Gleneagles Hospital
HONG KONG
港怡醫院

Hosp No.	:	HKID No.:
Case No.	:	
Name	:	
DOB	:	M / F
Adm Date	:	
Contact No.	:	

Procedure Information Sheet- Laparoscopic Assisted Vaginal Hysterectomy (LAVH) or Total Laparoscopic Hysterectomy (TLH) ± Bilateral Salphino-Oophorectomy

1. Introduction

1.1. Clinical diagnosis: fibroid / DUB / endometrial hyperplasia / _____

1.2. Indication for surgery: pelvic or abdominal mass / heavy menstrual flow / risk of cancer / _____

2. Nature of operation

2.1. General anaesthesia

2.2. Abdominal cavity inflated with carbon dioxide incisions made

2.3. Telescope and instruments passed into abdomen

2.4. Upper part of the uterus freed (with or without both ovaries and tubes)

2.5. Laparoscopic assisted vaginal hysterectomy:

- 2.5.1. Incision made around cervix vaginally
- 2.5.2. Lower part of the uterus freed vaginally
- 2.5.3. Uterus removed vaginally
- 2.5.4. May need episiotomy
- 2.5.5. Vaginal wound and abdominal wounds closed

2.6. Total laparoscopic hysterectomy:

- 2.6.1. Same as LAVH above except lower part of uterus freed laparoscopically

2.7. All tissue removed will be sent to the Department of Pathology or disposed of as appropriate unless otherwise specified

2.8. Photographic and/or video images may be recorded during the operation for education/research purpose. Please inform our staff if you have any objection.

2.9. Similarities with abdominal hysterectomy:

- 2.9.1. Same organ(s) removed
- 2.9.2. Same sequelae

2.10. Difference from abdominal hysterectomy

- 2.10.1. 3-4 smaller abdominal wounds
- 2.10.2. Less painful
- 2.10.3. Faster postoperative recovery
- 2.10.4. Earlier discharge
- 2.10.5. Shorter sick leave required
- 2.10.6. Slight increase risk of urinary tract injury

3. Benefits of the procedure

3.1. Relieve symptom(s) / remove and confirm pathology / _____

4. Other consequences after the procedure

4.1. No menstruation

4.2. Cannot get pregnant

4.3. Can have coitus

4.4. Should not affect hormonal status if ovaries are not removed; ovarian failure may occur 2-4 years earlier than natural menopause

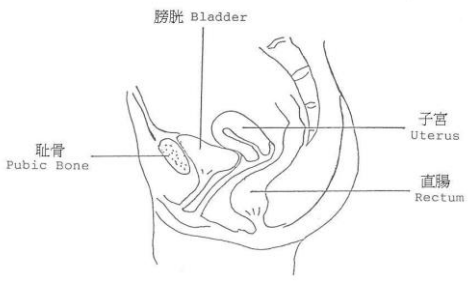
4.5. Climacteric symptoms if ovaries are removed in a premenopausal woman

5. Risks and complications may include, but are not limited to the following

5.1. Women who are obese, who have significant pathology, who have undergone previous surgery or who have pre- existing medical conditions must understand that the quoted risks for serious or frequent complications will be increased.

5.2. Anaesthetic complications

5.3. Similar complications as abdominal hysterectomy
5.4. Serious:
  5.4.1. Failure to gain entry into abdominal cavity and to complete the intended procedure, requiring Laparotomy
  5.4.2. Bleeding, may need blood transfusion
  5.4.3. Injury to neighbouring organs especially the bladder, ureters and bowels, may require repair (overall risk about 6 in 1,000, some of the injuries might not be noted at time of surgery)
  5.4.4. Return to theatre because of complications like bleeding, wound dehiscence
  5.4.5. Pelvic haematoma
  5.4.6. Pelvic abscess, infection
  5.4.7. Deep vein thrombosis and pulmonary embolism
  5.4.8. Risk of death (3 in 10000, rare)
  5.4.9. Wound hernia
  5.4.10. Vault prolapse
5.5. Frequent:
  5.5.1. Febrile morbidity
  5.5.2. Wound complications, pain, bruising, delayed wound healing or keloid formation numbness
  5.5.3. Tingling or burning sensation around the scar
  5.5.4. Frequency of micturition and urinary tract infection
  5.5.5. Ovarian failure
  5.5.6. Postoperative pain and difficulty and/or pain with intercourse
  5.5.7. Internal scarring with adhesion



6. Risks of not having the procedure

6.1. Progression and deterioration of disease condition
6.2. Exact diagnosis cannot be ascertained

7. Possible alternatives

7.1. Observation
7.2. Non-surgical treatment e.g. medical treatment, LNG- IUS (Mirena)
7.3. Myomectomy (for uterine fibroid)
7.4. Endometrial ablation / resection (for DUB)
7.5. Open/vaginal approach
7.6. Uterine artery embolisation
7.7. Others _____

8. Other associated procedures (which may become necessary during the operation)

8.1. Blood transfusion
8.2. Laparotomy (less than 5 in every 100)
8.3. Procedure for unsuspected ovarian disease: leave alone / cystectomy / salpingo-oophorectomy
8.4. Removal of tubes and ovaries (prophylactic or when affected)
  8.4.1. If removed – may need hormonal therapy; note the risk of hormonal therapy including increased risk of carcinoma of breast, deep vein thrombosis, gall stone and the need to pay for the cost if you do not have any climacteric symptoms
  8.4.2. If not removed – life time risk of carcinoma of ovary without hysterectomy is 1.4-2 in every 100 (common), reduced by 1/2 to 2/3 with hysterectomy; 5 in every 100(common) chance of future operation for ovarian pathology

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9. Special follow-up issue

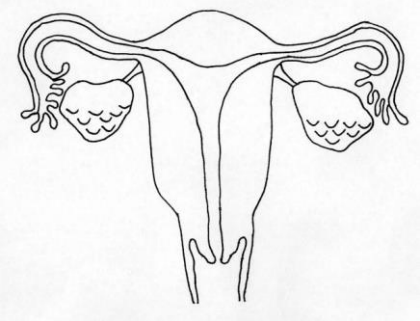
9.1. Avoid intercourse until examination by doctor at follow up

10. Statement of patient

10.1. Procedure(s) which should not be carried out without further discussion

11. Remark

11.1. The above mentioned procedural information is by no means exhaustive, other unforeseen complications may occur in special patient groups or different individual. Please contact your physician for further enquiry.



I acknowledged the above information concerning the operation or procedure. I have also been given the opportunity to ask questions and received adequate explanations concerning the condition and treatment plan.

Patient/ Relative Signature: _____

Patient/ Relative Name: _____

Date: _____