NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

# Information for patients and carers

## Surgery for Removal of Suspicious Ovarian Cyst or Ovarian Mass

# Introduction

If you have been diagnosed with an ovarian cyst or a pelvic mass (lump), the possibility of cancer may have been mentioned. It can be a frightening and unsettling time. Whatever you may be feeling try talking about it with someone who specialises in dealing with this condition, such as your Gynae-oncology clinical nurse specialist (CNS). They will listen, be able to answer any questions you may have and can put you in touch with other professionals or support agencies if you wish. Some useful contact numbers are also listed at the back of this booklet.

# What is staging surgery and why is it necessary?

Different types of cysts may develop on the ovary; they can vary in size and may affect one or both of the ovaries. Often the cause of the cyst is unknown. In some people, ovarian cysts may be found to be cancerous. The final diagnosis may not be possible until after the cyst has been removed. The type of surgery necessary will depend upon what is found at the time of the operation. Your doctor will discuss the options with you before surgery.

We use a combination of a scoring system, assessment of scans and blood tests to determine our concern about the risk of cancer, this is known as the Risk of Malignancy Index (RMI).

If the suspicion of cancer is high, we will advise you to have ‘staging’ surgery.

A person with cancer of the ovary may need to undergo surgery to remove either some or all of the tissues in this area (see diagram). How much is removed during the operation will depend upon the type of cancer cells, the size, the position and whether it has spread beyond the original area. Your general health and symptoms (such as discomfort, pain, nausea, vomiting, bowel or bladder habit changes or a reduced appetite) are also considered when planning your surgery.

Surgery involves:

- Total Hysterectomy (womb and cervix), removal of both tubes and ovaries (salpingo-oophorectomy) or just the removal of the affected ovary (oophorectomy) if future fertility is required.
- Assessment and removal of the pelvic lymph glands and possibly the lymph glands around the aorta
- Removal or biopsy of the fat pad in the abdomen (Omentum)

If there is a degree of uncertainty about the cancerous potential of the ovarian cyst/mass the surgery will involve removal of the affected ovary. This will then be sent to the laboratory for immediate examination under the microscope - this is known as a frozen section. You will still be asleep whilst this is happening.

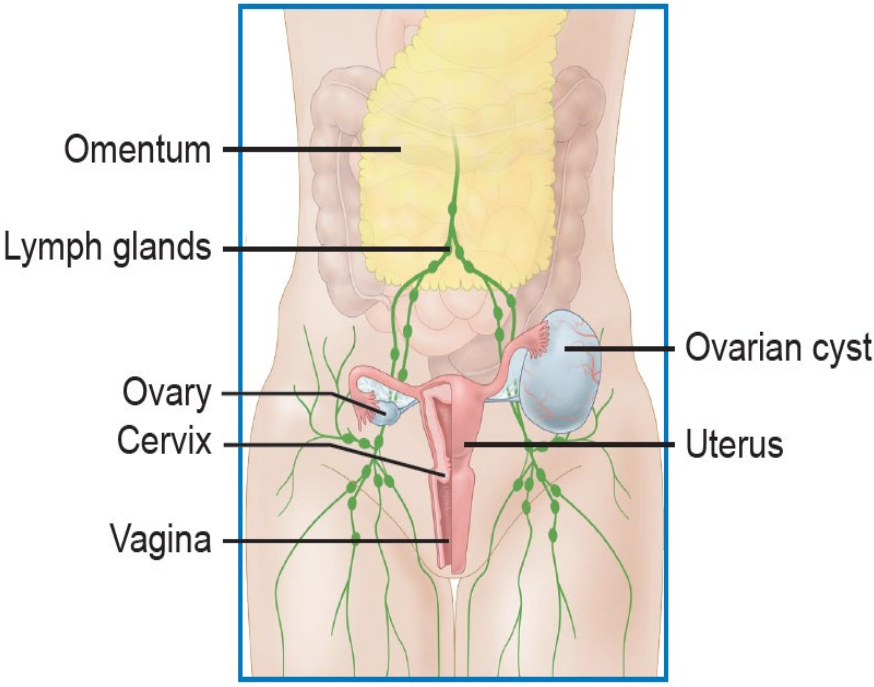
The pathologist will then inform the surgeon of the result (usually within 40 minutes).

