Surgery Information Packet

Thank you for trusting us with your health care. We strive to provide patient-centered and compassionate care in all settings. Please let us know if there are any areas for improvement. The information provided here is designed to help patients through the preparation for and recovery following urogynecologic surgery. Please read the pre and post-operative care information prior to your surgery so that you have the opportunity to ask questions.

There are many different kinds of surgery and sometimes adjustments are made in the operating room to provide the best possible care, so it is important that you know what is planned (and eventually done) for you.

You and your doctor have discussed your surgery, with your individual goals in mind.

- ☐ **Hysterectomy** – Removal of the uterus
  - ☐ Supracervical hysterectomy – done laparoscopically, leaves the cervix in place
- ☐ **Salpingoopherectomy** – Removal of the ovaries and fallopian tubes
- ☐ **Vaginal / Uterine suspension** – Reattachment of the top of the vagina/cervix to strong pelvic ligaments to correct (or prevent) vaginal prolapse
  - ☐ Uterosacral Ligament Suspension / Sacrospinous Ligament Fixation
  - ☐ Sacrocolpopexy (this usually involves using mesh material)
- ☐ **Cystocele repair** – Repair of the relaxed (or torn) wall between the bladder and vagina, using supportive sutures or mesh material (also called anterior repair, or bladder "tack")
- ☐ **Rectocele repair** – Repair of the relaxed (or torn) wall between the rectum and vagina, using supportive sutures or mesh material (also called posterior repair)
- ☐ **Enterocele repair** – Repair of the relaxed tissue at the top of the vagina that allows the intestines to bulge into the vaginal space.
- ☐ **Perineorrhaphy** – Usually accompanies a rectocele repair and helps to narrow the vaginal opening (it is similar to an episiotomy repair)
- ☐ **Anti-incontinence sling** – Provides support to the urethra using mesh material.
- ☐ **Urethral Bulking** – Narrows the urethra to help treat incontinence
- ☐ **Colpocleisis** – Involves sewing the front and back walls of the vagina together, so that they no longer prolapse. Patients will be unable to have intercourse following this procedure.
- ☐ **Removal / Revision of mesh** - usually performed for pain or mesh erosion
- ☐ **Cystoscopy** – Frequently it is appropriate for your surgeon to look inside your bladder to ensure that there has been no injury during surgery.

VAGINAL SURGERY is done through the vagina; no dressings are necessary.
LAPAROSCOPIC / ROBOTIC SURGERY is done through small incisions on your abdomen.
CYSTOSCOPIC SURGERY is done through the urethra, without any incisions.

You may have a combination of surgical approaches.

"**DAY-STAY" Procedures** – Patients usually go home 1-2 hours after their surgery.

During your surgical day:

You will have a nurse to help you throughout your day in surgery. You will have an IV for fluids and medications and your nurse will give you a snack after surgery.

Before you go home, your nurse will determine if you can empty your bladder completely, and give you complete instructions and supplies for your recovery at home. This includes prescriptions for pain medications, activity instructions and catheters (if necessary).

"OVERNIGHT" Hospitalizations –Your doctor will evaluate you the day after surgery to determine when it is appropriate for you to go home. **Most patients go home the day after surgery.**

During your hospitalization:

You will have a nurse and a nurses' aid to help you during your stay in the hospital. You will have an IV (or two) for fluids and medication and you may be given oxygen through a nasal tube.

You will have air compression boots on your legs and you will be encouraged to walk frequently after surgery to avoid developing blood clots.

The morning after surgery, you will probably no longer need oxygen, IV fluids or compression boots and these will be disconnected by your nurse.

If you have Medicare, you may want to bring your daily home medications to avoid medication charges.

Whenever you feel able, you may eat a regular diet, according to your medical needs. If you have special dietary restrictions (diabetes, gluten, etc.), please review them with your doctor BEFORE your surgery.

Once your doctor has evaluated you and determined that you can go home, the discharge planning with your nurse will begin. This usually involves a Bladder Challenge, during which your nurse will determine if you can empty your bladder completely.

Your nurse will give you complete instructions and supplies for your recovery at home. This includes prescriptions for pain medications, activity instructions and catheters (if necessary).

Your recovery at home: (Depends on the extent of surgery performed.)

DAY-STAY - Patients usually only need 1-3 days of narcotic pain medication use, if any. Physical limitations vary, but patients can generally resume their regular activities in 1-2 weeks. Talk to your doctor about the appropriate time to return to work.

OVERNIGHT – Patients might need up to 5-7 days of narcotic pain medication use and may feel fatigued for several weeks. Many women report not feeling completely well for 2 to 3 months after a hysterectomy. If you keep gradually increasing activity, you will help speed your recovery. Remember, surgery is really a kind of trauma; you should expect to feel weak, tired, and sore for many weeks as you progressively heal.

The two most difficult aspects of your recovery will involve bladder and bowel function.

BLADDER CARE : Before you go home from surgery, we will test your bladder function. **About 50% of women undergoing urogynecologic surgery will not be able to empty their bladder completely for 2-10 days after surgery.** The safest way to recover your bladder function is to perform self-catheterization; that is, void on your own as much as possible, and then insert a small tube through the urethra and into the bladder to drain the rest of the urine. Self-catheterization has the lowest bladder infection rate and the highest patient satisfaction rate. The nursing staff will test your bladder and then, if necessary, teach you how to self-catheterize or how to manage your temporary catheter.

