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TOTAL LAPAROSCOPIC HYSTERECTOMY (TLH)

Please read and sign the following consent form when you feel that you completely understand the surgical procedure that is to be performed and after you have asked all of your questions. If you have any further questions or concerns, please contact our office prior to your procedure so that we may clarify any pertinent issues.

Definition: Total Laparoscopic Hysterectomy (TLH) is an operation to remove the uterus (womb) and cervix with the aid of a small operating telescope, called a laparoscope. The laparoscope is inserted into the abdominal wall through a small incision and allows the doctor to examine the pelvis/abdomen. The uterus and cervix are removed without making a large abdominal incision. Hysterectomy does not require the removal of the ovaries; however the ovaries and tubes can be removed at the time of the hysterectomy if medically necessary.

Procedure: After sedation from general anesthesia is achieved; the doctor will make a small incision at or near your belly button, depending on the size of your uterus, for the laparoscope to be passed through and 2-4 additional incisions in your lower abdomen to insert necessary surgical instruments. Carbon dioxide gas will be used to inflate the abdomen to allow the doctor to insert the laparoscope and visualize the abdomen/pelvis. Through the guidance of the laparoscope the uterus will be freed from ligaments and surrounding blood vessels. An incision will be made at the top of the vagina to release the uterus and cervix; the vaginal incision will then be closed with dissolvable sutures and necessary blood vessels will be cauterized to prevent bleeding. The uterus is then removed through the vagina. If the uterus is large then an instrument called a Morcellator may be used to divide the uterus into small sections that are then removed from the body through one of the incisions. The procedure is then completed by suturing the top of the vagina, the necessary layers of the abdomen and skin, and then placing dressings over the incision sites.

Diagnosis: The most common reasons to have a TLH are: *Fibroids*- non cancerous tumors that cause pelvic pain, heavy and abnormal uterine bleeding, painful intercourse, or other symptoms. *Endometriosis*- growth of uterine lining in other parts of the abdomen or uterine muscle (adenomyosis) that causes pelvic pain. *Uterine prolapse*-the downward movement of the uterus into the vagina. TLH is also done for treatment of pre-cancerous lesions and *gynecological cancers*. Your physician will discuss your diagnosis with you prior to surgery and it will be documented in your medical record.

Expectations of Outcome: TLH typically takes 1-2 hours. When you awake from surgery you will have an IV and you may have a bladder catheter. Some patients will go home the same day as surgery while others may stay one night in the hospital and will be discharged on the day after surgery. TLH is a major surgery and recovery typically takes 2-4 weeks. Following the recovery from a TLH it is expected for women to have relief from pain and correction of abnormal uterine bleeding. You will have a pathology report to discuss with the doctor and determine if any further treatment is necessary. If uterine prolapse was an issue prior to surgery, those patients should have relief from vaginal pressure and pelvic pain.

Possible Complications of the Procedure: All surgical procedures, regardless of complexity or time, can be associated with unforeseen problems. They may be immediate or even quite delayed in presentation. While we have discussed these and possibly others in your consultation, we would like you to have a list of some specific complications so that you may ask questions if you are still concerned. Aside from anesthesia complications, a list of possible complications, would include, but are not limited to:

- Organ Injury:** During any part of the procedure, any organ in the abdomen or pelvis (liver, spleen, colon, intestine, bladder, stomach, ureter, etc) can be inadvertently injured. Often the injury is minor and can be treated with

relative ease; however if the injury is major or the repair is complicated, more extensive surgery may be necessary. This may prolong the hospital stay and recovery and might also necessitate additional surgical procedures in the future. While TLH has a lower incidence of complications for most injuries; Ureteral injury is statistically higher in TLH vs abdominal hysterectomy. The risk is approximately 3-4%. Ureteral injuries from electrical cautery instruments may not become obvious for 7-21 days after surgery. Your surgeon may look into your bladder near the end of your surgery to make sure that urine is entering the bladder from both ureters. To ease visualization of the urine you may be given an IV dye that will turn your urine blue for several hours. By looking in the bladder, the risk of unrecognized ureteral injury is lowered but not eliminated.

•Infections: Although prophylactic antibiotics are given through your IV prior to surgery, post operative infections can still occur. The most common type of infection is a bladder infection (UTI). A UTI can cause burning with urination, increased urinary frequency, blood in the urine, pelvic or back pain, fever and or chills. A wound infection can also occur in the incision sites on the abdomen. If an infection is present, the incision will be red, warm to touch and possibly oozing a brown odorous discharge. Pneumonia is an infection involving the lungs. Pneumonia may occur from lack of deep breathing after surgery due to pain from the incision sites. Early ambulation and deep breathing helps to reduce the risk of pneumonia. A pelvic abscess is when an infection occurs at the top of the vagina or the area where the uterus was removed from. Fever more than 100 degrees; increasing pain, severe constipation, and malodorous vaginal discharge can be signs of this type of infection. While rare, sepsis is another infection that can occur. Sepsis is when the infection enters the bloodstream and can make you very ill. Sepsis symptoms usually include: fever, chills, weakness, nausea, vomiting and or confusion. *If any of the above symptoms of infection occur, call our office.*

Vascular Injury: Any of the vessels inside the abdomen are at potential risk for injury during TLH. Inadvertent injury to a blood vessel can occur as instruments are introduced into the abdomen, during dissection of the uterus from the surrounding tissues, or from electrical injury to the vessel wall. Another type of vascular injury occurs when the sealed or sutured vessel comes loose after the procedure has been finished. Most of these injuries are recognized and resolved at the time of surgery. Major vessel injury or delayed bleeding may require additional surgery, prolonged hospital stay and recovery, readmission to the hospital, and blood transfusion.

