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Preoperative Instructions and Recovery Information (09/2010)

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 one week. For a laparoscopic hysterectomy the recovery is two weeks. For open laparotomy incision surgery of any type, the recovery is six weeks. 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 waste time and resources 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.

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–Dr. O’Hanlan 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 for blood work, EKG and Chest X-Ray. Please remember to give all of the documents in the "Hospital Documents" section to the nurses when you check in at the hospital.

Allergies and Current medications: Please fill out the last page list of **medication allergies** and a list of **all of your current medications with doses and frequencies, including herbal, naturopathic, and over-the-counter drugs**. Stop taking any aspirins or Motrin, Nuprin, Advil, ibuprofen-like substances 3 days before surgery. 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 7 days before your surgery. You must stop taking Mardil, Parnate, Eldepryl, Marplan Clorgyline, Brofaromine, Moclobemide and Tolozatone at least 14 days before your surgery. Stop all Plavix and Coumadin, 7 days before your surgery and discuss Heparin/Lovenox with your cardiologist and with Dr. O'Hanlan.

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 10% of women having open incisional surgery need some type of blood transfusion. There is a charge of \$150 to process each unit of self-donated blood. 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, 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, do not shave 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.

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.
4. Call the hospital (650-367-5627) if you feel weak from not eating so you can go early to the pre-operative area to get your intravenous fluids started. This will relieve your weakness.

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 Dr. O'Hanlan's office, 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 – A Board-certified 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 anesthesiologist 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.

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 cribbage 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. Dr. O’Hanlan 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 way 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 – There is almost always an assistant surgeon who helps Dr. O’Hanlan with the surgery, but she always performs 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. This is standard.

Observers and Industry reps in the OR – Dr. O’Hanlan is nationally recognized as a teacher of advanced laparoscopic procedures and cancer care, and uses state-of-the-art equipment. On many occasions, Dr. O’Hanlan invites other surgeons to observe her surgeries. Or, she requests that registered representatives from the companies that make Dr. O’Hanlan’s equipment attend to provide her with a newer, or recently improved version of her usual equipment. 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 first 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 morphine-like substance called Dilaudid in your buttock muscle, or as a push-button demand drip. You can use the Dilaudid until you are taking by mouth, when you will begin using the Vicodin. If you are not having significant incisional pain, try to minimize use of Dilaudid and Vicodin 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 Vicodin 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 Vicodin 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 (Gas-X), 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. Neither Dilaudid nor Vicodin should be used for this pain. You can try over-the-counter Gas-X at home as well, if the gas pains continue to bother.

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 injections of Toradol and Dilaudid are replaced by oral medications: Naprosyn and Vicodin. Naprosyn is the same as two Aleve pills, for prevention of pain. Vicodin is for breakthrough pain. Take two Aleve every 8 hours for 4 days after surgery to prevent pain, maximize your mobility, and minimize the need for constipating Vicodin. If your pain is greater than level 3 out of 10, take one half Vicodin at first, and see if you need the other half after 30 minutes.

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 or even severely bruised 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 Dr. O’Hanlan only if she does not already know about it. 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 surgery, once all incisions are dry.

If you have vertical 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. If you had clips or staples for your wound closure, relax: they don't hurt when they are removed!

If you had a lymphadenectomy - Expect to have swelling in your legs and lower abdomen for about 5 days after surgery. For 97% of women, this swelling disappears completely. For 3% it remains, but is less than at first. You will awake in the Recovery Room with an abdominal binder on, to compress your tiny incisions and prevent leakage of peritoneal fluid. If you do “spring a leak” just place a folded paper towel or washcloth in the binder to add more compression to the leaky incision. It will seal within 2-3 days, but it can be voluminous and scary. Not to worry, they all seal off.

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 before 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 1-2 days if you had an open horizontal incision, and about 4-8 nights in the hospital if you had an open vertical midline incision.

Discharge to Home – Walk, Eat, Pee, Gas. Plan to go home after you are eating, emptying your bladder, passing gas, and walking well. 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 three times daily outside your house to regain energy and relieve crampy GI pain. Increase your energy by walking whenever you can. Stairs are fine!!! Recovery occurs as you regain your energy over time. It is fine to push yourself and walk as much as you can to facilitate your recovery. Raise your energy level by stretching, floor exercises and walking frequently in the hospital and at home. There is no amount of walking or stairs that harms your incisions or your deeper surgery.
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 really works for surgical pain and reduces the need for the Vicodin (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 Dr. O'Hanlan if you need pain medications after one week.
4. If you suffer from constipation: do not push at home!!! Take your usual stool softener. 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. Dr. O'Hanlan 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. Dr. O'Hanlan calls you with the results of microscopic analysis of all tissues removed, and tells you what follow-up testing or treatments should be done. (radiation, chemotherapy, regular checkups) She faxes a note with all the surgical documents to your local referring doctor and to any other local treatment doctors required for your further care once home. Even if you are from afar, call Dr. O'Hanlan for any complications.

