My Gynecology Surgery

A Guide from Start to Finish

Department of Obstetrics and Gynecology

UNIVERSITY OF
MICHIGAN HEALTH
MICHIGAN MEDICINE

Welcome and thank you for choosing Michigan Medicine for your surgery!

We know that surgery can create a lot of questions, so we wrote this guide to help answer many common questions patients have. This should help you know what to expect around surgery. You should read it carefully and keep it for reference.

Every patient and every surgery is different – so always ask if you're not sure. The advice of your own surgeon is the ultimate advice you should follow.

Table of Contents:

Clinic and Hospital Phone Numbers

Obstetrics and Gynecology Call Center • Call the number and press 4 to speak with a nurse if you are calling about symptoms or problems.	(734) 763-6295
Midland Clinic • 4320 Campus Ridge Drive, Midland, MI 48640	(989) 837-9047
Pre-op Clinic	(734) 936-3604
East Ann Arbor Surgical Center • 4270 Plymouth Road, Ann Arbor, MI 48109	(734) 232-3053
C.S. Mott Children's Hospital and Von Voigtlander Women's Hospital • 1540 East Hospital Drive, Ann Arbor, MI 48109	(886) 936-8800
Brighton Center for Specialty Care Surgery Center • 7500 Challis Road, Brighton, MI 48116	(810) 263-4100
Gynecology resident on call • Use this number if you have urgent questions or concerns after 5:00 PM or on weekends or holidays.	(734) 936-6267
Billing	(734) 615-0863
Guest Assistance Program	(800) 888-9825
Medical Records	(734) 936-5490
Patient and Visitor Accommodations	(800) 544-8684

Patient Checklist for Before and After Surgery

Use this to guide you through your surgery!

Before your surgery:

To do:	Check when done:
Read the handout we gave you about the specific surgery you're having. Use the MiChart patient portal (at MyUofMHealth.org) to send a message to your doctor or call the clinic where you were seen to speak with a nurse if you have any questions.	☐
If you need checks for your heart, lung, or other health issues before surgery (also called **medical clearance**), make sure your other doctors complete the "Request for Preoperative Evaluation and Optimization" form that was sent to them. Return the completed form with any test reports to your surgeon. Check in with them to be sure this is all taken care of. • Be aware that delays in medical clearance could mean your surgery gets delayed.	☐
Improve your health by: • Asking your doctor if you need a referral to the Michigan Surgical and Health Optimization Program (MSHOP) • Being active and eating healthy foods • Asking your doctor for a referral to the M- Healthy Tobacco Consultation Service • Quitting smoking 6 weeks before surgery	☐
Make sure you have someone to drive you to and from the hospital.	☐
You have made sure someone will help you after you get home, and you understand what limitations you will have after surgery and for how long.	☐

To do:	Check when done:
If you care for another person, pets, or livestock, make sure someone else will do this for you for at least 2 weeks after your surgery. If the care involves heavy lifting, make sure someone will help you for up to 6 weeks after surgery.	☐
Read the "Pain Management After Surgery" and "Home Care After Surgery" sections of this book. Contact your doctor if you have any questions about the information.	☐

For your pre-surgery clinic visit:

To do:	Check when done:
Make a complete list of all the medications you take, including all supplements such as herbals, minerals, and vitamins. This includes medications you do not take every day. • For each medication, write the full name and dose and how often you take it. • **Bring this list with you to the visit.**	☐
Make a list of your drug allergies and sensitivities and bring it with you to the visit.	☐
Make sure you understand all of the instructions you received and ask questions as needed.	☐

1 week before your surgery:

To do:	Check when done:
Read all the pre-surgery instructions you received from the pre-surgery clinic visit. If you have questions, use the patient portal to send a message to your doctor or call the clinic to speak with a nurse.	☐

To do:	Check when done:
Follow the instructions you received at the pre-surgery clinic visit about your medications and stop taking everything you were told to stop taking a week before surgery.	☐
If you take a blood thinner medication, make sure you know when you should stop taking this around the time of your surgery.	☐
If your surgeon recommended it (and if you don't already have these are home), do the following: ☐ Buy white grape juice, a thermometer, and a bottle of acetaminophen (Tylenol®) 325 mg tablets. ☐ Order cranberry tablets online and start them 1 week before surgery.	☐
If you develop a fever, cold, cough, or rash before surgery, call your surgeon to discuss what to do.	☐

1 day before your surgery:

To do:	Check when done:
Answer the phone call from the nurse, who will tell you the time of your surgery and when and where to arrive. Ask any questions you have and bring up any new symptoms you're having.	☐
Make sure you know when to stop eating and drinking before surgery. If you eat or drink too close to the time of your surgery, that might delay my surgery.	☐
If you were told to do any of these things at your pre-surgery clinic visit, do the following: ☐ Follow the instructions for your bowel prep (please be aware that most patients do not need to do a bowel prep)	☐

☐ Drink 24 ounces (oz) of white grape juice the evening before your surgery	
The night before your surgery, shower with anti-bacterial soap and wash your body well, including your belly button.	☐
Do not eat anything after 12:00 AM (midnight).	☐

On the day of your surgery:

To do:	Check when done:
Based on the instructions you got at your pre-surgery clinic visit, do one of the following things: ☐ Drink only water up until 4 hours before the scheduled time of your surgery, and then do not drink anything after this. ☐ Drink 12 oz of white grape juice 2-3 hours before your scheduled surgery time, and then do not drink anything after this.	☐
Follow the instructions you received at the pre-surgery clinic visit about which medications you can and cannot take on the day of surgery.	☐
Shower with anti-bacterial soap. Do not put anything on your skin or hair after showering, such as makeup, gels, or lotions.	☐
Leave all valuables, including jewelry and money, at home. Wear comfortable, loose-fitting clothes. Do not wear contact lenses.	☐
If you use an insulin pump, bring extra patch supplies with you to the hospital.	☐
If you use a CPAP or a BiPAP machine, bring it with you to the hospital.	☐

Before you go home after surgery:

To do:	Check when done:
Review the information in the "Home Care After Surgery" section. Ask questions to make sure you understand all the instructions.	☐
If you're going to do self-catheterization after you get home, make sure you understand the instructions and have all the supplies listed in this guide before you leave the hospital.	☐
If you're going home with an indwelling catheter, make sure you understand all the instructions and have all the supplies listed in this guide before leaving the hospital.	☐

After your surgery:

To do:	Check when done:
Safely dispose of unused opioid medications.	☐

For your follow-up visit after surgery:

To do:	Check when done:
Share your thoughts with your doctor about how this experience went. Complete any surveys in the patient portal before your visit that ask for this information	☐
Find your Operative Report and (if it was done) a copy of the Pathology Report in the patient portal. If you need them printed, you can ask for this at your follow-up visit. Put it in the pocket on the back cover of the information booklet you receive.	☐
Make a list of any questions you have for your appointment.	☐

Preparing for Surgery

What should I do to prepare for my surgery?

Get medical clearance

- If your doctor tells you to get a **preoperative evaluation** (also called **medical clearance**) from your primary care provider (also called an internist), cardiologist, or other specialist, it is your responsibility to make sure this is done well before your surgery. We want you to get checked to make sure you are as healthy as possible when you have your surgery. If the evaluation, including all recommended testing, is not done in time, your surgery will be delayed.
- Our office will help with this by sending forms to these other providers, but it can be helpful for you to call your other healthcare providers to check in about this clearance. Sometimes you may have to see them for another appointment or have other tests done before surgery. Checking in early with your providers about this will help ensure that we don't have to cancel or delay your surgery while we wait for those other things to happen.

Work on your physical fitness

- Research shows that getting more physical activity before surgery can lower your risk for problems after surgery.
- Walking is a great way to improve your fitness level. Even if you start walking just a few weeks before surgery, it can make a big difference.
- If you want to do a fitness program with over-the-phone support, ask your doctor for a referral to the Michigan Surgical and Health Optimization Program (MSHOP). Learn more online at: UofMHealth.org/conditions-treatments/surgery/helping-patients-prepare-for-surgery

Quit smoking

- If you smoke, you many have more health issues that affect your surgery, including:
    - Your risk of having a lung problem is at least twice that of a non-smoker around the time of your surgery.
    - Your **incision** (the cut made during your surgery) may not heal as well.
    - Your risk of infection is higher.
    - Your heart has to work harder.
- This is a great time to quit smoking! We know it's never easy to quit, but some patients have had better success when they're motivated by an upcoming surgery. It is best to quit smoking at least 6-8 weeks before surgery. This gives your lungs more time to recover and get ready to have **anesthesia** (a medication to make you sleep and prevent you from feeling pain during surgery).
- Some tips for quitting include:
    - Set a quit date. Involve your friends and family.
    - Talk with your primary care provider about prescription medications to help you quit.
    - Ask your surgeon for a referral to the M-Healthy Tobacco Consultation Service.
- You can receive tobacco treatment services from the MHealthy Tobacco Consultation Service to help you quit tobacco use before surgery. The 6-week program covers preparing to quit, how quitting affects your body, tobacco treatment medications, setting a quit date, how to live free of tobacco, and preventing a relapse (going back to using tobacco) once you've quit. For more information, call (734) 998-6222 or e-mail QuitSmoking@med.umich.edu.
- Explore and use these online resources to help you quit:
    - CDC.gov/tobacco/about/how-to-quit.html

