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**(559)322-2900 (559)322-2901 (fax)**

| _______________________________ | _______________________________ |
|---|---|
| Name | Surgery |
| _______________________________ | _______________________________ |
| Date of surgery | Reason for surgery |

This document is intended to help you to be prepared for your surgery, to reduce any fear, counteract any misinformation, and ease any anticipation about your upcoming surgery. **As you read this, please highlight and underline any areas of concern, and write your questions on the sides of the pages so that you can be sure to ask them during your surgery-planning visit. Bring this material with you to every pre-operative visit *and* to the hospital** so that you can read and refer to it after your surgery because it also contains your discharge orders. **Your spouse, partner or friend who will be your main caregiver *should also read* this entire document to be most helpful during and after your hospitalization.**

**Choosing a date for your surgery** – Recovery from a laparoscopic outpatient procedure is about one week. For a laparoscopic hysterectomy the recovery is about two weeks. For open laparotomy incision surgery of any type, the recovery is six weeks. Recovery periods vary. Discuss this issue with your surgeon preoperatively. We build our office and surgical schedules around our commitment to your surgery date. Choose your date to allow for your recovery and so that you will not have any reason to cancel your surgery at the last minute. Last minute cancellations are troublesome because we cannot simply substitute another patient at the last minute. **So please, please check with your family and work before you choose your date, and try not to change it.**

**Insurance -** Make sure that we have all your up-to-date insurance information so that we can obtain authorization for your surgery. We do this as a courtesy, so you will know your portion of the probable charges. We expect your portion of payment at the time of surgery. We attempt to bill your insurance company as soon as possible after the surgery.

**Contacts -** Please make sure we have your local and your cell phone numbers so you can be contacted by the operating rooms if needed for any last-minute change in the surgery schedule.

**Final pre-operative visit**–Your surgeon will formally review with you your findings and will explain the risks, benefits, and alternatives of your specific surgical plan, and answer all your questions. After that, you will be asked to sign a consent form for your surgery. Remember that

these consents are written to assure your and our understanding of your proposed procedure. They are not contracts, so you can always change your mind. Ask all your questions, and know that there is no pressure to sign anything without your complete understanding and agreement. You will be given a folder for all of your surgical documents that will include both your copy of these consent forms, and the hospital's copy with your admitting orders and any pre-operative tests needed.

**Allergies and Current medications:** Please fill out the last page of this hand-out and list all **medication allergies** and **all of your current medications <u>with doses and frequencies</u>, including herbal, naturopathic, and over-the-counter drugs**. Stop taking any aspirins or Motrin, Nuprin, Advil, ibuprofen-like substances <u>3 days before surgery</u>. Use only Tylenol (acetaminophen) if you need pain relief before your operation. Stop all herbal remedies and nutritional supplements, Meridia, Fastin, Ionamin, Adipex and any amphetamines <u>7 days before your surgery</u>. You must stop taking Mardil, Parnate, Eldepryl, Marplan Clorgyline, Brofaromine, Moclobemide and Tolozatone at least <u>14 days before your surgery</u>. Stop all Plavix and Coumadin, <u>7 days before your surgery</u> and discuss Heparin/Lovenox with your cardiologist and with your surgeon.

**Pre Operative testing:** If you have had any blood work in the last few months, let us know, so we can avoid unnecessary blood-draws. Sometimes it is still necessary to draw your blood to establish current baseline values prior to surgery and to crossmatch for possible transfusion. All patients with heart or lung problems need a recent Chest X-Ray and EKG. These tests may be ordered ahead of time or we may ask you to have them done after your final pre-operative visit. Please remain flexible so that you can possibly stop by the hospital for these tests when requested.

**Blood Transfusions –** About 1% of women having laparoscopic surgery and 5-10% of women having open incisional surgery may need some type of blood transfusion. There is a charge to process each unit of self-donated blood. This charge is not covered by most insurance plans. Thus, donating your own blood for laparoscopic surgery will not be worth your trouble. If you are having surgery for a cancer, you may not donate your own blood. The risk of receiving hepatitis or HIV from the transfusion of banked blood is about 1 in 300,000 (which is very rare). Also, if you receive blood during your hospitalization, please arrange for a few friends or family members to donate for you after your surgery to replace the precious gift of blood that you received.