If the frozen section shows that this is cancer, then the surgery will involve:

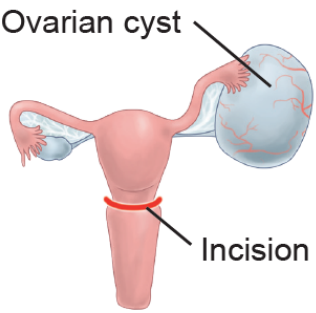
- A Total Hysterectomy which is removal of the womb, tubes, ovaries and cervix
- Removal of the pelvic lymph glands and possibly the lymph glands around the aorta
- Removal of the fat pad in the abdomen (Omentum)
- If the frozen section suggests that the cyst is benign (not cancer) then your options may include:
    - Hysterectomy and removal of the other ovary
    - No further surgery (if you wish to preserve your fertility)

At the start of the surgery if the cyst looks cancerous or there is obvious cancerous disease within the abdomen or pelvis then it will not be necessary to do the frozen section. The surgery will then be to remove as much of the visible cancer as possible.

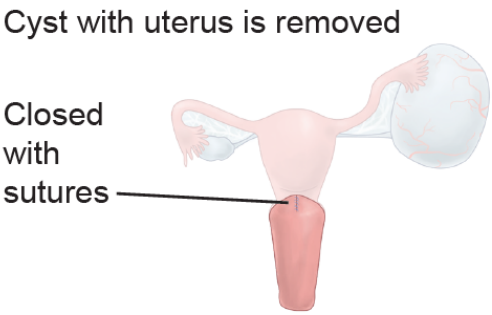
# Anatomy Diagrams



**Total hysterectomy**

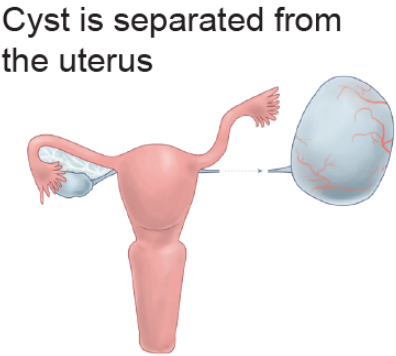



*Stage 1*




*Stage 2*

**Oophorectomy**




*Stage 1*


*Stage 2*

## Are there any alternatives to surgery?

The alternative is to choose not to have surgery, however without surgery it is not possible to be sure whether the cyst is cancerous or not. It is important that you have the opportunity to discuss your options with your doctor before making your decision.

## Fertility sparing options

In some cases where the cancer affects only one ovary it may be possible to preserve fertility by removing only the affected ovary. In the future, after completing your family it may be recommended for you to have the other ovary removed.

The loss of fertility can have a huge emotional impact and you may find it useful to discuss this and the options available to you with your doctor or your Gynae-oncology clinical nurse specialist.

## Are there any risks?

As with any operation, there is a risk associated with having a general anaesthetic. Also, as with all major abdominal surgery, there is the risk of bruising or infection in the wound. Internal bruising and infection may also occur. A blood transfusion may be required to replace blood lost during the operation. Rarely, there may be internal bleeding after the operation, making a second operation necessary.

Patients occasionally suffer from blood clots in the leg or pelvis (deep vein thrombosis or DVT). This can lead to a blood clot in the lungs. Moving around as soon as possible after your operation can help prevent this. The ward nurse will show you some gentle leg exercises, safe ways to move in and out of bed and breathing exercises to reduce the risk of blood clots or a chest infection. You will also be given special surgical stockings (anti-embolism stockings) to wear whilst in hospital and injections to thin the blood, you will need to have these injections for 4 weeks post operatively.

Rarely, the bladder or the ureter (tube which brings urine to the bladder) may be damaged. For this reason, a catheter (tube) needs to be in the bladder for 5 – 10 days after the operation to allow healing to take place. Some people may initially find it difficult to pass urine properly once the

catheter tube has been removed and so it may have to be reinserted for a short time to allow the bladder to rest further.

## What are the risks associated with a general anaesthetic?

Please refer to the separate Trust leaflet “You and your Anaesthetic”

## What else might happen as a result of my surgery?

Occasionally, if cancer is found depending on the extent and position, surgery may require operating either close to, or on the bowel. If an area of bowel affected by cancer must be removed, the sections of the unaffected bowel may be rejoined. This is known as ‘anastomosis.’

