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Information For F to M Transsexuals: Removal of the uterus (hysterectomy) and the ovaries (oophorectomy)

Welcome. I am a strong ally for Transgender rights and welcome you to my practice, along with my office staff and the staff at Sequoia Hospital. We are very happy to provide surgical care for you and hope you will feel at home with us. Please check out the notebook on Transgender issues in the lobby, and feel free to add any useful information to it at later appointments.

I've compiled this document specifically for my Transmen patients contemplating hysterectomy/oophorectomy, to help clarify choices and procedures. The first section discusses the options available for hysterectomy and other background information. The second section outlines planning, preparation, and procedures for surgery. The third section discusses recovery.

I. Overview of Hysterectomies

Any surgery should be done for a very good reason, by the most appropriate surgical route, in the least debilitating way, allowing the speediest recovery of function.

The older ways –Total Abdominal Hysterectomy (TAH)

Most surgeons can perform the most common hysterectomy, the TAH. TAH requires a four to eight inch abdominal incision (vertical if there is cancer or a large mass to be removed, and horizontal for benign and smaller masses) to remove the uterus, and ovaries, if needed. The TAH is usually ***only*** recommended when one cannot or should not have the less invasive techniques listed below. This incision is also done if there is difficulty performing the surgery through the scopes.

(LAVH) and (TVH):

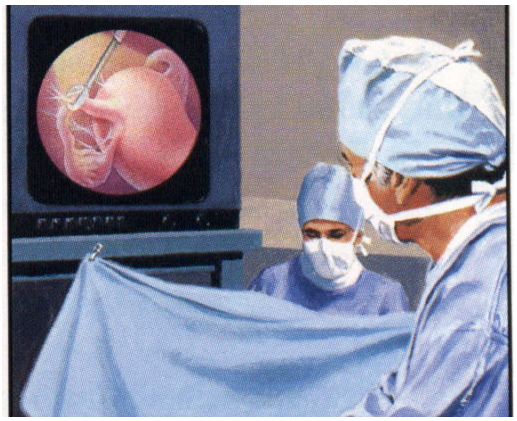
The LAVH is a laparoscopic assisted vaginal hysterectomy. It is very similar to the TLH except that the bottom portion of the uterus is dissected away by operating through the vagina, called vaginal hysterectomy. This technique requires some degree of vaginal laxity, and is easiest after one has had a baby or two.

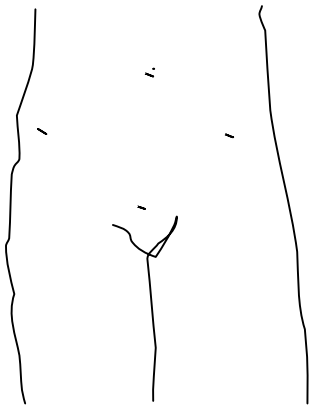
What we do - Total Laparoscopic Hysterectomy (TLH)

This is the procedure Dr. O'Hanlan usually performs. It involves removing the uterus by operating through the scopes and passing the tissue out through one of four tiny half-inch abdominal incisions. There is no requirement for a wide vagina or loose ligaments from childbirth, since there is no operating through the vagina (although if required tiny pieces of tissue can be passed down through it). Even massive uteruses and ovarian cysts, cancer and pre-cancer can ***all*** be treated using laparoscopic hysterectomy. Hospital stays are typically shorter and blood loss is about half compared to an abdominal hysterectomy. Pain is less and time off

from work is only two weeks, not the six weeks usually required after an abdominal hysterectomy.

There is also no increased risk of urinary leakage after the Total Laparoscopic Hysterectomy, and some even report that mild leakage was corrected. Dr. O'Hanlan connects the inner end of the vagina, where the uterus used to be attached, to the three ligaments that originally held up the uterus (Round ligament, Uterosacral ligament and Cardinal ligament). Dr. O'Hanlan uses this technique as often as is safe and effective, since it supports the vaginal structure, which in turn supports the bladder and prevents urinary leakage.





A. This is me in the operating room (not!).
B. These are the usual incisions for a laparoscopic hysterectomy. One incision is *inside* the bellybutton, and one is in the pubic hair.

B. Frequently asked questions

Pre-Op Examination

Some of our FTM patients have asked whether a pelvic examination is really necessary prior to surgery, since everything is coming out anyways. A complete examination including a pelvic is required by every gynecologist prior to surgery so that she can be certain that there will be no surprises at surgery. We know that for some transmen these exams are very difficult, and some may have avoided them entirely up until now. We do everything we can to reduce the discomfort of the exam itself, and most guys feel that we do a very, very respectful and tolerable job.

Will I need to bring a letter?

Dr. O'Hanlan follows common practice with regard to hysterectomy, which is not a "genital" reassignment surgery, per se. We treat many transmen in our practice, evaluating each patient on an individual basis, working with them to assess the medical utility and necessity of any procedure. Typically, we do not require letters of any kind. Our goal is to enhance the quality of life for each of our patients. Removing unhealthy tissue, reducing risk of cancers, reducing or eliminating debilitating pain: each of these interventions has been shown, both in our practical experience and by research data, to greatly enhance overall health and well-being.

Will my insurance cover this?

Because Jesse Helms amended the Americans with Disabilities Act to exclude required insurance coverage of any transgender care, insurance does not cover hysterectomy or oophorectomy unless there is medical necessity as relate to the dysfunction of the uterus, tubes or ovaries. If the

hysterectomy and oophorectomy is planned for transgender benefits, then you will need to arrange for coverage of the hospital, lab, anesthesia and surgery fees. Dr. O'Hanlan has negotiated for each of these fees to be charged in accordance with what is generally collected, so that our transguys not be bilked.

Will having a hysterectomy allow me to lower my testosterone dose?
Yes, you will be able to try lower doses of testosterone doses without the worry that your ovaries will start to work again.

Do I have to be on testosterone or be doing the "real life test" to have this surgery?
For surgeries performed for transgender benefits, Dr. O'Hanlan follows the HBIGDA rules and prefers that candidates be settled on Testosterone in their process. NO letter is necessary to document this fact, however.

Will Dr. O'Hanlan provide a certified letter confirming my gender surgery?
In many jurisdictions surgery such as a hysterectomy is either necessary or sufficient in order to change a gender marker on a birth certificate, drivers license, or other documents. It may also be useful for changing the marker on a passport or social security. In most cases the letter will need to be certified, and since an original copy may need to be provided, you may need to have several copies on hand. If you require a letter, Dr. O'Hanlan will provide it if requested at time of surgery. It is up to you to check into the requirements for each jurisdiction you'll be sending the letter to. If there is specific wording or information required in the letter, then you must let our office know in advance, so that we can provide the necessary information. Otherwise, our office has a standard letter which we will use.

