

## **Radical Hysterectomy**

I have been informed that I have cancer of the cervix. Treatment by radical hysterectomy and removal of the pelvic lymph nodes has been recommended. I understand the following about this surgery:

Stage I (early) cervical cancer may be treated either by radiation therapy or by radical hysterectomy and removal of the pelvic lymph nodes. Either treatment results in cure rates of about 90%. The potential risks of radiation therapy include injury to the bowel, rectum, or bladder, which may occur at the time of radiation or years after treatment. Radiation therapy also results in the loss of ovarian function (menopause) and some vaginal scarring. I have been offered referral to a Radiation Oncologist to discuss radiation therapy as a treatment option.

I understand that a radical hysterectomy is an operation which takes about two hours. The operation is usually done through a side-to-side incision which extends from one hipbone to the other across my lower abdomen just above the pubic hairline. This type of incision usually heals very well and leaves a minimal scar. At the time of surgery, my uterus, cervix, a portion of the upper vagina (less than one inch in length), the tissues immediately adjacent to the cervix, including the blood vessels and lymph nodes, and the pelvic lymph nodes will be removed entirely. If my age is less than 40 my ovary or ovaries will be left in place to provide hormonal function until menopause. If I am over 45, I may wish to have my ovaries removed. The risk of spreading of a cervical cancer to my ovaries is less than 1.5% overall. I have had the chance to discuss the disposition of my ovaries with my surgeon.

At the time of surgery, one of three things is likely. First, the surgery may be completed and the lymph nodes found to be free of spread of the cancer. In this type of situation, characteristics of the tumor may place me in either “high-risk” or “low-risk” group for recurrence. If my tumor characteristics place me in the “low-risk” group, no further treatment will be recommended. If my tumor places me the “high-risk” group, postoperative radiation therapy will be recommended. Second, there may be spread of the cancer in my lymph nodes, the tissues around the cervix or the cancer may extend to the core of the surgical specimen. In such a case, radiation therapy will definitely be recommended after surgery. Low-dose chemotherapy may be added to increase the effectiveness of the radiation therapy treatments. I understand that if there is spread of the cancer to my lymph nodes that this may decrease the cure rate to 65-75%. Third, there is a chance that my cancer has spread beyond the cervix and lymph nodes at the time of surgery. In such a case, my surgery will not be completed, although I will have a skin incision. In such a circumstance, I understand that the cancer will be treated primarily by radiation therapy with chemotherapy. This situation represents a case in which the expectations for cure may not be higher than 50%.

I understand that there are a number of potential problems with radical hysterectomy and removal of the pelvic lymph nodes function. This occurs because removal of the pelvic lymph nodes interferes with the nerve supply to the bladder. The most common problem encountered by women who have this type of operation is loss of bladder sensation. This means that the bladder may fill without my feeling fullness. If I am not aware of my bladder filling, and do not go to the bathroom, overflow leakage may occur. Another problem resulting from the operation is that the bladder may be more difficult to empty. Generally, these problems are of short duration and correct themselves within a matter of weeks to months. The loss of bladder sensation may last for a longer

period of time. However, because of the difficulties with bladder function, I understand that a suprapubic catheter will be left in my bladder. This catheter will be left in place for two to four weeks after surgery, at which time it may be removed. It is possible that bladder drainage for a longer period may be necessary. It is also possible, but unlikely, that I may need to learn to catheterize myself three or four times a day to empty my bladder.

Other complications that may occur with this operation include injury to the bladder or ureters (the tubes connecting the kidneys and the bladder), which may result in fistula formation (leakage of urine through the vagina), and may require surgical correction. I understand that this risk occurs in about 0.5% of women, or 1 in 200. Injury to the bowel is less common, but I may have difficulty with constipation following the surgery because of the same type of interruption of the nerve supply to the rectum as occurs with the nerve supply to the bladder. Other less common problems are the risk of bleeding which may require a transfusion or second operation, the development of blood clots in my legs or pelvis which could travel to my lungs (pulmonary emboli), weakness or swelling of my legs as a result of the surgery or the removal of lymph nodes, or injury to a major blood vessel in my pelvis. Another possible complication is infection of the wound or incision, and might result in the skin edges opening up and the fatty tissues under the skin needing to be packed with gauze dressings and irrigated with peroxide for several weeks after surgery. Another uncommon potential problem is the risk of pelvic infection, which might require antibiotics or, at worst the drainage of a pelvic abscess/infection.

I understand that my hospital stay will be about three days after surgery. I will be given intravenous fluids until my bowel returns to normal function, at which time I will be started on liquids followed by a regular diet. Indications of a return to normal bowel function will be passage of gas by way of my rectum (flatus). I understand that if my ovaries are left in place they have a very good chance of functioning until menopause. However, occasionally the ovaries will stop working and I may require hormone therapy in this case. Rarely, an ovary may twist and need to be removed surgically after my main operation.

I understand that all of these complications are rare and are certainly far less than risks of letting the cancer go untreated. The risks of a severe complication following surgery are no greater than the risk of a severe complication following radiation therapy.

If I have any questions or problems regarding my surgery or diagnosis, I may call Dr. Sutton at (317) 415-6740 or toll free at 1-888-488-1145.

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