When I got home, I looked up how much a gallon of milk weighs. It is about 8.6 pounds. This restriction is for eight weeks to make sure the vaginal cuff stitches heal properly and straining does not pull them apart.

Second, nothing inside the vagina for twelve weeks. This includes sexual intercourse, tampons, douches, water, or sex toys. No water inside means no baths, no hot tubs, and no swimming. Showers are fine.

43. How soon after surgery can I shower?

I was happy to hear that I had the green light to shower the day after surgery. After my back surgery, I could not shower for two weeks. I felt grimy, and that made my recovery harder. With this surgery, thanks to the glue covering the incisions, getting them wet did not create a problem.

44. When can I drive after surgery?

The doctor said that I should be able to drive as soon as I am no longer taking prescription pain medication. He also added that I should base the decision on how I feel. Braking quickly or turning my body should not cause pain.

I ended up taking my first short drive on day three.

45. How quickly can I return to work?

The doctor said that this really depends on the type of work I do. In his experience, most women are able to return to work in two to three weeks. However, those whose jobs include lifting heavy objects will take longer, since heavy lifting should be avoided for six to eight weeks. With my desk job, he thought my time frame would be at the shorter end, and he was right. I began working part-time after one and a half weeks, and full-time after two.

UNDERSTANDING WHAT TO DO BEFORE SURGERY

46. What medications will I need to have on hand before and after surgery?

Before the surgery:

- Hibiclens antiseptic skin cleanser.

After the surgery:

- Tylenol and prescription pain medication for pain.
- Docusate sodium capsules, a stool softener.
- Senna tablets, a laxative that helps the intestines move stool along.
- Milk of magnesia, a laxative that pulls water into the intestines to soften stool.

He said to take one Senna laxative tablet and one Docusate stool softener capsule twice a day after surgery, and to stop once I had a bowel movement. If there was no bowel movement within three days, he said I should add two to four tablespoons of milk of magnesia and follow the instructions on the bottle. He also added that I should drink plenty of fluids and walk as much as possible, as long as it was pain-free.

47. Do I need to take laxatives before surgery?

I read in the support forums that some women received instructions to take a laxative prep similar to the one people take before colonoscopies. Others had no instructions related to laxatives before surgery at all. So it became clear to me that clearing the pipes depended on the specific doctor's technique.

My doctor said that he does not use bowel prep because it can cause dehydration and make recovery harder. He also does not instruct women to take laxatives before surgery. Instead, he said I would need to follow a low-residue diet for five days before the surgery and have no food at all on the day of surgery.

A low-residue diet minimizes the amount of undigested food in the digestive tract. Even though the bowels are not empty, they are less bulky and more flaccid. This is enough to keep them out of the way during surgery.

This explanation was very helpful because I had assumed that bowel prep and laxatives were given to help prevent constipation after surgery. It turns out they are used to make sure there is enough room for the surgeon to operate so the bowels do not get in the way. The doctor gave me a totally different explanation for keeping the intestines less full than what I expected.

48. Should I be taking any vitamins before surgery, like iron?

No. This was one of the few monosyllabic answers I got.

49. Should I stop taking vitamins, supplements, or medications before surgery?

He asked what I currently took and told me to stop Omega-3 five days before surgery. He said Omega-3 can slow down blood clotting. The rest of my vitamins and medications were fine to take up until the day of surgery.

On the day of surgery, he told me to take nothing, not even my blood pressure medicine, which surprised me. He said anesthesia would control my blood pressure during the operation, and it is simpler if I do not have medications already in my system.

Since everyone takes different medications, it is important to ask your own doctor what you should stop and when.

UNDERSTANDING WHAT TO DO AFTER SURGERY

50. Should I wear compression socks after surgery?

During the consultation, I asked the doctor if I should buy compression socks to wear at home after surgery.

He said, "No. But you should try to walk as much as you can without pain, because that will increase blood circulation. That helps prevent blood clots and also helps with faster healing."

While I was at the hospital, compression socks were also not used. Instead, they used sleeves around my legs, from my ankles to my knees, that gently squeezed them at regular intervals. These are called intermittent compression devices (IPC devices).

These devices help prevent blood clots from forming in the deep veins of the legs. In addition, I was given a shot of a blood thinner before surgery.

The doctor said the risk of blood clots during this type of surgery is low. During the operation, the legs are elevated, and patients usually become mobile fairly quickly afterward, which further reduces the risk.

51. Should I use silicone scar tape on the incisions?

I had seen references to silicone gels and silicone sheets as treatments that can improve the appearance of scars. The marketing materials say silicone products "keep the scar hydrated" and "prevent scar tissue from growing excessively." I am generally suspicious of marketing promises, so I asked the surgeon if I should use them to reduce the visibility of my incisions.

He said he had no objections to silicone tape, but he did not think I would need it. The incisions from laparoscopic surgery are very small, and in his experience, silicone products are more useful after open surgeries, where the scars are larger.

My incisions were closed with surgical glue, which protected the cuts while they healed. They never hurt or itched. The surgeon cleared me to take showers the day after surgery.

The doctor said not to put anything on the incisions while they were still covered with glue. He explained that the glue helps the incisions heal smoothly. He advised against applying oils, creams, or even soap directly to the glue. Instead, he said, I should just let shower water run over the area and then gently pat it dry without rubbing.

He also suggested keeping the glue in place as long as possible. When the edges started to peel, he told me to trim the loose edges so the middle part would stay over the incision longer.

After the glue came off, he gave me the option of applying vitamin E to the skin around the scar to keep it soft and reduce itching. Moisturizers such as Aquaphor, Cetaphil, or Eucerin were also fine once the glue had fallen off.

I managed to keep the glue on for about three and a half weeks. When the glue came off, the scars were no longer pink. They looked good and did not itch, so I never saw the need to put any creams or oils on them.

A year later, the scars were flesh-toned and flat. I could not feel them with the tip of my finger, and could not tell exactly where they were.

52. Are there any dietary restrictions after surgery?

My doctor emphasized that “no-strain” foods are the key to making bowel movements easier. “No-strain” eating means good hydration through drinking lots of water, juice, and soups. The good news is that coffee can actually help here, since it is a mild bowel stimulant. Teas such as senna or peppermint are helpful as well. He also mentioned I should limit carbonation for a few days, so sodas and sparkling water should be out for a bit.

Fiber, he said, is my best friend, with foods like whole grains, berries, and leafy greens. He also added that the “P-fruits” are natural laxatives and I should add them to my diet: prunes, pears, and peaches.

53. Should I avoid soy milk?

I enjoy having my morning cereal with soy milk. However, after I was diagnosed with uterine cancer, I learned that hormones, especially estrogen, can fuel the growth of hormone-sensitive cancers such as uterine, ovarian, and breast cancers.

I read that soy milk contains compounds called isoflavones, which act like a weak version of natural estrogen. Because they look similar to the body's own hormones, they can attach to the same receptors that estrogen normally uses and can mimic some of estrogen's effects. I wanted to check whether it was safe for me to continue drinking soy milk or if I should stop.

The doctor said that drinking soy milk in moderation is safe. Something like one glass of soy milk a day is fine. However, he recommended that I stay away from high-dose soy supplements or concentrated soy powders because they can deliver much larger amounts of these compounds, which is not desirable for hormone-sensitive cancer survivors.

54. Will I need an abdominal binder? If so, how long should I wear it, and when?

The surgeon did not think I would need an abdominal binder. The binder provides gentle compression that keeps everything supported. It is most helpful for reducing pain from coughing, sneezing, or even laughing. The binder works a little like a soft corset, keeping the insides from shaking.

The wrap should not be too tight. He told me I should be able to breathe deeply and slide a hand underneath the material. If it is too tight, the binder can increase the risk of blood clots or press too hard on the abdomen.

He added that the best way to put the binder on is while lying flat in bed. This allows the organs to settle into a neutral position before I "lock" them into place with the Velcro closure.

In general, he said he recommends wearing a binder after open abdominal surgery, but not after laparoscopic surgery. Wearing a binder also has some downsides. If it is worn too much, it can weaken the core muscles and lead to back pain. Another issue is that binders are often made of synthetic, non-breathable elastic. This can trap sweat and moisture against the incisions. Friction from the binder moving against the skin can irritate the incision area and lead to a skin infection.

He said that if I decide to wear one, I should only use it when I am actively walking and take it off when resting or sleeping.

UNDERSTANDING LOGISTICS

55. How will my ride be notified once I am cleared to leave?

The doctor assured me the nursing staff would stay in touch with my family. He also said that I would be able to call them myself because patients are allowed to keep their cell phones.

Since I arranged to have my surgery in the afternoon, stay overnight, and be released in the morning, my ride did not wait around once they called me in for surgery. My family was kept informed about my progress through text messages, including when I was ready to be released the next morning.

56. When will I have to pay for the surgery? Do I need to pay my co-pay when I check in?

The doctor said my insurance would be billed after the surgery, when everything done during the procedure is known. After that, I would see the remaining balance in the hospital portal and be able to pay my co-pay there.

He told me not to bring a credit card to the hospital, just my cell phone and whatever personal items I might need.

57. When will my post-op appointment be?

The doctor told me his office would contact me to schedule a follow-up appointment about three weeks after surgery.

He explained what happens during the appointment will depend on how I am recovering. If I report no symptoms, no pain, and no unusual discharge, he will not do an internal exam, so the healing can continue undisturbed.

If something does not feel right, he will do the internal exam so he can take a look and see what might be going on.

WRAPPING UP THE CONSULTATION

This concludes the questions I asked during my consultation. My surgery was scheduled at a research and teaching hospital. At the start of the appointment, the doctor asked if I was comfortable having a medical resident join us and observe. Occasionally, when I asked a question, he would turn to her and explain something in more detail. I found that helpful because those extra details turned into a good teaching moment for both of us.

I appreciated that he never rushed me. He answered every question on my list in detail and even thanked me at the end for being so prepared. I walked out of that appointment much calmer. I knew what to expect, and I felt confident that I was in good hands.

As I finished some final paperwork before leaving, they asked if I would be willing to donate leftover tissue from my surgery for research. Using real human cells allows researchers to see how diseased cells actually behave. They might study how the tissue reacts to different medicines or look at the DNA and RNA to understand why some people are predisposed to certain illnesses or why a medication works for one person but not another. I said yes. It felt good to think that my tissue might help other women in the future.

GETTING READY FOR SURGERY

My surgery was scheduled for two weeks after the consultation. During those two weeks, I went on a bit of a surgery shopping spree, buying items that might help with recovery. I got the ideas for these things from books, internet searches, and discussions in Facebook groups.

In this chapter, I share what I learned. I ended up buying quite a few things that I thought might help. Some turned out to be very useful, others not so much. I added my comments explaining what actually helped and what didn't, so you can decide for yourself what might be worth getting.

