

## The Hospital Experience: What to Expect

Other than childbirth, many women have never been patients in a hospital before. Knowing what to expect can decrease anxiety and help you cope with surgery.

You will have to complete all preoperative examinations, procedures, and paperwork. Most patients for our practice will be undergoing surgery for cancer, or a suspected diagnosis of cancer, or have a technically difficult benign procedure to carry out. You will be told if you have to stay in the hospital, or whether you may be able to go home the same day as the surgery.

Cancer related procedures might require very customized surgery. This is determined when the cancer is actually examined during the operation. In general, most cancer patients must undergo a “staging” operation to determine where (if) the disease has spread in the abdomen or elsewhere. This often requires the removal of one or both ovaries, and the uterus. To determine spread, often times, lymph tissue is removed from around pelvic and abdominal blood vessels. A fatty colon appendage, called the “omentum,” may also need to be removed. These are the basics of most Gynecologic Oncology staging operations. Further surgery than this may be required to destroy cancer. This operation is called a “tumor debulking,” and literally means removing whatever tumor spread has occurred in the abdomen. Sometimes, parts of normal organs (most commonly intestine) have to be sacrificed in order to completely destroy the tumor. This will be decided during the operation. Your surgeon will be able to give you the best estimate as to what type of operation is most likely, but he is ready to change that plan should cancer spread become a factor during surgery.

Preoperative planning is very important. You will receive instructions to clean out your bowels (‘bowel prep’) the day before surgery. This is critical to allow safe repair of bowel. You may need to see other medical specialists (e.g. Cardiologists, Pulmonologists) or your doctor to control any pre-existing disease that you might have. You may be asked to undergo evaluation of your heart, lungs, or other critical systems prior to surgery. You must make sure that you undergo all tests and consultations; many times surgery will be cancelled if you don’t finish evaluation.

Expect to get a call from the hospital, and the Anesthesiologist, one day prior to the surgery. This is to ensure your safety, as well as to impart the exact time and location of your arrival to the hospital.

Writing a list of questions and bringing a spouse, family member, or friend can be helpful in receiving the most information possible. Some hospitals allow a family member or significant other to stay overnight with a patient while hospitalized. Ask your hospital or what their policy is regarding these accommodations.

You will work out a date for surgery, with our office staff. Plan to arrive early to the hospital and be sure to have carefully read and followed any pre-admission instructions. Valuables should be left at home. If taking any medications, bring a list including the

name of the drug, dosage, and frequency. After checking in at the admission department, the woman will go to the preoperative area and be prepared for the planned surgery. Consent forms will be explained and signed if not done so already. The patient will speak with the doctor or trained nurse who gives the anesthetic and may be given a sedative to help relax during the time before surgery.

At some point, an intravenous line will be started to administer fluids, medications, and blood, if required, as well as the short-acting drug that induces the general anesthesia. If the woman is to receive a regional anesthetic, which numbs the lower region of the body, a narrow tube (catheter) will be inserted into a numbed area of the back and into the narrow space around the spinal nerves. When the anesthetic is administered, the woman will no longer be able to move or feel below the block. Once asleep, a tube will be inserted through the woman's mouth and down her throat to administer a mix of oxygen and anesthetic gases to keep her deeply unconscious but breathing well. The tube will be removed before she wakes up.

During the operation, the surgeon/gynecologist may use scalpels, scissors, an electrical scalpel, or a laser beam. The surgeon will assess the abdominal fluid volume and samples of the fluid will be analyzed for the presence of cancer cells. When a woman seems to have early stage disease, tissue biopsies may be taken from several areas of the abdomen and beneath the diaphragm to be examined under a microscope. Pelvic and aortic lymph nodes may also be sampled for the presence of cancer cells. The surgeon will also carefully inspect the bowel. The incision site will be closed with staples, sutures, tape strips, or a combination and covered with a bandage. Occasionally, the surgical team must leave the incision open to heal from the inside out. In this case the incision will require irrigation or special dressing changes as specified by the surgeon.