**Preparing and packing for your hospital stay –** Wear comfortable clothes that you will be able to wear over your incisions during the drive home. Sweat suits are a great choice. Do not wear or bring jewelry to the hospital. There is no need for pajamas as the hospital provides covering for you. Bring your toothbrush and necessary cosmetics, a few light sanitary pads and any essential health aids. Do not wear any eye make-up, as it may enter your eye fluid during your anesthesia and cause severe iritis. Wear only glasses, not contacts, and be reassured that you can wear glasses, partial teeth, and hearing aids until the very last minute, taking them off in the operating room just before you go to sleep, and find them with you in the recovery room ready to put back on/in as soon as you wake up. While you are welcome to shave your legs if you prefer, <u>do not shave</u> the surgical site for us. We will shave only what is medically essential for the incisions in the operating room. Shaving before this time actually increases wound infection rates.

**Power of Attorney:** If you are single, widowed, or in an unregistered domestic partnership, bring a copy of your durable medical power of attorney to the hospital. This will make certain that health decisions are made for you by the right person, if, for any reason, you cannot make

your own decisions. If you are married or in a California Registered Domestic Partnership, your spouse is already legally your next-of-kin.

**Bowel Preparation for Surgery** – The entire length of your intestines must be emptied prior to surgery to make the surgery safer, the recovery easier**.** Empty bowels also make more room for us to operate. (Please leave your pharmacy phone number if a prescription(Rx) is needed).

- Choose and purchase ONE bowel prep from the selections below.
    - No Rx needed: Take 4 Dulcolax oral laxative tablets at 2pm. Drink two 10oz bottles of Magnesium Citrate at 6pm – followed by one quart of any clear fluids.
    - No Rx needed: Take 4 Dulcolax oral laxative tablets at 2pm. At 6pm drink one cup every 15 minutes of 8.3 ounce Miralax in 64 ounces of Gatorade or Crystal Light or Vegetable/Chicken Broth OR Knudson Organic Recharge Thirst Quencher.
    - Rx. If you can take pills easily: Osmoprep Pills. Take 4 tablets starting at 6pm with one cup of above fluid every 15 minutes for two hours. (Total 32 pills, 2 quarts fluid).
    - Rx. If you hate taking pills, and don't mind drinking lots of fluid. Rx Moviprep: mix 1 quart lukewarm water with powder. Drink one cup every 15 minutes, starting at 4pm, til gone, followed by 2 cups of any clear liquid. Repeat.
    - Rx. If you hate taking pills, and don't mind drinking lots of fluid. Rx Colyte (flavored powder) in a one-gallon bottle. Mix one gallon water with powder. Start drinking at 4pm until nearly-clear liquid comes from your rectum. Some drink it through a straw.
    - Rx. If you want a blend of two pills and two quarts of fluid. Rx HalfLytely. Take 2 Dulcolax oral laxative tablets at 2pm. At 6pm, drink one cup every 10 minutes until gone (80 min).
- 1 roll of very soft toilet paper, or Huggies brand non-scented moist towelettes for wiping, or A & D Ointment (to schmear over your anus (or all three!)).
- Aleve 220-mg gel caps, 30-tablets, for preventing pain after you go home. Even if this did not work for your arthritis…it works for surgical pain. Buy it.
- Optional: Milk of Magnesia to relieve any constipation after you go home. Tell me if you have chronic constipation or irritable bowel, as it will happen after your surgery as well.
- Optional: 6 containers of natural yogurt (Dannon, Yoplait, etc) or Acidophilus in any form for regulating your bowel after you go home.
- One week of healthy, easy to prepare foods to come home to, as you won't be driving for a week.
- Note: if you receive any advice from the anesthesiologist about when your last sip of water can be—follow the advice of the anesthesiologist. Otherwise follow these instructions.

_______________ **Two days before surgery:** Eat regular food today. Pack your bag. Clean your house. You will be a new and healthier person when you come home!

