Kate O'Hanlan, M. D.

F. A. C. O. G., S. G. O., F. A. C. S., F. M. I. G. S.

Laparoscopic Institute for Gynecology and Oncology

40 Buckeye

Portola Valley, CA 94028-8015

Phone: (650)-851-6669 ohanlan.com LIGOcourses.com FAX: (650) 851-9747

Preoperative Instructions and Recovery Information (7/2019)

This document is intended to help you prepare for your surgery, 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. Please have your spouse, partner, or friend who will be your main caregiver read this entire document so as to be most helpful during and after your hospitalization.

Choosing a date for your surgery – Recovery from a laparoscopic (tiny incisions) outpatient procedure is 1 week (myomectomy, ovarian cyst removal, treatment of endometriosis, suspension of vagina, etc). For a laparoscopic hysterectomy, the recovery is less than 2 weeks. For any open incision surgery (laparotomy) of any type, the recovery is 6 weeks. 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. We build our office and surgical schedules around our commitment to your surgery date. 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 current 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.

Pre-operative visit – Our doctors will have reviewed your entire medical history, and conducted a pre-surgical thorough exam, and then will formally review with you her findings and will explain the risks, benefits, and alternatives of your specific surgical plan and answer all your questions. Only after that, you will then be asked to sign a consent form for your surgery. Remember that these consents are written to ensure 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. We will give you 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, if required. Please bring this folder with this handout to the hospital with you. The nurse will ask for it if it is needed. You will need to re-read the post-operative instructions section before you leave the hospital.

Allergies and current medications: Please list of your current medications, including herbal, naturopathic, and over-the- counter drugs (with doses (mg) and frequencies (daily, twice daily, etc.) and all medication allergies on the last page of this document. Read carefully:

- Stop taking all aspirins or Motrin, Nuprin, Advil, ibuprofen-like substances 3 days before surgery. Use only Tylenol(acetaminophen) or Tramadol if you need pain relief before your operation.

1. Stop all herbal remedies and nutritional supplements, Meridia, Fastin, Ionamin, Adipex, and any amphetamines 7 days before your surgery. (All supplements, including CoQ10, green tea, gingko, ginseng, omega3FA, dong quai, willowbark.
2. If you are taking ANY BLOOD THINNER (Plavix, Pradaxa, Eliquis or Coumadin OR ANY OTHER CLOTTING MEDICATION), make a plan with your prescribing provider to stop taking them 7 days

before your surgery and discuss “bridge anticoagulation with Lovenox” with the prescriber and tell our team the “bridge plan.”

3. You must stop taking Mardil, Parnate, Eldepryl, Marplan Clorgyline, Brofaromine, Moclobemide, and Tolozatone at least 14 days before your surgery.

Take all of your other prescription medications (except as above) exactly as prescribed, the night before and the morning of your surgery with just a sip of water. Reduce your insulin or anti-blood sugar medication exactly to half what you use in the morning of the surgery. Bring all your medications in their bottles with you to the hospital so the nurses can record them. While in the hospital, you will receive all your necessary medications from the hospital pharmacy. Resume all your meds and supplements and herbal remedies upon discharge from the hospital.

Pre-operative testing – If you have had any blood work in the past few months, let us know so we can avoid unnecessary blood draws. Sometimes it is still necessary to draw your blood to establish a more current baseline value prior to surgery and to cross-match 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 stop by the hospital for these tests if necessary.

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. JEHOVAH’S WITNESSES: we will respect and will follow your instructions regarding what is allowed and disallowed. Tell us if you are a Witness.

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 any jewelry or make-up to the hospital. There is no need for pajamas, as the hospital provides covering for you. Bring necessary toiletries, a few light sanitary pads, any essential health aids (such as CPAP), and perhaps a puzzle book. Do not wear any eye make-up, as it may enter your eye fluid during your anesthesia and cause severe irritation. 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 finding them with you in the recovery room ready to put back on/in as soon as you wake up.