MY SURGERY SHOPPING LIST: COMFORT AND REST

1. 3D sleep eye mask

https://www.amazon.com/gp/aw/d/B09CZ68WV3

Taking the sleep mask to the hospital made a huge difference. In the recovery room, the lights are always on and intensely bright. This mask helped me rest and relax after the surgery. I was glad I bought the sleep mask.

2. Earplugs

https://www.amazon.com/gp/aw/d/B004CZYJLA

My favorite earplugs are the contoured earplugs from Flent. Hospitals are noisy places. Nurses and doctors are constantly talking to each other and to other patients. I was glad I had earplugs. They helped reduce the noise and made it easier to rest after surgery.

3. Recliner

https://www.amazon.com/gp/product/B08FM7VHTN

I worried a great deal about being able to get up from bed unassisted the day after surgery. My only other major surgery before this one was a lumbar disk fusion, and following that surgery I needed help getting up for several weeks.

I saw a number of women mention that a recliner turned out to be remarkably helpful for them during the first days after surgery. I did not own one and decided I should buy one. Another cost-effective option would have been to rent an electric recliner for a short period from Rent-A-Center instead of buying one. However, I wanted something that would still be useful later, not just for a few days after surgery.

I decided to buy a Timber Ridge Zero Gravity Chair that can be used both indoors and outdoors. A zero-gravity chair is not electric. Instead, it helps you get up by pressing the leg bar with your feet, which tilts the chair forward and helps you stand up without using your back or stomach muscles. A friend loaned me a zero-gravity chair when I was dealing with back problems, and it helped a lot back then.

I did end up using the chair, but not in the way I expected. I thought I would need it to help me get out of bed, but it turned out I did not need that kind of help. During laparoscopic surgery, no muscles are cut, and I was able to rise from bed without any pain.

However, I was coughing quite a bit after surgery because the breathing tube had irritated my throat. The coughing shook my insides and pulled on the internal scar, which was painful. I noticed that when I rested in the recliner, my lungs stayed clearer, and I coughed less than when I slept flat on my back.

I only slept in the recliner for a few days until the cough im-

proved, but I was glad I had it.

4. Tower fan

https://www.amazon.com/Dreo-Electric-Oscillating-Control-Bladeless/dp/B08PDDSDHY

I found a tower fan with a remote control to be incredibly useful. While my body was adjusting to the post-hysterectomy hormone changes, having a tower fan blowing gently on me all night solved my sleeping problems.

Another thing that helped was switching to 100% cotton bedding, especially the quilt I used. Polyester and other non-cotton materials do not breathe as well as cotton and did not let the fan move the heat away from me as effectively.

I also noticed that moving air from a fan worked better than just having the room cooler from air conditioning. There was a simple reason for this. Moving air from the fan constantly replaced the warm, humid air around my skin with drier air. That helped sweat evaporate faster and made me feel cooler. The air conditioner cooled the room overall, but did not move the air around my body the same way.

5. Flat pillow

A flat pillow was my best friend throughout the entire recovery. By a flat pillow, I mean a pillow with relatively low loft. It was something I already owned.

I used it to hold against my belly when I coughed so my body would not shake as much. I used it in the car to help cushion the bumps when we drove over potholes. When I slept on my back, I put the pillow under my knees to keep my legs slightly bent. When I slept on my side, I placed the pillow between my knees to keep my spine better aligned.

I read that some people use a wedge pillow, but many do not find it very comfortable. I believe that is because wedge pillows are often quite steep. The flat pillow kept my legs in a more natural position and was much more comfortable for me.

MY SURGERY SHOPPING LIST: BATHROOM AND HYGIENE

6. Silicone manual bidet

https://www.amazon.com/gp/product/B08M5QP37B/

I found a manual bidet (also sometimes called a peri bottle) very helpful. I used it to clean myself after each time I went to the bathroom.

The best kind is made from silicone rather than plastic. A small 12-ounce bidet works best. Silicone bottles are easier to squeeze and create a stronger stream of water. Many plastic versions produce a weaker stream. The link above is the one I used.

I am also a big fan of wet wipes. Once you experience how nice and clean you feel after using them, it is impossible to go back to dry toilet paper! Just don't flush them. The good news is that they don't stink in a trash can with a liner and a cover.

7. Mesh surgery panties

https://www.amazon.com/dp/B07DNSGBZ7

Surgical panties are disposable underwear made of mesh. The mesh lets the skin breathe, which helps healing. If you have spotting or light bleeding, you also do not have to worry about ruining your nice underwear.

Even though they are called disposable, they can actually be washed and reused a few times. They turned out to be more durable than I expected.

The hospital put a pair on me after surgery and gave me a few to take home. I did not know they would do that, and I had bought a package before the surgery. The ones I bought were black and looked nicer, but the hospital ones worked just as well. Since the hospital gave me several pairs to take home, buying them turned out to be unnecessary. I later heard from other women that they also went home with hospital mesh panties, so this seems to be pretty common.

8. Toilet safety rails

https://www.amazon.com/dp/B0BRB5RJXW

I had only had spinal disk fusion surgery before this one. So my only point of reference for recovery came from living through a spinal disk fusion. That surgery really debilitated me. Even getting up from the toilet felt difficult and painful for the first couple of weeks. At that time, I bought toilet safety rails, which I assumed I would also need after this surgery.

To my surprise, getting up from the toilet was not a problem at all this time. I could stand up without any help. I ended up not using the safety rails.

9. Raised toilet seat

https://www.amazon.com/Ccbello-toilet-seniors-Elevated-elongated/dp/B0C65N2786

I bought a raised toilet seat after my back surgery, so I got a chance to experiment with it. Since I saw this toilet aid mentioned as something that might help after a hysterectomy, I wanted to share my experience with using the seat.

I am short, and the raised seat lifted me enough that I was not able to plant my feet on the floor. As my feet dangled in the air, I had no way to brace myself against the floor. Without being able to brace, it became impossible for me to “perform the business” I was there to do. To be honest, I just could not do it while my feet were up in the air. I found the seat uncomfortable, despite it being soft and cushy.

After the back surgery, the safety rails proved to be much more helpful. I sat at the normal height, but the rails allowed me to push myself up with my hands when I had trouble getting up using my back muscles. After my laparoscopic hysterectomy, I had no trouble getting up from the toilet at all, so I did not need any aids.

If you are a shorter person like me, keep the issue with dangling feet in mind when deciding if this toilet aid will work for you.

10. Shampoo hat

https://www.amazon.com/No-Rinse-Waterless-Conditioner-Bedridden-Hospitals/dp/B0FD3NSG3G

I decided to include shampoo hats on my list even though I did not need them after my laparoscopic surgery, as I could take a shower the day after surgery. However, they were very helpful after my back surgery, so for someone who has an open hysterectomy, these hats might be a big help.

One of the things that made me quite miserable after my back surgery was that I was not allowed to take showers for several weeks to prevent infection. Having limp, dirty hair really dragged my mood down.

When I discovered shampoo hats, they made me much more comfortable. Shampoo hats do not require water. You warm one in the microwave, put the hat on your head, and it releases foam that lets you clean your hair. Once that is done, you remove the hat. There is no need to rinse. You simply dry your hair with a towel.

Shampoo hats are not perfect. Your hair is not as clean as after a nice warm shower, but it is much cleaner than before. These shampoo hats made me feel much better, and I hope they might be just as helpful to someone as they were for me.

11. Sanitary pads

https://www.amazon.com/dp/B0G5BJX4MD

My doctor told me that I might have some spotting after surgery. He explained that sometimes when the stitches dissolve, they leave behind tiny holes that can produce a small amount of blood. This often happens two to three weeks after surgery.

For this reason, I wore a pad for three or four weeks, just in case. I did not have any spotting or discharge after surgery, but everyone heals differently, and some women experience more spotting than others.

I started by wearing a regular feminine pad, changing it at least once a day. But for some reason, after wearing them for many days in a row, I began feeling they were irritating me, so I switched to baby cloth diaper inserts. They are made out of cotton and were much more comfortable. They are washable and come in a pack of ten, so I used one each day and threw them all in the weekly wash. They were gentler on my skin, and I created no extra waste.

https://www.amazon.com/ALVABABY-Diaper-Inserts-3-Layers-Diapers/dp/B00K4SYA2C

12. Body dryer

https://www.amazon.com/EEYBLAEEY-Negative-Heater-308-65lbs-Capacity/dp/B0DSDPCR14

Some women recovering from an abdominal hysterectomy have trouble bending down to dry their legs and feet because of pain from the large vertical or horizontal incision. While looking for possible solutions to this problem, I came across body dryers.

A body dryer is a platform you stand on after a shower. It blows air upward to dry your body. Some models include cool and warm settings and are controlled with a small remote.

I did not end up buying one, but it could be helpful for someone who has difficulty bending to dry their legs and feet after surgery.

MY SURGERY SHOPPING LIST: MOVEMENT AND SUPPORT

13. Belly binder

https://www.amazon.com/NYOrtho-Abdominal-Binder-Lower-Support/dp/B005DLL0CS

During my consultation, the surgeon said he did not expect that I would need a binder after laparoscopic surgery. However, I bought one just in case the surgery had to be converted to an open abdominal procedure.

The cost is about $20, and I decided this purchase would give me peace of mind knowing I would have a binder if I needed one. After open surgery, the hospital usually puts a binder on the woman if she needs one, but having two can be helpful because you can wear one while the other is being washed. The binders get sweaty, and if they are not cleaned, they may irritate the skin.

Keep in mind that it is important not to become dependent on the binder. If the abdominal muscles are constantly supported, they can become weaker. Still, wearing one for a week or two can give some support and compression if it feels helpful after open surgery.

Even though I bought one, I did not end up using it. I practiced putting on a binder before surgery and realized it was hard to tighten by myself without help. You also have to take it off every time you go to the bathroom, which happens many times a day. For me, the binder seemed like more trouble than help.

Some people say the binder helped them when they were coughing because it braces the belly. But it is not the only option. After my surgery, I had a cough because the breathing tube irritated my throat. The cough really shook my insides and pulled on the internal scar, the vaginal cuff. To reduce that pain, I pressed a flat pillow against my belly when I felt a cough coming on. The pillow helped stop the shaking, and that reduced the pulling on

the cuff.

So the binder turned out to be unnecessary, but a flat pillow was my best friend during the first week when I was coughing.

14. Unger grabbers

https://www.amazon.com/Unger-Professional-Nifty-Nabber-36/dp/B0000V0AGS

You can find a lot of different grabbers on the market. I bought several of them when I had my back surgery and had very limited ability to bend. I discovered a huge difference in how they handled and the effort each one required.