_______________ **One day before surgery, day of Bowel Prep***:*

1. Eat low or no-fiber food (meat, fish, dairy, eggs: no fiber today) for breakfast and lunch. You won't be eating dinner. You will not be hungry during or after the bowel prep.
2. Start bowel prep, much earlier if you have chronic constipation. You will develop painless almost clear diarrhea, and then it will become brown again. This can happen quickly, or it could take several hours. Whenever your stool fluid becomes nearly perfectly clear, without any formed solid material, (tiny flecks fine) you may stop the bowel prep drinks, and go to step 3.
3. After you develop nearly clear rectal outflow, continue drinking **any clear fluid** of your choice such as tea, soft drink or even more Gatorade/Broth until your urine is pale, dilute, and nearly clear before going to bed. This hydration is very important preparation for your comfort the next morning.

**Don't worry that your rectal outflow becomes cloudy brown again, because it will. That's fine.**

4. Call FWMG if you have any problems or questions about the bowel preparation or medications. Call FWMG if you cannot follow the above instructions, as she may need to modify them for you, or postpone your surgery. Finish your bowel prep.
5. Finish cleaning your home. This is a time for a real cleansing! When you come home, you can be the real, improved, new best you that you have only been on the inside so far.
6. After bowel prep: Do not eat anything. Nothing by mouth at all after midnight. (The anesthesiologist may tell you that you can have some clear liquid breakfast on the day of your surgery if your procedure is much later in the day. You may only have clear liquid, but carefully stop eating or drinking precisely according to the anesthesiologist's instructions.) For your safety, your surgery will be cancelled for another day if you have not followed these instructions correctly.

_______________ **The day of surgery***:*

1. Meds: Take your daily prescription medications with a sip of water.
2. Diet: Do NOT eat or drink anything unless instructed specifically to do so. Do not chew gum or suck mints.
3. Go to the hospital on time. Remain available by local phone or cell phone (make sure we have both of your numbers) in case your surgery time is changed. If the front door is locked very early in the morning, go to the side door on the right of the hospital.

**Hospital Check-in** – Bring your surgical folder containing your consents and orders with you and give the nurses all of these when you check in to the hospital. At the admitting desk, you will be required to show your insurance card and you will be asked to pay for your portion of the cost of the hospital stay. Keep the receipts and all printed information that you will receive during the check-in and pre-op processes in your surgical folder.

**Pre-operation Procedures** – A nurse will review the forms that you completed at FWMG and will ask you questions to complete new forms. Once the paperwork is complete, the nurse will give you your hospital gown. You may also receive a blood-thinning shot to your abdominal wall skin, called Lovenox, and have sequential compression devices placed around your legs. These are similar to automatic blood pressure cuffs and compress your legs during and after surgery to improve circulation and prevent clots. They actually give your legs a wonderful "massage" and are something to look forward to! If you have any questions about what is happening to you, don't hesitate to ask these nurses. They always want to relieve any anxiety that you might have, and answering all of your questions is key.

**The anesthesiologist** – An anesthesiologist will provide your anesthesia during the entire case. She/he will meet you in the pre-operative area after you have checked in to discuss your anesthesia plan. Be sure to tell the anesthesiologist if you tend to get easily nauseous because today there are medications that can be added to your IV to significantly reduce the chance of nausea after surgery. The preoperative team will start your IV and will give you medication that will help you to relax (quite nicely!) prior to surgery. All of the abdominal cases, by laparoscope or by open incision, require "general" anesthesia; that is to say, you will sleep painlessly through the surgery and remember nothing. The anesthesiologist may ask you if you would like to have an epidural WITH your general anesthesia.

**Pre-operation Waiting Time** – While all efforts are made to have you in pre-op for only a short period of time, an operation preceding yours, or an Emergency Room patient, could delay your start time—up to a couple of hours in some cases. A family member or friend is allowed to stay

with you in the pre-op area. Bring a game or cards to pass the time. If you are alone, bring a good book or a magazine.

**Going to the operating room for Surgery** – The person who accompanies you can stay with you right up until you are taken in to surgery. Your surgeon will give her/him an idea of how long the surgery will last. It is a good idea for that person to get something to eat right after you go in, so that she/he will be in the waiting room when you are done. The person waiting for you should be told that it is not unusual for a surgery to run past the estimated time period and not to panic if this occurs. The surgery might not have even started until hours after you were taken from the pre-operative area into the operating rooms. No one will notify her/him if surgery is running late, so even if two hours have passed, do not worry. Once you arrive in the OR, the anesthesiologist will give you intravenous medications to fall asleep.