One week before surgery, purchase the below items:

- Acetaminophen 500-mg and Aleve 220-mg gel caps, 30-tablets of each, for preventing pain for the first 2 days after you leave the hospital. Narcotics are no longer used after discharge, as acetaminophen with Aleve has been proven to provide equal pain relief as the previously-used narcotics. Even if these did not work for your arthritis or other pains …together they really work well for surgical pain. You must take these to prevent the usual discomfort from surgery.
- Chewing gum: Bring your favorite chewing gum to the hospital. Chewing gum hastens recovery of bowel function.
- Milk of Magnesia: to relieve any constipation or gas pains you might develop after you go home. If you have chronic constipation or irritable bowel syndrome, it will happen after your surgery as well, if you don’t prevent it with MOM.
- One week of healthy, easy-to-prepare foods for you to come home to, as you won’t be driving for this first week.

Two days before surgery:

Eat regular food today. Pack your bags. Remember what you forgot. Clean your house. Stock the fridge with healthy food that you love. You will be a new and healthier person when you come home!

Only if you were told that a Bowel Prep is needed on the day before surgery: Sometimes, the entire length of your intestines must be emptied prior to surgery to make the surgery safer and the recovery easier. Empty bowels also allow more room for me to operate. (if you were not notified to do this---you don't need this.)

Consider buying 1 roll of very soft toilet paper, or Huggies brand non-scented moist towelettes, or A&D Ointment, (or all three) for wiping and to smear over your anus in case it gets tender. Call us with your pharmacy telephone number if you need a Rx:

MIRALAX over-the-counter drink: Start drinking at 6 pm the night before. Mix two scoops/8ounces water repeatedly, or mix 8.3 oz. of Miralax/64 ounces of water, Gatorade or Crystal Light or vegetable/chicken broth OR Knudson Organic Recharge Thirst Quencher. Drink an 8-ounce glass every 15 minutes until stool becomes liquid and resembles "coffee with cream". (sorry coffee-drinkers)

Antibiotics will be prescribed to your pharmacy to help cleanse your bowels of bacteria for surgery. Neomycin 500+metronidazole 500 at 4, 6, 8pm. Take exactly as directed.

1. Eat low or no-fiber food today (For example: fish, dairy, eggs, meat, chicken all have no fiber and are 100% easily absorbed. All fruits, vegetables, grains, breads, nuts or legumes are excellent high-fiber-foods, but they'll make your bowel prep crampy and difficult.) You won't be eating dinner, but you will not be hungry during or after the bowel prep.
2. Start the bowel prep much earlier if you have chronic constipation. After you have ingested the prep, you will later develop painless, copious, ultimately 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 are fine), you may stop the bowel prep drinks and go to step 3.
3. After bowel prep, the night before, drink lots of any clear liquid that you would like until midnight.
4. Finish cleaning your home. This is a time for a real cleansing! When you come home you can be the real, the improved, the newest, bestest you.
5. You can have clear liquids on the morning of your surgery up to two hours before, but carefully stop eating any solid food for 6 hours before surgery. For your safety, your surgery will be cancelled for another day if you have not followed these instructions correctly.

The day of surgery: 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 through the Emergency Room entrance to the hospital.

1. Meds: Take only your daily prescription medications with a small sip of water. IF you are diabetic, reduce your diabetic injection meds by 50% that pre-op morning, but take no oral diabetes medications at all. Take all other prescription medications with only a sip. Bring all your medications, and give them to the admitting nurse to record.
2. Take a nice shower. It is fine to shave your legs if you prefer but, do not shave the surgical site for us. We will shave only what is medically essential for the incisions in the operating room, if needed. Shaving the incision site before this time is proven to increase wound infection rates. Apply no make-up. Wear no jewelry.
3. Bring: contact or glasses case, dental fixture cases, and YOUR CPAP machine (if you are on one). Pack an overnight bag. No need for your jammies—we got 'em.
4. Be on time. Bring a pillow in the car for the ride home to place over your lap and under the seatbelt.
5. If you feel weak from not eating the morning of your surgery, drink more liquids, and come earlier to the Short-Stay Unit (Pre-op) and get your intravenous fluids started sooner. This will relieve any weakness from prolonged fasting. Call the hospital (559-459-6000) to let them know you are coming and just come.