However, if this is not possible, the bowel will be diverted to open on the surface of the tummy. This is known as a ‘colostomy’ or ‘stoma’ and allows the stools (faeces) to be collected in a bag attached to your tummy, which can be removed and emptied as necessary. If this procedure is a likely possibility, it will be explained to you in more detail, either by the consultant performing the surgery, the stoma nurse, or by your Gynae-oncology clinical nurse speciality before your operation. It is important to note the risk of bowel surgery is about 1 in 100.

## Will I have a scar?

**Yes**. Although it will fade. The surgeon will make a vertical midline incision (also known as an ‘up and down cut’) and close the wound with either sutures (stitches) or clips. The area around the scar will feel numb for a while after the operation but sensation will return to it.

## What about losing my fertility?

If both ovaries and the uterus (womb) are removed, this will result in immediate loss of fertility. At any age, having to have your ovaries removed can affect the way a person feels about themself. The loss of fertility can have a huge impact, but reactions to this are personal and individual. You may feel the need to ensure that you have explored all the issues and any other options that may be available to you.

It is important that you have the opportunity to discuss these issues and feelings with your Gynae-oncology clinical nurse specialist before your operation and you are offered support afterwards.

Advice is also available from the specialist fertility team.

## Will I need hormone replacement therapy (HRT)

You may need HRT if you have both your ovaries removed and have not already been through the menopause. HRT is available in many forms – as an implant, patches (similar to a nicotine replacement patch), tablets, gels, sprays and vaginal creams. There are also alternative ways of managing the potential symptoms.

Please discuss the options available to you either with the gynaecological oncology team, before you are discharged from hospital, or with your GP. You can also contact your Gynae-oncology clinical nurse specialist or your consultant for further information or advice. Please note, we may advise waiting for your final histology results before prescribing any HRT.

## Is there anything I should do to prepare for the operation?

**Yes**. Make sure that all of your questions have been answered to your satisfaction and that you fully understand what is going to happen to you. You are more than welcome to visit the ward and meet the staff before you are admitted to hospital. Just ask your Gynae-oncology clinical nurse specialist to arrange this for you.

If you are a smoker, it would benefit you greatly to stop smoking or cut down before you have your operation. This will reduce the risk of chest problems as smoking makes your lungs sensitive to the anaesthetic.

You should also eat a balanced diet and, if you feel well enough, take some gentle exercise before the operation, as this will also help your recovery afterwards. Your GP, practice nurse at the surgery or doctors and nurses at the hospital will be able to give you further advice about this.

Before you come into hospital for your operation, try to organise things ready for when you come home. If you have a freezer, stock it with easy to prepare food. Arrange for relatives and friends to do your heavy work (such as changing your bed sheets, vacuuming and gardening) and to look after your children if necessary. You may wish to discuss this further with your Gynae-oncology clinical nurse specialist.

If you have any concerns about your finances whilst you are recovering from surgery, you may wish to discuss this with your Gynae-oncology clinical nurse specialist or the social worker. You can do this either before admission to hospital or whilst you are recovering on the ward. Just ask the ward staff if you would like to see a social worker.

## Will I need to have any tests before my operation?

**Yes**. These tests will ensure that you are physically fit for surgery and help your doctor to choose the most appropriate treatment for you.
You may have:

- An ECG (recordings of your heart)
- A Chest X-ray
- Respiratory function tests
- A blood sample to check that you are not anaemic and that the function of your kidneys and liver are normal
- An MRI, CT or ultrasound scan
- CPEX (exercise tolerance test)

Often the tests are arranged when you come to a pre-operative appointment in the out-patient department one or two weeks before surgery. You will be given the opportunity to ask the doctor and the Gynae-oncology clinical nurse specialist any questions that you may have. It may help to write them down before you come to hospital.

## When will I come in for my operation?

You will be admitted to the ward on the day of your operation.
You will meet the ward nurses and doctors involved in your care and the anaesthetist will visit you to discuss the anaesthetic and to decide whether you will have a 'pre-med' (tablet or injection to relax you) before you go to the operating theatre. You can ask any further questions you have at this time.