If you require the letter to be certified, there will be a fee for this service. Dr. O'Hanlan's office will contact you to make arrangements by having a notary public come to our office to sign letters on an as needed basis. If you would like multiple certified copies (some sources suggest 3-4 copies), there will be a fee per copy. Four letters certified, can cost something like $15 per letter.

I don't live in the Bay Area, or in California…Are there any surgeons near me who are good at this surgery and will accept transmen as patients?
You can take this document to any gynecologist's office and ask if they can help you to have the same level and quality of care. Ask what type of hysterectomy and oophorectomy the doctor can do.

C. Hysterectomy-- Facts versus Myths:

When a hysterectomy is called a "Total Hysterectomy" we mean that the entire uterus with cervix are removed. When the tubes and ovaries are removed, it is called a salpingo-oophorectomy. Thus a Total Laparoscopic Hysterectomy Bilateral Salpingo-oophorectomy removes all of the gynecologic tissues. Dr. O'Hanlan also offers to remove the appendix while she is inside the abdomen, so that you will never have to worry about developing acute appendicitis.
Many people wonder just how the uterus and other bits can go out through such tiny incisions. First of all, we typically use the incisions only for instruments. The Bellybutton incision is used to insert a tube to inflate the abdominal cavity with carbon dioxide to that there is room to see the organs using a small fiber-optic video camera. The other three incisions are where Dr. O'Hanlan

inserts the surgical tools for disconnecting the uterus and all with minimal bleeding. Typically, these pieces are cut up and then passed out through the vaginal opening. Then the upper end of the vagina is sewed shut.

The following are *the facts* for the vast majority, despite what you may read on the Internet, or hear from friends. Patients who are happy with their surgical results often do not make websites, write books or talk about their surgery, so the Internet and books are not always a reliable source for information. In medicine, we report results of surgery and patients' opinions about their experiences by analyzing *hundreds* of questionnaires and publishing the data. This way you can evaluate what the *probable* results of surgery will be, and not be misinformed or biased by individual stories that you have heard. Such stories may have had multiple factors that were *not* described or accounted for, such as whether or not the ovaries were removed, and if so, what, if any, hormone therapy was prescribed afterward? In the correct dose? Were there other problems? Many such factors can impact the postoperative comfort and sexual function.
So, here are the facts based on research and data from large numbers of patients:

1. **Hysterectomy does not ruin your sex life.** Orgasms will be the same. Lubrication will be the same. Your libido will not change. These things *do* change as you age and with Testosterone injections. But a hysterectomy will not ruin any of these for you.

2. **Hysterectomy *will not* make you age faster.** The menstrual symptoms simply go away. No hormones can prevent aging, wrinkles or arthritis.

3. **Hysterectomy *will not* make you get fat**. Neither will removal of the ovaries. Research tells us that many gain weight as they age, especially if they don't exercise and modify their eating habits. Testosterone won't make you overeat or gain weight. However, the increase in metabolism experienced by many transmen on "T" may lead to overeating. If you eat more than you need and exercise less than you should, then you will gain weight. Whether before or after surgery, on or off of "T": you must exercise all your life and eat no more than you need all your life.

4. **Hysterectomy *will not* cause bladder leakage or prolapse of your organs.** Studies of over 16,616 patients in the Women's Health Initiative confirm that there is the exact same rate of prolapse of the bladder (32%) and the rectum (18%) with and without hysterectomy. Having children and obesity were the strongest risk factors to predict for prolapse. (Hendrix, AJOG, 2002) In fact, research also shows that weight loss is one of the most effective non-surgical remedies for urinary leakage of all types.

5. **Removing the uterus, cervix and ovaries *will* remove the risk of uterine and cervical cancer, and radically reduces your risk of ovarian cancer.**

6. **The testosterone you take *will* have an adverse effect on your cardiac cholesterol profile.** The hormone replacement testosterone used by most transmen places you at risk for many of the same health problems as any genetic male. Eating a very healthy diet, exercising, and managing your cholesterol, blood pressure and blood sugar carefully, will help you reduce these risks.

II. Planning and Preparation for Your Surgery

This rest of this document is intended to help you prepare for your surgery. While not every situation can be foreseen, many folks have a remarkably similar experience. Dr. O'Hanlan hopes that you can use this information to reduce any fear, counteract any misinformation, and ease any anxiety about your upcoming surgery.

Read, prepare, and ask questions

Make sure to read *all* our material and prepare yourself for each step of the process. **Your spouse, partner or friend who is your caregiver *should also read* this entire document** to be most helpful during your hospitalization. **As you read, *please highlight and underline any areas of concern* so that you can be sure to cover them with Dr. O'Hanlan during your surgery-planning visit.**

Bring this material with you to your pre-operative visit *and* to the hospital. If and when questions come up, *compile a written list* to ask at your preoperative visit and prior to surgery so that your hospitalization can go as smoothly as possible for you. **Keep this document in the surgical folder that we will give to you.** You will need to *re-read it* and refer to it in the hospital and later at home.

Scheduling surgery & the Pre-Surgery visit with Dr. O'Hanlan

Please make sure there won't be any reason to cancel your surgery at the last minute. We build our office and surgical schedules around our commitment to your surgery date. Last minute cancellations waste time and resources because other patients cannot be simply substituted in at the last minute. Plan for and around this day carefully so that you will not need to cancel it. When you set the surgery date, we will also schedule a pre-surgery visit. This is typically a few days before surgery. Fees for the surgery have already been negotiated by me with each entity serving you, so that no entity bilks you with inordinate fees. Each fee has been set so that the same amount that they usually collect for their work from insurance companies is similarly charged to you: Surgeon 3,000; Assistant 1,000; Anesthesia 600; Pathology 300; Hospital 6,000. Forms are attached at the end of this document to fill out and affix each check to, for delivery to the hospital.

Risks of surgery and consent:

When you come in to discuss your proposed surgery with Dr. O'Hanlan, bring in your list of questions, as well as a list of all of your current medications (see B4 below). Dr. O'Hanlan will formally review with you her findings from your physical (pelvic) examination. She will explain the risks, benefits, and alternatives to your surgical plan. Ask Dr. O'Hanlan all your questions.