Hospital Check-in – 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, then go to the Short-Stay Unit (Pre-op) on the second floor. Keep the receipts and all printed information that you receive during the check-in and pre-op processes in your surgical folder. Bring your surgical folder that we gave you containing your consents and orders and give the nurses all of these when you check in to the hospital if they ask for them.
Show your medications and CPAP machine to the nurse.

Pre-operation procedures – A nurse will review the forms that you completed and will ask you questions to complete new forms. Once the paperwork is complete, the nurse will give you your hospital gown. You may medications, and a blood-thinning shot to your abdominal wall skin, called Lovenox. 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 by answering all of your questions.

Anesthesia – A certified anesthetist will provide your general anesthesia during the entire case. 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 anesthetist will meet you in the pre-operative area to explain your anesthesia plan. Be sure to tell him/her if you tend to get easily nauseous because today there are medications that can be added to your IV to significantly reduce any chance of nausea after surgery. If you find that you are simply too, too nervous, ask the nurse to request from the anesthesiologist an anti-anxiety shot that will help you to relax (quite nicely!) prior to surgery.

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. We 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 anesthetist will give you intravenous medications to fall asleep.

The assistant surgeons –There is almost always an assistant surgeon who helps our doctors with the surgery, but the Oncologist always performs all of your surgery. In addition, other doctors with other specialized 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 –On many occasions, other surgeons or medical device makers are invited to observe surgeries to improve care. 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 done entirely respectfully, and is strictly monitored 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. If your urge to pee is too bothersome, ask for the medication to ease this sense of urgency. 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 the time when I dictate the operation report 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 90 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 to receive 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.

If the bladder tube feels especially uncomfortable, ask your nurse to check to see if it can be adjusted. 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. There may also be tubing just outside your nostrils to provide oxygen. (If your mouth gets too dry, ask your nurse to for a mouth moisturizer.) You might feel "trapped" by a lot of tubes, but you can sit up when you feel like it. Before you get out of bed, sit with your legs dangling off the bedside for 5 full minutes, then go for a 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! It will help relieve gas pains and shoulder pains.

Pain Prevention, three ways, before and after surgery: Inflammation and pain slow your recovery, inhibit your movement, and delay normal bowel and urinary function. By preventing and staying ahead of pain and inflammation with preventive round-the-clock medications, you can have a rapid and comfortable resumption of your normal life. My approach while you are in the hospital is to aggressively prevent the pain with many medications that have been shown to work together to prevent pain better than narcotics. The recovery is entirely manageable; however, everyone experiences pain differently.

Whatever your pain threshold, expect to experience some discomfort after your surgery, but not too much. Report your level of pain 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.

1. **Incision discomfort in first 24 hours**: This is dull and constant and will actually subside significantly over the first 12 hours, becoming more of an ache. Even though you are taking the Acetaminophen and an NSAID to prevent pain, if you do experience pain that is above, say, level 3 out of 10, then ask for and take the narcotic medication. For this "breakthrough" pain in the hospital, you will receive a morphine-like substance in your IV line or by mouth. If you are not having significant incisional pain, don't ask for a narcotic, as these drugs will slow your bowels from pumping and can delay and prolong the cramping phase and inhibit your bladder from emptying. The incisional pain from laparoscopic surgery is minimal after 12 hours and most patients need only Acetaminophen and an NSAID (Tylenol and Aleve) after discharge.
If you have a vertical surgical incision or a lymph node dissection, you will wake up with a binder (like a girdle) compressing your abdomen. Keep this binder centered over your incision(s) to keep comfortable pressure on it. Use the binder at home for three days, as tolerated, but do keep it on in the hospital. Your incisions should cause minimal pain after discharge.
2. **Intestinal cramps**. After surgery, your bowels quit pumping. Chewing gum can speed up the recovery of your bowels. About 12-36 hours after surgery the gut resumes pumping and you will go through a 2-4-hour cramping phase as it gets back to coordinated pumping. Some people experience no cramps and only a very few will have severe cramping. We will give you Simethicone (Gas-X), if you request it, 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. Chewing gum can help the "crampy phase" as there is no cure for it other than a "tincture of time" and walking. (Please, thus, walk and chew gum!) Narcotics should not be used for this pain. You can use over-the-counter Gas-X and gum at home as well.
3. **Rib or 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 remains outside the bowels in the abdominal cavity 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 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 Acetaminophen and an NSAID can help.
4. **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 inserted to help you breath during the surgery and was

removed before you woke up. If bothersome, ask for some throat lozenges for relief. Sometimes a patient wakes up with some numbness in a small area of the tongue, or fingers. This will go away after 7-10 days.

