



**Queensland  
Government**

## Hysterectomy (Vaginal, Laparoscopic, Abdominal)

Facility:

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth:

Sex:  M  F  I

### A. Interpreter / cultural needs

- An Interpreter Service is required?  Yes  No  
 If Yes, is a qualified Interpreter present?  Yes  No  
 A Cultural Support Person is required?  Yes  No  
 If Yes, is a Cultural Support Person present?  Yes  No

### B. Condition and treatment

The doctor has explained that you have the following condition: *(Doctor to document in patient's own words)*

.....  
 This condition requires the following procedure. *(Doctor to tick as appropriate - include site and/or side where relevant to the procedure)*

The following will be performed:

Removal of the uterus (womb). This will be performed in the following way:

- Vaginal (through the vagina).  Yes  No  
 Laparoscopic ('key hole')  Yes  No  
 Abdominal (through cut in abdomen)  Yes  No  
 Ovaries will also be removed  Yes  No  
 If yes, which ovaries  Left  Right

### C. Risks of a hysterectomy (vaginal, laparoscopic, abdominal)

There are risks and complications with this procedure. They include but are not limited to the following.

#### General risks:

- Bleeding could occur and may require a return to the operating room. Bleeding is more common if you have been taking blood thinning drugs such as Warfarin, Aspirin, Clopidogrel (Plavix or Iscover) or Dipyridamole (Persantin or Asasantin).
- Small areas of the lung can collapse, increasing the risk of chest infection. This may need antibiotics and physiotherapy.
- Increased risk in obese people of wound infection, chest infection, heart and lung complications, and thrombosis.
- Heart attack or stroke could occur due to the strain on the heart.
- Blood clot in the leg (DVT) causing pain and swelling. In rare cases part of the clot may break off and go to the lungs.
- Death as a result of this procedure is possible.

#### Specific risks:

- Infection in the operation site or pelvis or urinary tract, requiring antibiotics and further treatment.

- Injury to other organs such as the ureter(s) (tube leading from kidney to bladder) bladder or bowel.
- A connection (fistula) may develop between the bladder and the vagina, or bowel or peritoneum.
- Bowel blockage after the operation.
- Abdominal Hysterectomy:
  - bleeding into the abdominal wound from surrounding blood vessels.
  - poor wound healing.
  - the wound scar may become thickened, red and painful.
- Vaginal Hysterectomy:
  - risk of conversion to laparotomy (cut made in the abdomen).
  - higher risk of ureteric injury.
  - recurrence of prolapse ie. vaginal repair may not be successful, in the short or long term and may need corrective surgery.
  - occurrence of pain during sexual intercourse or altered sexual function after vaginal repair.
- Laparoscopic assisted Vaginal Hysterectomy:
  - risk of conversion to laparotomy (cut similar to Abdominal Hysterectomy).
- Change in bladder and bowel habits.
- Feelings of depression and anxiety.
- Onset menopause in pre-menopausal women if both ovaries are removed.

### D. Significant risks and procedure options

*(Doctor to document in space provided. Continue in Medical Record if necessary.)*

### E. Risks of not having this procedure

*(Doctor to document in space provided. Continue in Medical Record if necessary.)*

### F. Anaesthetic

This procedure may require an anaesthetic. *(Doctor to document type of anaesthetic discussed)*

DO NOT WRITE IN THIS BINDING MARGIN

PROCEDURAL CONSENT FORM





# Hysterectomy (Vaginal, Laparoscopic, Abdominal)

Facility:

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth:

Sex:  M  F  I

## G. Patient consent

I acknowledge that the doctor has explained;

- my medical condition and the proposed procedure, including additional treatment if the doctor finds something unexpected. I understand the risks, including the risks that are specific to me.
- the anaesthetic required for this procedure. I understand the risks, including the risks that are specific to me.
- other relevant procedure/treatment options and their associated risks.
- my prognosis and the risks of not having the procedure.
- that no guarantee has been made that the procedure will improve my condition even though it has been carried out with due professional care.
- the procedure may include a blood transfusion.
- tissues and blood may be removed and could be used for diagnosis or management of my condition, stored and disposed of sensitively by the hospital.
- if immediate life-threatening events happen during the procedure, they will be treated based on my discussions with the doctor or my Acute Resuscitation Plan.
- a doctor other than the Consultant may conduct the procedure. I understand this could be a doctor undergoing further training.

