Patient Information

NHS
Royal Devon and Exeter
NHS Foundation Trust

Having a Laparotomy
for Gynaecological Surgery

What is a Laparotomy?

A Laparotomy describes an incision made in the abdomen. This can be horizontal (low down on the 'bikini line') or vertical ('midline') depending on the purpose of the operation. The surgeon can then look thoroughly inside the abdomen and pelvis.

Introduction

There are many possible reasons for needing this particular operation:

- For a Hysterectomy when it is not possible to do the operation from below via the vagina, or with keyhole surgery. This might be the case when the uterus is enlarged, for example by fibroids, or when access to the vagina is difficult, for example when there has been no previous vaginal birth.
- To remove fibroids from the uterus without removing the uterus.
- For cancer, or possible cancer. This could be cancer in the ovaries, tubes, lining of the uterus (endometrium), or cervix. Occasionally nearby organs such as the colon (bowel) can be affected making it necessary to remove a piece of bowel, maybe resulting in the formation of a colostomy. When a 'Staging' Laparotomy is performed biopsies are sent to the laboratory for examination, they maybe taken from surrounding tissue such as lymph nodes in the abdominal cavity, and some of the fatty tissue covering the bowel. Your surgeon may take a sample of fluid (peritoneal washings). In some cases of cervical cancer a Wertheim's (radical hysterectomy) is performed; this involves removal of the womb, tubes, ovaries, part of the vagina and some of the pelvic lymph glands.
- Sometimes a switch to laparotomy is needed when keyhole surgery (laparoscopy) is not the optimal surgical approach.

What will happen?

Most women will be asked to attend a pre-operative assessment clinic between a few days to two weeks before admission. A leaflet about this clinic will be sent to you with your appointment letter. At that clinic the pre-op nurse will advise you about when you are to stop eating and drinking, they will also explain what will happen before and after your operation to help you recover quickly and fully. They will give you two high calorie drinks to be consumed during the clear fluids only period. A diary will also be given to you to explain each step of your recovery. If your consultant thinks that there may be a need to operate on your bowel, arrangements will be made for you to see the stoma nurse prior to your operation.

Before your operation

As soon as you know that you need an operation, try to get yourself into the best physical shape so that you may recover more quickly. Stop smoking, eat a healthy diet and if able, take regular exercise. If possible make plans with your family or friends to arrange for some extra help for your first couple of weeks at home.

Important: Women on the oral contraceptive pill should, if possible, stop taking it one month before the planned operation and if necessary, use alternative forms of contraception. Women on hormone replacement therapy do not necessarily have to do this before the operation unless specifically advised to do so.

The day of your operation

You will normally be admitted to the ward on the day of your operation. Have a bath or shower before you come into hospital. All makeup, nail varnish and jewellery, except plain rings, are to be removed. After your shower, do not use any powder, body lotion or any highly scented products. You are not expected to shave or wax pubic hair.

After reporting to the Centre for Women's Health at the appointed time, you will be shown to an area of the ward or clinic to enable the nurse to take your blood pressure, pulse and temperature. There will also be some paperwork that the nurse will have to complete as part of the admission procedure.

It is usually not possible to be absolutely certain in advance what time your operation will be taking place. The running order of an operating session is constantly reviewed in light of developments, and so can be changed even at the last minute, for example to accommodate an emergency case.

Every day, while you are in hospital, you will be asked to wear some anti-embolic stockings and given a small injection in the top of your arm. This is an anti-coagulant (thins your blood), to help prevent deep vein thrombosis (blood clots, usually in the legs).

A member of the surgical team will come and talk you through the operation and take your consent if that has not been done already. Please tell him or her if anything has changed since the decision was made to do the operation.

The anaesthetist will see you on the ward prior to your operation, to discuss your anaesthetic and pain relief. Often a physiotherapist will also see you pre-operatively, to discuss how to get in and out of bed comfortably, exercises for afterwards and advice for when you go home.

At the appropriate time the nurse will ask you to put on your theatre gown and anti- embolic stockings, some people will have electronic boots to prevent thrombosis, e.g. If you are diabetic or are having a longer or more complex operation.

About 15-30 minutes before your operation one of the nurses will take you to theatre. Whilst most people walk to theatre, a wheelchair or a trolley is available for those who need it.