We give you three medications to prevent pain throughout your stay:

A.) For decades, the class of Non-Steroidal Anti Inflammatory Drugs, NSAID's, that include Ibuprofen (or Motrin) and Naproxen (Aleve), and Celecoxib (or Celebrex), have been found effective for surgical pain when combined with acetaminophen. It has been shown in good research that an NSAID and Acetaminophen are exactly as effective as a narcotic and Acetaminophen, so we only prescribe an NSAID and Acetaminophen for home use. Even if you feel that these meds don't work on your chronic back pain, arthritis, or pelvic pain, they really do work for surgical pain, so do purchase them. We do not prescribe any narcotics for home use.

B.) Acetaminophen (or Tylenol) works to prevent pain sensation by the brain as well.

C.) Gabapentin (or Neurontin) calms nerves from conducting pain messages to the brain, and is proven to reduce pain, nausea, vomiting, and urinary retention after surgery. Gabapentin will be given only once, before your surgery, because it can make you a little sleepy.

All three classes of these medications work at very different points along the pain transmission pathway to prevent pain sensation after your surgery. Two hours before your surgery, all three medications are given to you by mouth with just a sip of water. Then Acetaminophen and an NSAID are given intravenously soon after your surgery. Automatically every 6 hours after your surgery, these meds are given by IV until you begin eating and then you receive them orally to continue to prevent the pain.

Get out of that bed!!! - The most important factor in your recovery is walking. The second most important factor in your healing is walking. I bet you know what the third most important factor is! Get out of bed as soon as the nurses let you and walk in the room and later in the hallways to hasten your recovery of your overall sense of well-being. Walks up and down the hallways are best. All meals in the hospital and at home should be eaten in a chair, not the bed.

The morning after your surgery – The tubes come out and you move even more!!!! The intravenous line, the bladder catheter, and the leg compression devices are removed. You may shower and pat your incisions dry.

Your bladder – Once the catheter (the tube that drains the bladder) is painlessly removed the morning after your surgery, some women notice a feeling in their bladder as it empties in its new configuration. This "odd" bladder 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 2 weeks.

Call the nursing staff if you find that you cannot empty your bladder within 4 hours after the catheter is removed. About 5% of women will have difficulty emptying their bladder after surgery. Some women need extra bladder rest before their bladders work well again and may need to have the catheter re-inserted for a short while. The combination of anesthetic medications, the pelvic nerve's response to recent surgery, and pelvic tissue swelling causes a temporary inability to empty the bladder. The treatment is to put a catheter back in the bladder for 4 days. It can be removed painlessly and easily at home then, with 100% return to normal function. Sometimes the bladder needs just a tincture of time to get to normal.

Try to empty your bladder every 2 to 4 hours to begin to familiarize yourself with your renewed bladder function. 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 production during times of stress, and then releases it once the stress has passed. This "diuresis" is normal and, in fact, reassuring that all is well. It is called the "diuretic phase."

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.

Your bowels – You may experience a painful cramp every time you empty your bowels for about 2 to even 4 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 (swear, really!). Try to remember this fact when you have cramping after meals 2 to 4 weeks after your surgery—it is normal! And temporary! Chewing gum actually has been proven to help return of GI function. 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 at all), then bloatiness (intestines not pumping much), then gas pains (intestines pump in a very uncoordinated fashion), and finally passage of gas (intestines finally coordinated pumping) when you will finally begin to 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 2 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.