Your temperature, pulse, blood pressure, respiration rate, height, weight and urine are measured to give the nurses and doctors a base line (normal reading) from which to work. You will be asked to sign a consent form to confirm that you understand and agree to the operation.

You will be asked to have only clear fluids (water) up until 2 hours before surgery. You will not be allowed to have anything to eat or drink after this time, including chewing gum or sweets. A 'drip' may be attached to your hand / arm to provide you with fluids and prevent dehydration during this time.

You will be given special surgical stockings (anti-embolism stockings) to wear and will have injections to prevent blood clots (also known as DVT or deep vein thrombosis) forming after surgery. These injections will continue for 28 days. This is necessary, because when you are recovering from the operation, you may be less able to walk around and keep the blood circulating in your legs.

## What happens on the day of my operation?

You will wake up in the recovery room before returning to the ward, occasionally you may go to the high dependency unit (HDU) which is part of the critical care unit (CrCU) for 24 hours and then back to the ward. This will depend on how long the surgery has taken and the level of nursing and medical support needed after the operation, but this will be discussed prior to surgery if it is likely to happen.

You may still be very sleepy and need the support of oxygen which will be given through a clear facemask to help you breathe comfortably immediately after your operation. Your blood pressure, heart rate and breathing rate will be monitored regularly. A 'drip' will be attached to your hand or arm to provide you with fluids and prevent dehydration. You will be encouraged to eat and drink as soon as you are able.

A catheter (tube) will be inside your bladder to drain urine away and allow your bladder to rest. The catheter will need to stay in until you are taking oral fluids adequately and you are able to walk to the toilet (usually 2-3 days). You may also have trouble opening your bowels or have some

discomfort due to wind for the first few days after the operation. This is temporary and we can give you laxatives or painkillers if you need them.

## How will I feel after my operation?

Please tell us if you are in pain or feel sick when you return to the ward or HDU. We have tablets/injections that we can give you as and when required, so that you remain comfortable and pain free. An epidural may be inserted in your back at the time of your general anaesthetic to provide pain relief for between 24 - 48 hours. Alternatively, you may have a device that you use to control the pain yourself. This is known as patient-controlled analgesia or a PCA and you will be shown how to use it. The anaesthetist will discuss these options with you before the operation.

You may have some vaginal bleeding or a blood stained discharge. The wound will have a special dressing on it to keep it clean and dry for 2-3 days after the operation and, depending on the type of incision used, the sutures or clips will be removed 5-10 days later. Alternatively, you may have dissolvable sutures, but you will be informed if this is the case.

## Is it normal to feel weepy or depressed afterwards?

**Yes**. It is a very common reaction to the diagnosis, to the operation and to being away from your family and friends. If these feelings persist when you leave hospital, the advice and support of your friends, family, GP, your Gynae-oncology clinical nurse specialist or the specialist social worker may be able to help you.

## When can I go home?

You will be in hospital anywhere between 3 to 14 days, depending on the type of operation you have had, your individual recovery, how you feel physically and emotionally and the support available at home. This will

be discussed with you before you have your operation and again whilst you are recovering. Sometimes patients will require to stay in hospital for a longer period of time.

## When can I get back to normal?

It is usual to continue to feel tired when you go home. It can take up to 3 months to fully recover from this operation, sometimes longer, However, your energy levels and what you feel able to do will usually increase with time. This differs for each individual, so you should listen to your body and rest when you need to. This way, you will not cause yourself any harm or damage.

For the first 2 to 3 weeks after surgery lifting should be restricted. Light activities such as dusting and washing up can be started. Break up your activities so that you are doing a small amount at a time. Limit your lifting to kettles (not a full kettle), small saucepans and items weighing approximately the same as one litre water bottles. Gradually build up to more strenuous activities such as vacuuming after 4 weeks but listen to your body and stop if you feel discomfort or pain.

Remember to lift correctly. Bend your knees. Keep your back straight and tighten your pelvic floor and abdominal muscles. This should be a habit for life.

Try not to stand for long periods at a time initially. Many everyday chores can be done sitting down such as ironing and peeling vegetables.

If chemotherapy is required, this is normally given on an outpatient basis, if this is necessary your Gynae-oncology clinical nurse specialist will discuss this with you.

## When can I start driving again?

Returning to driving will depend on the type of surgery you have had. This will vary between 6-8 weeks.