You will be asked to sign consent forms for your surgery during this visit. These consents are written to assure your understanding of your proposed procedure. They are not contracts. **Ask all your questions, and know that there is no pressure to sign anything without your complete understanding and agreement.** You will be given a folder for all of your surgical documents that will include both your copy of these consent forms and the hospital's copy. Please remember to give all documents in the "Hospital Documents" section to the nurses when you check in at the hospital.

If you are from out of town:

If you are from out of town you will need to make sure you bring all appropriate paperwork with you. You may want to discuss your surgery plans with your doctor, to arrange for any post-surgical

care one you have returned home. Make sure you read all the way through this document before leaving, so that you can prepare everything before leaving home.

We will be happy to provide you with a list of local hotels from every price range. Please make sure we have your local number so you can be contacted by the operating rooms if needed. If you have a cell phone in use while in town, provide us with that number, as well.

List of current medications and drug allergies:

Fill out the last page carefully and include **all of your current medications**. The list **must include doses and frequencies used for all prescriptions and non-prescription medications**, including any herbal, naturopathic, and over-the-counter drugs. It should also list any **drug allergies**. Dr. O'Hanlan will review this list with you at your pre-surgery visit, and it goes in your surgery folder.

For your safety during anesthesia:

At least 14 days before surgery, you must stop taking:
Mardil, Parnate, Eldepryl, Marplan Clorgyline, Brofaromine, Moclobemide and Tolozatone.
At least 7 days before surgery, you must stop taking:
Meridia, Fastin, Ionamin, Adipex and any amphetamines.
At least 3 days before surgery stop taking herbal remedies, aspirin or Motrin/Nuprin/Advil/Ibuprofen-like substances. These medications can prevent normal blood clotting, which is vital for surgery.

Use Tylenol or acetaminophen pain relievers, if you need pain relief before your operation. Continue taking your Testosterone shots or using your patches or gels on your regular basis.

The Tablets: At your physical exam, Dr. O'Hanlan may have prescribed low-dose Estradiol suppository tablets. You will be taking these every night for two weeks up to surgery. As Dr. O'Hanlan has told you, these tablets help maintain mucosal tissues and will play an important role in your internal healing. After surgery, you will continue taking them, but at reduced a frequency of two tablets per week. Once we are sure the internal scar line is cleanly healed, you will no longer need the tablets. In any case, the hormone dose is local and so low that it will not interfere with your testosterone treatment.

Blood Transfusions – Really rare for Transmen hysterectomies. Expected blood loss is small for all laparoscopic surgeries. Donating your own blood will <u>not</u> be worth your trouble.

C. Preparations for Surgery

Packing clothing for your hospital stay: Wear comfortable clothes that you will be able to wear over your incisions during the drive home. Sweat suits are a great choice. There is no need for pajamas as the hospital provides covering for you. Do not wear or bring jewelry to the hospital. Bring your toothbrush and necessary cosmetics, a few sanitary pads and any particular health aids. Wear glasses, not contacts, and be reassured that you can wear glasses, partial teeth, and hearing aids until the very last minute. You'll take them off in the operating room just before you go to sleep, and find them with you in the recovery room ready to put back on/in as soon as you wake up.

Shaving: Please do not shave the surgical sites. Shaving the surgical site in advance actually increases wound infection rates. We will shave only what is essential for our incisions in the operating room.

Medical Power of Attorney and other documents: If you are single, widowed, or in an unregistered domestic partnership, bring a copy of your durable medical power of attorney, or plan to sign one upon admission to the hospital. If for any reason you cannot make your own decisions, this will ensure that health decisions are made for you by the right person. Remember to bring this document, and the rest of your folder, to the hospital.

Check with hospital the day before: The day before your scheduled surgery date by 4 pm, someone from the hospital will call you at the number you provided. They will confirm the time of your surgery and the time for you to check into the hospital. If your surgery is scheduled for Monday, this call should come on the Friday before (no one will be there on Sunday to call you). If you have not received a call by 4:00pm, call the operating room of the hospital you are scheduled for and ask for your surgery and check in times. Keep the entire day of surgery available, as surgery times change and you might receive a call with a new time for check in. Sequoia Hospital 650 367-5627.

Bowel Preparation for Surgery – The entire length of your intestines must be emptied prior to surgery to make the surgery safer, the recovery easier**.** Empty bowels also make more room for me to operate. (Call us with your pharmacy phone number if Rx needed).

- Choose and purchase ONE bowel prep from the selections below.
    - No Rx needed: Take 4 Dulcolax tablets at 1pm, and at 4pm, drink one 10 ounce bottle of Magnesium Citrate – followed by one quart of any clear fluids.
    - No Rx needed: Take 4 Dulcolax at 1pm, and at 4pm drink one cup every 15 minutes of mixture of 8.3 ounce Miralax in 64 ounces of Gatorade or Crystal Light or Vegetable/Chicken Broth OR Knudson Organic Recharge Thirst Quencher..
    - Rx. If you can take pills easily: Osmoprep Pills – 32 tablets. Take 4 tablets with one cup of above fluid every 15 minutes for two hours. (total 32 pills, and 2 quarts fluid).
    - Rx. If you hate taking pills, and don't mind drinking lots of fluid. Rx Moviprep: mix 1 quart lukewarm water with powder, starting at 4pm. Drink one cup every 15 minutes til gone, followed by 2 cups of any clear liquid. Repeat.
    - Rx. If you hate taking pills, and don't mind drinking lots of fluid. Rx Colyte (flavored powder) in a one gallon bottle. Mix one gallon water with powder. Drink until nearly-clear liquid coming out rectum.
    - Rx. IF you want a blend of two pills and two quarts of fluid. Rx HalfLytely. Take 2 tablets, then after first BM, drink one cup every 10 minutes until gone (80 min).
- 1 roll of very soft toilet paper, or Huggies brand non-scented moist towelettes for wiping, or A & D Ointment (to schmear over your anus (or all three!)).
- Aleve 220-mg gel caps, 30-tablets, for preventing pain after you go home. Even if this did not work for your arthritis…it works for surgical pain. Buy it.
- Optional: Milk of Magnesia to relieve any constipation after you go home. Tell me if you have chronic constipation or irritable bowel, as it will happen after your surgery as well.
- Optional: 6 containers of natural yogurt (Dannon, Yoplait, etc) or Acidophilus in any form for regulating your bowel after you go home.
- Must: buy healthy, delicious, favorite, easy to prepare foods for you to come home to, as you won't be driving for a week.