Your incisions – Your incisions should stop hurting in a few days after your surgery. You may shower, swim, bathe, or soak in a hot tub any time after your surgery, once all incisions are dry. If any of your incisions develop oozing after you go home, cover them to protect your clothes with non-sterile dressings such as paper towels or Band-Aids®—fine to still shower with dressing on, then re-apply new dry dressing afterward. Some will get huge black and blue bruise marks around the incision, in their lower abdomen or even down to the upper legs after going home. This is because some blood can ooze deep beneath the outer skin after the surgery (in a layer that we cannot see) and cause a large, painful bruise.
Such a “hematoma” will resolve, but it will be achy and discolored for about a month. We actually cannot prevent those…sorry. If you have diabetes, we manage your blood sugars in the hospital much more closely than you do at home. We also give you some sugars in the IV fluids, so you really may need some insulin even though you may be totally and only on oral diabetic medications. You will be back on your same meds at home, but let us keep your sugars in the perfect range “in house.” Careful management of your glucose levels at home facilitate a safer recovery. If you have a vertical incision, you may shower, swim, bathe, or soak in a hot tub once the incision is dry and closed. Even long vertical midline incisions generally stop hurting in less than 1 week. If you have any open 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. If you had clips or staples for your wound closure, relax, they don’t hurt when they are removed! We arrange for these clips to be removed 10-12 days after your surgery by your local nurse or doctor.

If you have drains – These temporary plastic tubes are meant to drain unwanted collection of bodily fluids where the surgery was, so if fluid escapes around or through the tubing, all is well. If fluid passes around the tubing, it can be messy and maybe scary…. just place a non-sterile dressing (such as paper towel, washrag) around the tubing, under your binder to absorb the fluid, and keep your clothes clean. You may shower with the dressing over your drains, but then after you dry, change the dressing to a new dry one. When the bulb fills with fluid, open the stopcock and pour out the fluid into a measuring cup, and write down the volume, then discard into toilet or sink. Squeeze the bulb to recompress the suction and put the stopcock back. Don’t worry about the redness around the opening, as it heals perfectly well after the tube is removed. We will arrange for all tubes and clips to be removed painlessly by your local practitioners at/or around 10 days after the surgery was performed.

If you had a lymphadenectomy – Expect some swelling in your legs and lower abdomen for about 5 days after surgery. It can be stunning. For 97% of women, this swelling disappears completely. For 3%, some of it remains, but is much less than at first. You will awaken in the Recovery Room with an abdominal binder (like a

girdle) 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. Also, you may have some numbness in your thighs and lower abdominal skin. This should fade over time.

If you need hormone therapy – If you are already menopausal and not using hormones, it will not be necessary for you to start taking them, but you might notice a mild difference for a short while after your ovaries are removed. If you are youngish, or if you are already on HRT and your ovaries were removed, your replacement hormones will 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 were started on hormones in the hospital, the adequacy and efficacy of your dose will be assessed in the first few weeks after discharge. If the dose of estrogen you are taking is too much, you may develop tender breasts. Too low a dose of estrogen can leave you with insomnia, hot flashes, and depression. Call if you have these symptoms before your 6-week visit so no one suffers! About 15% of women require changes of dose, route, or type of hormone a few times until it is just right for them. You will feel mentally and physically normal when you are on the right dose for you. Our office is good at hormone replacement therapy, so use us and help us get you to your normal.

Discharge Instructions – In general, you will spend 1 night in the hospital if you had a laparoscopic hysterectomy, about 2 days if you had an open horizontal incision, and about 4-8 days in the hospital if you had an open vertical midline incision.

Walk, Eat, Pee, Gas. Plan to go home after you are walking well, eating, emptying your bladder, and passing gas. You should have no nausea.

• 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. Make sure that you poop regularly!!! Or use Miralax regularly. If you suffer from constipation: do not sit and push on the toilet!!! Take your usual stool softener. For gas pains or constipation: Take Milk of Magnesia or Miralax as directed on the bottle. Make sure you poop easily, daily, forever!