**The assistant surgeons and other medical costs–**There is almost always an assistant surgeon who helps your surgeon with your surgery. In addition, other fully trained medical doctors with other specialty expertise may be consulted to help in your care. You will receive a bill from any of these doctors who participate in your care. The anesthesiologist and the pathology department will also bill you for services rendered.

**Observers and Industry reps in the OR –** Surgical methods continue to improve. Your FWMG doctors are often asked to use newer state of the art equipment. When doing so, we need to have the industry reps present to help our OR staff. There is no experimentation going on. (That would be unethical without your fully informed consent.) No one sees your face, your privates, or your name. This is strictly controlled by our OR Staff.

**Post-operation —**You will be taken to the Recovery Room after your surgery, and you will wake up slowly. You will not have any sense of the amount of time that has passed since you closed your eyes, so it can be a bit confusing. You will have a tube in your bladder to drain the urine so you won't have to get out of bed to empty your bladder. You may feel an urge to urinate, but be assured that your bladder is being emptied for these about 24 hours through the tube. The nurse in the Recovery Room should ask you to rate your pain on a scale of 1 to 10 with 10 being the worst pain imaginable. Be honest when asked, because that determines the pain medication that you will be given. This is when I dictate the operation and go out to tell your family about the findings. After this time is another good opportunity for your family members to eat because it will be approximately ninety minutes before you will be taken to your hospital room where they can be re-united with you.

**Once settled in your room**, you will probably experience a little bewilderment that you got through it all! You will also probably be surprised that you are not having much pain. There will be an IV in your arm to keep you hydrated and for pain medication. You will have a tube in your bladder to drain it so you won't have to get up to empty your bladder. The sequential compression devices will be on your legs and will inflate periodically to prevent blood clots. There will be a fingertip sensor-clip that measures your oxygen levels. You might feel "trapped," but you can sit up when you feel like it, get out of bed to sit in a chair or walk around in the hallways. Hold a pillow to your stomach to help you get a good cough and clear your throat and lungs frequently. Stretch and move in bed, then get out of bed to start walking. Walking helps your recovery. More walking is better! Unlimited walking is best!

**The recovery is entirely humane. Everyone experiences pain differently.** Whatever your pain threshold, expect to experience some discomfort after your surgery, but not too much. Report to your nurse what the level of pain is from 1 to 10: 1 is very minimal pain, and 10 is unbearable pain. There is medication for each level of pain. Typically only the first 12 hours require medication. For many women, just understanding the cause of the discomfort can help.

**There are three different causes of pain, and three different ways to manage any post-surgical discomfort:**

1. Incision discomfort. This is dull and constant and will actually subside significantly over the first 12 hours, becoming more of an ache. You will have two *intravenous* medications for incisional pain: one to prevent it and one to treat it, followed later by two *oral* medications that also prevent and treat the pain. Your incisional pain is prevented by an intravenous medication similar to Aleve (Naprosyn) called Toradol. The nursing staff gives the Toradol automatically every 6 hours until you begin eating and then you receive the Naprosyn orally to continue to prevent the pain. When you go home you will continue to take Aleve to prevent the pain for the first three days. For any "breakthrough" pain that the Toradol does not prevent, you will receive a narcotic in your buttock muscle, or as a push-button demand drip. You can use the narcotic until you are taking by mouth, when you will begin using an oral narcotic. If you are not having significant incisional pain, try to minimize use of narcotics as these drugs will slow the bowels from pumping and can delay and prolong the cramping phase. The incisional pain from laparoscopic surgery is minimal after a few hours and many patients use none of their prescribed medication at home. If you have a vertical open laparotomy incision, you will wake up with a binder (like a girdle) compressing your abdomen. Keep this binder centered over your incision to keep comfortable pressure on it. Use the binder at home only if you still want to, but keep it on in the hospital. Your incision should cause less pain every day, and not require prescription medication after a few days.

2. Intestinal cramps. After surgery, your bowels quit pumping. About 12-36 hours after surgery, it is normal to go through a 2-4 hour cramping phase as the gut resumes pumping. Some people experience no cramps, and only a very few will have severe cramping. We will give you Simethicone, which can help ease the crampy pains, but the key to alleviating this pain is to walk in the hallways as soon as possible to stimulate your bowels to resume normal function rapidly. Nothing you eat or drink will affect the "crampy phase" and there is no cure for it other than a "tincture of time" and walking. Narcotics should not be used for this pain.