Unger grabbers worked best for me and gave me incredible dexterity. They made picking up everything from a tiny sewing needle to a heavy can of tomatoes easy.

I have Unger grabbers in two lengths: 36" and 24". I found that the shorter grabber works best for doing laundry. I used it to pull one wet item at a time out of the washer so I could stay under the post-surgery lifting limit.

The longer grabber made this harder because you have to lift wet items over the edge of the washing machine while squeezing the handle. I am short, so it was difficult for me to lift high enough and control the grabber at the same time.

The 24" grabber was perfect for laundry. The 36" grabber worked well for everything else, whether I was picking things up from the floor or reaching items on a high shelf.

MY SURGERY SHOPPING LIST: PAIN AND PHYSICAL COMFORT

15. Hysterectomy pillow

https://www.amazon.com/gp/aw/d/B0F9NRN58Y

A regular flat pillow works just as well as a special hysterectomy pillow. And after you heal, you won't be left figuring out what to do with a special-purpose pillow you no longer need.

A flat pillow is very helpful if you cough, sneeze, or laugh. Pressing it against your belly stops the shaking and reduces the pulling on the internal scar. You can also use it to hold a cold or hot pack, or use it in the car to get more comfortable.

A pillow you already own will do everything a hysterectomy pillow does without any extra cost.

16. Ice packs

https://www.amazon.com/FlexiKold-Gel-Pack-Standard-Large/dp/B0091IOISW

I expected to use ice packs a lot. In the end, I barely touched them. My external incisions did not hurt or itch. Even though I did not use them, I think having a couple of ice packs on hand is a good idea, so I still recommend buying them.

17. Heating pad

https://www.amazon.com/gp/aw/d/B07VYVBL71

My doctor mentioned that a heating pad can soothe painful muscles stretched by surgical gas, so I bought one. Since I never had gas pain, I did not end up using it. Still, it is another item worth having at home for various muscle aches and pains, so I recommend buying one.

18. Vibrating heating pad

https://www.amazon.com/dp/B085QKQMP1

I saw several references to vibrating heating pads and decided to try one. I was disappointed. I would describe the massaging feature as very mild. It was more of a buzzing than a real vibration. I found the buzzing distracting and annoying rather than relaxing. The main benefit came from the heat, not from the vibration. Heat increases blood flow, relaxes muscles, and reduces stiffness, which is why ordinary heating pads are widely used for pain relief.

The massaging part brought me no benefit, only added cost. I do not recommend it. A plain heating pad works better and costs less.

MY SURGERY SHOPPING LIST: BOWEL MOVEMENT HELP

19. Sunkist prunes

https://www.amazon.com/Sunsweet-Amazin-Pitted-Dried-Prunes-Unsweetened-Gluten-Free-Natural-Minerals-Resealable/dp/B092P48SJL

Prunes were critical to my easy recovery. I ate them in addition to laxatives and a stool softener during the initial days after surgery.

They helped me have an easy and practically strain-free bowel movement on day three. That was a huge relief. I ate three prunes with every meal, for a total of nine per day, until that important milestone.

After that, I stopped the laxatives and stool softener, but I continued to eat two or three prunes in my breakfast cereal to make sure I did not strain while I was healing. I think prunes are incredibly delicious, so they felt like a little treat every morning.

20. Prune juice

https://www.amazon.com/R-W-Knudsen-Organic-Prune-Juice/dp/B0FXQH9L1Q

During the early days of recovery, I also drank prune juice. I enjoyed the flavor, especially cold, right out of the refrigerator. However, I thought the dried prunes were more effective. If I had to choose between prune juice and prunes, I would go with the prunes.

MY SURGERY SHOPPING LIST: MEDICATIONS

21. Stool softeners and laxatives

Before my surgery, I had a phone conference with the surgeon's medical assistant, during which we went over my current medications. We also discussed the prescriptions the surgeon wanted me to use after surgery. They were for pain control and bowel movement help. I asked if I could fill them before surgery so they would already be at home when I returned from the hospital. This was not a problem, and she sent the prescriptions to my pharmacy right away.

She gave me a prescription for a stool softener: docusate sodium 50 mg / sennosides 8.6 mg. This is one pill that combines two ingredients. The docusate softens the stool and makes it easier to pass, while the senna helps the intestines move.

She also gave me a prescription for MiraLAX, polyethylene glycol 3350, which is a powder mixed with water or juice. It makes the stool softer and bulkier. The two medicines together help avoid straining.

In addition to these medicines, I also ate three prunes with every meal and drank a lot of water and juice. This regimen helped me have a pretty easy bowel movement on day three after surgery.

22. Pain relief

The medical assistant gave me a prescription for pain medication and told me to take the prescription pills or Tylenol as needed. In the end, my pain level was so low that I did not use either one, but knowing they were available to me if needed was comforting.

Worrying about being in pain does not help recovery, and having that safety net ready made the healing process less stressful.

Note that I generally prefer ibuprofen for pain relief, but my doctor told me not to use it right after surgery. Ibuprofen, like other nonsteroidal anti-inflammatory drugs (NSAIDs), can thin the blood. This can make it harder for blood to clot, which is important for healing after surgery.

23. Cough drops, cough syrup, and throat lozenges

My throat was irritated after surgery because of the breathing tube used during anesthesia, and that made me cough. Coughing caused my body to shake, and that movement pulled on the internal scar and was painful.

Having cough drops, cough syrup, and throat lozenges helped reduce the coughing and made me more comfortable.

24. Gas-X

https://www.amazon.com/Gas-X-Strength-Chewable-Tablet-Cherry/dp/B079MFPXRZ

I discussed Gas-X and gas pain in the questions "What can be done about surgical gas pain?" and "Does Gas-X help with surgical gas pain?" in the chapter "57 Questions I asked my surgeon." Even though Gas-X does not help surgical gas pain, it does help with bloating in the stomach, which is unrelated to the surgical gas. Some people feel better taking Gas-X because it gives them the sense that they are doing something proactive. Since the doctor said this drug causes no harm, I included Gas-X in my list.

MY SURGERY SHOPPING LIST: SEX

25. Cuff tear fears

One of the most common concerns I saw in the discussion groups was the fear of a cuff tear. When it happens, it is very painful and usually involves significant bleeding. As scary and memorable as these stories are, cuff tears are actually quite rare.

The most common cause is penetrative sex before the cuff has fully healed. It can also happen from excessive straining during bowel movements or from lifting heavy objects.

One way to ease some anxiety during the first intimate encounters is to use OhNut depth-limiting rings, which prevent deep penetration. Several companies sell them, for example, The Pelvic People.

Another way to overcome early fears of cuff damage is to experiment solo first. This can help rebuild confidence that nothing hurts and everything functions normally. Many women report that sex is actually better after a hysterectomy because the underlying problem that caused pain before the surgery has been removed.

MY SURGERY SHOPPING LIST: EVERYDAY ESSENTIALS

26. Cell phone and a long cell phone charging cable

https://www.amazon.com/Durcord-Upgarded-Charging-Compatible-Sam-Sung-Silver/dp/B0CL4WP7BP

When you are in the hospital, a cell phone lets you call family. You can also use the phone to listen to music or audiobooks to block out the hospital noise and pass the time. It is important to have a long charging cable because the outlet might be far from the bed, and you still want to be able to use the phone while it is charging.

27. Thermometer

https://www.amazon.com/Thermometer-Adults-Digital-Seconds-Reading/dp/B08B8BDG42

When I got home from the hospital, I checked my temperature every day. It is an easy way to notice any problems early, since a fever is a sign of infection. My discharge instructions included a phone number to call if my temperature went above 101.8°F.

28. Precooked meals

One of the most useful things I did before surgery was to cook and freeze as many meals as would fit into my freezer. It was nice not to have to worry about cooking or shopping for several weeks.

I cooked all my favorite meals, so I actually looked forward to my homemade frozen dinners. Each container had just the right amount for one meal. Most food freezes very well, but it can lose some flavor if you freeze and reheat it more than once.

29. Lip balm

https://www.amazon.com/Lip-Balm-Pomegranate-Moisturizer-Conditioning/dp/B00HJZT0YQ

One small thing I found helpful was lip balm. My favorite is Burt's Bees. Small comforts like this can make a surprising difference during recovery. Hospital air and indoor heating often make the air very dry, and it is easy for lips to become chapped. Having lip balm nearby is a simple way to stay comfortable. Little things like that do not seem important ahead of time, but when you are recovering and trying to rest, they can make the whole experience feel easier.

30. Mirror

https://www.amazon.com/MIRRORVANA-Hand-Mirror-Ergonomic-Handle/dp/B0CXGB63D3

I assume most people own a hand mirror, but if you don't, it is helpful to get one to watch the progress of healing of external incisions.

31. Home comforts

The last few things on my shopping list were regular everyday comforts. I made sure I was not running low on things like toilet paper, paper towels, toothpaste, toothbrushes, deodorant, books to read, and other small items I might need during recovery.

This will probably be a different list for each person, so I recommend looking around your home and making sure you are not about to run out of any of your personal essentials.

HOME PREPARATION

Getting prepared and organized is what keeps me calm. With all the items purchased, my attention shifted to making my home more comfortable after surgery.

Both my bedroom and my office with the computer are upstairs. Like many other women, I worried about the level of pain and my ability to go up and down the stairs right after surgery. I decided to set up a sleeping area downstairs in case it would be difficult for me to go upstairs. I also set up a computer I could use in the living room.

I did the laundry, washing all the bedding and clothing. I brought enough clean clothes downstairs to last a few days. I made sure that, if necessary, I could live on the first floor for the first few days. I arranged things so everything I might need was within reach without bending, since I did not know how flexible I would be right after surgery.

I installed toilet safety rails in the downstairs bathroom. I also made sure my freezer had plenty of ice packs and that my heating pad was ready to use near my bed. Alternating heat and cold is often helpful for pain control, and I wanted to be ready to use both.

While preparing the house, I also spent time cooking and freezing my favorite meals. I cooked as many meals as would fit into the freezer. I labeled each meal by name because once the containers get frosty, it is hard to tell one frozen dinner from another.

The hospital provided instructions for my pre-surgical preparation:

- I was to follow a low-residue diet for five days.
- Three days before surgery, I had to start showering with Hibiclens and changing the bedsheets every day so my clean body rested on clean bedding.
- I was to stop all vitamins and supplements five days before surgery.
- On the day of surgery, I was not to take any medications, including the blood pressure medication I normally take.
- I was not to eat any food on the day of surgery and was not to drink water starting two hours before surgery.
- I was to arrive at the hospital two hours before the scheduled surgery.