• Exert yourself. Walk for 20 minutes 3 times daily outside your house to regain energy and relieve crampy GI pain. Increase your energy by walking whenever you can. Stairs are fine!!! More stairs are great!!! 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, doing floor exercises, yoga, and walking frequently outside your home. There is no amount of walking or stairs that harms your incisions or your deeper surgery. JUST DO IT!!!

• **To prevent incisional and surgical pain at home: Take acetaminophen 500mg (Tylenol) (two tablets) with 220mg (Aleve) (two tablets), thus four tablets four times a day for 2 days regardless of your pain level. That is four tablets, taken together, four times a day. This really works for surgical pain (does not constipate or slow GI function or make you listless).**

• If you have crampy GI gas pain—just go walking for that pain, and chew some gum. Surgical pain is virtually absent within a few days after surgery and by 2 days you should not need any medication for pain. Call this office if you need more pain medication than this, as something may be wrong, and we need to speak with you.

• Leave the sealant glue or clips on the incisions (but shower as usual, and pat incisions dry). You may peel the glue off your incision any time after 7 days. We will arrange for you to have your clips and drains removed 10 days after the surgery. If your incision becomes newly red, tender, swollen, or oozes green or smelly fluid, cover it, and call our office so we can reassure you or ask you to come in for an exam.

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-very-deep within (It's not!). The uterus and cervix are not any part of your orgasm and their removal does not impact the ease of achieving orgasm, strength 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 normal for them afterwards. Our doctors are 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 (yes, even the same day as discharge!) in any and every way that pleases you. Just no penetration for six weeks. The upper inner vaginal incision takes much longer to seal itself than the outer skin incisions. 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, go ahead and check it out (but stay outside, please!) just as soon as you feel like it! You will be able to resume vaginal penetration after it is confirmed by speculum exam that the upper vaginal incision has healed enough, at the 6-week exam, or possibly later if healing is not adequate. When you resume penetration, don't go too very deep for another month.

Return to exercise – Just do it. APPLIES TO EVERYONE. 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. Get dressed every day. Do not stay in bed. All meals at the table. 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 number 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 1 week after laparoscopic surgery and 2 weeks after standard open abdominal laparotomy. Vigorous recovery and activity are encouraged and you can nap in between. Just do it.

Vaginal bleeding – You might experience a 2-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 out of 1,800 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 an office treatment. If you have any sense of emergency, call me first and then go to the 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 cell number.

Vaginal discharge – The upper 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 entire 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 spot on your undies of normal white vaginal fluid.

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 small incisions, entails a 2-week disability leave. Laparoscopic removal of ovaries entails a 1-week disability. We cannot honestly or ethically extend the disability unless you have a documented complication from the surgery.

Driving - Do not drive until 1 week after laparoscopic procedures and 2 weeks after open incision procedures. This is not because you can't physically push the gas pedal, because most can. But what you cannot RELIABLY do is reliably 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 functions. We will call 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). We fax 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 us for any complications.

About complications – Your consent form mentioned that there could be unexpected effects of the surgery. Over 97% of surgeries go perfectly well, but many factors can affect the outcome, usually an unforeseen situation 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 in 3%. 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 finished will occur in about 1% of women. Injury to the bladder, ureter, or bowel occurs in 2%. Overall, about 3% of patients need an additional operation to achieve their complete recoveries.

While we take every effort to prevent and avoid these complications, they still occur in about 3% of women. Unfortunately, when a complication happens to you, it is easy to forget that you are part of a small 3%, 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.

IF YOU THINK YOU ARE HAVING A COMPLICATION, FIRST REVIEW THIS HANDOUT 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, or have fever over 101.0, any shaking chills, burning upon urination, cloudy or smelly urine, or if you still have unaddressed pain: 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. BUT…. Call me on my cell phone (650-245-3250) for medical emergencies, only. No Rx refill requests, and no appointment requests please! Call office for those needs.