I have been given the following Patient Information Sheet/s:

- About Your Anaesthetic and/ OR
- Epidural & Spinal Anaesthesia
- Hysterectomy (Vaginal, Laparoscopic, Abdominal)
- Blood & Blood Products Transfusion

- I was able to ask questions and raise concerns with the doctor about my condition, the proposed procedure and its risks, and my treatment options. My questions and concerns have been discussed and answered to my satisfaction.
- I understand I have the right to change my mind at any time, including after I have signed this form but, preferably following a discussion with my doctor.
- I understand that image/s or video footage may be recorded as part of and during my procedure and that these image/s or video/s will assist the doctor to provide appropriate treatment.

On the basis of the above statements,

## I request to have the procedure

Name of Patient: .....

Signature: .....

Date: .....

### Patients who lack capacity to provide consent

Consent must be obtained from a substitute decision maker/s in the order below.

Does the patient have an Advance Health Directive (AHD)?

Yes ▶ Location of the original or certified copy of the AHD: .....

No ▶ Name of Substitute Decision Maker/s: .....

Signature: .....

Relationship to patient: .....

Date: ..... PH No: .....

Source of decision making authority (tick one):

- Tribunal-appointed Guardian
- Attorney/s for health matters under Enduring Power of Attorney or AHD
- Statutory Health Attorney
- If none of these, the Adult Guardian has provided consent. Ph 1300 QLD OAG (753 624)

## H. Doctor/delegate Statement

I have explained to the patient all the above points under the Patient Consent section (G) and I am of the opinion that the patient/substitute decision-maker has understood the information.

Name of Doctor/delegate: .....

Designation: .....

Signature: .....

Date: .....

## I. Interpreter's statement

I have given a sight translation in

.....  
(state the patient's language here) of the consent form and assisted in the provision of any verbal and written information given to the patient/parent or guardian/substitute decision-maker by the doctor.

Name of Interpreter: .....

Signature: .....

Date: .....

DO NOT WRITE IN THIS BINDING MARGIN

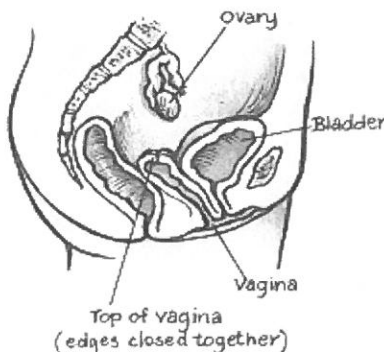
# Consent Information - Patient Copy

## Hysterectomy (Vaginal, Laparoscopic, Abdominal)

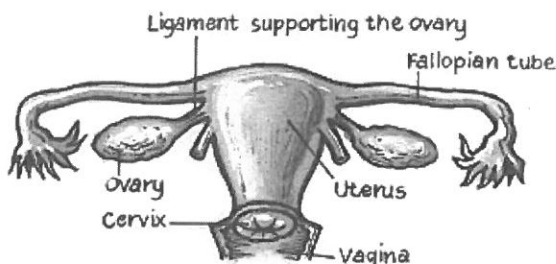
### 1. What do I need to know about this condition?

The uterus (also known as the womb) is a pear shaped organ that sits between the bladder and the rectum (back passage).