• Note: if you receive any advice from the anesthesiologist about when your last sip of water can be—follow the advice of the anesthesiologist. Otherwise follow these instructions.

_____ *Two days before surgery:* ***Eat regular food today. Pack your bag. Clean your house. You will be a new and healthier person when you come home!***

_____ *One day before surgery***:**

1. Eat low or no-fiber food (meat, fish, dairy, eggs: no fiber today) for breakfast and lunch. You won't be eating dinner. You will not be hungry during or after the bowel prep.
2. At 4:00pm: Start drinking bowel prep. (Start at 2pm if you have chronic constipation.) After this combination, at some point, you will develop painless diarrhea, which will become almost clear once the intestines are cleaned out, and then it will become brown again. This can happen quickly, or it could take several hours. Whenever your stool fluid becomes nearly perfectly clear, without any formed solid material, (tiny flecks fine) you may stop drinking Gatorade or broth, and go to step 3.
3. After you develop nearly clear rectal outflow, continue drinking any clear fluid of your choice such as tea, soft drink or even more Gatorade/Broth until your urine is pale, dilute, and nearly clear before going to bed. This hydration is very important preparation for your comfort the next morning. **Don't worry that your rectal outflow becomes cloudy brown again, because it will. That's fine.**
4. Call Dr. O'Hanlan's office if you have any problems or questions about the bowel preparation or medications. Call Dr. O'Hanlan if you cannot follow the above instructions, as she may need to modify them for you, or postpone your surgery.
5. Finish cleaning your home. This is a time for a real cleansing! Finish packing!

After bowel prep: Do not eat anything. Nothing by mouth at all after midnight. (The anesthesiologist may tell you that you can have some clear liquid breakfast on the day of your surgery if your procedure is much later in the day. You may only have clear liquid, but carefully stop eating or drinking precisely according to the anesthesiologist's instructions.) For your safety, your surgery will be cancelled for another day if you have not followed these instructions correctly.

_____ *The day of surgery***:**

1. Meds: Take your daily prescription medications with a sip of water.
2. Diet: Do NOT eat or drink anything unless instructed specifically to do so. Do not chew gum or suck mints.
3. Go to the hospital on time. Remain available by local phone or cell phone (make sure we have both of your numbers) in case your surgery time is changed. If the front door is locked very early in the morning, go to the side door on the right of the hospital.
4. Call the hospital (650-367-5627) if you feel weak from not eating so you can go early to the pre-operative area to get your intravenous fluids started. This will relieve your weakness.

III. Hospital Check-in and Surgery

Waiting At Home - Remain available by telephone in case your surgery time changes. Call the hospital (650-367-5627 for Sequoia) if you have questions or need to arrive early.

Hospital Check-in: When you get to the hospital, go to the pre-operative area.
At the check-in desk, you will be required to show your insurance card and you will be asked to pay for your portion of the cost of the hospital stay. Make sure you have the surgical folder given to you at your pre-op visit. If you are paying out-of-pocket, this folder will include letters confirming the cost of surgery. You will need to show the hospital these. They will also need copies of the consent forms, and any medical power of attorney documents you brought with you. Keep the receipts and all printed information that you will receive during the check-in and pre-op processes.

Pre-operation Paperwork – A nurse will be assigned to you to assist you with all of the details of pre-op. She/he will go over the forms with you that you completed at Dr. O'Hanlan's office, and will ask you questions to complete new forms. Please be aware that you are going to be asked several times to acknowledge that you know that your operation is "elective," or optional, and that you know that you will not be able to have a baby after having a hysterectomy. The word "optional" may make you question your decision; but all such surgery is elective or optional -even surgery for cancer- because at all times you are in charge of your body. You have elected or opted for this therapy after considering all the risks, benefits, and alternatives. Be sure that you are very clear about the reasons why you are electing this surgery prior to coming to the hospital. When asked to acknowledge that the surgery is optional enough times, it is not unusual to question your decision.

Pre-operation Procedures – Once the paperwork is complete, the nurse will give you your hospital gown and full-length stockings, which are similar to thick nylons (not pantyhose). The stockings are tight and help to prevent blood clots during surgery. You may also receive a shot to help prevent blood clots. The nurse will put sequential compression devices around your legs. These are similar to automatic blood pressure cuffs and compress your legs during and after surgery to improve circulation and prevent clots. When you are taken to your operating room for surgery, the nurse will plug them in. They actually give your legs a wonderful "massage" and are something to look forward to! If you have any questions about what is happening to you, don't hesitate to ask these nurses. They want to relieve any anxiety that you might have, and answering all of your questions is one of the best way to accomplish that.

Pre-operation Waiting Time – While all efforts are made to have you in pre-op for only a short period of time, an operation preceding yours, or an Emergency Room patient, could delay your start time—up to a couple of hours in some cases. Your partner, family member, or friend is allowed to stay with you in the pre-op area. Bring a cribbage game or cards to pass the time. If you are alone, bring a good book or a magazine. The time waiting without any real idea of how long it might be can be stressful, no matter how positive you are.

Your team

1. The anesthesiologist – a fully trained anesthesiologist will provide your anesthesia care. She/he will meet you in the pre-operative area after you have checked in to discuss your anesthesia. Be sure to tell the anesthesiologist if you tend to get nauseous easily because today there are medications that can be added to your IV to significantly reduce the chance of nausea after surgery. After discussing your anesthesiology, the anesthesiologist will start your IV and will give you medication that will help you to relax (quite nicely!) prior to surgery.

Assistant surgeons – Usually Dr. O'Hanlan will stop by to see you in pre-op to let you know what to expect and to answer any final questions. She will bring members of the surgical team with her to introduce them to you. Since Dr. O'Hanlan is your private practice physician, she will perform your surgery. There is almost always an assistant physician who helps Dr. O'Hanlan with the surgery. This is standard, as nearly every major surgical procedure requires an assistant surgeon to hold the instruments and the tissue for the surgeon. In addition, fully trained medical doctors are at the hospital night and day and are available to help you should any emergency arise.

Your spouse, partner, friends and family– The person who accompanies you can stay with you right up until you are taken in to surgery. Dr. O'Hanlan will give her/him an idea of how long the surgery will last. The person waiting for you should be aware that it is not unusual for a surgery to run way past the estimated time period and not to panic if this occurs. Remember that the surgery might not have even started until hours after you were taken from the pre-operative area into the operating rooms. No one will notify her/him if surgery is running late, so this person should not worry even if two hours have passed. It is a good idea for them to get something to eat right after you go in, so that she/he will be in the waiting room when surgery is finished. (There are vending machines and a hospital cafeteria. Usually coffee is available in the pre-op area.)

