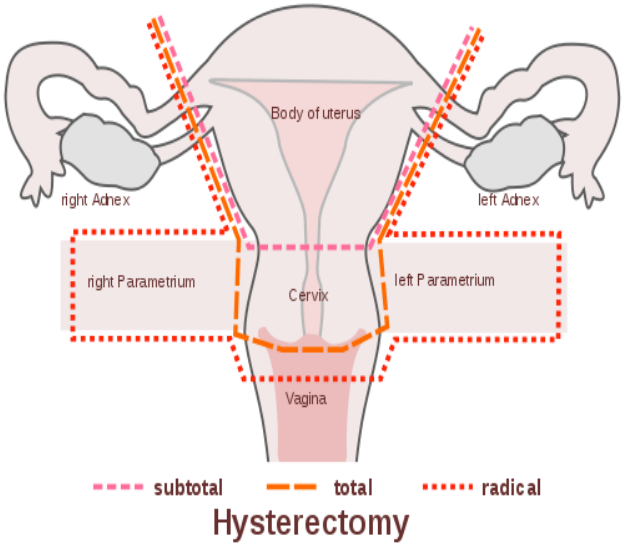
INFORMATION LEAFLET ON TOTAL LAPAROSCOPIC RADICAL HYSTERECTOMY (TLRH) FOR EARLY STAGE CERVICAL CANCER

(TREATING EARLY STAGE CERVICAL CANCER BY RADICAL HYSTERECTOMY THROUGH KEYHOLE SURGERY)



Aim of the leaflet

This leaflet is aimed at patients and their relatives, carers, nursing and medical staff who are involved in looking after these patients as well as required to give information about this procedure to patients, relatives and carers.

Introduction

The National Institute of Clinical Excellence (NICE) stated in May 2010 that there is now evidence on the efficacy and safety of laparoscopic radical hysterectomy for early stage cervical cancer. NICE is the body comprising of expert health care professionals and people representing patients and their carers that produces guidance (advice) for the NHS about preventing, diagnosing and treating medical conditions.

Cervical cancer is the second most common cancer in women under 35 years in the UK. The most common symptoms are abnormal vaginal bleeding or discharge, and discomfort during intercourse.

The International Federation of Gynaecology and Obstetrics (FIGO) system is used to stage cervical cancer from I to IV. Early stage cervical cancer refers to cancer confined to the cervix (neck of the womb) and has not spread to the walls of the pelvis or the lower part of the vagina and that the lymph glands are not involved on MRI scanning prior to surgery.

Early stage cervical cancer is usually treated by radical hysterectomy. Radiotherapy may be used, with or without surgery, and is usually combined with chemotherapy. More advanced cervical cancer is generally treated with radiotherapy and chemotherapy.

The main surgical options for treating early stage cervical cancer are:

1. Radical hysterectomy or
2. Radical trachelectomy with laparoscopic (key-hole) pelvic lymph nodes removal. This is only done for young women who are keen to preserve fertility for future reproduction.

You should have discussed management options with your gynaecological oncologist and come to the agreement that you needed a radical hysterectomy. A radical hysterectomy is an operation to remove the womb, neck of the womb, top of the vaginal, the tissues around the neck of the womb and the top of the vagina as well the lymph glands in the pelvis. The most common form of surgery to treat early stage cervical cancer is to remove the womb and structures connected to it, such as the cervix, upper vagina and lymph nodes (glands that are part of the immune system and can become involved by the early spread of cancerous cells). This is called a radical hysterectomy. Traditionally, this is usually carried out through an open abdominal incision (a large vertical mid line or low transverse incision).

This can also be safely carried out by keyhole (laparoscopy) as described below by appropriately trained ‘key-hole’ surgeons. If successful, this would mean a shorter

hospital stay (2-3 days) instead of the usual 5-7 days following a major abdominal cut. There is however in about 5 % of cases the surgeon might not be able to complete your operation by keyhole if there are any intraoperative difficulties. If this happens, you will end up having a big cut on your tummy.

Preparation:

It is important that you are as fit as possible. If you smoke try to give up as soon as possible as smokers are much more likely to develop chest infections after surgery. Many women suffer from constipation after surgery. We advise that you buy **docusate** from your local pharmacy. **Docusate** is a laxative, which takes 1-2 days to achieve effect. Take one capsule (100mg) three times a day. This keeps the bowel motion soft, so that there should be less need to strain to open your bowels in the post- operative recovery period. You should start to take this, 3 days before your operation and afterwards until normal bowel function returns.

Prior to surgery you may be given an enema or suppository (medicine which is given via the rectum). This will empty the lower bowels, which makes the operation easier.

The operation:

The procedure is done with the woman under a general anaesthetic. The abdomen is insufflated (distended) with carbon dioxide and several small incisions are made to provide access for the laparoscope and surgical instruments. The surgeon inserts a thin telescope (laparoscope) and surgical instruments through the small cuts to carry out the whole operation.