From puberty, every 26 to 30 days the uterus begins a menstrual cycle, during which time the uterus prepares itself to receive and nourish a fertilised egg (ovum). If the egg is not fertilised, then the thickened lining of the uterus sheds as a period (menstrual bleeding). If the egg is fertilised, then the cycle changes. Periods stop and the uterus grows to provide nourishment and support for the growing baby until birth.



*The female organs after Hysterectomy*



*The uterus, tubes and ovaries*

The most common conditions of the uterus, for having a Hysterectomy are:

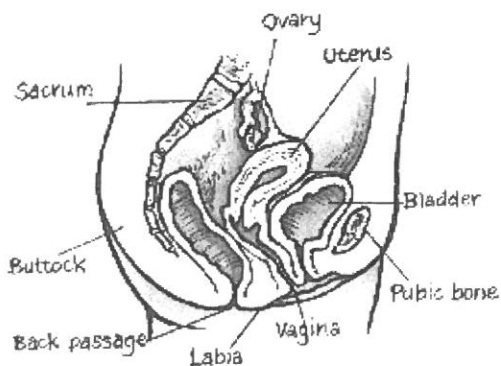
- uterine disease.
- diseases of tubes and ovaries.
- as part of the treatment for a prolapse.
- bleeding not controlled by conservative treatment.

### 2. What do I need to know about this procedure?

There are three ways to remove the uterus:

#### Vaginal Hysterectomy

Removal of the uterus through the vagina. The vagina is stitched from below and there is no cut in the abdomen. Sometimes, a laparoscope (telescope type of instrument) is also used. The surgeon will discuss this with you.



*The female organs before Hysterectomy*

#### Abdominal Hysterectomy

Removal of the uterus through a cut in the lower abdomen. The cut is about 15 – 30 cm's depending on your size and weight and is usually below the bikini line from side to side.

It may be necessary to cut down the abdomen from the belly button down to the pubic area rather than across.

The surgeon will discuss with you the best surgery for your condition. You may need removal of one or both of the ovaries, but this depends on the reason for your Hysterectomy, your age and their condition in relation to disease.

#### Laparoscopic assisted Hysterectomy

About 4 small "keyhole" cuts are made in abdomen to divide the attachments of uterus, ovaries and tubes in pelvis. The Uterus is usually removed via vaginal route.

### 3. What are the benefits of having the procedure?

The decision to have a Hysterectomy depends on the type of problems you are having and how bad they are. It also depends on whether you need major surgery to make your life better or, if you have a life threatening illness, to prolong your life. You need to discuss this with your surgeon.

### 4. What are the risks of not having the procedure?

This depends on the reason for the surgery:

- For prolonged bleeding, you may develop anaemia, which may need blood transfusions, and continued problems with heavy and irregular periods.
- If you have a prolapse, the uterus can drop down into the vagina and even outside the vagina where it can develop ulcers and cause considerable pain and discomfort.
- If you have a suspected tumour, then possible spread of cancer may result.

# Consent Information - Patient Copy

## Hysterectomy (Vaginal, Laparoscopic, Abdominal)

### 5. What are some alternative treatments?

Other treatment options will depend very much on what the cause of the problem is.

For prolonged and heavy bleeding:

- birth control pills or other oral medicines.
- a Mirena, a slow-release hormone system inserted into the womb, lasting 5 years.
- Endometrial ablation (removal of the lining of the uterus). This controls bleeding in 70 – 80% of cases but also causes sterility.
- Myomectomy (surgical removal of fibroids) if womb is desired to be retained.

For chronic pain.

This may require treatment with:

- anti- inflammatory drugs.
- birth control pills.
- physical therapy.
- psychological counselling.

### 6. My anaesthetic

This procedure will require an anaesthetic.

See **About Your Anaesthetic information sheet and /or Epidural & Spinal Anaesthesia** for information about the anaesthetic and the risks involved. If you have any concerns, discuss these with your doctor.

If you have not been given an information sheet, please ask for one.

