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General principles

Preoperative Management
- many patients are fit and healthy and can be done as day cases
- anxiety an issue
- preoperative diclofenac and ranitidine
- consent for rectal medications

Intraoperative Management
- PONV cares - avoid N2O, prophylactic anti-emetics
- pelvic surgery associated with VTE -> prophylaxis important
- prophylactic antibiotics
- OCP:
  › Combined pill ↑s risk of VTE x3-4 (POP does not change risk)
  › no need to stop for minor procedures
  › consider stopping 4 wks prior to elective major surgery
  › must advise alternative forms of contraception
- watch for vagal stimulation (cervical dilation, peritoneal stimulation, traction of uterus) -> have atropine drawn up
- stimulation -> laryngospasm (get deep)
- patient moved often (head down, down table, lithotomy)
- watch for pressure areas and nerve compression
- hypothermia care
- SV with facemask often acceptable (or LMA)

Postoperative Management
- simple analgesics
- anti-emetics
- monitor for perforation -
  › small tears may be treated with Abx
  › larger tears ➞ laproscopy
ERPOC
- incomplete miscarriage (6-12wks)
- Suction TOP (up to 12wks)
- STOP - surgical termination via D&C >12wks
- MTOP - >16wks prostaglandin +/- ERPOC

Preoperative Management
- quantify preoperative blood loss (vitals and Hb)
- IV access

Intraoperative Management
- supine
- LMA or ETT
- avoid high conc of volatile ⇒ uterine relaxation
  ↳ use prop/opioid to deepen
- short procedure
- oxytocin 5IU IV

Postoperative Management
- oral analgesia
- anti-emetic

Laparoscopy
= intra-abdominal examination of gynaecological organs through rigid scope

Preoperative Management
- usually fit, young adults
- consent for suppositories
- preoperative NSAIDS

Intraoperative Management
- supine
- lithotomy
- head down
- short acting NDNMBD (mivacurium 0.15mg/kg ≈ 15min of block)
- proseal LMA or ETT
- short acting opioid (fentanyl)
- ask surgeon to use LA
- watch for abdominal organ perforation
- watch for gas embolism from CO2

Postoperative Management
- morphine may be required
- shoulder tip pain common - > try and expel much of the CO2 at the end of the procedure

Tension-Free Vaginal Tape
= tape insertion for stress incontinence
Preoperative Management
- may have co-morbidities
- may be large

Intraoperative Management
- lithotomy
- pain minimal
- GA (LMA) or spinal or local + sedation (discuss with surgeon)
  ↓ many would prefer ability for pt to cough to adjust tape .: avoiding Ga helpful
- NSAIDS

Postoperative Management
- daycase usually
- opioids only rarely required

Abdominal Hysterectomy
= removal of uterus through abdominal incision (may include ovaries)
- if performing pelvic lymph node dissection then may take much longer ⇒ A line, careful fluids

Preoperative Management
- may have menorrhagia or PMB -&gt; check Hb, G+H
- check U+E -&gt; may have ureteric obstruction
- anxiety
- PONV common
- DVT prophylaxis

Intraoperative Management
- supine
- head down
- GA (ETT) + IPPV + NDNMB + spinal & opioids
- PONV cares
- Pfannenstiel incision (bikini line) -&gt; bilateral ilio-inguinal blocks, TAP blocks or LA infiltration
- Midline incision -&gt; epidural or RSC's
- warm

Postoperative Management
- simple analgesia + PCA

Vaginal Hysterectomy

Preoperative Management
- degree of prolapse determines difficulty of surgery
- patients usually older and maybe frail
- may be performed with initial laproscopy to assist removal of ovaries/tube removal through vagina

Intraoperative Management
- GA (LMA) or spinal
- SV
- IV morphine
- careful with positioning (OA and nerve injury)
- may do a laparoscopic assisted approach -&gt; to also remove ovaries and tubes

Postoperative Management
- opioids, NSAIDS and LA
**Ectopic Pregnancy**

= laparotomy/laparoscopy to stop bleeding from ruptured tubal pregnancy

**Preoperative Management**
- presentation variable; haemodynamically normal -> severe hypovolaemic shock
- large bore IV access
- cross-match & FBC, coag screen on arrival
- if patient unstable get another anaesthetist to help

**Intraoperative Management**
- RSI with pt draped & surgeon scrubbed & ready to operate
- ketamine good agent
- IV resuscitation
- warm

**Postoperative Management**
- correct coagulopathy
- PCA

**Cancer Surgery**
- incl cervical, endometrial, ovarian
- surgery range from local removal, to en bloc resction of all pelvic organs => abdominal organs & peritoneum

**Preoperative**
- standard assessment
- quantify distal cancer spread
- ovarian Ca:
  - 90% of stage III-IV cancer will have ascites
  - ?if rapidly growing whether should be drained preop
- Paraneoplastic syndrome:
  - Ovarian:
    - cerebellar degeneration
    - nephritic syndrome
    - retinopathy
    - cauda equina syndrome
  - Uterine:
    - hypercalcaemia
    - retinopathy
    - periph neuropathy
    - encephalitis
    - myelitis
    - dermatomyositis
- high VTE risk - start LMWH pre-op
- obesity = RF

**Perioperative**

**Induction**
- GA
- spinal only for radical vulvectomies

**Maintenance**
- VTE care: SCDs, LMWH
- cell salvage:
  - not historically used due to malignancy risk
- some trials says safe in Ca work
  - warming

**End of case**
- TAP block vs wound/RSC catheters

**Postop**
- PCA
- PONV cares
- delirium:
  - post op 17.5%:
  - RFs:
    - >60
    - ↓albumin
    - ↑ed co-morbidities
    - blood transfusion
    - immobility
- chronic pain 5-30%:
  - mostly surgical factors
  - poorly controlled pre or post op pain is a contributing factor

**Special Points**
- DVT
  - risk of 7-45% post op gynae Ca via various mechanisms:
    - Tissue factor release from tumour cells ⇒ procoagulant
    - venous stasis from pelvic tumour compressing vessels
    - immobilisation
  - RFs:
    - ovarian clear cell ↑risk
    - CVL ≈ UL thrombosis 27-66%
    - chemo & radio 1×2-6 risk
    - use of EPO for ↓Hb