Post-Op Recovery:

After surgery, Dr. O'Hanlan will find your person in the waiting room and will let her/him know how the operation went. After this time is another good opportunity for that person to eat because it will be approximately one to one and a half-hours before you will be brought to your hospital room where they can be re-united with you.

You will be taken to post-op after your surgery, and you will wake up slowly. You will not have any sense of the amount of time that has passed since you closed your eyes, so it can be a bit confusing. You will have a tube in your bladder to drain urine, so you won't have to get out of bed to empty your bladder. You may feel an urge to urinate, but be assured that your bladder is being emptied for these first 24 hours through the tube.

When you wake up, the nurse in post-op should ask you how bad your pain is on a scale of 1 to 10 with 10 being the worst pain imaginable. Be honest when asked, because that determines the pain medication that you will be given. You will be in post-op for one to one and a half hours and will then be taken to your room where your family or friend can wait to see you.

Re-read the following sections in the hospital as you recover from surgery

IV. Recovery in the Hospital

The First Few Hours: Once settled in your room, you will probably experience a little bewilderment that you got through it all! You will have an IV in your arm to keep you hydrated, a tube in your bladder to drain it so you won't have to get up so frequently, and a long "cuff" on each of your legs that inflates periodically to prevent blood clots from forming, and a finger-tip clip that measures your oxygen levels.

At first, you might feel a bit trapped, but you can sit up and if you feel like it sit in a chair or walk around. See how you feel. Some will actually want to walk in the hall; others need to rest in the bed. Be as active as you feel able to be. Stretch in bed. Practice lifting your legs in bed. Walking helps you to be mentally alert and in charge of yourself, and it speeds up your recovery. Ask the nurses to help you move around. Any amount of moving you do tonight is great.

Clear your throat and lungs frequently, and cough as needed until your throat is clear. Hold a pillow to your stomach to help you get a good cough.

Pain: **Everyone experiences pain differently.** There are people with a very high pain threshold, and there are those who have a very low threshold. Whatever your threshold of pain, it is reasonable to expect to experience some discomfort after your surgery. For many, just understanding the cause of the pain can help, because it reduces their anxiety about the pain. There are three different causes for pain after your surgery, and there are three different ways to manage each:

1. The first is the pain from the incisions. This is dull and constant and will actually subside significantly over the first 12 hours, becoming more of a dull ache. **You will have two intravenous medications for this pain: one to prevent it and one to treat it.** To reduce stress on the incision, hold your pillow over your incision while you cough. If you have a long vertical incision, you will have a binder (like a girdle) compressing your abdomen: keep it on in the hospital. You may adjust it to center over the incision and keep comfortable pressure on it.

2. The second is shoulder pain (or sometimes diaphragm pain). This can result from the gas used to inflate your abdominal cavity during laparoscopic surgery. There is nothing wrong with your shoulder! Although the gas is deflated from the abdomen after the surgery, a small amount of gas still can remain and may cause pain in your right shoulder (and sometimes in your left shoulder) or across the diaphragm along the lower ribcage. Usually starting the morning after the surgery, it is mild, constant and tolerable. It may take several hours to several days before this pain goes completely away. **Moving around in bed** into different positions and **getting out of bed to walk** can reduce this pain sooner, but **prevention with Aleve (called Naprosyn in the hospital) and treatment with Vicodin can help.**

3. The third is intestinal and bowel pain. This is your bowels starting to resume their normal function. The intestinal tract tends to quit pumping during surgery and tries to return to a normal coordinated pumping function about 24-36 hours after surgery. You may feel total abdominal crampy discomfort or spasmodic pain for about 6 hours as it resumes pumping.

Some people experience little or no problem, and only a very small percentage of people will have severe pain from this. You may ask for **Simethicone or Gas-X**, a pill that contains Simethicone, which can help ease the gas pains, but **the key to alleviating this pain is to walk in the hallways as soon as possible** to stimulate your bowels to resume normal function rapidly. Nothing you eat or drink will worsen or improve the "gas phase" and there is no cure for it other than a "tincture of time" and walking. You may request a Dulcolax laxative to speed up passage of your bowels if you feel they are sluggish or constipated. **Vicodin should not be taken for this pain**.

Pain Management in the First 24 Hours: Your incisional pain is controlled by an intravenous medication similar to Aleve, called Toradol, which prevents much of the pain. In addition, a Morphine drip is included with your IV to treat any "breakthrough" pain that the Toradol does not prevent. The nursing staff gives the Toradol automatically unless you have

stomach ulcers. You will be able to control how much Morphine you receive (with maximum limits set by the doctors, of course) by pressing a button to release small doses of the Morphine when you are starting to experience pain that breaks through the Toradol.

With the Morphine, most patients are able to rest comfortably. You can push the button as often as you feel that you need to, but the preset minimal interval usually allows a dose about every ten minutes. Some use the morphine frequently over the first day, while others find little need after the first few hours. If you are not having significant incisional pain, try to minimize morphine use. This drug is constipating; it will slow the bowels from pumping, which prolongs cramping.

The Morning After Surgery – Your catheter, IV lines, sequential compression device and hose will all be removed. Once you no longer need an intravenous fluid line, you may shower. Just pat your incisions dry. You will begin to feel stronger.

Switch to oral Pain medications. The Morphine drip and Toradol are discontinued and replaced by two quite similar oral medications. Naprosyn is a non-constipating pill that is similar to Aleve or Motrin, replacing the IV Toradol, and is prescribed to prevent you from having incisional pain. This medication can be quite sufficient: about one third of patients need no Vicodin tablets. But if you have pain that prevents you from moving about, you can request a Vicodin. Vicodin replaces the morphine and is used to treat the pain that the Naprosyn or Aleve does not prevent. Naprosyn is the same as two Aleve pills. The plan is for you to start taking the Naprosyn/Aleve regularly for the first seven days after your surgery to maximize your comfort, maximize your mobility, and minimize the constipation from Vicodin.

Take your Bowels on a walk – Vicodin can be very constipating. Don't ask for Vicodin for the gas pains unless you really need it, because it slows your bowels significantly. You can even try taking half a Vicodin for your pain and later take the other half if it doesn't work. **Walking is the most important factor in your bowels resuming normal function**. Get out of bed as soon as the nurses let you so that you can walk in the room and later in the hallways to hasten the recovery of your intestinal function.