3. Shoulder pain can result from the gas that was used to inflate your abdominal cavity *if laparoscopic surgery was performed*. This gas is deflated from the abdomen after the surgery, but a small amount still remains and may cause you to have a sense of pain in your right shoulder (and sometimes in your left shoulder). It is mild, constant and tolerable and usually starts the morning after the surgery. There is nothing wrong with your shoulder, however. This pain can take several hours to a few days to completely resolve. Moving around in bed into different positions and getting out of bed to walk can relieve this pain sooner, and Aleve can help.

**Sore throat –** You may notice that your throat is sore or that you are hoarse or have laryngitis after the surgery. This is because a tube was placed to help you breath during the surgery and was removed before you woke up. If bothersome, ask for some throat spray for relief.

**Your Lungs –** Since the breathing tube in your lungs induces mucus secretion, you will have a cough when you wake up. Hold your pillow over your incision(s) for comfort while you cough. Use the breathing device (spirometer) frequently to help to re-expand and open your lungs to their normal volume; otherwise, a fever may develop. If you feel short of breath, cough a few times, and use the spirometer. The nurses check your oxygen levels frequently and may ask you to wear a little tube near the outside of your nose to add some extra oxygen to your blood.

**The day after surgery** – The tubes come out and you move even more!!!! The intravenous line, the bladder catheter and the leg device are removed. You may shower and pat your incisions dry. The injection pain medications are replaced by oral medications. Usually this is Motrin and Percocet, Vicodin or Tylenol #3.

**Your Bowels** –The most important factor in your bowels resuming normal function is walking. Get out of bed as soon as the nurses let you and walk in the room and later in the hallways to hasten the recovery of your intestinal function. You may experience a painful cramp every time you empty your bowels for about two to even **four** weeks after the surgery, especially if you already have some irritable bowel syndrome (IBS) or just crampy bowels in general. This will get completely back to normal once the normal post-operative inflammation from the surgery has resolved, by one month (really!). Try to remember this fact when you have cramping after meals two to four weeks after your surgery—it is normal! And temporary!

If you have had open incisional surgery, your intestines will take about 5 days to resume their normal function. You will go through a phase of belching (intestines not pumping), then bloatiness (intestines not pumping much), then gas pains (intestines pump in an uncoordinated fashion) and finally passage of gas (intestines coordinated) when you finally feel normal. This is sometimes the most trying part of recovery, but everyone resumes their normal function.

**Your Abdomen –** Some women worry about how the space occupied by their uterus will be filled. The intestines and the colon move about in the abdominal cavity sliding over each other every minute as they pump. Removal of a normal or enlarged uterus/ovaries simply makes more room for the intestines to slide around on each other and for you to have a slightly flatter stomach. The lower abdominal wall will be swollen after your surgery, but this will mostly resolve within two weeks. You may notice that your upper body is swollen and puffy after the surgery. This is due in part to the surgery being done with your body in a head-down tilt, and in part to fluid shifts from the surgery. All of your upper body swelling will resolve within a few days. Some women get huge black and blue marks in their lower abdomen or upper legs after going home. This is because some blood can ooze deep beneath the skin after the surgery, and cause a large bruise. It will resolve.

**Your incisions –** Your incisions should stop hurting in a few days after your surgery. Even long vertical midline incisions generally stop hurting in less than one week. Call Dr. O'Hanlan for any development of new or increased redness, tenderness, discharge, swelling of your incision.
**If your umbilical or other incisions develop oozing after you go home, cover it and call your doctor.** The umbilical incision often can ooze for a day or so, especially if the "skin-glue" is dislodged a bit—**not to worry**. You may shower, swim, bathe or soak in a hot tub any time after your laparoscopic surgery, once all incisions are dry. If you have open laparotomy incision, you may shower, swim, bathe or soak in a hot tub once the incision are dry and closed. If you have any wound packing or dressing, leave the dressing on while you shower (but no bath or hot tub) and then

put on a new dry dressing after you get out. Once all incisions are sealed (no more discharge or wetness), you may swim or bathe in a hot tub.