You will be taken to the anaesthetic room, where you will meet the anaesthetist again and their assistant. Your surgeon and anaesthetist will check your consent form with you again at this point. You will be anaesthetised in this room and then transferred asleep into the operating theatre. Someone stays with you the whole time from when you leave the ward until you return. The time taken to do the operation can vary considerably from 1 hour to most of the day. It may be necessary to take photographs as part of your medical records.

After your operation

The anaesthetist will wake you up after the operation is completely finished. This will take place in the operating theatre itself, but this rarely remembered by the patient. You will be transferred onto your bed and taken into the recovery room and checked regularly by the nursing team until you are sufficiently awake and recovered to return to the ward. Regular checks are continued on the ward to ensure that your pulse and blood pressure are satisfactory.

For pain relief you may have rectus sheath catheters: these are small tubes placed in your abdominal wall to allow regular injections of local anaesthetic without causing you any discomfort. In some cases the anaesthetist will discuss the option of a spinal anaesthetic to help with pain relief during and after surgery. Another option for pain relief is a PCA (patient controlled analgesia). There are separate leaflets about these and you will be given one at your pre-operative assessment. You may also be given regular pain relief such as diclofenac (an anti- inflammatory) and paracetamol at regular times. You may have oxygen for about 24 hours following your operation.

There will be a fluid 'drip' connected to a plastic tube into your arm and also a catheter tube in your bladder, ensuring that it does not become over full. Your fluid input and output will be recorded regularly by the nursing staff.

You will be able to drink water immediately when you come back from theatre, and usually begin to eat if you wish. The following day (your first day post-op) you will be able to eat and drink. Many people begin with a variety of fluids including soup, ice-cream and light food. You may have increased wind like pain; this can be in the abdomen, shoulder and back. Eating small quantities, especially fruit and vegetables, and drinking plenty of fluid will help to re-establish your normal bowel movements. Painkillers and moving about will also ease the discomfort.

On your first day you will be given help with washing, and will sit in a chair for a while. You will take short walks, and have your meals in the dining room. The drip, catheter, rectus sheath catheters or PCA and any other tubes will usually be removed on the first day. Dissolvable stitches are usually used in your wound, and these do not need to be removed.

As discussed in the pre-assessment clinic, you will be discharged when you have achieved the goals of eating, drinking, walking, and you are comfortable with tablets for pain relief. Usually this is within 2-3 days depending on your progress and type of operation. Your GP will be sent details of your operation and your discharge date. You will be given some pain relieving tablets to take home.

When can I return to normal?

There are no absolute rules. It is normal for people to feel tired and for the abdomen to be quite sore for about 2-3 weeks. The soreness is due to internal bruising in the area of the operation, there will be bruising around the abdominal wound as well. After a hysterectomy a small amount of bleeding or brownish discharge from the vagina is not unusual and may persist for a few weeks. It is best to avoid sexual intercourse for 6 weeks and until the discharge has settled.

In the absence of any complications and depending on which type of operation has been performed, you may feel well enough to return to normal activities anything from 3-4 weeks after the operation, this includes returning to work. It can, however, take longer. It is best to build up slowly with gentle exercise once the initial discomfort of the operation has worn off with the aim of restoring general physical fitness which has been lost. Driving may also be resumed once you are sufficiently comfortable and able to perform an emergency stop. It may be advisable to consult your insurance company for advice in this area.

Any tissue or organs removed during the operation will be sent for examination in the laboratory. Pathology results will be available several weeks after your operation: you will be contacted by phone or letter and may be sent an appointment to see the Consultant again. There will also be a routine follow up appointment 6-8 weeks following your operation. If you have any concerns prior to this, please ask your GP to contact your Consultants team. Alternatively, please phone **Wynard Ward** on **01392 406512**.

Rare/special events

In the case of **Wertheim's hysterectomy** the catheter may be 'supra-pubic' (it goes into your bladder through your abdomen just above your pubic bone).

You may have a **drain** (a small plastic tube to drain away any excess fluid away from the wound).

If the operation has involved the bowel you may have a **naso-gastric tube** (this passes into your stomach via the nose draining away any excess stomach juices which helps to prevent nausea and vomiting), you may also have a colostomy. Very occasionally the bowel can 'go on strike,' this is known as an ileus. It can cause abdominal pain, distension, vomiting and constipation. You will not be able to eat until your symptoms settle, usually it will resolve itself. You will remain in hospital until the ileus has improved.

Possible risks and complications

All operations carry some degree of risk. Serious complications involving a risk to your life are rare if you are otherwise fit and healthy, do not smoke and not overweight.

