Surgery for Ovarian Cancer

Patient Information – Gynaecologic Oncology

Key messages

- The goal of this patient information is to provide you with information prior to your upcoming surgery.
- Please read this information carefully and bring this paperwork with you when you come for pre-admission clinic.
- During the pre-admission clinic you will meet with the surgeon, anaesthetist, a junior doctor and pre-admission nurses. The surgeon will consent you for surgery and you will have an opportunity to ask any questions then. This clinic can be very busy, and you will receive a lot of information, hence why it is important to read this information prior to your clinic appointment. We also strongly recommend that you bring a support person to clinic with you.
- If you have any questions or concerns in the meantime, you can call our gynae-oncology clinical nurse specialist (CNS) on 027 905 8059, or our cancer nurse coordinator (CNC) on 021 824 694, between 8.00 am and 4.00 pm Monday to Friday.

About surgery for ovarian cancer

Your doctors have recommended an operation as part of your treatment of a possible or confirmed ovarian cancer. This surgery is either performed at the start of your ovarian cancer treatment (**primary 'cancer reducing' surgery**) or after chemotherapy has already started (**interval 'cancer reducing' surgery**). The aim of surgery for ovarian cancer is to remove all or as much of the tumour as possible.

During this procedure we shall remove the ovaries, fallopian tubes, uterus (womb) and cervix (unless you have previously had a hysterectomy or related surgery). We will also remove the omentum (an apron-like fold of fatty tissue that hangs down from the stomach and covers the abdominal organs in the lower abdominal area) and possibly the appendix, and part of the peritoneum (the inner lining of the abdomen). These are all common sites for spread of ovarian cancer.

On a small number of occasions, we shall also need to remove a piece of affected bowel. We usually aim to join up the bowel within your abdomen if at all possible but might need to form a stoma (an opening on the abdominal wall) to allow the passage of faeces into a bag on the abdomen. This can be reversed at a second operation in a proportion of patients, often in 6-12 months. Occasionally the stoma will be permanent.

In addition, we may remove some of the lymph nodes in the pelvis or next to the large blood vessels in the abdomen (pelvic and para-aortic lymph node sampling).

Usually, we use a midline incision (up and down cut on the abdomen) rather than a bikini line or transverse incision. The exact procedure that is carried out will depend on your particular circumstances, including your general fitness and health, the nature of your current condition, and your previous surgical history.

All patients in whom cancer reducing surgery is recommended will also have their case discussed by a group of specialists in the multi-disciplinary team meeting, which will also include a review of your recent blood tests and scans.

The medical team will discuss with you the exact details of your planned surgery in the preadmission clinic before your operation. Decisions about treatment and care are best when they are made together. You will have the opportunity to talk with your surgeon about your options, and to share your views and concerns. You will also meet the nursing team who will discuss the expectations before your surgery, after your surgery, and when you get home.

Some commonly asked questions about your upcoming surgery

Who will perform my procedure?

A consultant gynaecological oncologist surgeon or a senior trainee in gynaecological oncology (working under supervision) will perform this procedure.

What type of anaesthetic will I have?

Your surgery will be performed under a general anaesthetic. This means you will be fully asleep for the duration of your surgery. The anaesthetist may also recommend you have a spinal injection placed before your surgery starts. This allows local anaesthetic and pain medication to be delivered around the nerves in your lower back which helps with pain relief after surgery. Your anaesthetist will discuss the procedure, benefits and risks with you before surgery.

What happens to my tissues after surgery?

All the tissue that is removed during the surgery is looked at under the microscope by a pathologist. After this you will get asked when are consented for surgery if you want your tissues returned to you or if you would like the hospital to dispose of it.

We would also like to invite you to donate a small amount of this spare tissue to be stored for future research and become a part of our gynae-oncology tissue bank. Studying tissue samples is useful for many things:

- Helping doctors and scientists work out why and how changes occur in tissue.
- Allowing us to understand how these changes are related to changes in your cells, chemical makeup or genetic information.

If this is something you are interested in doing, we will speak to you in more detail about it at the pre-admission clinic.

What are the risks of this surgery?

- Bleeding which may require a blood transfusion
- Infection – you will be given antibiotics at the start of surgery to reduce the risk of infection
- Blood clots forming in the legs or lungs – you will be given a month of once daily blood thinning treatment after your surgery to reduce the risk of clots
- Problems with the wound on your abdomen healing
- Damage to surrounding structures in your abdomen like bowel, bladder or ureters (tubes that drain urine from kidneys to the bladder)
- Need to have a second operation

What happens after surgery?

Following your surgery, you will usually be in hospital around 3-5 days but it may be longer if you have had bowel surgery. You will initially have a catheter (tube) draining your bladder which is removed at 24-48 hours after your surgery. You will usually have a pain medication pump (PCA) for a similar time before switching to pain medication tablets. You will be supported to get out of bed and walking around the ward the day after surgery as this helps with your recovery. You will also likely be allowed to eat and drink immediately following your surgery. Occasionally after this type of surgery, the bowel is slow to start working again and you can develop something called an ileus, which is when the bowels stop working all together. If this happens, you will not be able to eat food until this settles which can take a few days. You will have staples in the wound which need to be removed 10 days after surgery. The recovery period following this surgery will be 6 weeks.

During your hospital stay you will be able to have a support person/support people present on the ward with you.

For more information about:
hospital and specialist services, go to www.cdhb.health.nz | your health and medication, go to www.healthinfo.org.nz