**Your Bladder –** Once the catheter (the tube that drains the bladder) is painlessly removed on the morning after your surgery, some women notice a feeling in their bladder as it empties in its new configuration. This "odd" feeling is normal and disappears usually within two weeks after the surgery. Some women have trouble sensing when their bladders are full at first, but this resolves also within the first two weeks. Try to empty your bladder every two to four hours to begin to familiarize yourself with your renewed bladder function.

Call the nursing staff if you find that you cannot empty your bladder within four hours after the catheter is removed. Some women need an extra day of bladder rest before their bladders work well again and may need to have the catheter re-inserted. You will notice that you will pass about a quart of urine more than usual on the days following your surgery. This is because the body holds water in and reduces urine during times of stress, and then releases it once the stress has passed. This is normal and, in fact, reassuring that all is well. It is called the "diuretic phase."

**Hormone therapy –** If your ovaries were removed, or if you are already on HRT, hormones can be started on the day after surgery, and you will go home on them. Make sure you have your prescription for home use of hormones. Read the materials you were given about hormone therapy so that you can help yourself get to the optimal dose for you as soon as possible. If you are already menopausal and not using hormones, it will not be necessary for you to start taking them, as you will likely only notice a difference for a short while. Even though you may have been in the menopause, without hormones for along time, you may still get a few hot flashes after your ovaries are removed. If you were started on hormones in the hospital, the adequacy and efficacy of your dose will be assessed at this meeting. If the dose of estrogen you are taking is too much, you may develop tender breasts. Too low a dose of estrogen can result in insomnia, hot flashes and depression. Call if you have these symptoms <u>before</u> your visit. About 10% of women require changes of dose, route or type of hormone a few times until it is just right for you.

**In general, you will spend one night in the hospital if you had a laparoscopic hysterectomy, about 2-4 days if you had an open incision.**

**Discharge to Home** – WEPG…..Walk, Eat, Pee, Gas. Plan to go home after you are eating, emptying your bladder, passing gas, and walking well. You do not have to have a bowel movement to be discharged. You should have no nausea.

1. Diet: Resume eating regular food and drink plenty of fluids. If your bowels are not yet regular, take some prune juice or Milk of Magnesia to facilitate normal function.
2. Exert yourself. Walk for 20 minutes <u>three times daily</u> outside your house to regain energy and relieve crampy GI pain. Increase your energy gradually by walking whenever you can. Stairs are fine!!! Recovery occurs as you <u>regain your energy</u> over time. <u>It is fine to push yourself and walk as much as you can</u> to facilitate your recovery. Raise your energy level by <u>stretching, floor exercises</u> and walking frequently in the hospital and at home.
3. To prevent incisional and surgical pain: Take two tablets of Aleve 220mg every 8 hours for four days regardless of your pain level. This <u>really works for surgical pain and reduces the need for the Vicodin</u> (which constipates and slows GI function and makes you listless). You will have a prescription for some Vicodin pills in case you have any breakthrough pain. Take one-half Vicodin

(or other prescription pain medication) for breakthrough pain only. Don't use Vicodin for crampy GI gas pain—just go walking for that pain. Surgical pain is virtually absent within a few days after surgery and by four days you should not need any medication for pain. Call your doctor if you need pain medications after one week.

4. If you suffer from constipation: do not push at home!!! You may need your usual stool softener for greater ease in passing stool at home. For gas pains or constipation: Take Milk of Magnesia as directed on the bottle.

5. If your incision oozes fluid, cover it, and call our office so we can reassure you or ask you to come in for exam. Leave sealant glue or steri-strips on the incisions (but shower as usual, and pat incisions dry). You may peel these off your incision any time after 10 days.

**Return to sexuality -** The surgery in your abdomen does not involve removal of *any* of the organs of sexual activity or enjoyment. The female orgasm takes place in the muscles surrounding the vaginal opening, not any deeper, even though the orgasm feels very oh-so-deep within (It's not!). The uterus and cervix are not any part of your orgasm and their removal does not impact on the ease of achieving orgasm, quantity of contractions, or quality of your orgasm. Good research has been done on women comparing their sexual function before, and at 3, 6, 9, and 12 months after hysterectomy, revealing a slight *improvement* in sexual function for most women, but overall, no detriment. Some women will notice differences if their hormones are not kept tuned afterwards. Your surgeon is adept at finding the right hormone replacement regimen, as needed, to keep you feeling your normal best. Sexual enjoyment should be exactly the same. Let us know if it is not. You may return *immediately* to sexual activity on the outside of your vagina in any and every way that pleases you. This is a great time to learn new cleverness in your sexuality and add to your repertoire of techniques for pleasure and orgasm, both by yourself and with your partner. So please go ahead and check it out (again, stay on the outside, please!) just as soon as you feel like it! You will be able to resume vaginal penetration after the upper vaginal incision is checked at the 6-week exam, or possibly later if healing is not adequate. When you resume penetration, be gentle for another month.