After the operation, the woman is transferred to the post-anesthesia recovery room where she slowly wakes up after the general anesthesia and regains sensation and movement below the waist if given regional anesthesia. Her blood pressure, temperature, heart rate, and respiratory rate will be monitored, in addition to any pain or nausea. Then she will be transferred to the room where she will stay during the rest of her hospitalization. The nurses will help her transfer from the stretcher into bed and orient her and any family members to the room.

Most women will be placed on bed rest immediately following surgery. During the initial post-operative period, a drain placed in the urethra ("Foley catheter") remains inserted into the bladder to drain urine and monitor hydration. When abdominal surgery requires partial bowel removal, a tube is sometimes placed through the nostril, into the stomach ("nasogastric" or "NG" tube) that serves to decompress the digestive tract and remove gastric fluid. Other plastic tubes, may be used to drain excess blood or tissue fluid from inside body cavities, and may remain for a few days or possibly until the follow-up appointment. Intravenous fluids continue until a woman can drink clear liquids without experiencing nausea or vomiting. In addition to IV fluids, other IV medications such as antibiotics may be administered as ordered by the surgical team.

Pain control, in regard to comfort and level of activity, is one of the most important priorities in the recovery period. Regarding comfort, the surgeon may order a Patient - Controlled Analgesia pump (PCA), which delivers a programmed amount of pain medication directly into the vein or epidural space when the patient presses a button. Other forms of pain medication may include a shot or an oral pill. Verbalizing one's pain to the nurse and medical team is important in monitoring and treating pain efficiently. The goal is to stay ahead of the pain and therefore be able to recover as quickly as possible and begin increasing activity level.

Nausea is commonly experienced following surgery; it can result from anesthesia, pain medication, or manipulation of the digestive tract during surgery. If you suffer from motion sickness, post-surgery nausea can be more severe and you should tell the anesthesiologist beforehand so that they can use different drugs to better control the nausea. If nausea occurs, it can be treated with medications as needed. If nausea is persistent, the medical team may change the woman's pain medication to see if her nausea resolves.

During the recovery period, it is important for the woman to deep-breathe several times each hour to prevent serious lung problems. The surgeon may have a woman use a simple plastic device called an incentive spirometer, to promote breathing exercises to help expand the lungs and aid in producing a cough to clear any respiratory tract secretions. While in bed, compression devices may be placed around a woman's legs or feet to help prevent blood clots in the legs. Sometimes, a subcutaneous injection of a blood thinner is used to discourage postoperative blood clots. In addition, as soon as possible, a woman should get out of bed and begin to walk. It will be difficult to get out of bed initially, but with practice and the help of a nurse or family member, it will become easier and less uncomfortable. Walking helps prevent blood clot formation, expands the lungs, increases digestive tract motility, and increases blood flow to the surgical site.

The nurse and nursing staff will provide most of the post-operative care. Some of this care includes monitoring vital signs, emptying drains, inspecting the surgical site, physical examination, wound care, administering medications, assessing pain and effectiveness of pain medications, and assisting the patient in activity. The nursing staff works closely with the team of physicians and reports any changes or needs the patient may have. Throughout the day one can expect to see a variety of physicians as part hospital care. The Gynecologic Oncologist usually only sees the patient once each morning or may simply speak with the team that follows the woman. Plan to ask any specific questions related individual treatment and the recovery process. Writing down questions often is useful.

Discharge preparations will begin on or before the day of operation in anticipation of any special needs, equipment, or care that may be necessary. Nurses, physicians, home health care coordinators, and social workers collaborate in planning each individual discharge. Their goal is to identify all home needs and to establish the necessary

resources to ensure that each requirement is met. A home health care nurse may be utilized if a woman will require wound care, special medications, or physical therapy.

Prior to discharge, the nurse or physician will review activity restriction including driving, strenuous exercise, and heavy lifting. The patient will be given prescriptions for pain medication and any other medications as determined by the medical team. The patient or a family member will need to call the office within 1-2 days of discharge to schedule a post-operative appointment. Post-operative appointments are scheduled one to two weeks from the date you were discharged. A phone number for the physician on call will be given for any questions or concerns that may arise. Once home, enjoy the company of friends and family as a support and comfort while the healing process continues. Focus on strength and success as each day of recovery builds hope and character.