My hospital bag contained the following items:

- My photo ID (driver's license)
- My health care proxy
- Eye drops for my dry eyes
- Basic grooming items in case I stayed overnight
- Eye mask
- Earplugs
- Cell phone
- Charger and extension cord
- Earbuds for audiobooks on my phone
- COVID mask
- Reading glasses

- Travel tags attached to my bag with my name and phone number

I left my credit cards at home, as the hospital instructed. I also put a flat pillow in the car for the ride home.

The hospital made a note of all my medications, and the surgeon's assistant told me not to bring any with me. She explained that the hospital cannot use medications that patients bring. They have to dispense all medications themselves so they know exactly what and how much the patient has taken. The only exception was my eye drops. She said I should bring them and keep them in my purse.

I prepared comfortable clothes to wear to the hospital, loose pants and a loose shirt. I did not bring a nightgown because wearing the hospital gown makes it easier for doctors to reach what they need during checks. I also did not bring extra underwear, planning to wear the same things I arrived in.

I often see women asking what to wear to the hospital. My main suggestion is to wear what you are comfortable in. I did not have any trouble pulling my pants up or down after laparoscopic surgery. If you have an abdominal incision, then a dress might be more comfortable. I did not need a loose waistband because all my incisions were below the waist, so the waistband did not touch any sensitive areas.

You will not need pajamas. You will be in a hospital gown that opens in the back, and even if you stay overnight, your own nightclothes will not be very useful. The main goal is to give doctors quick access in case of an emergency.

With these preparations done, the day of surgery finally arrived.

THE SURGERY

The surgical options

Before my consultation, I kept hearing terms like total, partial, and radical hysterectomy. At first, it was confusing, so I spent some time trying to understand what those terms actually meant.

The key thing to remember is that the uterus and cervix belong to the same uterine structure. The ovaries are separate organs and are not part of the uterus. And the same is true for the fallopian tubes; they are organs in their own right.

Doctors often combine the removal of these organs during the same surgery. The long names of the surgeries simply list which organs or tissues are being removed. Breaking the words apart helped me understand what each part of the surgery description was saying.

• A partial hysterectomy removes the uterus but leaves the cervix in place. Partial means that part of the uterine structure is removed.

• A total hysterectomy removes both the uterus and the cervix.

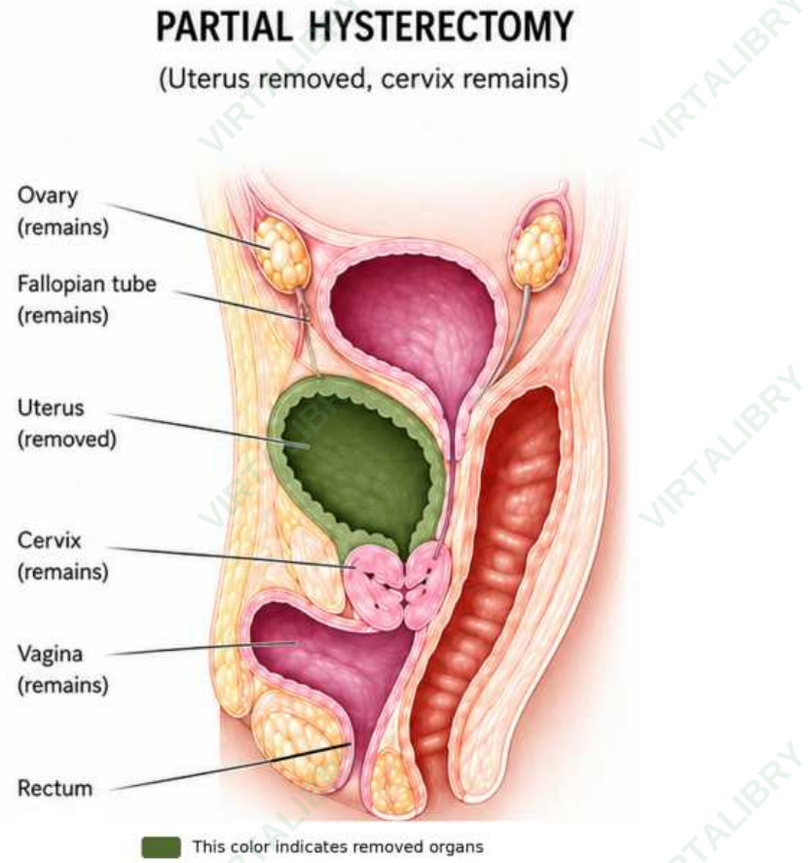
• A salpingectomy means removal of the fallopian tubes. If both tubes are removed, it is called a bilateral salpingectomy.

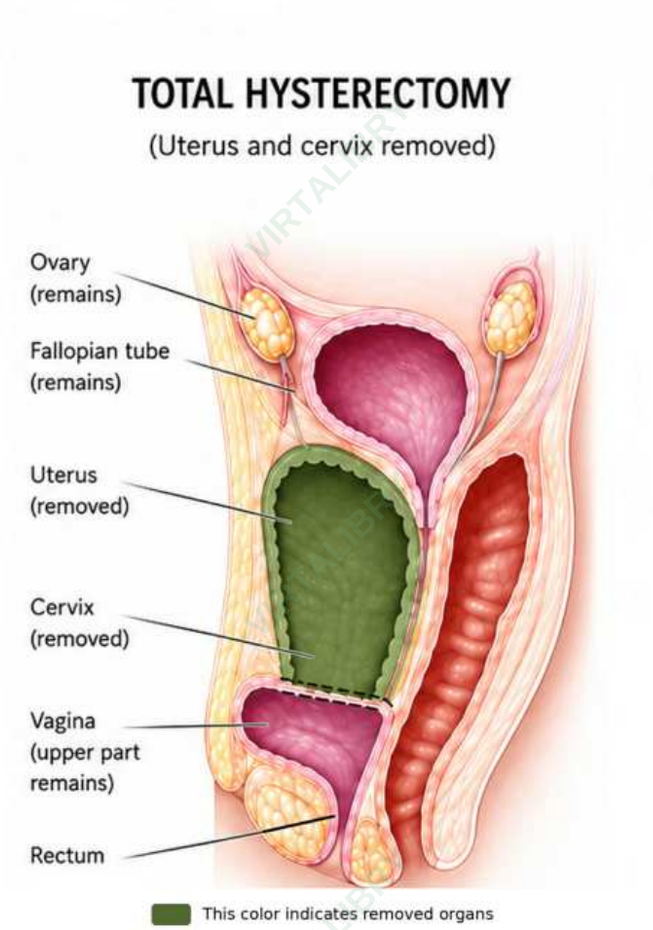
• An oophorectomy means removal of the ovaries. If both ovaries are removed, it is called a bilateral oophorectomy.

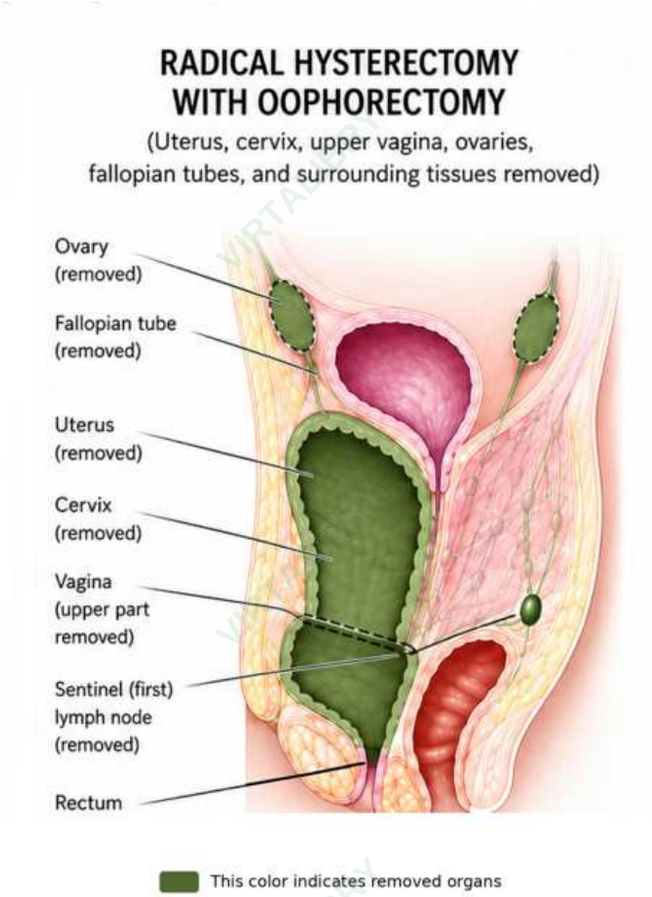
• A lymphadenectomy means removal of nearby lymph nodes so they can be checked for cancer cells.

• A radical hysterectomy removes the uterus, cervix, surrounding tissues, the upper part of the vagina, and usually nearby lymph nodes.

For example, a total hysterectomy with bilateral salpingo-oophorectomy and lymphadenectomy means the uterus, cervix, fallopian tubes, ovaries, and nearby lymph nodes were removed during the same surgery.




TOTAL HYSTERECTOMY
(Uterus and cervix removed)
Ovary (remains)
Fallopian tube (remains)
Uterus (removed)
Cervix (removed)
Vagina (upper part remains)
Rectum
This color indicates removed organs

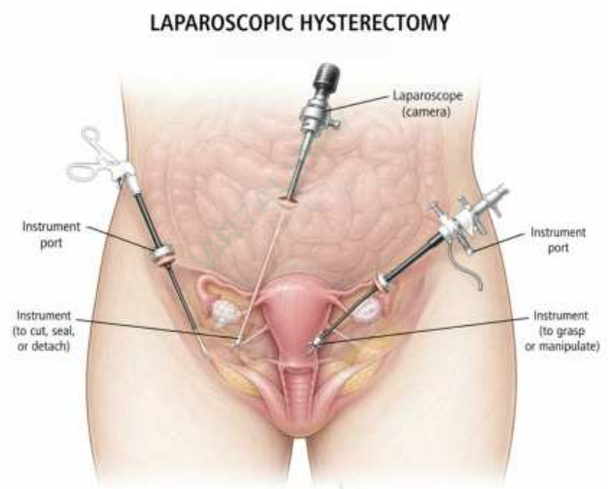

RADICAL HYSTERECTOMY WITH OOPHORECTOMY
(Uterus, cervix, upper vagina, ovaries, fallopian tubes, and surrounding tissues removed)
Ovary (removed)
Fallopian tube (removed)
Uterus (removed)
Cervix (removed)
Vagina (upper part removed)
Sentinel (first) lymph node (removed)
Rectum
This color indicates removed organs

HOW THE SURGERY CAN BE PERFORMED

There are three main ways a hysterectomy can be performed.

