



Royal College of Obstetricians and Gynaecologists

Consent Advice No. 4

May 2009

ABDOMINAL HYSTERECTOMY FOR BENIGN CONDITIONS

This is the second edition of this guidance, which was previously published in October 2004 under the title *Abdominal Hysterectomy for Heavy Periods*.

This paper provides advice for clinicians in obtaining the consent of women undergoing abdominal hysterectomy under general anaesthesia. This paper is intended to be appropriate for a number of procedures and combinations and the consent form should be carefully edited under the heading 'Name of proposed procedure or course of treatment' to accurately describe the exact procedure to be performed, after discussion with the woman. The paper follows the structure of Consent Form 1 of the Department of Health, England/Welsh Assembly Government/Scottish Government/Department of Health, Social Services and Public Safety, Northern Ireland. It should be used in conjunction with RCOG Clinical Governance Advice, *Obtaining Valid Consent*.¹

The aim of this advice is to ensure that all women are given consistent and adequate information for consent; it is intended to be used together with dedicated patient information. After discharge, all women should have clear direction to obtaining help if there are unforeseen problems.

Clinicians should be prepared to discuss with the woman any of the points listed on the following pages.

Presenting information on risk

Term	Equivalent numerical ratio	Colloquial equivalent
Very common	1/1 to 1/10	A person in family
Common	1/10 to 1/100	A person in street
Uncommon	1/100 to 1/1000	A person in village
Rare	1/1000 to 1/10 000	A person in small town
Very rare	Less than 1/10 000	A person in large town

The above descriptors are based on the RCOG Clinical Governance Advice, *Presenting Information on Risk*.² They are used throughout this document.

To assist clinicians at a local level, we have included at the end of this document a fully printable page 2 of the Department of Health, England/Welsh Assembly Government/Scottish Government/Department of Health, Social Services and Public Safety, Northern Ireland, Consent Form 1. This page can be incorporated into local trust documents, subject to local trust governance approval.

CONSENT FORM

1. Name of proposed procedure or course of treatment

Total/subtotal abdominal hysterectomy – removal of uterus with or without cervix.

If it is the intention to preserve normal ovaries, then the words ‘with conservation of the ovaries’ should be added.

If it is the intention to remove an ovary or ovaries then the words ‘with removal of tube(s) and ovary(ies)’ should be added. The potential for unexpected disease of the ovaries should be discussed.

2. The proposed procedure

Describe the nature of abdominal hysterectomy. Explain the procedure as described in the patient information. The implications of the operation should be discussed before a decision is made. The woman should be informed that the operation will leave her infertile. She should be advised of the potential impact of the operation on sexual function, bladder function and psychology. The intended incision (midline or transverse), and alternative treatment options should be discussed.

If the plan is for a total hysterectomy, the woman should be informed that, occasionally, it may be necessary to limit the operation to a subtotal hysterectomy for technical reasons. If the ovaries are to be removed in a premenopausal woman, she should be informed that this would mean immediate surgical menopause and the long-term health implications should be discussed.

Note: If any other procedures are anticipated (for example, ovarian cystectomy, incontinence surgery) these must be discussed and a separate consent obtained.

3. Intended benefits

While menstrual bleeding is guaranteed to be abolished by total hysterectomy, the effect on pelvic pain and premenstrual symptoms is not guaranteed and the likelihood of this effect should be discussed.

4. Serious and frequently occurring risks^{3,4}

It is recommended that clinicians make every effort to separate serious from frequently occurring risks. Women who are obese, who have significant pathology, who have had previous surgery or who have pre-existing medical conditions must understand that the quoted risks for serious or frequent complications will be increased.

4.1 Serious risks

Serious risks include:

- the overall risk of serious complications from abdominal hysterectomy is approximately four women in every 100 (common)
- damage to the bladder and/or the ureter (seven women in every 1000) and/or long-term disturbance to the bladder function (uncommon)
- damage to the bowel: four women in every 10 000 (rare)
- haemorrhage requiring blood transfusion, 23 women in every 1 000 (common)
- return to theatre because of bleeding/wound dehiscence, and so on: seven women in every 1000 (uncommon)
- pelvic abscess/infection: two women in every 1000 (uncommon)
- venous thrombosis or pulmonary embolism, four women in every 1000 (uncommon)
- risk of death within 6 weeks, 32 women in every 100 000 (rare).

The main causes of death are pulmonary embolism and cardiac disease.

4.2 Frequent risks

Frequent risks include:

- wound infection, pain, bruising, delayed wound healing or keloid formation
- numbness, tingling or burning sensation around the scar (the woman should be reassured that this is usually self-limiting but warned that it could take weeks or months to resolve)
- frequency of micturition and urinary tract infection
- ovarian failure.

5. Any extra procedures which may become necessary during the procedure

- Blood transfusion
- Repair to bladder, bowel or major blood vessel
- Oophorectomy for unsuspected disease.

Oophorectomy for unexpected disease found at hysterectomy should not be performed without consent. All women undergoing hysterectomy should be informed that unexpected disease may be found in one or both ovaries and their wishes (to remove this or leave alone) should be documented.

