SALPINGO-OOPHRECTOMY INFORMATION & CONSENT

We recommend that you read this handout carefully to prepare yourself or family members for the proposed procedure. A proper understanding of the procedure, its preparation, and post-procedure expectations and care can improve your safety and outcome. We strongly encourage you to contact your Care Center prior to your procedure if you still have any questions or concerns.

Definition

Salpingo: Referring to fallopian tubes

Oophrectomy: Removal of the ovary

A salpingo-oophrectomy is a procedure where the fallopian tube(s) and ovary(ies) are removed. Both of the fallopian and ovaries can be removed or only one of each. This procedure can be done by itself or in conjunction with other procedures. This procedure is commonly done with a hysterectomy. The hysterectomy can be done for many reasons including:

- *Fibroid tumors* – non-cancerous tumors that can cause pelvic pain and pressure, heavy uterine bleeding, painful intercourse, abdominal distortion, and other symptoms
- *Endometriosis* – a condition in which tissue normally found within the uterine lining grows in other parts of the abdomen or uterine muscle (adenomyosis) where it can cause pain
- *Dysfunctional uterine bleeding*
- *Chronic pelvic pain*
- *Cancer of the uterus, ovaries, or cervix* – these conditions are usually best treated by a gynecologic oncologist specially trained to perform surgery for cancer
- *Fallopian tube cysts*

This procedure can be done by a laparoscope (telescopic instrument inserted through small incisions) or by a laparotomy (traditional "open" abdominal surgery). Your doctor will be able to analyze both the fallopian tube and the ovary with this procedure.

Preparation

As with all procedures where general anesthesia is administered, you will be asked not to eat or drink anything after a certain time on the evening prior to your surgery. You may brush your teeth in the morning but should not swallow the water. If you are on medications that must be taken, you will discuss this with your provider and/or the anesthesiologist at your pre-operative visit and instructions will be given to you. You are obligated to inform us if anything has changed (medication or otherwise) since your previous visit. The procedure may not be performed if you are currently taking or have recently taken any medication that may interfere with your ability to clot blood (blood thinners, aspirin, anti-inflammatory medicines, etc.). The most common of these medications is aspirin and all related pain relievers or anti-inflammatory compounds (whether prescription or over-the-counter).

Procedure

How the procedure is done depends upon if another procedure it is being done at the same time.

If the procedure is done by a laparoscope, your doctor will insert a camera into a small incision in your belly button. Your doctor will visualize the ovaries and the fallopian tubes. Your doctor will need to make more incisions into your abdomen so that they can insert surgical instruments through these incisions.

Your doctor will then remove the ovary(ies) and the fallopian tube(s) with surgical instruments. The instruments will allow the doctor to grasp the ovaries and the fallopian tubes for removal. Your doctor will send these to pathology to be evaluated.

If this is done by an incision into your lower abdomen, your doctor will identify the uterus and ovaries, along with the fallopian tubes. Once these are identified your doctor will remove them carefully.

Regardless of how the procedure is done, your doctor will make sure that there is no bleeding and then remove the surgical instruments and close the incision(s). You will be transported to the recovery room.

Post Procedure

In the recovery room, your doctor will make sure that you have tolerated the procedure well. If the procedure is done by a laparoscope, you will be able to go home that day.

If the procedure is done as a part of another procedure, you may need to stay overnight for your recovery.

Your doctor will prescribe medication to control most of your pain.

Your doctor will give you specific instructions when you go home regarding lifting and other daily activities.

Expectations of Outcome

The expectations of this procedure will depend upon why it was being done and what procedure it was being done with. You can expect that either one or both of your ovaries or fallopian tubes will be removed after the procedure. There is a chance that your doctor may not be able to remove all of the ovary or the fallopian tube because of scar tissue around those structures.

If both ovaries are removed and you were not menopausal prior to the procedure, you will be menopausal immediately and unable to become pregnant with your own biological children. You may experience menopausal-like symptoms such as hot flashes, night sweats, mood changes, sleep disturbances, headaches, vaginal dryness, and/or thinning of the bones. Your doctor will counsel you to see if you are able to take replacement estrogen for these symptoms.

You should not experience heavy bleeding or chills/fever. If this happens, please call you doctor.

Finally, if your doctor is not able to remove the ovary(ies) and/or tube(s) with laparoscopy, the procedure may need to be continued through an incision into your lower abdomen (laparotomy). This may also be done if your doctor thinks that additional surgery should be done that cannot be done with laparoscope.