- A laparoscopic hysterectomy, done manually or with the aid of a robot, uses small incisions in the abdomen, usually about a quarter-inch wide. Surgical instruments and a camera are inserted through these openings. The uterus and other organs are removed through the vagina.
- A vaginal hysterectomy is performed entirely through the vagina. No abdominal incisions are needed.
- An abdominal hysterectomy involves a larger incision in the abdomen, typically six to eight inches long. The organs are removed through that incision.

Recovery is usually faster after laparoscopic or vaginal surgery. However, open abdominal surgery may be necessary if the uterus or fibroids are too large to remove through the vagina.



While preparing for surgery, I found many discussions online about whether laparoscopic or vaginal surgery is "better." The reality is that each method has advantages and limitations.

The key thing, however, is to let the surgeon choose the procedure they are most skilled at performing. That will make the biggest difference in the outcome.

I found a detailed comparison of vaginal and laparoscopic procedures in a medical review article, which I include in the references at the end of the book. That article goes into the advantages and limitations of laparoscopic and vaginal approaches in a lot of detail.

PRE-SURGICAL APPOINTMENT

My pre-surgical appointment with the surgery coordinator was a few days before the surgery. It was done over the phone, so I did not have to drive into downtown Boston.

During the call, she sent my prescriptions to the pharmacy and emailed me a PDF with instructions on how to prepare for the surgery. The instructions covered things like the low-residue diet and the Hibiclens regimen, as well as the restrictions after surgery.

One of her instructions surprised me. She told me not to take my blood pressure medication on the day of surgery. She explained that my blood pressure would be controlled with anesthesia medications during the procedure. Jumping ahead, my blood pressure was normal after the surgery. The day after surgery, I returned to my regular medication schedule.

GENETIC TESTING

When my biopsy results came back, some markers in the report suggested the possibility of genetic changes in my tumor cells. Genetic changes, also called DNA mutations, mean the genes that normally control cell growth are altered or damaged. Some mutations happen only in the tumor as normal cells become cancer cells, while others can be inherited and affect future risk for other cancers, like a BRCA gene mutation. Because of those markers, the pathologist who analyzed the biopsy sample recommended genetic testing to understand the mutations better, find out if any of them were inherited, and help guide treatment after surgery. We discussed these markers during my pre-surgical consultation, and the surgeon gave me a referral to a genetic testing specialist.

I met with the specialist over Zoom. We discussed my family history as well as the results of my biopsy. She concluded that I was a good candidate for genetic testing. I had a choice between running the entire panel of known genetic markers or testing only for the BRCA gene. I chose to do the whole panel to gather as much information as possible.

The genetic test itself is a blood test. The results take about three weeks, so they arrived shortly after my surgery. The surgeon explained that this timing worked because the results would guide decisions after surgery rather than change the surgery itself.

After the results came in, we had another Zoom meeting to discuss them. Waiting for results when you do not know what they will show is always stressful, but having more information helps doctors determine the right treatment.

Of course, cancer can happen without known genetic markers, and not everyone with these markers develops cancer. However, the probability of cancer is higher for people who carry them. The genetic counselor shared that women with a BRCA1 mutation have a 55–65% chance of developing breast cancer by age 70, and those with a BRCA2 mutation face about a 45% chance. In comparison, the general population averages about a 12% lifetime risk.

Women with a BRCA1 mutation are at a 39–44% chance of developing ovarian cancer by age 80, while those with a BRCA2 mutation have about a 20% chance. The general population risk is less than 1–2%.

My results came back negative, and it was good to have that weight off my mind.

SURGERY DAY: BEFORE SURGERY

The day before the surgery, I received a call confirming that the time for my surgery had been locked in. Until that call, my surgery could still have been moved if someone with a more urgent problem needed care.

The hospital booked my surgery for the afternoon, so I did not have to rush too much in the morning. The pre-surgical instructions called for no food after midnight, but I could drink water up to two hours before the surgery. I had to remove my earrings and any other body piercings if I had them, and not use deodorant. I took my final Hibiclens shower, made a quick check of the items in my hospital bag, and then we headed out for the one-hour drive to the hospital.

When we arrived at the hospital, I was immediately taken for a blood test to double-check my blood type and for an EKG to check my heart. I did not need a separate physical before the surgery because this testing was done right before the procedure.

My surgery was scheduled for 3:00 p.m., and about half an hour before that, a nurse led me into a curtained-off area to change from my street clothes into a hospital gown. She placed all my belongings on the shelf under the gurney. She also gave me a cap to cover my hair.

Once I was lying on the gurney, covered with a warm blanket, they gave me a shot of heparin in my thigh and inserted IVs in both of my arms. The IVs were done flawlessly. They needed only

one try for each arm, and it was completely painless. It made me feel confident seeing how skilled the nurses were, especially because I had a very different experience during my previous surgery.

The surgery took place in a teaching hospital, and during my pre-surgical consultation, I asked my surgeon if he would be the one doing my surgery. I wanted to make sure it would not be a resident learning on me. He explained that many surgeons and doctors are involved in each procedure. He said he would be the one removing the organs, the resident would close the incisions, and the anesthesiologist would monitor me while I was under. He also said there would be other doctors involved in the procedure as well.

I saw some comments in discussion groups where women advised avoiding teaching hospitals because there are extra people involved in the procedure and more people seeing their private parts. I disagree with that thinking. Teaching hospitals are often among the best hospitals in the country. I would rather go to a great hospital with extra observers than to a less experienced hospital with a smaller team.

While the nurses prepped me for surgery, several doctors stopped by to talk with me. When the anesthesiologist came to introduce himself, I told him about my dry eyes problem. He said he would make sure to put eye drops in my eyes before bringing me out of anesthesia. He asked for my eye drops and put them in the pocket of his jacket after making a few notes in my chart.

Then one of the nurses smiled at me and asked if I was ready to take a trip. I nodded, and she rolled the gurney into the operating room.

SURGERY DAY: THE SURGERY

The surgeon's note said that I should be positioned while awake, so I learned some interesting details about the operating room. The nurse rolled my gurney next to the operating table and told me to slide over onto it. As I slid to the right, I expected to touch a cold metal surface. However, to my complete surprise, I discovered that the operating table wasn't the cold metal I expected. It was covered with soft foam, which reminded me a lot of memory foam.

I asked the surgeon's assistant, the resident who had introduced himself earlier, why the operating table did not have a metal surface like the ones I had seen on medical shows. He laughed and explained that if it were metal, I would slide off the table during surgery because the table is tilted. This tilted position is called the Trendelenburg position and usually involves a tilt of about 15° to 30°, with the patient's feet positioned higher than the head. The tilt allows the bowels to slide upward toward the diaphragm and gives the surgeon better access to the pelvic area.

The nurses placed my feet into stirrups, which were also covered with soft foam and supported my entire calf from the heel to the knee. I found these stirrups much more comfortable than those used during routine gynecological exams.

Once they tilted the table, with my feet slightly above my head, the resident asked if I felt comfortable. Surprisingly, I did.

After that, they placed the mask on my face. I asked if I should

count backwards. I guess they do not do that anymore because the resident laughed again and said, “Sure, count backwards every other number.” I did not even have time to say a single number before I was out.

After the surgery, the surgeon posted a detailed report describing exactly what was done during the procedure. Reading it later helped me understand exactly what happened during the procedure.

The surgeon performed the surgery laparoscopically through four small incisions near my belly button, each about a quarter of an inch long. He used carbon dioxide gas through a needle inserted into the central incision to gently inflate my abdomen so he could see and work inside more easily. Then he removed the inflation needle and placed a tiny camera called a laparoscope through the same opening. The camera stayed there while the surgical instruments passed through the other incisions.

The surgeon detached the uterus from the ligaments and blood supply that held it in place and then removed it through an incision made at the top of the vagina where the cervix had been.

Because of the cancer diagnosis, the surgeon also removed the first lymph node that drains the area around the uterus. This is called the sentinel lymph node. A tracer dye is injected near the tumor area, and it travels through the lymph channels to that first node. If that node does not contain cancer cells, it is a good sign that the other lymph nodes are not involved.

The report also noted that the surgeon rinsed the pelvic area with saline solution, and the fluid was sent to the lab to check for cancer cells. In the pathology report, they referred to this as pelvic washing. Then the surgeon sutured the internal incision at the top of the vagina, creating the vaginal cuff. He used surgical glue to cover the small external incisions. This allowed me to take showers as soon as I came home because the skin incisions were sealed and protected.

Two details caught my attention. One described the type of

thread used to close the vaginal cuff. The surgeon used a PDS dissolvable suture with tiny barbs along the thread. The barbs allow the thread to grip the tissue so the surgeon does not have to tie many knots, and the thread slowly dissolves over time as the tissue heals. The other detail that surprised me was how little blood I lost during the surgery: only 20 mL, which is about four teaspoons.

I opened my eyes what seemed like seconds later, feeling well and refreshed. I was not groggy, not nauseous, and not in pain. My eyes were pleasantly moist, not dry at all. I noticed I was very hungry, completely starving to be accurate. It was after four o'clock, and I had not eaten all day. Many women worry about nausea after anesthesia. It was nice to wake up hungry instead.

SURGERY DAY: AFTER SURGERY

The surgery started at 3 p.m., and my family received a text at 4:20 p.m. saying that I was in the recovery room. I don't know exactly how long it took them to send the message, but it is safe to assume that the surgery itself took less than one hour and twenty minutes.

Later, they moved me from the recovery room to the observation bay, where patients are monitored after surgery. A fabric curtain surrounded my bed, which gave me some privacy. The staff did not allow visitors in this area, probably to reduce the risk of infection, but I also appreciated that it kept conversations to a minimum and helped keep the area quiet. In my past hospital stay, hearing constant chatter between patients and visitors made it difficult to rest, whereas the noise level stayed pretty low in this area.

The nurse asked if there was anything I wanted from my bag, and I took out my cell phone, my earplugs, and my eye mask. Then she put the bag back under the bed. She also handed me a menu and asked if I would like to order dinner. I don't remember what I ordered, but I thought the food tasted delicious. I suspect a lot of that had to do with not eating all day!

After the surgery, I woke up with a Foley catheter, which has a small inflatable balloon at the tip that keeps the tube in place inside the body, and compression booties on my legs to prevent blood clots. Both stayed on me until the morning. The catheter

didn't bother me at all, but the booties kept moving and compressing my legs, and that movement woke me up several times during the night.

Other than being woken up by the booties, I rested very comfortably in the observation bay. The nurses were amazingly nice and responsive. When I needed something, the nurse would be by my side while my hand was still moving away from the buzzer.

My insurance billed this as day surgery because spending the night in the observation bay does not count as a hospital stay. The insurance company told me that if I had been assigned a room, it would have been considered a hospital admission, whereas the observation bay is not.