### 7. What are the risks of this specific procedure?

There are risks and complications with this procedure. They include but are not limited to the below and the following table.

General risks:

- Infection can occur, requiring antibiotics and further treatment.
- Bleeding could occur and may require a return to the operating room. Bleeding is more common if you have been taking blood thinning drugs such as Warfarin, Aspirin, Clopidogrel (Plavix or Iscover) or Dipyridamole (Persantin or Asasantin).
- Small areas of the lung can collapse, increasing the risk of chest infection. This may need antibiotics and physiotherapy.
- Increased risk in obese people of wound infection, chest infection, heart and lung complications, and thrombosis.
- Heart attack or stroke could occur due to the strain on the heart.
- Blood clot in the leg (DVT) causing pain and swelling. In rare cases part of the clot may break off and go to the lungs.
- Death as a result of this procedure is possible.

### 8. What are the specific risks of Vaginal Hysterectomy?

- risk of conversion to laparotomy (cut made in the abdomen).
- higher risk of ureteric injury.
- recurrence of prolapse ie. vaginal repair may not be successful, in the short or long term and may need corrective surgery.
- occurrence of pain during sexual intercourse or altered sexual function after vaginal repair.

### 9. What do I tell my doctor?

Tell your doctor if you have;

- large amounts of bloody discharge from the wound and/ or the vagina.
- fever and chills.
- pain that is not relieved by prescribed pain killers.
- swollen abdomen.
- leaking from the vagina.
- swelling, tenderness, redness at or around the cut.

#### Notes to talk to my doctor about:

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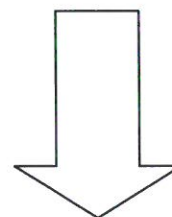
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**Specific risks continues in the table  
on the next page -**



## Consent Information - Patient Copy Hysterectomy (Vaginal, Laparoscopic, Abdominal)

### 8. What are the specific risks of this surgery?

The risk	What happens	What can be done about it
Excessive bleeding	Severe bleeding from large blood vessels about the uterus or vault of vagina may occur. This is not common.	Emergency surgery to repair the damaged blood vessels after the operation. A blood transfusion may be required to replace blood loss. A vaginal pack may be used to control the bleeding.
Infection	Infection in the operation site or pelvis or urinary tract may occur. This is not uncommon.	Treatment may be wound dressings and antibiotics.
Bladder or Bowel injury	Nearby organs such as the ureter(s) (tube leading from kidney to bladder), bladder or bowel may be injured.	Further surgery will be needed to repair the injuries. For bladder injuries, a catheter (plastic tube) may be put into the bladder to drain the urine away until the bladder is healed. For ureter injury, a plastic tube (stent) is placed in the ureter for 6 weeks and then removed by cystoscopy or sometimes a ureteric reimplantation via laparotomy will be necessary. If the bowel is injured, part of the bowel may be removed, with a possibility of a temporary or permanent colostomy (opening onto the abdomen so that waste can pass out).
A leak between the bladder and vagina	Rarely a connection (fistula) may develop between the bladder and the vagina. This causes leakage of urine via the vagina, which you will have no control over.	This will require further corrective surgery.
Bleeding into the wound	There may be bleeding into the wound from surrounding blood vessels.	A drain into the wound for a few days and treatment with antibiotics.
Bowel blockage	The bowels may not work after the operation. This may be temporary or in the longer term, a bowel obstruction can develop.	Treatment may be a drip to give fluids into the vein and no food or fluids by mouth. If it doesn't get better, bowel surgery may be necessary which may include a colostomy. This can be temporary or permanent.
Poor wound healing	The layers of the wound may not heal well and the wound may burst open. A hernia (rupture) may form in the long term.	This may require long term wound care with dressings and antibiotics. A hernia may need repair by further surgery.
The wound may not heal normally.	The scar can be thickened, red and may be painful. This can be disfiguring.	This is permanent.
Change in bladder and bowel habits	A change in the sensory nerves of the bladder and bowel due to surgery. Constipation and bladder problems may occur. An increased risk of incontinence (uncontrolled passing of urine) may result later in life.	Medication may be used to control constipation. Advice on managing incontinence.
Feelings of depression and anxiety	Psychological changes may occur after surgery. Feelings of depression and anxiety can be prolonged after surgery.	Counselling may be of benefit. Anti depressants may be prescribed for a short while.
Increased risk in smokers.	An increased risk of wound infection, chest infection, heart and lung complications, thrombosis.	Increased risk in smokers.