Possible Complications

All surgical procedures, regardless of complexity or time, can be associated with unforeseen problems. They may be immediate or quite delayed in presentation. Aside from anesthesia complications, it is important that every patient be made aware of all possible outcomes, which may include, but are not limited to:

- *Wound Infection* – the incision sites can become infected. While typically resolved with antibiotics and local wound care, part or all of the incision may open and require revision.
- *Deep Vein Thrombosis (DVT)/Pulmonary Embolus (PE)*: In any operation (especially longer operations), you can develop a clot in the vein of the leg (DVT). Typically, this presents 2-7 days (or longer) after the procedure as pain, swelling, and tenderness to touch in the lower leg (calf). Your ankle and foot can also become swollen. Although less likely, this blood clot can move through the veins and block off part of the lung (PE). This would present as shortness of breath and possibly chest pain. We may sometimes ask the medical doctors to be involved with the management of either of these problems.
- *Blood Loss/Transfusion:* Significant blood loss is rare with laparoscopic procedures. Uncommonly, small or large blood vessels can be injured during placement of the instruments into the abdominal cavity or during the dissection. Minor to moderate bleeding can usually be controlled through the laparoscope. Instances of severe bleeding may require conversion to an open procedure. If severe bleeding occurs, transfusion could be necessary.
- *Organ Injury:* During initial placement of the instruments or during any part of the dissection, any organ in the abdomen or pelvis (liver, spleen, colon, intestine, bladder, stomach, ureter, uterus, tubes, ovaries, etc.) can be inadvertently injured. Often, the problem can be treated through the laparoscope. In other instances, conversion to an open operation may be necessary. Treatment depends on the particular organ injured and the severity of the injury.
- *Subcutaneous Emphysema*: In rare instances, the carbon dioxide gas (CO_2) can escape into the subcutaneous (below the skin) tissue plane. In the post-operative period, this would present with minor to severe swelling and bruising (depending on the amount of gas in the tissue). The gas eventually gets reabsorbed by the body, and the swelling and bruising resolve with time.
- *Tension Pneumoperitoneum*: The pressure of CO_2 gas in the peritoneum (intra-abdominal space) is carefully monitored, and there are short intermittent fluctuations of no consequence. Sometimes, the pressure can remain high for a prolonged period. In this instance, the elevated pressure can push upward on the chest cavity and cause problems with proper ventilation (breathing). This may result in blood pressure fluctuation and problems with the heart. In rare instances, high intra-abdominal pressures can result in a tension pneumothorax (collapse of the lung due to high surrounding pressures). See pneumothorax below.
- *Gas Embolism*: This unusual problem results from a significant amount of CO_2 gas getting into the blood vessels. The result can be changes in heart rhythm and blood pressure. While cardiac arrest (complete stop of the heart) is possible, it is highly unusual.
- *Pneumothorax (Collapse of the Lung)*: This can occur if one of the instruments is inadvertently placed in the thoracic (chest) cavity or if dissection opens a small hole in the pleura (chest cavity lining). A chest tube (lung cavity drain) would be placed that will be removed in a few days. There are rarely long-term complications as a result. If this is not recognized however, CO_2 gas can force its way into the cavity outside of the heart and lung blood vessels (pneumomediastinum) or even directly around the heart (pneumopericardium). These very rare complications can be life threatening and require immediate attention in an intensive care setting.

- *Urinary Tract Infection or Urosepsis (Bloodstream Infection)*: An infection of the urinary tract may be a simple bladder infection that presents with symptoms of burning urination, urinary frequency, and a strong urge to urinate. This will usually resolve with a few days of antibiotics. If the infection enters the bloodstream, you may feel ill. This type of infection can present with both urinary symptoms and any combination of the following: fevers, shaking chills, weakness or dizziness, nausea, and vomiting. You may require a short hospitalization for intravenous antibiotics, fluids, and observation. This problem is more common in diabetics, patients on long term steroids, or in patients with disorders of the immune system.
- *Ileus or Bowel Obstruction*: Because we operate near the intestines, they can go into prolonged spasm (ileus), or they may become blocked (obstruction). Treatment ranges from observation to open surgery.
- *Hernia*: Not all small incisions are sutured closed in the deep layers. It is possible to develop a small hernia (tissue protrusion) in the wound. Treatment can be observation (if it is only a cosmetic issue) or a surgery to repair the weak area of supportive tissue.
- *Lymphocele*: A lymphocele is a collection of lymphatic fluid (tissue fluid that drains through the lymph nodes) that can rarely accumulate in patients that undergo removal of lymph nodes. Despite careful attention, it is possible for some of the fluid to persistently leak from tiny lymphatic channels. These collections can form in the abdomen or pelvis and may compress nerves (causing weakness in the leg) or blood vessels (increasing the risk of a deep vein thrombosis). Typically, the first sign of a pelvic lymphocele is ankle and foot swelling on the side of the lymphocele. Treatment ranges from observation (most often a self-limiting process) to a minimally invasive drainage procedure. The need for an open procedure is uncommon.
- *Chronic Pain* – As with any procedure, a patient can develop chronic pain in an area that has undergone surgery. Typically, the pain disappears over time, although some pain or feeling of numbness may persist. If persistent, further evaluation may be necessary. If the surgery was performed for pain relief, some pain may remain. There is also the possibility that this procedure will not take away your pain at all.

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Patient Name Date

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Patient/Health Care Agent/Guardian/Relative Signature

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Physician Signature

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Witness Signature