You may feel more comfortable if a folded towel is placed under the seat belt across your abdomen. You need to be able to fully concentrate, make an emergency stop and look over your shoulder to manoeuvre. It is a good idea to check your insurance policy.

## When can I return to work?

This will depend upon the type of work you do, how well you are recovering, and how you feel physically and emotionally. It also depends on whether you need any further treatment (such as chemotherapy) after your operation.

Some people will feel ready to return at 4-6 weeks if the job is part time or not physically demanding. However, if your work is more physically demanding, 6-12 weeks is recommended. It may be helpful to slowly increase your hours and duties over a period of time.

This can be discussed further with your doctor, your Gynae-oncology clinical nurse specialist or GP.

**Remember** that returning to a normal life takes time. It is a gradual process and involves a period of readjustment which will be individual to you.

## What about exercise?

It is important to continue doing the exercises shown to you by the ward nurses for at least 6 weeks after your operation.

**Walking**: It is important to continue with the regular walking you were doing whilst in hospital. Start with 10-minute walks 1-2 times per day and gradually increase the pace and distance you walk. You may find you can walk 30-60 minutes after 2-3 weeks.

Gentle, low impact exercises such as **Pilates** and **yoga** may be enjoyable and beneficial and they can be started as soon as you feel able, usually from 4 weeks.

**Swimming**: You may resume or start swimming once your wound has completely healed and once any vaginal bleeding or discharge has stopped. Some people may feel ready after 2-3 weeks, but others may not feel ready till 6 weeks.

**Competitive sport and high impact exercises** are best avoided for 6-12 weeks, depending on your previous level of fitness.

Your Gynae-oncology clinical nurse specialist will be happy to give advice on your individual needs.

## Sexual activity

Following surgery, you may not feel physically or emotionally ready to start having sex again for a while. It can take at least 2 months to physically recover from the operation and even longer for energy levels and sexual desire to improve. During this time, it may feel important for you and your partner to maintain intimacy, despite refraining from sexual

intercourse. However, some couples are both physically and emotionally ready to resume having sex much sooner and this can feel like a positive step. If you have any individual worries or concerns, please do discuss them with your clinical nurse specialist.

It can also be a worrying time for your partner, who should be encouraged to be involved in discussions about the operation and how it is likely to affect your relationship afterwards. Their involvement can have a positive influence on your recovery.

If you do not have a partner at the moment, you may have concerns either now or in the future about starting a relationship after having this operation. Your clinical nurse specialist may be able to offer support or be able to refer you to someone who can help. Please do not hesitate to ask them if you have any queries or concerns about your sexuality, change in body image or your sexual relationship either before or after surgery.

## Will I need to visit hospital again after my operation?

**Yes**. It is very important that you attend any further appointments arranged for you at the hospital.

An appointment will be made to discuss your results and any further treatment options, if necessary. Depending on the histology results you may need to attend for regular follow-up appointments in future at your local hospital.

## Should I continue to have cervical smears?

**No**. Cervical smear tests are not necessary after this operation if the womb and cervix have been removed.

Please note that if your cervix (neck of the womb) was not removed, a smear may be taken as part of your routine examination.

## How do I make a comment about my treatment?

We aim to provide the best possible service and staff will be happy to answer any questions you may have. If you have any suggestions or comments about your visit, please speak to the ward staff.

## Clinical Trials

A clinical trial may be discussed with you as a potential option for treatment. This discussion does not commit you to taking part.
You may also want to ask your doctor or nurse if there are any clinical trials available for which you might be suitable.

## Contact details

Should you require further advice or information please contact the team on 01772 524211 - Monday to Friday (8.30 am to 4.30 pm).
You may also contact the following departments for advice:

Gynaecology Outpatient Department: 01772 524386

Gynaecology Ward: 01772 524231

## Sources of further information

www.lancsteachinghospitals.nhs.uk
www.nhs.uk
www.accessable.co.uk
www.patient.co.uk

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www.lancsteachinghospitals.nhs.uk/patient-information-leaflets

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If you want to stop smoking, you can also contact Smokefree Lancashire on Freephone **08081962638**

## Please ask a member of staff if you would like help in understanding this information.

## This information can be made available in large print, audio, Braille and in other languages.

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