Your Bladder – Once the catheter (the tube that drains the bladder) is painlessly removed on the morning after your surgery, some may notice a feeling in their bladder as it empties in its new configuration. Call the nursing staff if you find that you cannot empty your bladder within four to six hours after the catheter is removed. The nurse may need to get the doctor's order to reinsert the catheter into your bladder to drain it. The reinsertion causes a weird sensation, but it is not actually painful. Some may need an extra day of bladder rest before their bladders work well again. The catheter will be removed the next morning with a high probability of good function after the extra rest.

You will notice that you will pass about a quart of urine more than usual on the days following your surgery. This is because the body holds water in and reduces formation of urine during times of stress, and then releases it once the stress has passed. This is normal and, in fact, reassuring that all is well. It is called the "diuretic phase."

Discharge to Home – Plan to go home after you are eating without nausea and walking well. Most patients are able to leave the hospital by 24 to 36 hours following surgery. You don't have to have passed gas, but there must be no nausea with meals. You will use the Aleve pills you

purchased for the next seven days, taking two every 8-12 hours to prevent pain. You will also have a prescription for 10 Vicodin pills in case you have any breakthrough pain. A prescription for a stool softener will be issued and may offer you greater ease in passing stool during your recovery at home.

My complications: 1030 cases as of February, 2009	Total		Re-operation	
	Number	%	Number	%
Urinary tract injuries:				
Hole in bladder, repair	15	1.46%	2	0.19%
Ureter injury, repair	3	0.29%		
Ureter injury, reimplanted	4	0.39%	4	0.39%
Ureter injury, tube placed	3	0.29%	3	0.29%
Urinary tract subtotal	25	2.43%	9	0.87%
Intestinal Injuries				
Bowel injury from dissection	3	0.29%	2	0.19%
Bleeding				
Post-operative bleeding	6	0.58%	6	0.58%
Blood clot in tissues	6	0.58%		
Vaginal cuff bleed	12	1.17%	8	0.78%
Bruising (large)	2	0.19%		
Infections				
Pelvic inflammation	11	1.07%		
Pelvic fluid collection	2	0.19%		
Pelvic abscess	6	0.58%	4	0.39%
Colon inflammation	2	0.19%		
Wound healing problems				
Bowel obstruction	3	0.29%	3	0.29%
Incisional hernia	4	0.39%	4	0.39%
Vaginal injury 6 wks later	5	0.49%	3	0.29%
Converted to open (failed TLH)	3	0.29%		
Retained surgical device	1	0.10%	1	0.10%
TOTALS	**91**	**8.83%**	**40**	**3.88%**

Your informed consent - Overall, the benefits of the surgery have to outweigh the 5% risks of surgery. But when your body has a problem that is highly likely to be correctable by surgery, then a small amount of risk is very reasonable to undertake. The alternative is always not to operate, or to try medical or other therapies, and accept responsibility for the results. When you sign up for surgery, you are also accepting the surgical results, a very high likelihood of correcting the problem

and a very low likelihood of complication. It is this understanding that constitutes your informed consent to surgery.

Dr. O'Hanlan has performed over 1030 total laparoscopic hysterectomies, and over 3,000 open laparotomy procedures. She has published over 35 peer-reviewed journal articles about gynecologic surgery and frequently analyses her surgical data.

In general you will spend one night in the hospital if you had a laparoscopic hysterectomy, about 3-5 days if you had a horizontal incision, and about 3-6 nights in the hospital if you had an open vertical midline incision.

Discharge to Home – Walk, Eat, Pee, Gas. Plan to go home after you are eating, emptying your bladder, passing gas, and walking well. You should have no nausea. You will use the Aleve pills you purchased for the next four days, taking two every 8-12 hours to prevent pain. You will also have a prescription for 10 Vicodin pills in case you have any breakthrough pain. If you suffer from constipation: do not push at home!!! You may need your usual stool softener for greater ease in passing stool at home. You may shower and simply towel-dry your incisions. Leave your incision sealant (Dermabond) for Dr. O'Hanlan to remove at your post-op visit at her office.

1. Diet: Resume eating regular food and drink plenty of fluids. If your bowels are not yet regular, take some prune juice or Milk of Magnesia to facilitate normal function.
2. Exert yourself. Walk for 20 minutes three times daily to regain energy and relieve crampy GI pain. Increase your energy gradually by walking outside your house whenever you can. The pain after surgery is not as limiting a factor as fatigue. Recovery occurs as you regain your energy over time. It is fine to push yourself and walk as much as you can to facilitate your recovery. Raise your energy level by stretching and walking frequently in the hospital and at home.
3. To prevent incisional and surgical pain: Take two tablets of Aleve 220mg every 8 hours for four days. This really works for surgical pain and reduces the need for the Vicodin (which constipates and slows GI function and makes you listless). Use either one half or one Vicodin (or other prescription pain medication) for breakthrough pain only. Don't take Vicodin for crampy GI gas pain. Surgical pain is virtually absent within a few days after surgery and by this time you should not need any medication for pain. Call Dr. O'Hanlan if you need pain medications after one week.
4. For gas pains or constipation: Take Milk of Magnesia as directed on the bottle.
5. Leave sealant or steri-strips on the incisions (but shower as usual, and pat incisions dry).
6. No vaginal penetration until clearance at your six-week exam. (Although, any sex is fine on the outside, so **please** be clever as soon as you feel like it!) You may not be cleared then, but soon after.

V. Recovery at home

PLEASE CALL OUR OFFICE:

If you feel that you are getting sick or worse than what you had in the hospital.
If you have increasing or new pain any time, or are not getting better,
If you have fever over 101.0, any shaking chills, burning upon urination,
If you have cloudy or smelly urine, yellow/green or smelly vaginal discharge,
If you still have pain after a week, or think you need more than the 10 Vicodin you were given.