Conventionally, a hysterectomy is performed by dividing the main supports of the uterus and cervix. If the ovaries are to be preserved, they may need to be moved away from the pelvis and anchored to the side of the lower abdomen to protect them from potential radiotherapy damage if this is required later. The pelvic lymph nodes (lymph glands) are removed through one of the abdominal incisions or through the vagina.

The main benefits of keyhole approach are

- Early mobilisation, thus reducing the risk of clots in your legs or lungs
- Less pain and therefore reduced need for very strong pain killers
- Reduced blood loss, thereby reducing the need for blood transfusion
- Shorter length of stay in hospital
- Shorter recovery period and
- Minimal abdominal scarring

Possible Risks and Complications

As with any operation there are risks and complications, which can occur, but it is important to remember that these risks are uncommon. The anaesthetist will discuss risks associated with general anaesthetic and pain control after surgery.

You may have some blood loss at the time of your operation and blood transfusion may be required. There is a small risk of developing an infection in the chest, wound, pelvis or urine. Antibiotics will be given at the start of your operation to help reduce these risks. With any operation, there is a small risk of blood clots developing in the veins of the leg or pelvis, which can travel to the lungs (pulmonary embolism), which could be serious. We will give you injections to thin the blood down and get you to mobilise early after your operation to help minimise you risk of getting blood clots. We may ask you to take some injections home to give to yourself. If you are not able to do this by yourself, a close relative can do it for you.

There is a risk of bowel and blood vessels injuries (2 in 1000) associated with laparoscopic surgery. There is a risk that a small hole can develop in the bladder or in the ureter (tube which carries urine into the bladder from the kidneys). You may require a further procedure to correct this, either at the time of surgery or at a later date. As with the traditional open radical hysterectomy, during laparoscopic radical hysterectomy, the bladder will need to be mobilised away from the top of the vagina

so that adequate normal tissue can be taken well away from the site of cancer. During this process, some nerves that supply the pelvis and bladder may be damaged. This may affect your sensation and bladder function. It may take several weeks before your bladder begins to work normally again. Very occasionally, some changes in bladder sensation and bladder function may remain a long-term problem. The nurses can teach you to catheterise yourself if necessary to help with bladder management. However, the majority of patients are usually able to pass urine spontaneously after the catheter has been removed usually after 3-5 days.

Following a radical hysterectomy and especially due to removal of the pelvic lymph glands, there is a small risk of developing swelling in the legs or lower abdomen (lymphoedema) or you can develop a fluid collection where the lymph glands were removed in the pelvis, this is called a lymphocyst. This would normally resolve on its own, although occasionally may require surgical drainage.

Post-operative care

Following your operation, you will return to the ward usually with a drip and a urethral catheter. You may also have a drain. You may be given patient controlled analgesia (PCA). However, if you have had a spinal anaesthesia, a PCA may not be required but you will still be closely monitored and appropriate painkillers will be administered to you if you require this. The urethral catheter will usually be left in place for about 5 days. A leg bag will be attached to this so that you are able to secure this by a special tape to your upper thigh and be able to wear lose clothing. This should not limit your mobility in any way at all. You will usually be discharged home with this after about 48 hours. You will be asked to return to the ward on the fifth day after your operation to have this removed. Following its removal, you will then be observed on the ward for a few hours when the nurse will advise you to drink some liquids (usually water) and try to empty your bladder as you would normally do. A bladder scan will then be carried out to measure the amount of urine left in your bladder. Usually, if this is less than or equal to 150mls on two consecutive measurements, you will then be allowed home. If on the other hand, the amounts are in excess of 150mls, the catheter will be put back in or you will be given the

option of self-catheterisation. Future management will usually be discussed with your consultant at this time.

Recovery and follow up

Usually, your recovery will be much quicker than if you had your operation done open (laparotomy). However, it can take up to 6 weeks to recover fully. If you require further treatment with radiotherapy, this might even take longer. It is okay to have hormone replacement therapy if you have had your ovaries removed.

Your first follow up appointment will usually be 2 weeks to discuss the results. If you do not need further treatment, subsequent follow –up appointments will be every three months for 2 years and then six monthly for one year.

When to seek medical advice after total laparoscopic radical hysterectomy? (The following are only a guide and are by no means exhaustive. Please contact your doctor or the hospital if you are worried about anything).

- Heavy vaginal bleeding
- Offensive vaginal discharge
- Burning and stinging sensation when you pass urine
- Red, painful and discharging wounds
- Abdominal swelling, pain, fever, vomiting
- Constant and heavy fluid loss from the vagina
- Painful and swollen legs
- Shortness of breath

For further information, please either visit any of the following websites or call the telephone numbers:

www.macmillan.org

Edwina.dobson@nuh.nhs.uk

www.jotrust.co.uk

Macmillan cancer Information and Support Centre.

Based in H block at Nottingham City Hospital opposite the lifts on B floor.

Tel 0808 808 00 00.

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