Fibroid and Pelvic Wellness Center of Georgia
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Surgical Consent

Consent Details

Your doctor has recommended surgery as an option for you in hopes of relieving certain symptoms and/or problems about which you have complained. This is an introduction to what you can expect from this surgery.

Procedure

Total Laparoscopic Hysterectomy, Bilateral Salpingo-oophorectomy, Uterosacral Ligament Suspension, Cystoscopy, Paravaginal Repair, Mini Sling, Posterior repair

Indication

Prolapse Uterus, Cystocele, Rectocele, Stress Incontinence

Hysterectomy, the surgical removal of the uterus and cervix, is the most common non-pregnancy related major surgery performed on women in the United States. Approximately 600,000 women undergo this procedure every year, 90% of the time the procedure is elective (non-emergent).

The most common reason for hysterectomy are:

- Fibroid tumors – non-cancerous tumors that can cause pelvic pain and pressure, heavy bleeding, painful intercourse, abdominal distortion and other symptoms
- Endometriosis – a condition in which tissue like that normally found within the uterine lining grows in other parts of the abdomen or uterine muscle (adenomyosis) where it can cause pain
- Uterine prolapse – the sinking or downward movement of the uterus from its normal position into the vagina
- Cancer of the uterus or cervix – these conditions are usually best treated by a gynecologic oncologist specially trained to perform surgery for cancer.

Hysterectomy does not require the removal of the ovaries, in fact, only around half of hysterectomies are done with removal of ovaries. Dr. Hawkins will discuss with you if removal of your ovaries is recommended or not. The fallopian tubes however are removed standardly with the removal of the uterus. The fallopian tubes serve no function without

the attached uterus and in recent studies have been thought to be associated with ovarian peritoneal cancer.

Hysterectomies can generally be accomplished through several different approaches:

- Total Vaginal Hysterectomy (TVH): operating entirely through the vagina to remove the uterus and the cervix. Removal of the tubes and ovaries can also be performed vaginally.
- Total Laparoscopic Hysterectomy (TLH) or Laparoscopic Assisted Vaginal Hysterectomy (LAVH): operating through the abdomen with telescopic vision and small instruments through small incisions to remove the uterus and cervix.
- Robotic Assisted Hysterectomy: laparoscopy with the assistance of a robot to aid in visualization and instrument movement. The surgery is performed by the surgeon not the robot. The robot cannot move without the command of a human.
- Laparotomy (Total Abdominal Hysterectomy or TAH): traditional "open" abdominal surgery that allowed the surgeon to see and reach into the pelvis. This is often used when a larger uterus is present or other procedures are planned.

The approach to hysterectomy will depend on your symptoms, the size of your uterus, any previous surgeries you might have had, treatment goals and the preference of Dr. Hawkins. The pros and cons of each will be discussed with you in your consultation.

Uterosacral Ligament Suspension is a surgical procedure utilized for the treatment of vaginal vault prolapse (i.e. relaxation). Vaginal vault prolapse is best described as relaxation of the deepest point of the vagina. Dr. Hawkins uses the original ligaments known as uterosacral ligaments and attaches the deepest point of the vagina (a.k.a. the vaginal vault) and/or uterus to the original points of attachment thus pulling the vault and/or uterus to its original position. The cure rate for this procedure is approximately 80- 85%.

The paravaginal repair is an abdominal procedure that corrects a cystocele (bulge of the anterior vaginal wall). The supporting layer of the ceiling of the vagina is known as pubocervical fascia. This layer supports the bladder. When the pubocervical facia breaks or weakens, this allows the bladder to sag or fall down. When the pubocervical fascia detaches from the walls of the pelvis (levator ani and obturator internus muscles) this is known as a paravaginal defect. Fixing these defects will fix a sagging bladder (i.e. cystocele) and this procedure is known as a paravaginal repair. This procedure can be performed through the vagina or through the abdomen.

Alternatives to the paravaginal repair include: 1) do nothing and live with the prolapse and its associated symptoms 2) doing pelvic floor exercises i.e. Kegels 3) using a pessary- a

temporarily placed synthetic rubbery/plastic device used to buttress or support the inside of the vagina.

Patients who have stress urine incontinence (cough or sneeze leakage) are candidates for a **sling procedure**. This procedure involves making a vertical 1 inch incision in the skin of the vagina directly beneath the urethra and then placing the sling (synthetic mesh tape) under and beside the urethra and inserting into the obturator muscle & possibly the obturator fascia. Unlike the TOT and TVT slings this minimally invasive sling does not have an exit would and thus is truly minimally invasive. The whole surgery is performed using one small incision. This operation is known as the Mini Sling which was first introduced into the USA in 2006 and has been used since that time with great success. The cure rates of the mini sling approximates 90% after the first year, 5 year studies and their cure rates are pending. The mesh that is used is FDA approved and is a Type I, macroporous polypropylene mesh. Many studies have confirmed the mesh tapes safety and efficacy when used for treating SUI.