*Cancer Spread: If the Uterus contains a fibroid tumor then the chance that the Fibroid could represent a cancer called Leiomyosarcoma is approximately .25% (.23% to .27%). If an unanticipated cancer (Ovarian, Endometrial, Fallopian Tube, or Leiomyosarcoma) were morcelated by knife or power equipment then the cancer would be upstaged. This increases the possible treatments needed (such as additional surgery, Chemotherapy, and/or Radiation) and can increase the probability of cancer spread, recurrence, and cancer death.

•Blood Loss/Transfusion: The vaginal region is vascular. Usually the blood loss in this procedure is minimal to moderate. In some cases blood loss can be significant enough to necessitate a blood transfusion. If a transfusion is necessary, there is a small risk of blood related infections such as Hepatitis or HIV.

•Painful Intercourse and Vaginal Shortening: After a hysterectomy, the shape of the vaginal vault can change. In rare cases, the depth of the vagina may be lessened and the angle changed. Some women may complain of pain or difficulty with intercourse. Sometimes this complaint is temporary, but it can also be permanent.

•Hematoma: When a small blood vessel continues to bleed after the procedure is over, the area of collected blood is referred to as a hematoma. The body normally re-absorbs this collection over a short period of time and surgical drainage may be necessary, however, this is rare.

•Chronic Pain: With any procedure, a patient can develop chronic pain in an area that has undergone surgery. Typically, the pain disappears over time, although some feeling of numbness may persist.

•**Deep Vein Thrombosis (DVT)/Pulmonary Embolus (PE):** In any operation (especially longer operations), you can develop a clot in a vein of your leg (DVT). Typically, this presents two to seven days post op as pain, swelling and tenderness to touch in the lower leg area. Although less likely, this blood clot can move through the veins and block off part of the lung (PE). This presents as shortness of breath and chest pain. *If you notice any of these signs, call our office.*

•**Lower Extremity Weakness/ Numbness:** While this is rare, it is possible that due to the positioning of your legs in the lithotomy position (legs in the air/stirrup) for a long period of time or direct injury to nerves by surgical instruments, you may develop weakness or numbness in your legs. It is usually self-limited, with a return to baseline.

Cuff Dehiscence: If the top of the vagina does not heal properly after surgery then the skin edges may separate. This can cause bleeding and in rare cases can allow intestines to herniate into the vagina. The occurrence of cuff dehiscence is greater in TLH than in other forms of hysterectomy. This complication may not occur until as much as 8 weeks after surgery. It is extremely important to not resume intercourse (vaginal penetration) until released to do so by your surgeon. *If you have sudden onset of watery or bloody discharge beyond what a light sanitary pad would take care of, then call our office.*

Permanent Injury/Death: Permanent injuries from surgery are rare but do occur. Permanent injuries may involve removal of organs not planned during the original surgery, pain that does not resolve with time, or diminished ability to enjoy life. Death is extremely rare from Gynecologic surgery but does occur. The most common reasons are massive blood loss, overwhelming sepsis, heart attack, DVT/Pulmonary embolus, stroke, and anesthesia complications.

Additional Procedures/Consultations: If there are unanticipated findings, difficulty during the surgery, or a situation where your doctor does not believe that he has the expertise to accomplish all of your case then an intra-operative consultation may be necessary. Intra-operative consultation is when another physician or surgeon is asked to give recommendations, assist or take over a surgical case. This occurs at your doctor's discretion for your safety and without regard to whether the other physician is on your insurance panel. By signing below you give consent to intra-operative consultations if necessary.

Photographs/Recordings: Still photographs and digital recordings of your surgery may occur for documentation of intra-operative findings or for educational purposes.

Consent:

I, Dr. _____, have counseled _____ regarding her planned surgery. In my professional opinion I believe that the surgery is reasonable and most likely will result in a beneficial outcome. It is my belief that the patient has considered her options and fully weighed the risks of surgery.

Signed _____ Date _____ Time _____

I, _____, believe that the surgical procedure listed above is the best option for me. My situation is not an emergency and I understand that I have other options, including not having surgery. I understand that complications, bad outcomes, and unanticipated events will occur occasionally during surgery and recovery. I understand that my doctor and his surgical team are not perfect and at no point have I been guaranteed any outcomes or results. I have been given the opportunity to ask all my questions and I believe that I have all the information necessary to make a reasonable decision. Therefore, I elect to give my consent and proceed with the above surgery, as witnessed by my signature below.

Patient Signature _____ Date _____

Witness Signature _____ Date _____