Follow these guidelines:

7. **Diet:** Resume eating regular food and drink plenty of fluids. If your bowels are not yet regular, take at two servings of live yogurt or acidophilus tablets per day for three days to restore healthy bacteria in your intestinal tract and to facilitate normal function.
8. **For crampy GI pain**: **Walk** for 20 minutes three times daily to regain energy and to relieve pain. Increase your energy gradually by walking outside your house whenever you can. You will see that the pain after surgery is not as limiting a factor as low energy. Recovery occurs as you regain your normal energy over time. It is fine to push yourself and walk as much as you can to facilitate your recovery. Listen to your body and raise your energy level by stretching and walking frequently as soon as your arrive home.
9. **For incisional and surgical pain**: Take two tablets of Aleve 220mg every 8-12 hours to prevent pain. This really works for surgical pain and reduces the need for the Vicodin (which constipates and slows GI function and makes you listless). Use either one half or one Vicodin (or other prescription pain medication) for breakthrough pain only. Don't take Vicodin or other narcotic pain medicine for crampy GI gas pain.
10. **For gas pains or constipation**: Take Milk of Magnesia as directed on the bottle. Eat prunes with yogurt.
11. Leave the sealant or steri-strips on the incisions until they fall off by themselves. Even if they are mixed with dark brown old blood, they are forming a healthy scab, under which you are healing. (But you can shower as usual, and pat the incisions dry).
12. Call for a post-op appointment (which will occur within 10 to 14 days).
13. No vaginal penetration until Dr. O'Hanlan examines the upper vaginal incision at your six-week visit and gives clearance. (Although, any sex is fine on the outside, so be clever!)
14. Remember to keep walking, and to use as little Vicodin as possible. You may experience a painful cramp every time you empty your bowels for about two to four weeks after the surgery. This happens most often in those who already have some irritable bowel syndrome or just crampy bowels in general. This will get back to normal once the normal post-operative inflammation from the surgery has resolved. Try to remember this fact when you have cramping after meals two to four weeks after your surgery—it is normal! And temporary! Once you go home, stretching, particularly stretches focused on your lower back, can help. Above all else, remember that some pain is natural after surgery, and does not indicate that a problem is developing, but it should diminish some every day.
15. **Drain your bladder often –** Try to empty your bladder every two to four hours to begin to familiarize yourself with your renewed bladder function. At first you may have trouble sensing when your bladders is full, but this will improve. Nearly everyone has normal bladder function within the first two weeks. Once the catheter (the tube that drains the bladder) is painlessly removed many notice a feeling in the bladder as it empties in its new configuration. The bladder had to be gently peeled off of the uterus to remove the uterus, and now sits in a revised position above the vagina. This "odd" feeling is normal and disappears, usually within two weeks after the surgery. Use Kegel-type exercises to restore bladder strength.
    You may have heard that hysterectomy causes the bladder to leak later on. This can be true for vaginal hysterectomies, but it is not true about the type of laparoscopic hysterectomy we do. Having a wide, prolapsing vagina, being overweight, smoking, having children, and plain old aging can increase a one's chances of developing a droopy vagina or a leaky bladder, but a laparoscopic or abdominal hysterectomy does not increase your likelihood of leaky bladder later on.

Some worry about how the space occupied by their uterus will be filled. The intestines and the colon move about in the abdominal cavity sliding over each other every minute as they pump.

Removal of a normal or enlarged uterus/ovaries simply makes more room for the intestines to slide around on each other and for you to have a slightly flatter stomach. The lower abdominal wall will be swollen after your surgery, but this will resolve entirely after a few weeks. You may notice that your upper body is swollen and puffy after the surgery. This is due in part to the surgery being done with your body in a head-down tilt, and in part to fluid shifts from the surgery. All of your upper body swelling will resolve within a few days.

Vaginal Discharge -- It is **normal to have some vaginal discharge that is tan to brown** to frankly bloody for the first four to six weeks. The inner end of the vagina from which the cervix and uterus above were removed has been sewn shut. Even though the outside skin incisions heal promptly and rather perfectly, the inner vaginal incision does not. It really takes about 6 weeks to close, and discharge rarely persists much longer. You might experience a two-day period of bright red bleeding around the 14-28th day after your surgery. The sutures at the end of the vagina dissolve, allowing the end of the vagina to "settle" into its new position, causing bleeding that will stop without any treatment.

Rest assured that your discharge will resolve completely once the upper end of the vagina has completely healed but this takes a variable amount of time. Don't forget the 2-day episode of bleeding in the second to fourth weeks after surgery. The bleeding can be quite red, but call if it is bigger than a period, or does not resolve on it's own.

If the vaginal discharge is increasingly yellow-green or very smelly, it can be a sign of infection. Call Dr. O'Hanlan if your discharge concerns you.

Your incisions – Your incisions should stop hurting in a few days after your surgery. Even long vertical midline incisions generally stop hurting in less than one week. Call Dr. O'Hanlan for any development of redness, new tenderness, any discharge, new swelling or increased pain in your incision. Surgical pain is virtually absent within one week after surgery and by this time you should not need any medication for pain. Call Dr. O'Hanlan if you feel you still need pain medications after one week.

Sometimes the incisions cannot be perfectly put together, especially if you had previous surgery in the same area. If your incision develops oozing after you go home, cover it and call Dr. O'Hanlan only if she does not already know about it.

Packing - Many Transmen choose to wear a prosthesis, or "packer," even 24 hours a day. The packer or its strap may chafe against the lowest abdominal incision, leaving the site open to infection. So it is advisable to wait at least 10days before packing, longer if the incision is not completely healed, and to ensure that both packer and support strap are changed or cleaned daily.

Hormone therapy – Continue your testosterone regimen –injections, patches or gel— without interruption. You may have some worsening of hot flashes, but this will ease over time.

Return to sexuality – You may return immediately to sexual activity in any and every way that pleases you, *provided it is on the outside of the vagina.* For those transmen who do enjoy vaginal sex, **no penetration is allowed until after the 6 week post-op visit with Dr. O'Hanlan**. Otherwise, go ahead and start having non-penetrative sex just as soon as you feel like it!

Be assured that the surgery in your abdomen does not involve removal of any of the organs of sexual activity or enjoyment. Orgasm takes place in the muscles surrounding the vaginal opening, not any deeper, even though the orgasm feels very deep within. The uterus and cervix are not a part of orgasm and their removal does not impact on the quantity of contractions or quality of your orgasm. Good research has been done comparing sexual function before, and at 3, 6, 9, and 12 months after, hysterectomy. The finding was that there was a slight *improvement* in sexual function for most women, but overall, there was no change. Some noticed differences, however, if their hormones were not kept tuned afterwards. Not surprisingly, since surgery is often part of the process of identity affirmation, many transmen have reported improvements in sexual pleasure after surgery.

More on Exercise – Surgery causes more exhaustion than pain during the second week and thereafter. The challenge is to get back to your usual exercising self as soon as possible, but you will also need to rest as needed. You will nap plenty, early in your recovery, and less as your energy returns to normal. You are encouraged to begin walking vigorously as much and as often as tolerated immediately after your surgery, both in the hospital, and definitely the day after your discharge.