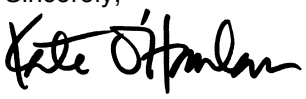
My complications from 2304 TLH cases, over 20 years:	Non-re-operative complications #	%	**Re-operative complications** #	%	Total complications in my practice #	%
Urinary tract injuries:						
Chemical cystitis	2	0.1%			2	0.1%
Hole in bladder, repair	16	0.7%	2	0.1%	18	0.8%
Ureter injury, repaired	8	0.3%			8	0.3%
Ureter fistula re-implant			4	0.2%	4	0.2%
Ureter kink/injury, tubed			5	0.2%	5	0.2%
Urinary tract subtotal	26	1.1%	11	0.5%	37	1.6%
Bleeding post-operatively						
Pelvic	3	0.1%	16	0.7%	19	0.8%
Retroperitoneal hematoma	6	0.3%			6	0.3%
Subcutaneous hematoma	7	0.3%			7	0.3%
Vaginal cuff	4	0.2%	9	0.4%	13	0.6%
Infectious						
Pelvic inflammation	15	0.7%			15	0.7%
Pelvic collection, granuloma	2	0.1%	1	0.0%	3	0.1%
Pelvic abscess	6	0.3%	5	0.2%	11	0.5%
Wound healing problems						
Vaginal injury 6 wks later	2	0.1%	3	0.1%	5	0.2%
Incisional hernia			5	0.2%	5	0.2%
Bowel adhesion/ obstruction			3	0.1%	3	0.1%
Intestinal injury						
Chylous ascites resolved	2	0.1%			2	0.1%
Perforation or Injury	2	0.1%	7	0.3%	9	0.4%
Diverticulitis, C. Difficile	2	0.1%			2	0.1%
Nerve injury	1	0.0%			1	0.0%
Converted to open						
Planned: 4 cancer, 5 fibroids						
Unplanned (fibroids, obesity)	16	0.7%			16	0.7%
Unplanned (vascular injury)	3	0.1%			3	0.1%
Retained surgical device/tissue			2	0.1%	2	0.1%
TOTAL	97	**4.2%**	62	**2.7%**	159	6.9%

Your informed consent – Overall, the benefits of the surgery planned have to outweigh the 3% risks of surgery or we should not be doing 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.

I have performed over 2,500 laparoscopic hysterectomies and 3,000 open-incision procedures. I have published 62 peer-reviewed journal articles about gynecologic surgery and surgical results. I teach these procedures that you are having. I have provided 29 teaching surgical videos on the LIGOcourses.com website. My overarching goal is that all patients receive as minimally-invasive surgery as possible.

Because surgery is my passion and what I trained for until age 32, and have practiced for 33 years, (yes, I'm 65) 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 are unproven, irresponsible, useless or unnecessary (e.g.: supra-cervical hysterectomy, endometrial ablation, or 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 provided information, asking all your questions, living a healthy lifestyle, and following through on our care plans. I will give you my utmost care. And we will ask that you give yourself the same respect."

Sincerely,



Kate O'Hanlan, MD

Kate O'Hanlan, M. D.

F. A. C. O. G., S. G. O., F. A. C. S., F. M. I. G. S.

Laparoscopic Institute for Gynecology and Oncology

40 Buckeye

Portola Valley, CA 94028-8015

Phone: (650)-851-6669 ohanlan.com LIGOcourses.com FAX: (650) 851-9747

YOUR PRE-OPERATIVE RESPONSIBILITIES

1. 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.
2. Have your spouse, partner, or friend who is assisting you during your post-operative recovery read this entire handout so that he or she can help you in the hospital and after you are discharged.
3. 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.
4. Make sure that you understand the procedure I recommend, as well as the benefits and the likelihood of achieving them, and the risks of complications and the likelihood of them occurring, and any alternatives to surgery. I will review 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.

Name of the person who has read this handout and will be helping you: _____

List all new medications, including non-prescriptive, over-the-counter drugs (herbs, supplements, vitamins) and please give precise doses and frequencies for each one:

_____
_____
_____
_____
_____
_____

State all allergies/sensitivities to medicines and effects: ___No allergies

_____
_____

Give the contact information of your current physician (s) (name/address/phone and fax numbers) so I can keep them well informed about you.

_____
_____
_____
_____
_____

Commit to your own health: start exercising and eating healthy well before surgery.

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 for clarification.

_____ _____ _____

Your signature Print your name Date