IF YOU ARE PHYSICALLY ABLE, YOU SHOULD PLAN ON LEARNING TO PERFORM SELF-CATHETERIZATION BEFORE OR AFTER YOUR SURGERY.

BOWEL CARE : It is VERY important that you keep your bowel movements soft so that you do not strain excessively. Anesthesia, decreased activity, and pain medications all tend to make you constipated. This is especially important if you have had a hysterectomy with vaginal suspension and/or a rectocele repair. We strongly encourage you to start this regimen **right away,** so that you have a bowel movement within a few days of going home:

High fiber diet—fruits, vegetables, grains like bran, brown rice, whole wheat, bran/high fiber cereal.

Drink 6-8 glasses of water a day. A half glass of prune juice with a half glass of warm water in the evening may also be helpful.

Take a fiber supplement--Citrucel, Fibercon, or Metamucil--twice a day.

STOOL SOFTENER - Take 2 PeriColace capsules every night until you have a regular bowel movement (decrease to one 1 per night if bowel movement is loose).

If you become constipated, take milk of magnesia, or Dulcolax (both over-the-counter medications).

If you still have not moved your bowels by 4-days after surgery, use a Dulcolax suppository or a fleet enema.

ACTIVITY / LIFTING : You should get up, shower, and dress every day. Go out for a walk if the weather permits, remembering moderation is the key. If you are exhausted after a walk or on the following day, do not walk as far. Listen to your body; it will tell you if you are doing the right amount of exercise. You may go carefully up and down stairs as you need to, but use the handrail. You should not bike or do aerobics.

As a general guide try not to lift anything heavier than ten pounds (a gallon of milk weighs 10 pounds) for six weeks following surgery (two weeks for minor surgery). You should not be lifting grocery bags, laundry baskets, or using a vacuum. When doing even light lifting, make sure that you bend at the knees and not at the waist. Don't hold your breath; holding your breath when you lift increases pressure in your pelvis. Try to protect your new pelvic support – the more you challenge your repair with impact activities, the greater the chance the problem will recur.

Avoid any activity that requires you to GRUNT or STRAIN.

DRIVING / TRAVEL : No driving while taking strong pain medication such as Ultram (Tramadol), Vicodin (hydrocodone), Percocet (oxycodone), or Tylenol with Codeine (acetaminophen with codeine). If you feel any pain when you move your legs suddenly, your reflexes will be slowed and you will not be a safe driver. For about 6 weeks after surgery, you are also at risk for developing blood clots in your legs. Because of this, if you are driven in a car, stop at least every hour so you can walk around. The action of the large muscles in the legs helps pump blood. If you sit in a cramped position for too long, you increase your risk of forming a life-threatening clot. You may travel by plane as early as two weeks after surgery – as long as you feel that you will be comfortable sitting for several hours. You should get up and walk around every hour as much as possible to decrease the risk of blood clots.

BATHING : You may shower, bathe, and/or use sitz baths any time. If you have a catheter in your bladder, simply bring the collection bag into the shower, or put it next to the tub. You may also be given a plug for your catheter so that you can disconnect the bag

VAGINAL CARE : Nothing should be placed in your vagina except vaginal cream if prescribed by your surgeon. You should not have intercourse or use tampons until after your surgeon examines you at your 6 weeks appointment. You may have some vaginal spotting. This is normal. If you are bleeding enough to saturate a pad in an hour, **call immediately**.

PAIN MEDICATIONS : Pain medications are important to your recovery – they help you sleep better and move more easily when you first get home. Try to take her medications with a few bites of food to avoid nausea and vomiting.

REMEMBER: Pain medication like Vicodin, Percocet, and codeine can cause constipation, generally not as often with Ultram (tramadol).

Although the amount of pain medicine needed varies from person to person, we suggest you follow our recommendations about scheduling your medicine.

(you may have individual adjustments due to allergies, etc.)

Ibuprofen (Motrin, Advil) 600mg every 6 hours to decrease inflammation
Acetaminophen (Tylenol) 1000 mg every 6 hours
Tramadol (Ultram) 50-100mg every 8 hours
Oxycodone 5-10mg every 6 hours (ONLY IF NEEDED FOR SEVERE PAIN)

These medications work best when staggered so that you are taking something every 3-4 hours.

OTHER MEDICATIONS : Resume all of your pre-operative medications unless told otherwise.

CONTACTING YOUR CARE TEAM :

You should not hesitate to call with any problems or questions, no matter how minor. We need to hear from you immediately if you have:

- A fever greater than 100.4
- Increasing or severe pain
- Vaginal bleeding greater than 1 pad an hour
- Redness, painful swelling or leakage from any visible incision
- Inability to drink fluids or pass your urine
- Inability to move your bowels more than 4 days after surgery

Main Patient Number:	352-265-8200		
Fax:	352-265-8202		
Nursing Staff :	352-265-8568	or	352-265-8569
Scheduling Staff :	352-265-8574	or	352-265-8575

After hours : 352-265-0111, the operator will page the physician on call

MyChart: https://mychart.shands.org is a new an effective way for you to interact with your health care team. Non-urgent questions can be sent directly to your surgeon. You can also access test results, request prescription refills or request an appointment.

Non-urgent questions should be directed to the nurses, coordinators, or by using MyChart