Fibroid and Pelvic Wellness Center of Georgia
Soyini Hawkins, MD, MPH

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

Robotic Total Laparoscopic Hysterectomy, Bilateral Salpingectomy, Possible Uterosacral ligament suspension, Cystoscopy

Indication

Abnormal uterine bleeding

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): 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 or prevention 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 to its original position. The cure rate for this procedure it is treating significant prolapse is approximately 80- 85%.

Post procedure

You will be in the recovery room for a short time before being sent home or to your hospital bed. Most patients undergoing a simple laparoscopic or robot hysterectomy will go home and about 10% will stay overnight. If other procedures are planned in combination with the hysterectomy this may require spending one night. 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 possibly a dressing 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 8 weeks) 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 following a TLH, four – six weeks for a TAH, with longer time off if your occupation requires strenuous activity or heavy lifting. In the first 48 hours, 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

Hysterectomy is a major surgery and you will need several weeks of recovery before you feel well. With passing days and weeks, you will see improvement and gradually resume your normal activities. It is common for women to report feeling tired and weak several weeks after surgery.

Most women will feel better following hysterectomy, both in improved mood and sense of wellbeing. Many women report an improved sex- life after surgery. This can be from relief of constant pain, improved energy, and no worry of pregnancy.

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 at 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:

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Damage to adjacent organs: There is a risk during hysterectomy of recognized and unrecognized damage to bowel, bladder, nerves, vessels, fallopian tubes, ovaries, and the kidney tubes (ureters). 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. 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.

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.

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

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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.

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.

Painful intercourse and vaginal shortening: After hysterectomy the shape of the vaginal vault can change. In a certain case, the depth of the vagina may be lessened, angle 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.

Unintended Dissemination of an Unrecognized Malignancy: Less than 1/8000 women who undergo hysterectomy for fibroids will have an unrecognized malignancy. Currently there is no reliable method to differentiate between benign fibroids from malignant fibroids (leiomyosarcoma or endometrial stromal sarcoma) before they are removed. If this is suspected at the time of hysterectomy a specialist will be called to assist in removal and management of the cancer.

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 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.

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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 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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Name of person giving consent (patient) Name of person obtaining consent