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. (Imagine taking off your bra after a long day, your breasts simply settle into their natural position!) In 6 women the bleeding has required an emergency trip back to the office or hospital for cautery or suture, because it was profuse. If you think the bleeding is heavier than a period, call me so I can be on alert, and possibly plan to meet you for a treatment. If you have any sense of emergency, go to the Sequoia Emergency Room, and have them call me—they have all my numbers. If the bleeding is dramatic (it was for two women), simply go to your nearest hospital emergency room and have me called through my office number.

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.

About complications - Dr. O'Hanlan has performed over 1200 total laparoscopic hysterectomies, and over 5,000 open-incision procedures. She has published over 40 peer-reviewed journal articles about gynecologic surgery and frequently analyses her surgical data. (see website for link to pubs)

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 into the tissues or internal bleeding after the surgery is done will occur in about 2% of women. Injury to the bladder, ureter or bowel occurs in 2.3%. Overall about 4% of patients need some additional operation to get their complete recovery. While Dr. O'Hanlan 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, you will get back to your normal health and life. Rest assured that with over 26 years of surgical experience, Dr. O'Hanlan 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 Dr. O'Hanlan and her surgical associates every day of your hospitalization and recovery.

My complications: 1177 cases from September, 1996 to February, 2010	Total number of complications		Complications requiring Re-operation	
	Number	%	Number	%
Urinary tract injuries:				
Hole in bladder, repair	15	1.3%	2	0.2%
Ureter injury, repair	4	0.3%		
Ureter injury, re-implanted	4	0.3%	4	0.4%
Ureter injury, tube placed	4	0.3%	4	0.3%
Urinary tract subtotal	27	2.3%	10	0.8%
Intestinal Injuries				
Bowel injury from dissection	3	0.3%	2	0.2%
Bleeding				
Post-operative bleeding	8	0.7%	8	0.8%
Blood clot in tissues	8	0.7%		
Vaginal cuff bleed	13	1.1%	9	0.9%
Infections				
Pelvic inflammation	13	1.1%		
Pelvic fluid collection	3	0.3%	1	.1%
Pelvic abscess	7	0.6%	4	0.4%
Colon inflamed, infection	2	0.2%		
Wound healing problems				
Bowel obstruction	3	0.3%	3	0.3%
Incisional hernia	4	0.4%	4	0.4%
Vaginal injury 6 wks later	5	0.5%	3	0.3%
Converted to open (failed TLH)	15	1.3%		
Retained surgical device	1	0.1%	1	0.1%
TOTAL	112	9.5%	45	3.8%

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 you are seriously sick, or your life is threatened, or your issue is a real emergency. Call me on my cell phone number (on outgoing message) for real emergencies. Please do not use my cell phone unless it is medically emergent.

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. Laparoscopic removal of ovaries entails a 1-week disability. Dr. O’Hanlan cannot honestly or ethically extend the disability unless you have a documented complication from the surgery.

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.

Because surgery is my passion and what I trained for until age 32, and taught for ten years, and practiced for twenty-five, I offer what I believe to be the very highest quality of care. I will not operate on a problem that is not likely to be correctible. I do not do certain procedures that I believe are not indicated or tried and proven, or that are irresponsible (e.g.: supra-cervical hysterectomy, endometrial ablation, myomectomy on peri-menopausal women). I will refer you to any surgeon by whom your situation would be better managed. My commitment to your health is absolute. I urge you to partner with me in that endeavor by reading all my information, asking all your questions, living a healthy lifestyle, and following through on our care plans. I will give you my utmost best.

Finally, if you appreciated your surgical experience and the care of our Sequoia Hospital Staff, let Sequoia know. Also let us know how we can improve. Send your letters to the President, Glenna Vaskelis, Sequoia Hospital, 170 Alameda de las Pulgas, Redwood City, CA 94062-2799

And if you have extra money that you want to share with our Sequoia Hospital mission of being a healing force in our California community, send a donation of any amount to the Sequoia Hospital Foundation, same address as above and on the web at: <http://www.sequoiahospitalfoundation.org>

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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 Dr. O'Hanlan for clarification.

Signature

Print name

Date