Stress urine incontinence is not a life threatening condition and only the patient and makes the final decision as to surgery. She should make this decision only after being made an informed consumer by knowing the risks, benefits as well as the alternatives to surgery. Options to this therapy include nonsurgical therapies such as: kegel exercises, electrical stimulation, biofeedback, and barrier devices. Other options (surgical) include: periurethral injection of bulking agents such as collagen, traditional slings using biologic grafts or a piece of the patient's own fascia, abdominal bladder neck suture suspensions such as the Burch or MMK or artificial urethral sphincters (AUS). The latter (AUS) is rarely used in women because of the high rate of erosion of the device, and the need to replace the device after ten years (a second surgery).

A **posterior repair** is a surgical procedure for the treatment of a specific type of vaginal prolapse known as a rectocele or a rectum that bulges upward into the vagina. The rectum bulges upwards due to damage of the supportive layer known as rectovaginal fascia. Thus a posterior repair is a surgical procedure used to repair this supportive layer and create better support for a weak vaginal floor. The procedure involves cutting the overlying vaginal skin to access the damaged supportive tissue known as rectovaginal fascia. Once the rectovaginal fascia has been identified it is repaired with sutures that may or may not be permanent and then the excess vaginal skin is removed and the edges of the skin are re-approximated using dissolvable sutures.

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Post procedure

You will be in the recovery room for a short time before being sent to your hospital bed. There may be discomfort around the incision sites, within the vagina, and on the lower abdomen depending on the procedure you had performed. Most patients have some sense of urgency (the feeling of a need to urinate). There will be either glue covering your laparoscopic incision or a possibly a dress over your staple line, both of which should remain undisturbed until your follow up visit. If you have staples return to the office in one week for removal. Sometimes a catheter is left in the urethra and removed the afternoon or morning after surgery.
There may be small blood stains on the abdominal dressing or menstrual pad. If the dressing or pad becomes soaked, or you see active blood oozing, please contact us immediately. You may shower the day after surgery, but no swimming, or tub baths. It is normal to have some bloody discharge from the vagina for up to a week. If you have significant bleeding you should call our office. We ask that you refrain from any strenuous activity, heavy lifting, intercourse, or straining (usually for 12 weeks) or until Dr. Hawkins tells you that you may resume. Every patient has some degree of swelling and bruising, and it is not possible to predict in whom this might be minimal or significant.

We strongly encourage you to take two- three weeks off from work, with longer time off if your occupation requires strenuous activity or heavy lifting. In the first 48 hrs., it is to your advantage to often rest in a lying down position. Periodic walking is encouraged. Some patients have almost no discomfort while others are somewhat uncomfortable for a few days to weeks. Severe pain is unlikely but possible. You will be provided with a prescription for pain medication to alleviate most of your discomfort. Take the medication as prescribed and as needed.

Expectations of Outcome

“Normal Voiding: after an anterior repair or sling procedure may be delayed for many weeks due to swelling and operative manipulation. Improvement is usually gradual and not immediate.

There is an entity termed “bladder instability” that should be understood. It is actually not a complication of surgery because we expect some degree of its presentation in anywhere form 30-40% of patients following repair of bladder. Occasional a foley catheter is needed to drain the bladder for several days. The symptoms are usually mild and resolve with time. In some patients medication, could be necessary to relax the bladder. Very rarely are other treatments needed.

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Risks

All surgical procedures, regardless of complexity or time, can be associated with unforeseen problems. They may be immediate or even quite delayed in presentation. While we have discussed these and possibly others and your consultation, we would like you to have a list so that you may ask questions if you still have concerns. Aside from anesthesia complications, COVID-19 associated complications (during COVID-19 pandemic) and unlikely death, it is important that every patient be aware of all possible outcomes, which may include but are not limited to:

Damage to adjacent organs: There is a risk during anterior and posterior repair of recognized and unrecognized damage to bowel, bladder, urethra, nerves, vessels, ovaries, and the kidney tubes (ureters). Though unlikely there is also risk of fistula (a hole between two structures) formation. A fistula is an abnormal connection or passageway between the bladder, ureters, urethra and the vagina and may result in continuous uncontrollable urine loss. Though fistulas can normally be fixed this usually requires another surgery in the future.

Often the injury is minor and can be treated with relative ease. In other instances, when the injury is extensive or the repair is complicated, more extensive surgery may be necessary and occasionally other surgical specialists are called to assist.

Suture erosion - into bladder or urethra (<1%) or into the vagina (1-2%).