The risks of a general anaesthetic

General anaesthetics have some risks, which may be increased if you have chronic medical conditions, but in general they are as follows:

- **Common temporary side effects** (risk of 1 in 10 to 1 in 100) include bruising or pain in the area of injections, blurred vision and sickness, these can usually be treated and pass off quickly.
- **Infrequent complications** (risk of 1 in 100 to 1 in 10,000) include temporary breathing difficulties, muscle pains, headaches, damage to teeth, lip or tongue, sore throat and temporary problems with speaking.
- **Extremely rare and serious complications** (risk of less than 1 in 10,000). These include severe allergic reactions and death, brain damage, kidney and liver failure, lung damage, permanent nerve or blood vessel damage, eye injury, and damage to the voice box. These are very rare and may depend on whether you have other serious medical conditions.

Laparotomies are generally straight forward. They enable your surgeon to perform procedures which may well alleviate or diagnose problems that have been affecting and interrupting your life.

Rare major problems

- **Haemorrhage (bleeding).** Unexpected bleeding may occur especially when the operation has been complex. This may require transfusion of blood or extra fluid and occasionally bleeding can occur some hours after the surgery necessitating a second procedure. Very occasionally bleeding occurs during a Myomectomy (removal of fibroids), if this cannot be easily stopped, your surgeon may have to proceed to performing a hysterectomy.
- **Damage to the bladder, ureter (connection between kidneys and bladder) and other organs.** Some of these structures are attached to the womb and need to be released during hysterectomy. Damage can occur if they are particularly adherent (stuck), for example due to previous surgery or Caesarean delivery. If this damage is identified at the time of the operation it can usually be repaired successfully with no long-term effects on your health. Very occasionally urine can leak through a connection (fistula) that develops between the bladder and the vagina and a further operation maybe required.
- **Thrombosis and pulmonary embolism (clots in the blood that may affect the legs and the lungs).** This can be a very dangerous complication. As already stated you will be given protection with anti-coagulant injections before and after your operation to reduce this risk. You will also wear anti- embolic stockings or boots to help with your circulation.
- **Death** Very rare unless you have any co-existing medical conditions or poor fitness for major surgery.

Minor complications

- **Premature menopause.** Even if the ovaries are conserved at the time of hysterectomy, it is possible that the menopause may occur approximately 1-2 years earlier. This increases the risk of osteoporosis and heart disease. If the symptoms of the menopause (hot flushes, sweats, vaginal dryness and mood changes) occur it may be advisable to discuss hormone replacement, if it is appropriate, with your doctor.
- **Wound infection.** A certain amount of bruising is normal, but occasionally the abdominal wound becomes increasingly swollen, red and painful, indicating infection. Sometimes the wound may produce a discharge. You should see your GP or practice nurse if this occurs. Very occasionally it is necessary to perform a small operation to release an abscess (collection of infection) if it forms within the wound.
- **Adhesions.** Almost all patients undergoing abdominal surgery will develop some adhesions (internal scarring) They usually cause no symptoms and you are not aware of them. Rarely they can cause persistent pain or problems with bowel function.

- **Hernia.** Occasionally a small hernia (lump) can form under the skin incision once it has healed. This is caused by a small piece of fat or bowel bulging through the deep cut in the tummy wall. This may need an additional procedure to repair it.
- **Frequency and pain on passing urine.** Occasionally, after a hysterectomy you may feel the need to pass urine more frequently. This is a result of slight bruising and swelling of the bladder, due to its close proximity to the uterus (womb), and possibly after the removal of the catheter. Pain relief is recommended and also a urine test to eliminate infection.
- **Internal infection.** If the site where the womb used to be becomes infected, there may be an increasingly smelly discharge and increased bleeding from the vagina. Your GP may prescribe antibiotics to treat this.
- **Chest infection.** This is more likely to be a complication if you continue to smoke.
- **Prevention** – antibiotics are given during your anaesthetic to try and reduce the chances of these infections.

What will I feel like?

After your operation, even quite some time later, you may feel emotional. This is a normal reaction which the doctors and nurses understand. You may find it helps to talk with the staff caring for you. So don't bottle up your feelings.

As time passes you will begin to feel better but you may still have 'up' days and 'down' days. It may take up to 6 – 12 months before you feel you have really adjusted physically and emotionally to what has happened. Some women find it helps to talk to their doctor, a specialist nurse or an organisation. Please feel free to express your concerns.