You may resume stretches and Yoga as soon as you feel like it. You may lift any weight you feel comfortable lifting when you go home. You may resume floor exercises immediately, but do not resume power weight lifting (as with dumbbells and barbells) until one week after laparoscopic surgery and two weeks after standard open abdominal laparotomy.

Driving - Do not drive until one week after laparoscopic procedures and two weeks after open incision procedures. This is not because you can't physically accomplish the task of driving, because most can. But what you cannot do is jam on the breaks in an emergency with normal strength and reliability without hurting yourself or another person in the early phase of healing after surgery.

VI. Return to work, Post-Op Visits and Long-term care.

Disability Leave after Surgery – The general rule is that an open surgery (laparotomy incision) entails a 6-week period to resume normal, full workloads, including heavy lifting. A laparoscopic hysterectomy, with the four tiny incisions, entails a 2-week disability leave. **Dr. O'Hanlan cannot extend the disability unless you have a documented medical complication from the surgery.**

First post-operative visit at 10-14 days– Dr. O'Hanlan will check your recovery and make sure that you are healing well. Your abdominal dressings will be removed and incisions inspected during this post-operative visit. If you are from a distance, this visit may take place by phone, but Dr. O'Hanlan reserves the right to ask you to come in if there is any worry about your recovery.

6 week post-op visit and final visits – Your next visit will be in 5-6 weeks.
For Transmen on testosterone, the very low estrogen levels in the vaginal tissue can affect proper healing. The inner vaginal incision will be inspected with a speculum at this visit. Most always, the end of the vagina will have developed some excessive growth of scar tissue called "granulation

tissue." This is easily treated with a medicated Q-tip (silver nitrate, $AgNO_3$) at your 6-week post-op visit, and every month until it is gone. There is no charge for these additional visits, as they are part of your surgical recovery.

Unfortunately this granulation tissue is more common among those with very low estrogen effect, including Transmen. However, it is best to treat the scar line until completely healed, to prevent future problems, including persistent smelly discharge, spotting, or infection. Be patient, granulation tissue may take one or quite a few treatments with medicated Q-tips every four weeks before the upper end completely and perfectly seals. All these visits for treatment of granulation tissue are included in the surgical fee.

Continued use of the low-dose Estradiol suppository tablets will also greatly enhance proper scar tissue formation, and minimize the number of post-op treatments of granulation tissue.

Follow-up for out-of-town patients - It may be difficult for some of my out-of-town patients to make frequent return visits. I encourage all of my patients to return to see me for the 6 week post-op visit. At that visit, I will be able to assess whether follow-up treatments will be required. If they are necessary, you may be able to arrange with your local doctor or clinic to provide this treatment, which is not difficult to do. Our office will provide you with an explanatory letter to bring to your doctor, detailing both the problem the treatment is dealing with, and the treatment itself. Usually this entails additional treatment of the internal incision with the medicated Q-tips with AgNO3.

Before leaving the area after surgery, please make sure you have obtained a copy of the surgical report. This report details the surgery and all procedures. Should any complications arise once you have returned home, this document will help your doctors evaluate your situation.

Long-term Pelvic Care - Many Transmen ask if they still need a pelvic examination after a total hysterectomy. While uterine, cervical and ovarian cancer risks are remote after the surgery, there is no need for a yearly pap unless you are a smoker, have ever had warts or abnormal pap smears. Do see a physician if you ever develop a discharge or bleeding after you have completely healed from your surgery. However, after age 40, annual colo-rectal exams, performed as part of a pelvic exam, are critical tools for ensuring colon and rectal health.

VII. Complications, Risk and Informed Consent

Risks of complications: There can be unexpected effects of the surgery, as the consent form mentions. While over 95% of surgeries go perfectly well, unforeseen situations from your anatomy or the condition being treated can arise. No two people are built the same. The reasons for your surgery, be it pain, bleeding, cancer, endometriosis, ovarian masses, or whatever, have a multitude of physical presentations. Unexpected findings can necessitate a change in approach, or *even result in a second surgery*.

Adjacent organs can be impinged upon by adhesions, cancer, endometriosis, or other organs, and can be *injured* on purpose or incidental to your primary procedure. Excess bleeding or internal bleeding after the surgery is done occur in about 1% of patients. Abscesses develop in about 1% of patients. Injury to the bladder, ureter or bowel occurs with about 2% frequency of each. Overall about 5% of

patients need some additional treatment (operation or x-ray or procedure) to get them back on track for their complete recovery. While Dr. O'Hanlan takes every effort to prevent and avoid these complications, ***they occur regardless in about 5% of patients***.

Unfortunately, when a complication happens to you, it is easy to forget that you are part of a small 5%, as it definitely feels like **it is 100% of you**! Rest assured that with over 18 years of surgical experience, Dr. O'Hanlan has seen and managed most every type of clinical presentation and surgical outcome. Your surgical and medical care will be consistently managed and expertly provided by Dr. O'Hanlan and her associates every day of your hospitalization and recovery.

Consent and Commitment

Your informed consent – You must decide whether, overall, the benefits of the surgery outweigh the 5% risks of surgery. When a problem is present in your body and is highly likely to be correctable by surgery, then a small amount of risk is very reasonable to undertake. The alternative is always not to operate, or to try medical or other therapies, and accept responsibility for the results. When you sign up for surgery, you are accepting responsibility for the surgical results, with the very high likelihood of correcting the problem as well as including a 5% complication rate. It is this understanding that constitutes your informed consent to surgery.

My Commitment to You: Surgery is my passion**.** Because it is what I trained for until age 32, have taught for ten years, and have practiced since 1986, I offer what I believe to be a very high quality of care.

I will not operate on a problem that is not likely to be correctible by surgery. I do not do certain procedures that I believe are not indicated or tried and proven, or that are irresponsible. I will refer you to any surgeon whom your situation would be better managed by. If I don't do the procedure you need, I will refer you to someone who does.

My commitment to your health is absolute. I urge you to partner with me in that endeavor by reading all my information, asking all your questions, living a healthy lifestyle, and following through on our care plans. I will give you all my best.

Cost negotiated for cash payment for TLH/BSO/Appy:

Sequoia Hospital for OR and 23 hour stay:	6,500.
Anesthesia for 2 hours, (250/hour if more):	600.
Assistant surgeon fee	1,000.
My surgical fee	4,000.
Pathologist for TLH/BSO/Appy	300.

Please bring checks to Laurie at last appointment before surgery.