Scar Tissue Formation: Scar tissue can form within the abdomen or within the cavity of the uterus that can lead to infertility.

Treatment failure: Failure of the surgery resulting in recurrent cystocele or rectocele vaginal drop (20%) within 12months.

Mesh complication: The sling has potential complications when a permanent synthetic material (mesh tape) is used. Though there are many types of complications, mesh complications can be divided into four different types: 1) erosion - into the urethra, bladder, or bowel (<1%) 2) extrusion - of the mesh into the skin of the vagina (1%) 3) infection- the synthetic mesh gets a bacterial load and this makes the mesh a focal point for pus collection (<1%). 4) pain - the mesh heals in a way that causes pain in the vagina or pelvis (<1%).

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Convert to Open Surgery: If the surgery is not able to be completed laparoscopically due to extreme difficulty, adhesive disease, injury to adjacent organs or heavy bleeding, it may be necessary to convert to an open incision (8-10cm) to complete the procedure. With Dr. Hawkins this occurs less than 10% of time.

Pelvic infection or abscess: Signs of infection that you should watch for are: foul smelling discharge, tenderness, or pain in the vagina and pelvic for more than two days, significant bleeding, fever, chills, nausea, vomiting, weakness, and feeling ill. You must contact us immediately or go to the nearest emergency room if you have any of these symptoms.

Wound infection: The incision site can become infected. While infections typically resolved with antibiotics and local wound care, occasionally part or of all of the incision may open and require revision. Cleaning the incision with soap and water daily (do not rub), keeping it dry and avoiding baths and swimming helps reduce the risk of infection.

Hernia: Although some of the incisions are sutured closed, it is possible to develop a small hernia (tissue protrusion) in the wound. Avoiding heavy lifting for 8 weeks after surgery can reduce this risk.

Cuff Dehiscence: The vaginal cuff (top of the vagina) is closed after the uterus and cervix are removed. This is the weakest part of the procedure because the cuff is sutured to itself and if compromised or pushed apart can separate. It is important not to place anything inside of the vagina or lift heavy objects for 6-8 weeks to allow for healing of this part of the vagina. If healing is compromised the cuff can open, or bleed and repair usually requires emergent surgery.

Death: When a hysterectomy is performed for reasons other than cancer or pregnancy complications, the risk of death is 6-11 per 10,000 hysterectomies.

Blood Loss Transfusion: Usually blood loss in this procedure is minimal to moderate. In some cases blood loss can be significant enough to necessitate transfusion to replace blood loss to hemorrhage.

Bleeding/hematoma: When a small blood vessel continues to ooze or bleed after the procedure is over, the area of collecting blood is referred to as a hematoma. The body normally reabsorbs this collection over a short period of time, and surgical drainage is rarely necessary.

Painful intercourse and vaginal shortening: After vaginal repair, the shape of the vaginal vault can change. In a certain case, the depth of the vagina may be lessened, angel changed or scar

tissue may form. While usually not a probable, some women may complain of pain or difficulty with intercourse. Most of the time it is temporary.

Chronic pain: As with any procedure, a patient can develop chronic pain in the area that has undergone surgery. Typically, the pain disappears overtime, although some feeling of numbness may persist. If persists, further evaluation may be necessary.
Lower Extremity Weakness/ Numbness: This, too, is a rare event that may arise due to your positioning on the operating table. It is possible with the procedures in which you are in the lithotomy (legs up in the air) for a long time. The problem is usually self-limited, with a return to baseline expected.

Urinary Tract Infection or sepsis: Although we may give you antibiotics prior to and after the operation, it is possible for you to get an infection. The most common type is a simple bladder infection that presents with symptoms of burning urination, urinary frequency, and a strong urge to urinate. This usually resolves with a few days of antibiotics. If the infection enters into your bloodstream, you may feel very ill. This type of infection can present with both urinary symptoms and any combination of the following: fevers, shaking chills, weakness, or dizziness, nausea and vomiting. You may require a short hospitalization for intravenous antibiotics, fluids, and observation. This problem is more common in diabetics, patients with long term steroids, or in patients with disorders of the immune system.

Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE): In any operation, especially long operations, you may develop a clot in the vein of your leg (DVT). Typically this presents 2 to 7 days (or longer) after the procedure as pain, swelling, and tenderness to touch in the lower leg (calf). Your ankle and foot may become swollen. If you notice these signs, you should go directly to the emergency room and also call our office. Although less likely, this blood clot can move through the veins and block part of the lung (PE). This would present as shortness of breath and possibly chest pain.

You are consenting to the surgery mentioned above in light of these risks. All questions were answered to your satisfaction. You are also consenting to the use of videotaping or pictures for educational purposes only.

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Signature of person giving consent (patient)/Date Signature of person obtaining consent/ Date

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