6. What the procedure is likely to involve, the benefits and risks of any available alternative treatments, including no treatment

In cases of dysfunctional uterine bleeding, the woman should understand that no pathological cause has been identified to explain her menstrual symptoms. Other treatments, such as vaginal hysterectomy, the levonorgestrel-releasing intrauterine system, endometrial ablation and pharmacological therapies, must be discussed, together with the option of no treatment. When an abdominal hysterectomy is offered, there should be discussion of the total method and subtotal method. All women considering removal of the ovaries should be informed of the effect of this on the risk of ovarian and breast cancer.

7. Statement of patient: procedures which should not be carried out without further discussion

Other procedures which may be appropriate but not essential at the time should be discussed and the woman's wishes recorded.

8. Preoperative information

A record should be made of any sources of information (such as RCOG or locally produced information leaflets/tapes) given to the woman before surgery.

9. Anaesthesia

Where possible, the woman must be aware of the form of anaesthesia planned and should be given an opportunity to discuss this in detail with the anaesthetist before surgery. It should be noted that, with obesity, there are increased risks, both surgical and anaesthetic.

References

1. Royal College of Obstetricians and Gynaecologists. *Obtaining Valid Consent*. Clinical Governance Advice No. 6. London: RCOG; 2008 [www.rcog.org.uk/womens-health/clinical-guidance/obtaining-valid-consent].
2. Royal College of Obstetricians and Gynaecologists. *Presenting Information on Risk*. Clinical Governance Advice No. 7. London: RCOG; 2009 [www.rcog.org.uk/womens-health/clinical-guidance/presenting-information-risk].
3. JMcPherson K, Metcalfe MA, Herbert A, Maresh M, Casbard A, Hargreaves J, *et al*. Severe complications of hysterectomy: the VALUE study. *BJOG* 2004;111:688-94 (additional data from Dr MJA Maresh FRCOG, Manchester).
4. National Collaborating Centre for Women's and Children's. *Heavy Menstrual Bleeding*. Clinical Guideline. London: RCOG Press; 2007 [www.nice.org.uk/Guidance/CG44].

This Consent Advice was produced by Dr LC Edozien FRCOG, Manchester, with the support of the Consent Group of the Royal College of Obstetricians and Gynaecologists.

Peer reviewed by:

Dr SIMF Ismail MRCOG, Yeovil; Mrs AA Hare FRCOG, New South Wales; Dr PP Fogarty FRCOG, Belfast; RCOG Consumers' Forum

The final version is the responsibility of the Consent Group of the RCOG.

**The Consent Advice review process will commence in
2013 unless otherwise indicated**

DISCLAIMER

The Royal College of Obstetricians and Gynaecologists produces consent advice as an aid to good clinical practice. The ultimate implementation of a particular clinical procedure or treatment plan must be made by the doctor or other attendant after the valid consent of the patient in the light of clinical data and the diagnostic and treatment options available. The responsibility for clinical management rests with the practitioner and their employing authority and should satisfy local clinical governance probity.

Patient identifier/label

Name of proposed procedure or course of treatment

(include brief explanation if medical term not clear) *Total/subtotal abdominal hysterectomy.*

Statement of health professional (to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy)

I have explained the procedure to the patient, in particular, I have explained:

The intended benefits: *While menstrual bleeding is guaranteed to be abolished by total hysterectomy, the effect on pelvic pain and premenstrual symptoms is not guaranteed and the likelihood of this effect should be discussed.*

Serious risks:

- *Damage to the bladder and/or the ureter (7 women in every 1000) and/or long-term disturbance to the bladder function (uncommon)*
- *Damage to the bowel, 4 women in every 10000 (rare)*
- *Haemorrhage requiring blood transfusion, 23 women in every 1000 (common)*
- *Return to theatre, 7 women in every 1000 (uncommon)*
- *Pelvic abscess/infection, 2 women in every 1000 (uncommon)*
- *Venous thrombosis or pulmonary embolism, 4 women in every 1000 (uncommon)*
- *Risk of death within 6 weeks is 32 women in every 100000 (rare)*

Frequent risks:

- *Wound infection, bruising, delayed wound healing or keloid formation*
- *Numbness, tingling or burning sensation (this is usually self-limiting but could take weeks or months to resolve)*
- *Frequency of micturition and urinary tract infection*
- *Ovarian failure*

Any extra procedures which may become necessary during the procedure

blood transfusion

other procedure (please specify) *Repair to bladder, bowel or major blood vessels; oophorectomy for unsuspected disease*

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient.

The following leaflet/tape has been provided

This procedure will involve:

general and/or regional anaesthesia

local anaesthesia

sedation

Signed

Date

Name (PRINT)

Job title

Contact details (if patient wishes to discuss options later)

Statement of interpreter (where appropriate)

I have interpreted the information above to the patient to the best of my ability and in a way in which I believe s/he can understand

Signed

Date

Name (PRINT).....

Top copy accepted by patient: yes/no (please ring)