The catheter was removed in the morning after the nurse used it as part of a bladder test. The nurse filled my bladder with 200 mL of saline solution and then removed the catheter. The removal didn't hurt. Then she asked me to go to the bathroom and pee into a cup so she could measure how much fluid came back out. The nurse explained that if I had a small cut somewhere in the bladder or urethra, the liquid would leak along the way, and I would produce less than she had put in during the test.

I wondered if I would be able to pee right away. The nurse told me they would not release me until I successfully managed to pee. She said not to worry; they would wait no matter how long it took. Fortunately, I had no trouble going to the bathroom. The only difficulty was making sure I caught all the pee in the cup. I am not used to needing to aim while I pee! This test was not unpleasant; plus, it had a big benefit. If there was any damage, the doctors would know before I left the hospital so they could repair it. Small nicks in the bladder that went unnoticed might lead to infection.

Overall, I was doing well. I was not in pain. I had no trouble getting up from bed without help and walking around. The resident from my surgical team came by to see me and examined the incisions on my belly. He jokingly said, “I did a great job, I have to

say. Your incisions look great!" He asked me how I felt and, after looking at the nurse's notes, he cleared me to go home.

After I was cleared to go home, the nurses told me to get dressed and then surprised me by giving me a lot of freebies. One nurse gave me at least half a dozen mesh surgical panties. I also had one pair already on when I woke up. These panties are made of mesh and allow air to circulate around the incisions. Another nurse asked if I wanted the heavy blanket they had folded many times into a small square and placed on my belly overnight. For some reason, the heaviness of the blanket provided a lot of comfort, so I said, "Yes!"

The nurses noticed that I kept coughing because the breathing tube had irritated my throat. They asked if I wanted to take a flat pillow to hold against my belly. They told me that coughing would be less painful if I pressed the pillow against my belly. They also gave me a large number of sanitary pads. When I came into the hospital, my duffel bag was almost empty. When I headed home, it was stuffed. Not something I expected, and it left me with the sense of being very well cared for.

While we waited for my ride to arrive, the nurse explained the details of my discharge papers. The instructions stated not to lift anything heavier than a carton of milk. The nurse covered instructions related to sex: no sex for eight to twelve weeks and, in general, not to insert anything into the vagina. However, external stimulation was okay after three weeks.

My incisions were covered and sealed with surgical glue, which meant showering right away was fine. The instructions said to let only water run over the incisions. No soap, no oil, and no cream on the incisions until the glue falls off. The instructions also said to gently pat the incisions when I dry them so there is no rubbing of the skin.

A nice trick for drying the belly button without scrubbing is to use a hairdryer. This works really well, especially if you have a deep one. The warm air dries the area without rubbing.

The instructions told me to take a laxative and a stool softener until the first bowel movement. If my temperature rose above 101.8°F, I was to call the hospital. It also stated that light spotting was okay, but if I was saturating more than one pad an hour, I should call the hospital.

I was told to walk as much as possible without experiencing pain.

I was glad the nurse went over the discharge papers with me instead of just handing them to me. By the time I left, I understood what to watch for, what not to do, and when to call the hospital.

SURGERY DAY: THE DRIVE HOME

The thought of the trip home after my hysterectomy made me really nervous. With the timing hitting rush hour, I knew the drive would be well over an hour. When my ride arrived, I told the nurse. She gave me my pain pills and told me to get comfortable in the wheelchair with my overstuffed duffel bag.

Getting in and out of the car turned out easier than I expected. During the ride, I held the pillow against my belly for support, and it helped. Even going over potholes didn't hurt.

We had a funny moment on the way back. I was starving, so we swung by a fast-food place. Apparently, we drove into the exit entrance by mistake. Out of nowhere, a police car pulled up with flashing blue lights.

The officer walked over and said, "You entered through the exit."

My friend looked appropriately guilty, gestured toward me, clutching my pillow, and explained, "We are on our way home from the hospital. She had surgery, she's hungry, and I was just trying to get her food as quickly as possible. I did not realize it was an exit. Sorry, officer."

I guess I looked pretty pathetic, because the officer nodded and said, "Alright, go ahead and get her food. But don't do it again!"

We laughed about it later, crisis averted, and I got my meal.

Before the surgery, I was aghast that I would be sent home so quickly after major surgery. But it worked out just right. I felt

fine, and I was much more comfortable at home than in the hospital.

AFTER SURGERY: WEEK 1

Since I had no idea how debilitated I would be after surgery, I hired a helper through my insurance for two visits to help with cleaning, laundry, and taking out the garbage. The insurance company found someone in its network, and we exchanged a few texts to set up the first visit a few days after my surgery. Two days before the surgery, she canceled. The insurance company failed to find a replacement in time. That really stressed me out.

Surprisingly, the surgery didn't leave me debilitated at all. Some friends had offered to come and help with chores, but I found myself totally self-sufficient and able to do everything I had expected the helper to assist me with. It surprised me how well my body handled the surgery.

The pain getting up from the bed after surgery worried me more than anything else. Fortunately, the laparoscopic procedure made it far easier than I expected, as the surgery left the core muscles needed to raise myself from the bed intact.

However, for those who have abdominal surgery, I want to recommend looking up the roll technique for getting out of bed. There are good YouTube videos that demonstrate it. I learned this technique after my back surgery and found it incredibly helpful because it taught me how to use my legs and their momentum to get up.

I had no pain unless I coughed. I did not take any medications once I got home. Even Tylenol turned out unnecessary. When I

sensed a cough coming, I would grab my trusty pillow and press it against my belly. That stopped the shaking that tugged on my internal scar and stopped the pain.

In fact, during the first day after the surgery, I wondered if they had actually done the surgery. I did not understand how they could have removed a bunch of organs and left me with less pain than I would have with a scrape on my knee. But then I coughed, and it hurt. In an odd way, I felt relieved. Okay, they did the surgery.

I had no bleeding, spotting, or discharge. I still wore sanitary pads, just in case, because the doctor said spotting might happen when the stitches started to dissolve. I also had no unusual or bad odor. At the hospital, the nurses told me that a bad odor can be a sign of infection and is something not to ignore.

I did have to be careful and slower than usual. For example, when doing laundry, I took out one wet item at a time so I would not go over the weight limit. I used a grabber to reach into the washer so I did not have to lean over the edge and press on my incisions.

If I wanted to vacuum, I would roll the vacuum over the wood floor without pushing hard, and I never emptied it because doing so required lifting the vacuum. I kept the garbage bags light. Taking them out was not a problem because I already did a lot of walking as part of my healing routine.

My discharge notes had no restrictions on bending. I could bend without pain, but I still tried not to do it, using my grabber when I dropped things on the floor.

I came across some discrepancies in the discussion groups about bending restrictions and hernia risk. That happened because some women shared recoveries from open surgery, while others were talking about laparoscopic surgery. With laparoscopic surgery, the incisions are very small, approximately ¼ inch long, so the abdominal wall is affected much less. With open surgery, the incisions measure around six inches, and a cut of that size raises

the risk of a hernia.

It also depends on what you are bending to pick up. Reaching down to pick up a piece of paper is usually not an issue. Bending to lift a laundry basket or a toddler is an entirely different situation and carries a much higher risk.

Before my surgery, I set up a bed downstairs in case walking up the stairs would be painful. It turned out the stairs were not a problem, and I was able to sleep in my own bed on the second floor. I did not need the recliner to help me get up from the bed because I could do it without pain. However, the recliner did come in handy because I coughed less when my back was more upright. So for the first two nights, I slept in the recliner because coughing woke me up when I was lying down. In the end, I did use the recliner, but for a totally different reason than the one I bought it for.

For the first week after surgery, my main activity was walking. The doctor said that walking would be my best medicine, so I treated walking like a job. I started with walks of about ten minutes followed by ten minutes of rest, then another ten minutes of walking and ten minutes of rest, and slowly increased the amount of continuous walking. It was winter, so I walked mostly inside because I did not want to slip and fall on snow or ice. I did not keep track of minutes, but my goal was to walk at least 5,000 steps a day, starting the day after surgery.

I listened to audiobooks while I walked so it wouldn't get boring and so I didn't have to stay tied to the TV for entertainment, since the TV couldn't move with me. In the afternoons, I would get very sleepy. My eyes would grow heavy and start to close. As soon as that happened, I would take a twenty-minute nap. I discovered that if I slept longer than that, I would wake up groggy and then not sleep well at night. So I used a kitchen timer to wake me up.

These naps really worked. I was completely recharged afterward and was not tired anymore. I had always thought the idea of

power naps was just a catchy phrase, but I discovered they worked for real. Many women ask if it is normal to be so tired. It is. I got really exhausted in the afternoons, especially in the first couple of weeks. It makes sense: the body is using a lot of energy to heal. The good news is that this fatigue goes away with time. For me, it took about three weeks. For others, it can take longer or pass sooner.

My appetite did not really change after the surgery. I was able to eat normally. I just tried to drink more liquids than I usually do to help with bowel movements. I have seen some women mention that they are less hungry in the first days after surgery. That was not my experience, but it seems to happen to some people.

I noticed that many women in support groups ask about the best sleeping position. I used to be a side sleeper, but after the surgery I was much more comfortable sleeping on my back, with a flat pillow under my knees. Over time, it became my favorite position. Even though I am not uncomfortable on my side, I now spend most of my time sleeping on my back.

I ate my precooked frozen meals. I drank a lot of water and juice. I ate three prunes with every meal as both a treat and a way to help keep bowel movements soft. I also took laxatives and stool softener medications.

The big achievement during the first week was a bowel movement on day three. Thanks to my regimen of medications and prunes, it was relatively strain-free. It was quite a relief to accomplish that task.

After that, I stopped the medications but continued eating three prunes with every meal for another two weeks. Then I cut down to three prunes with breakfast. You know it is time to cut down when the bowel movements get too watery. The goal is soft but solid.

My doctor cleared me to drive as soon as I was not taking pain medications. Since I did not take any pain medications, when I needed to drive for a short errand on day four, I checked that

the braking motion didn't hurt and went ahead with it. It was so good to be able to do regular things again.

I had one minor issue that I did not expect. I had what I would describe as a mild groin pull after the surgery. I felt it on the right side when I positioned my leg a certain way while walking or when lying down. I did not have this pain before surgery, so I connected it to the way my legs were positioned during the operation. It was not severe, but it took about six months to heal enough that I no longer noticed it.

AFTER SURGERY: WEEK 2

My coughing improved day by day and stopped completely after one week. By the middle of the second week, I wanted to get back to work. I began working part-time remotely, which still left me plenty of time for walking and taking my power naps in the afternoon.