**Return to exercise – Just do it.** Surgery causes more exhaustion than pain after the first day or so. The challenge is to get back to your usual exercising self as soon as possible. You will nap plenty in your early recovery, and nap less as your energy returns to normal. Once you get out of bed, you are encouraged to begin walking vigorously as much and as often as tolerated immediately, both in the hospital, and definitely after your discharge. You may go up or down **any amount of steps**, **any number of floors**, and are encouraged to do so frequently in your recovery. You may lift any weight you feel comfortable lifting when you go home. You may resume all of your floor stretches, exercises and Yoga immediately. Do not begin or resume power weight lifting (as with dumbbells and barbells) until one week after laparoscopic surgery and two weeks after standard open abdominal laparotomy. Vigorous recovery and activity are encouraged, and you can nap in between.

**Do not drive until one week after laparoscopic procedures and two weeks after open incision procedures.** This is not because you can't physically accomplish the task of driving, because most can. But what you cannot RELIABLY do is jam on the brakes for an emergency without hurting yourself or another person in the early phase of healing after surgery.

**Your post-operative care** – We will call you to check your recovery and make sure that you are healing well and that your organs are resuming their normal function. You will have at least 2 post operative appointments- about at 2 weeks and about 6 weeks.

**Vaginal Bleeding -** You might experience a two-day period of bright red bleeding around the 14-28th day after your surgery. The stitches at the top of the vagina dissolve at this time, allowing the end of the vagina to "settle" into its new position. The bleeding can be quite red, but not bigger than a period, and typically resolves without treatment. If you are bleeding heavy enough to saturate a pad every hour, you need emergency care. Call your surgeon or go to the emergency room at Clovis Community Hospital.

**Vaginal discharge** –The inner end of the vagina from which the cervix and uterus above were removed has been sewn shut. Even though the outside skin incisions heal promptly and rather perfectly, the inner vaginal incision does not. It really takes about 6 weeks for the upper vagina to close. It is normal to have some tan to brown to frankly bloody vaginal discharge for the first six weeks. This discharge will resolve completely once the upper end of the vagina has completely healed. The upper end of the vagina will nearly always have some excessive growth of scar tissue called "granulation tissue." This is treated with a [Silver Nitrate] medicated Q-tip at your 6-week post-op visit. The granulation tissue may take a few monthly treatments with medicated Q-tips before the upper end seals completely and you have your normal minimal opalescent vaginal fluid.

**Final Visits** – At your 6-week visit, inner vaginal incision will be inspected with a speculum. There is usually some excess scar tissue, called granulation tissue, at the inner vaginal cuff, which will need to be touched with a silver nitrate medicated Q-tip. A repeat inspection 4-6 weeks later may be necessary for a few months to be sure all the granulation has resolved. This is normal. There is no charge from our office for these additional visits, as they are part of your normal surgical recovery. If you are from a distance, you may choose to have the granulation treated by your local physician, but they may charge you for an office visit.

**Disability Leave after Surgery –** The general rule is that an open surgery (laparotomy incision) entails a 6-week period to resume normal, full workloads, including heavy lifting. A laparoscopic hysterectomy, with the four tiny incisions, entails a 2-week disability leave. With the addition of vaginal surgery, you may also need 6 weeks off.

**About complications –** Your doctor is fully qualified to perform your surgery. Even the best surgeons and the nicest patients have complications. Full informed consent needs to be obtained before your surgery. This means you understand all the possible complications to surgery.

