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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

By Surgery

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

Laproscopy

= 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 (fentanil)
- 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 -> check Hb, G+H
- check U+E -> 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) -> bilateral ilio-inguinal blocks, TAP blocks or LA infiltration
- Midline incision -> 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 -> 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 rescetion 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 ↑x2-6 risk
    - use of EPO for ↓Hb