By the end of the second week, I was comfortable going on long rides as a passenger. We often go on weekend trips, and I was ready to resume them. For us, these rides are typically two or three hours each way. We did make a small accommodation for my recovery, stopping every hour so I could take a short walk and use the bathroom. Overall, I was pretty much back to normal, other than avoiding lifting heavy items and sex. Mentally, I felt like myself the whole time. I was not emotional. I was relieved. I know that is not the case for everyone. Some women describe feeling emotional, anxious, or low during recovery. That is something to be aware of. It is not unusual, and for most, those emotions settle down over time.

I made it a daily habit to log into the hospital portal to see what new information had been posted about my surgery. I found detailed notes about everything that was done during the procedure, various blood tests, and eventually, about ten days later, the pathology report.

The report contained a lot of medical terminology, which I copied and pasted into my favorite AI chatbot and asked for a plain

English translation. The easy-to-understand version was very helpful. It gave me a chance to fully understand the report and prepare a list of questions for the surgeon. I did not have to spend time asking the doctor what each term meant. This is not the same as getting medical advice from AI. In this case, AI is acting as a translator of the information provided by the lab.

Often, people struggle with what to say to someone after surgery. It can be hard for them to figure out what might be helpful. It is uncomfortable. It is not that they do not care; it is that people often get uneasy around someone who is not well.

At one point, I asked someone close to me, "Why are you minimizing my surgery?" He said, "To make you feel better, so your recovery is easier." Hearing that answer was actually helpful. I am glad I asked. It helped more than quietly getting upset because I thought he did not see my surgery as a big deal.

Sometimes what people think will help you is actually the opposite of what you want to hear. But they mean well.

AFTER SURGERY: WEEK 3

During the third week, I worked eight-hour days, but stretched them out longer so I had time to get up every hour for a short walk and rejuvenate myself with an afternoon nap.

In the middle of the week, I noticed something in the toilet that looked like half-cooked rice vermicelli. The pieces were translucent and off-white in color. I remember staring at them for a few seconds, thinking, what the heck are those? What did I drop in there? Finally, I realized I was seeing some of my stitches after they came loose and got washed out when I peed.

Even though the doctor had warned me that I might have some bleeding when the stitches dissolved, I did not have any spotting.

How long it takes for stitches to dissolve is a common question, and I learned there is no single answer. It depends on what type of suture the surgeon used. My surgeon used a PDS dissolvable suture, which can take several months to fully dissolve. What I did not realize was that they do not just dissolve all at once. They slowly break down over time, and small pieces can come loose earlier while the remaining thread is still holding the incision together.

In the first three weeks, I lost 5 pounds, and as I write this book, my weight has stayed steady at that level. Overall, I felt so good that I had to mentally remind myself I was still healing because I felt like I could do more than I knew I should.

FOLLOW-UP APPOINTMENT

My post-surgical follow-up appointment took place three weeks after surgery. This appointment was mostly a conversation and did not include an internal exam. The surgeon said that since I felt well, with no discharge and no pain, he preferred not to do an internal exam that might disturb the healing tissues. His approach was to protect the healing process, but if I had reported any problems, he would have examined me.

The doctor took a quick look at my external incisions, and then we spent the rest of the time discussing the pathology results and going over my post-surgery care. I also got a chance to ask more questions.

WHY SOME RECOVERIES ARE MORE PAINFUL

I told the doctor I expected to have more pain and asked if it was unusual to feel so little discomfort after the surgery. He said it is common in his practice because early-stage cancer is usually a small lesion in an otherwise healthy uterus, so recovery is often not very painful. He explained that more painful recoveries tend to happen when the surgeon has to do a lot of additional work, such as removing adhesions, which are bands of scar-like tissue that can form after chronic inflammation or previous surgeries and make organs stick together. This extra work causes more trauma during surgery and leads to a longer and more painful recovery.

Since I did not have adhesions, he was not surprised that my recovery had been nearly pain-free. He told me to continue doing what I was doing and to avoid sex and lifting heavy items for at least another five weeks.

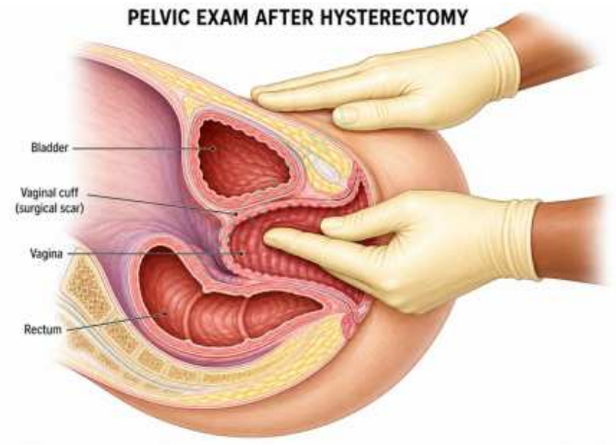
WHY FOLLOW-UPS ARE NEEDED

I asked the doctor if I needed to see him again. He told me that I would need regular follow-ups with a gynecologist every six months for five years, and then once a year for another five years. However, I did not need a gynecologic oncologist like him anymore because I no longer had cancer. I was a little disappointed because I thought he was a great doctor and I liked how patiently he answered my questions. But I understood that there were women who needed him more than I did.

I asked him why I still needed regular follow-ups if the uterus and the cancer had already been removed.

He explained that endometrial cancer is usually slow-growing and tends to spread locally first, which is one of the reasons it is often caught early. But there is always a chance that a small number of cancer cells could have already left the original tumor before surgery. Those cells can travel through nearby tissue, the lymph system, or the bloodstream and settle somewhere else in the body, where they can start growing again.

He told me that for early-stage cases like mine, the risk of recurrence is relatively low, generally in the range of about 5–10%. When recurrence does happen, it is most often local, meaning in nearby areas such as the top of the vagina. This is why regular internal exams are done to catch it early, even though the chances of it happening are not high.



During the exam, the doctor looks at the vaginal cuff with a speculum and also feels the area with a manual exam. He asks about symptoms like bleeding, discharge, or pelvic pain. A cancer lesion would look different from the surrounding tissue. It might have a different texture and be thicker or lumpier. Bleeding or spotting is often the first noticeable sign and should not be ignored. A diagnosis of uterine cancer is scary, but the most common form of endometrial cancer is curable, especially when it is caught early.

HORMONE THERAPY AFTER CANCER

There are very strong opinions about the necessity of hormone therapy after a hysterectomy. So I asked my oncologist about hormone treatments. He explained that cancers like endometrial, ovarian, and breast cancer are often hormone-sensitive. This means the cancer cells have receptors for hormones like estrogen, and those hormones can stimulate them to grow.

For someone who has never had cancer, the discussion about hormone therapy is different. Some newer studies suggest hormone therapy can be safe for some women with no cancer history. These studies clearly state that their findings do not apply to women who have had cancer.

Once there has been a cancer diagnosis, especially a hormone-sensitive one, the situation changes. The concern is no longer just about managing menopause symptoms. The concern becomes whether additional hormones could act as fuel for any remaining microscopic cancer cells.

Even though my uterus was removed, the doctor explained that recurrence can still happen in other places, such as the vaginal cuff, pelvic tissue, or even the lungs. These are not new cancers. They are the same type of cells that may have spread before the surgery. If those cells are hormone-sensitive, then hormones could stimulate them.

Because of this, hormone therapy is not recommended in situations like mine. Based on my personal and family history, my

doctor felt that the risk was not worth taking, and I chose not to use hormone therapy.

He also gave me an example of how something harmless-sounding is not always neutral. Some substances can be converted by the body into estrogen. For example, DHEA is a hormone the body naturally produces in the adrenal glands. It is also sold as a supplement. The body can convert DHEA into estrogen. After menopause, when the ovaries are no longer producing much estrogen, these sources can become a more noticeable part of the total hormone level.

I saw some women online strongly recommending hormone therapy for everyone. I understand they meant well and were speaking from their own experience. But what is right for one person is not necessarily right for another. Each case is different, and the details matter.

For me, the decision was simple. The risk of recurrence may be low, but it is not zero. I did not want to do anything that might increase that risk, even slightly.

THE SIX-MONTH FOLLOW-UP

A Pap smear

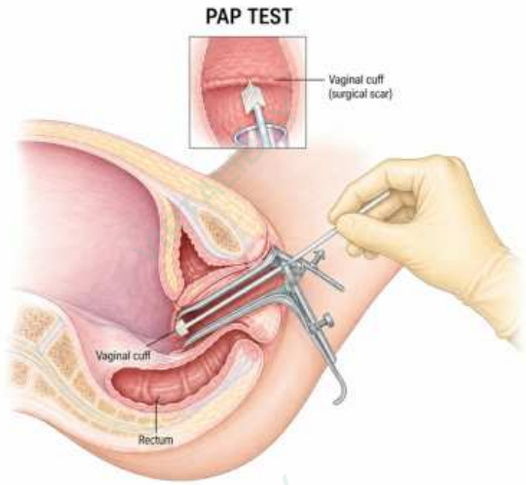
Six months after my surgery, I saw a gynecologist for my first follow-up appointment. I was not sure what to expect. After the nurse took my vitals, she told me the doctor would be doing a Pap smear.

"A Pap smear?" I asked, looking at her with surprise. "But… I don't have a cervix to swab!"

She explained to me that this time the doctor would be swabbing the scar. It made sense. Since I no longer had a cervix, the cells had to be collected from the vaginal cuff instead.

During the appointment, in addition to the Pap smear, the doctor looked at the vaginal cuff and pressed on my belly from the outside. I asked him how it looked, and he said the scar looked well-healed and not irritated. The test was not painful. It felt just like all my previous Pap smears.

I read that not every doctor does a Pap smear after this type of surgery, but mine did. I was glad because I wondered how a regular gynecologist, who is not a cancer specialist, would be able to tell if there was a recurrence. Sending cells to the lab made the follow-up seem more complete to me and made me feel much more confident that any abnormal cells would be detected early.



I remembered what my oncologist had told me, that if uterine cancer comes back, it usually shows up close to where the uterus was, at the vaginal cuff. So that is where they collect the cells. Now his explanation and this test all fit together.

Vaginal atrophy

During our discussion about how everything was healing, the gynecologist said the surgery site looked very good, but he also noticed signs of vaginal atrophy.

I asked him to explain what it meant. He said it meant the vaginal walls were thinning, because the tissue appeared more pale than in a premenopausal woman. This happens when the body produces less estrogen, which for me had started with natural menopause, not the surgery. Even though he could see the pale tissue that signals thinning, I did not have any symptoms, at least so far.

I was not sure what vaginal dryness would feel like. I asked what symptoms it caused. He said it can show up in different ways. Some women have itching or vaginal burning. There can be pain or light bleeding with sex, and sometimes watery discharge from irritation or white flaking in the underwear. He also mentioned urinary urgency, minor incontinence, like small leaks when sneezing or laughing, and frequent urinary tract infections. He explained that infections can result from small tissue tears, which can happen from normal activities like vigorous wiping, as well as from sex.