Your consent form mentioned that there could be unexpected effects of the surgery. While over 96% of surgeries go perfectly well, many factors can affect the outcome. Some of these factors are a result of unforeseen situations from your anatomy or the condition being treated. No two people are built the same. The reasons for your surgery, be it pain, bleeding, cancer, endometriosis, ovarian masses, or whatever, have a multitude of physical presentations. Unexpected findings can necessitate a change in approach, or *even result in a second surgery*. Adjacent organs can be impinged upon by adhesions, cancer, endometriosis, or other organs, and can be *injured* on purpose or incidental to your primary procedure. Excess bleeding or internal bleeding after the surgery is done occur in about 1% of women. Injury to the bladder, ureter or bowel occurs in 2.5%. Overall about 5% of patients need some additional operation to get their complete recovery. While your surgeon takes every effort to prevent and avoid these complications, *they occur in about 4% of women*. Unfortunately, when a complication happens to you, it is easy to forget that you are part of a small 4%, as it definitely **is 100% of you**! Even if you have to have another operation, as some 4% do, you will get back to your normal health and life. Rest assured that with over many years of surgical experience, your surgeon

has seen and managed most every type of clinical presentation and surgical outcome. Your surgical and medical care will be consistently managed and expertly provided by your surgeon and her surgical associates every day of your hospitalization and recovery.

**Possible complications:**

Urinary tract injuries
- Hole in the bladder
- Injury to the ureter
- Need to re-operate on the urinary tract

Intestinal Injuries
- Hole in the colon or the small bowel

Bleeding
- Internal
- Vagina
- Incisions

Infections
- The vagina, pelvic abscess, urinary tract, wound incisions

Wound healing problems
- Hernias

**IF YOU THINK YOU ARE HAVING A COMPLICATION, FIRST REVIEW THIS HANDOUT OUT TO SEE IF YOU ARE HAVING AN EXPECTED EXPERIENCE THAT IS NOT LIFE THREATENING.**
**If you feel that you are getting sick and need care, or getting worse than how you felt in the hospital, having increasing or unexplained new pain, or not getting gradually better, if you have fever over 101.0, any shaking chills, burning upon urination, cloudy or smelly urine, or if you still have pain after one week, or think you may need more than the 10 Vicodin you were given: call the office. Leave a message if you do not feel that your life is threatened or your issue is an emergency. If you have an emergency after office hours, go to the ER at Clovis Community Hospital.**

**Your informed consent -** Overall, the benefits of the surgery have to outweigh the 4% risks of surgery. But when your body has a problem that is highly likely to be correctable by surgery, then a small amount of risk is very reasonable to undertake. The alternative is always not to operate, or to stick with medical or other therapies, and accept the results. When you sign up for surgery, you are also accepting the surgical results: a very high likelihood of correcting the problem and a very low likelihood of complication. It is this understanding that constitutes your informed consent to surgery.

## Your pre-operative responsibilities

1. Make sure that you understand your diagnosis. Ask me all your questions. Keep a list of all questions that come up after the visit and use that list at our next visit.

2. Make sure that you understand the procedure I recommend: the benefits and likelihood of achieving them, the risks of complications and likelihood of them occurring, and the alternatives to surgery. I will tell you this information before surgery at your final pre-operative visit, but before you sign your consents, make sure that I have answered all your questions to your satisfaction.
3. Read all of the handouts that I have given you. Be ready to ask your questions that develop from reading your handouts. Know how your recovery at home will proceed.
4. Have your spouse, partner or friend who is assisting you during your post-operative recovery read this entire handout so that they can help you in the hospital and after you are discharged.
Name of the person who has read this handout and will be helping you:
______________________________________________________________
______________________________________________________________

5. List all medications, including non-prescriptive over-the-counter drugs, herbs, supplements, vitamins, and please give precise doses of each:
______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________

6. State all allergies/sensitivities to medicines and effects: __No allergies.
______________________________________________________________
______________________________________________________________
______________________________________________________________

7. Give the names of your current physicians, address, phone and fax numbers so I can keep them well informed about you.
______________________________________________________________
______________________________________________________________
______________________________________________________________

8. Commit to your own health: start exercising and healthy eating well before surgery.
9. With my signature below, I certify that I have read the handouts given to me, and that I understand my diagnosis and the procedure planned. I understand the instructions and will follow them or I will call my surgeon for clarification.

| ________________________ | ____________________ | ______________ |
| --- | --- | --- |
| Signature | Print name | Date |