**Death is a rare event as a result of hysterectomy surgery – at a rate of 6 women in 10,000 cases.**

**9. What do I need to know about recovery from this procedure?**

After the operation, the nursing staff will closely watch you until you have recovered from the anaesthetic. You will then go back to the ward where you will recover until you are well enough to go home, usually about 2 days after vaginal surgery and 4 - 5 days after abdominal surgery.

If you have any side effects from the anaesthetic, such as headache, nausea, vomiting, you should tell the nurse looking after you, who will be able to give you some medication to help.

- Pain

You can expect to have pain in the operation site. There are a number of ways in managing your pain. You may have:

- a drip with painkillers into the spine, which deadens the area below your waist.
- a drip with painkillers that you can give yourself when you feel pain.
- be given injections.

It is important that you tell the nursing staff if you are having pain. Your pain should wear off within 7 - 10 days. If it does not, you must tell your Doctor.

- Diet.

You will have a drip in your arm when you come back from surgery. This will be removed when you are able to take food and fluids by mouth and you are no longer feeling sick.

It is not unusual to feel sick for a day or two after surgery. Tell the nurse if this happens to you so that you can have drugs to stop it. To begin with, you can have small sips of water, and then slowly take more until you are eating normally.

- Wounds.

Vaginal Hysterectomy

You may have a drain into the vagina, which will be removed after 24 to 48 hours following surgery.

Abdominal Hysterectomy

You may have clips or stitches or a combination of both. These will stay for 5 – 10 days depending on your surgeon.

Your wound may have a dressing and a wound drain, which is removed after 3- 4 days or as soon as the drainage has stopped.

Continue to keep your wound clean and protected until healed and no seepage is present.

Vaginal and Abdominal Hysterectomy

You will have a very light blood loss from the vagina for 4 to 6 weeks after surgery. If the bleeding is heavy – you must tell your doctor.

- Bladder and bowels.

You may come back from theatre with a tube into the bladder (catheter) to drain the urine from the bladder into a plastic bag. This is removed within a day or two of surgery.

You must not strain to make your bowels move. The nursing staff will check with you daily until you have a normal bowel motion and, if you are having problems, they will give you some medicine to help.

- Your lungs and blood supply.

It is very important after surgery that you start moving as soon as possible. This is to prevent blood clots forming in your legs and possibly travelling to your lungs. This can cause death.

To help prevent clots forming in your legs, you will have support stockings (TEDS) on before you go to surgery and these will stay on until you are walking on your own. You may also be put on drugs to thin your blood.

Also, you need to do your deep breathing exercises, ten deep breaths every hour, to get the secretions in your lungs moving and help prevent a chest infection.

At all costs, avoid smoking after surgery as this increases your risk of chest infection which causes coughing - a painful experience after abdominal surgery.

- Exercise.

Do expect to feel tired for sometime after surgery. You need to take things easy and gradually return to normal duties, as you feel able to. It usually takes about 6 weeks to recover and up to 6 months to feel back on top of things again. You should not drive during the first 2 - 4 weeks – until you can brake suddenly without pain.

Do not lift heavy weights for at least six weeks after surgery. This is to stop a rupture where the cut was made and allow healing to take place inside.

You may have sexual intercourse about 6 weeks after surgery.

**Notes to talk to my doctor about:**

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