He also explained something I did not know. Even after natural menopause, the ovaries are not completely inactive. They still produce small amounts of hormones, mainly androstenedione and testosterone. Fat cells then convert those hormones into a weaker form of estrogen called estrone. This creates a small “trickle” of estrogen, which helps keep vaginal tissue somewhat healthy. When the ovaries are removed, the ovarian part of the trickle stops, which contributes to the thinning of the vaginal walls.

He told me that if there are no symptoms, there is no need for treatment. He also said staying physically active helps improve blood flow in the pelvic area, which keeps the tissue healthy.

Vaginal atrophy treatments

I asked him about possible treatments in case I started having symptoms later. He went over a few options that are considered relatively safe for uterine cancer survivors, noting the risk for each:

Moisturizers: no estrogen-related cancer risk. These help hydrate the existing tissue and are available over the counter. They are usually applied inside the vaginal canal with an applicator a few times a week.

Hyaluronic acid: no estrogen-related cancer risk. This provides deeper hydration and is often used by cancer centers. It is typically used as a vaginal gel or suppository inserted into the vaginal canal.

Laser therapy: no estrogen-related cancer risk. This uses light to stimulate collagen. The downside is that it is very expensive. This is done in a doctor's office, not something you apply yourself.

Vaginal estrogen: low cancer risk, but not zero risk. This helps reverse thinning of the tissue and requires a prescription. It is usually applied locally as a cream, a small tablet, or a ring placed inside the vaginal canal.

He also gave me a more practical list of what to use and what to avoid. For everyday dryness and itching, he mentioned products like Replens, Hyalogyn, Good Clean Love Restore, PrevaLeaf Oasis, and Emerita. For sex, he suggested water-based lubricants like KY Jelly or Astroglide, and said silicone-based ones last longer because they are not absorbed by the skin. He specifically mentioned avoiding Vaseline, because it can block pores and increase irritation and infection risk.

For daily comfort, he said some women use simple options like vitamin E suppositories or small amounts of oils such as olive, coconut, grapeseed, sunflower, or apricot oil. He also told me to

avoid anything scented or flavored, since those can be irritating.

One thing he pointed out that I would not have thought about is that some "natural" products are not necessarily neutral. Things like wild yam, black cohosh, and kudzu can have estrogen-like effects. For someone with a history of hormone-sensitive cancer, that is something to discuss with a doctor before using, and his advice to me was to avoid them.

THE TWELVE-MONTH FOLLOW-UP

The twelve-month follow-up went much the same way as the six-month visit. Both appointments consisted of a brief discussion where the doctor asked about symptoms like pain or bleeding and then did a Pap smear. The results of both, to my relief, came back negative.

At the same twelve-month mark, my primary doctor ordered a bone density scan because five years had passed since my last one. I read about concerns that lower levels of estrogen are linked to lower bone density. Estrogen helps protect bone, so when it drops after surgery that includes removal of the ovaries, bone loss can speed up. Because of that, I expected my bone density to be negatively affected.

However, it surprised me to see that my bone density was 8% higher than it had been five years earlier. My primary doctor was very pleased with the results and said this was likely due to my regular calcium and vitamin D3 routine. My bone density had been going down when I was taking calcium alone, but it increased after I added vitamin D3. She encouraged me to continue with a daily dose of 1200 mg of calcium and 4000 IU (100 mcg) of vitamin D3.

HOW TO USE SUPPORT GROUPS TO PREPARE

As I conclude my story, I wanted to share an insight into hysterectomy support groups that took me a while to understand but eventually became genuinely helpful. Before my surgery, I spent a lot of time reading posts in hysterectomy support groups to prepare myself. They were extremely helpful, but also, at times, very scary.

One thing I came to understand is the nature of these groups. Most people who post are either just starting out and trying to understand what is coming, or they are dealing with problems and looking for help. When things go smoothly, people usually move on and rarely come back to write about it. There are a few women who share positive experiences, but those threads are usually short. There is simply less to say when things go well. Facebook's algorithm makes long discussions more visible because longer threads are treated as higher-interest topics and get higher priority. Because of that, you end up seeing a lot more difficult experiences than easy ones. Shorter threads about easy recoveries exist, but they are often hidden by the algorithm and never shown to newcomers. That is discouraging and scary.

I remember reading stories of women struggling and thinking that all of those things might happen to me. Those posts were useful, as they helped me anticipate possible problems and pre-

pare my home. They helped me think through what I might need and what limitations I might have after the surgery.

My own experience turned out to be completely different from what I expected. I had my hysterectomy for uterine cancer, and it was caught early enough that I did not need any additional treatment. My recovery was smooth. I had no pain unless I coughed. I did not take any pain medication, not even Tylenol. I had no gas pain and no spotting. I never felt debilitated.

My incisions healed well. Four of them became invisible, and the fifth looks like a small pink freckle that keeps getting lighter. In two weeks, I felt like my normal self again, and now, more than a year later, I have had no setbacks.

When you read support groups, use what you read as preparation for all eventualities, but do not assume that everything you read will happen to you. The groups show you what can happen, not what will happen.

Easy recoveries are possible. In the end, my recovery was much easier than I had imagined. This is one of the main reasons I decided to write this book. I wanted to help women prepare without being scared.

THE FINAL THOUGHTS

My final thought is about how important it is to leave reviews for doctors. Looking back, the most important factor in my experience was choosing an experienced doctor who had performed many surgeries similar to mine. I relied on other women who shared their experiences on Healthgrades and used that information to find the doctor who seemed right for me. I hope many of you will do the same, whether your experience was good or bad, to help other women find their great doctor.

Before surgery, I wondered what it would mean for me as a woman. Losing reproductive organs sounds like losing something fundamental. But that was not my experience. I still feel like myself. My personality, my emotions, my relationships, all of that stayed the same. The surgery removed a sick organ, not who I am. As I healed, I realized that nothing about my femininity was taken away. I hope other women can come to feel whole again the same way. I wish you an easy recovery and smooth healing, and I hope this book will help you along that path.

Resources I Found Helpful

Comparison of hysterectomy approaches

Pickett CM, et al. "Surgical Approach to Hysterectomy for Benign Gynaecological Disease." *Cochrane Database of Systematic Reviews*. 2023, Issue 8: CD003677.
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Vaginal cuff separation after hysterectomy

Uccella S, et al. "Vaginal Cuff Dehiscence in a Series of 12,398 Hysterectomies: Effect of Different Types of Colpotomy and Vaginal Closure." *Obstetrics & Gynecology*. 2012;120(3):516-523.
https://pubmed.ncbi.nlm.nih.gov/22914459/

Cronin B, Sung VW, Matteson KA. "Vaginal Cuff Dehiscence: Risk Factors and Management." *American Journal of Obstetrics and Gynecology*. 2012;206(4):284-288.
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How long absorbable stitches take to dissolve

Ethicon. "PDS Sutures Comparison Table: STRATAFIX and PDS Absorption Times."
https://www.jnjmedtech.com/system/files/pdf/PDS-Sutures-Comparison-Table.pdf

Ethicon. "Synthetic Absorbable Sutures: Vicryl, Monocryl, and PDS Absorption Times."
https://www.jnjmedtech.com/system/files/pdf/Ethicon%20Suture%20Chart.pdf

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A huge thank you to my editors, who helped me bring this book to life.

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Kendra, thank you for making sure I wrote what I meant, and meant what I wrote. Thank you for always being so helpful and supportive.

Matt, you always know how to help me find just the right words to express my feelings.

BOOKS BY THIS AUTHOR

Back Surgery Step By Step Recovery Guide: What Your Doctor Can't Tell You

Written from first-hand experience, this guide focuses on the practical details of preparing for and recovering from back surgery. This book supplements the medical information from your doctor with the practical details patients often need most: what to bring to the hospital and rehabilitation facility, mobility tools that can make recovery easier, physical therapy exercises that helped most, and realistic expectations about pain, limitations, and daily life during recovery.

How To Find Care For Your Elderly Parent: A Guide To Selecting Assisted Living And Nursing Home, Plus What To Do When The Money Runs Out

Based on the author's experience moving her mother from independent living to assisted living and then to a nursing home, this guide helps families understand the choices, paperwork, and financial issues involved in elder care. The book covers what questions to ask before selecting a facility, what to know before signing forms, and what to do when savings run out and Medicaid becomes part of the process. It includes detailed tips, lessons learned, and practical guidance to help caregivers feel less overwhelmed and better prepared.

Heal Your Shoulder: Rotator Cuff Rehabilitation

This book shares the shoulder exercises and recovery tools that helped me after a rotator cuff injury caused by everyday activities, including computer use. After months of physical therapy, I share the nine exercises that helped me recover from a rotator cuff injury, along with the substitute for in-person massage that helped relieve my aching shoulder.

Show Some Spine: The Most Effective Physical Therapy Exercises For A Strong Back

This guide brings together the lower-back physical therapy exercises I found most helpful after months of supervised rehabilitation. The book focuses on ten core exercises that became part of my routine, with clear instructions and additional exercises for variety. It is designed for busy people who want a manageable way to strengthen their back, even when they only have a few minutes a day.

A Patient's Guide To Cataract Surgery: Normal And Lasik Reshaped Cornea

A practical patient guide to cataract surgery, with special attention to the extra questions that come up when cataract surgery is performed after LASIK. The book is based on first-hand accounts of four surgeries: two after LASIK surgery and two without a LASIK history. It explains what to expect before, during, and after cataract surgery, how prior LASIK can affect measurements and lens choices, and how vision and recovery may feel from the patient's point of view, both with and without a history of LASIK.

Eyelift Surgery And Recovery Diary: Ptosis,

Eyelifts, Punctal Plugs, And Dry Eyes

This patient diary covers both drooping eyelid, or ptosis, correction and regular eyelift surgery, with daily recovery photos. The book answers the questions patients often have before surgery: whether it is possible to work the next day, how much bruising to expect, when it feels comfortable to go out in public, and what items may help during recovery. In addition to daily recovery photos, this book includes easy-to-understand medical details, and follow-up notes through ten months after surgery.

ABOUT THE AUTHOR

Kady Dash

After going through several medical procedures, I learned that good information about surgery preparation and recovery is hard to find. Doctors do a good job explaining the surgery itself, but they usually describe it from the medical point of view, not from the practical side.

What is often missing is the patient perspective: what it feels like, what the pain level is, what items may help during recovery, and what small details matter after surgery. These are the aspects I address in my books.

I write only about procedures I have gone through myself. I hope my insights are helpful to others preparing for similar experiences. Keeping notes also helped my own recovery, because it gave me something useful to focus on.

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