Chapter 3

Preoperative Counseling

"No one who respects the law and likes to eat sausage should ever watch either being made."

-Benjamin Franklin

To explain the prefacing quote, the line is meant to explain or draw homage to those surgeons who make it a point of discussing every possible complication of a surgery simply for the purpose of attempting to talk the patient out of the surgery, or to attempt to send the patient somewhere else. I'm not ashamed to say that I have seen this strategy undertaken much more often by practitioners who are on salary as opposed to those paid as a percentage of their productivity. While there is certainly nothing dishonorable about doing whatever you can to get out of a surgery that you do not feel comfortable doing, there is something wrong with overstating the risks of an otherwise routine procedure to a patient who needs it. I think it is reasonable to broadly go over possible complications, but an in-depth discussion of what it is like to have a bowel movement through the colostomy is not appropriate for standard hysterectomy. “Injury to the bowels, bladder, urine tubes, or blood vessels” will suffice.

My experiences observing colleagues explain surgical procedures to patients in the preoperative area have been disturbing, to say the least. For the purposes of this text, I’m going to limit the discussion to appropriate counseling for a hysterectomy, as the premise of this text is that you are trying to offer your patient the most minimally invasive hysterectomy possible. My several world records demonstrate that you have indeed come to the right place to achieve this endeavor. But how we might offer preoperative counseling, in simple terms, is a deeper question.

I believe the best counseling comes from statistic-based analysis. If you open half of the hysterectomies that you perform, your patient deserves to know this, (although the same could be said with regard to your state medical board.) My suggestion is to come up with a statistical analysis by looking at your past data. Decimal points are

not important, but commonly experienced complications should be described as common.

One particular pearl is the subset of patients that fear a urinary catheter more than they fear death itself. A urinary catheter is a painful thing without question, but different patients have different capacities to tolerate this. If a woman has multiple cesarean sections, and is deathly afraid of the presence of a postoperative urinary catheter for any extended period of time, then this should be discussed extensively preoperatively. An extensive discussion should be had with the patient regarding the nature of scar tissue following cesarean sections and the necessary dissection to bring the bladder off of the uterus. It should also be discussed that this dissection may result in a cystotomy, and that the successfulness of this dissection will absolutely be based minimally upon the skill of the surgeon and mostly on the already-present scar tissue from the patient's prior cesarean sections. If she is so absolutely and pathological afraid of an indwelling catheter, although it pains me to even type this out - this patient may be better served with a laparotomy.

In the end, unique to this described technique, you must inform the patient that this surgery will be accomplished one of three ways: laparoscopic single port, laparoscopic multi-port, or an open Pfannenstiel laparotomy.

I don't think it is necessary to discuss with the patients who are not candidates for laparoscopic hysterectomy, but clearly not every patient is. A patient with a 50cm uterus does not need this discussion. Barring these very unusual cases, ***the ideal time to decide the proper route for the hysterectomy will be at time of entry into the abdominal cavity, usually through the umbilicus, and decisions for method of completion of the surgery should be reserved for that time alone.*** You should provide

your patient with your best estimates based on your skill, previous accomplishments, and of course your assessment of the patient's individual risk factors. These will certainly include, but not be limited to, including their weight, uterine size, previous abdominal surgeries, and any previous accounts of the quantity of intra-abdominal adhesions.

One additional aspect of preoperative preparation which should not be overlooked is the necessity to be aware of the anesthesia available. I am not an across-the-board proponent of all of the ERAS (Enhanced Recovery After Surgery) protocol, or other protocols that depend on multiple factors in order to theoretically improve postoperative recovery. From my experiences at multiple institutions, restricting eating and drinking or failing to do so has essentially no bearing on the patient's recovery, and whatever minor hunger pangs occur from the patient missing breakfast before surgery, they have no bearing on recovery whatsoever. This is not to say I'm a stickler for an 8 hour fast *(*quite the contrary, there is probably no harm to throwing the old NPO rules out the window), I believe that there is no real benefit with regards to postoperative recovery.

As for the preoperative carbohydrate drinks, I also think the data behind this practice is useless. There is no flavor of Kool-Aid™ that will make your patient's wounds heal faster, and shame on you if you thought there was.

Finally, while early feeding and carbohydrate rich solutions in the intraoperative period are utter bullshit, I am convinced that ***combined spinal and general anesthesia is not***. I am uncertain about the reasons for this and I am uncertain that anyone truly understands the reasons why this anesthesia is superior, but it simply is true.[16] When I converted my ultra high-volume hysterectomy service from general anesthesia to a combined spinal general service, we

went from patients who had a 20% chance of requesting a second hospital day postoperatively to patients that routinely had to be warned to avoid sexual activity immediately following surgery. The results were *that* good.

As a surgeon, it is beyond my scope to understand the physiology of why this occurs or perhaps I am just not smart enough. Whatever the reason, combined general anesthesia with epidural or spinal anesthesia is a requirement for any minimally invasive hysterectomy, and if anesthesia that can provide these services is not available, I would recommend delaying the procedure until such services *are* available.

References:

16) Ghodki, P. S., Sardesai, S. P., & Naphade, R. W. (2014). Combined spinal and general anesthesia is better than general anesthesia alone for laparoscopic hysterectomy. Saudi journal of anaesthesia, 8(4), 498.
17) Suryavanshi, V. S., Sahu, A., & Harde, M. (2016). Efficacy of combined epidural general anesthesia for attenuating haemodynamic responses in gynaecological laparoscopic surgery. International Journal of Contemporary Medical Research, 3, 1354-8.