    - CDC.gov/tobacco/campaign/tips/quit-smoking
    - EXProgram.com
- Explore and use these phone resources to help you quit:
    - Michigan Department of Community Health Tobacco QUIT NOW: (800) 784-8669
    - National Cancer Institute: (800) 4-CANCER
    - Nicotine Anonymous: (415) 750-0328
- If you have a smartphone, there are many phone apps that can help you quit.

Reduce or stop drinking alcohol

People who drink 3 or more alcoholic drinks a day can have more complications after surgery than people who drink less alcohol. Try to reduce or stop drinking alcohol before surgery. Talk with your primary care provider about strategies for this.

Take cranberry supplements

- During your surgery, we usually insert a **catheter** (a thin, flexible tube) into your bladder. In most cases, the catheter is removed later that day or the next morning. This brief catheterization increases your risk of developing a UTI in the weeks after surgery.
- Cranberries contain proanthocyanidins (PACs), which help to prevent **urinary tract infections** (**UTIs**, also called **bladder infections**). A National Institute of Health-funded study done through the University of Michigan showed that taking cranberry supplements for gynecologic surgery reduced patients' risk of developing a UTI by half. Because of this study, we may recommend that you use TheraCran® One cranberry supplements to reduce your risk of developing a UTI.
- 2 weeks before your surgery, order a 6-week supply of TheraCran® One capsules. The cost is less than $40 with our discount code (provider

code: 948109). You can order online at Theralogix.com/landing/MICH or call (877) 772-9470. If you call, say you want the 42-day supply single shipment and give them the provider code: 948109.

- For the best UTI protection, we recommend using cranberry supplements both before and after your surgery.
    - One week before your surgery, start taking 1 TheraCran® One capsule once a day. If you still haven't received the shipment by 1 week before your surgery, start taking it whenever you do get it. It will still help reduce your risk of UTIs.
    - Continue taking 1 capsule per day until 5 weeks after the surgery.
    - If you want, you can continue taking capsules after 5 weeks after your surgery, especially if you regularly get UTIs. Research has shown that a daily dose of 36 milligrams (mg) of PACs decreases the risk of having a UTI. TheraCran® One is a certified cranberry supplement that contains 36 mgs of PACs in 1 capsule. You can also use a different cranberry supplement or drink 8-10 oz of cranberry juice cocktail (27% juice) a day.

Call your insurance company about coverage for your surgery

- We know that worries about paying for surgery can be stressful. At the time of scheduling your surgery, please ask questions of our scheduling team if you have them. They can often direct you to other resources.
- There are many insurances companies and plans. To get the best advice, we recommend talking to our experts. Contact our financial counselors by phone at (855) 855-0863 or (734) 615-0863 on Monday through Friday from 8:00 AM – 4:00 PM, or e-mail them at PFC-Counselors@med.umich.edu.
- It is always a good idea to call your insurance company to make sure there are no pre-surgery requirements about testing or letters that they need to provide coverage for the surgery.

- When you call your insurance company, they may ask you about CPT (procedural) codes for the surgery. Below is a list of some common codes. Ask the surgery scheduling team to make sure you know which specific ones apply to you:

Surgery type	CPT code(s)
Abdominal hysterectomy	58150, 58152
Vaginal hysterectomy	58260, 58262
Laparoscopic-assisted hysterectomy	58550, 58552, 58553, 58554
Laparoscopic hysterectomy	58570, 58571, 58572, 58573, 58541, 58542, 58543
Laparoscopic myomectomy	58545, 58546
Abdominal myomectomy	58140, 58146
Colpocleisis	57120
Anterior and posterior repair	57260
Uterosacral ligament suspension	58400
Sacrospinous ligament suspension	57282
Vaginectomy	57106
Mid-urethral sling/TVT	57288

Get disability or work release forms

- If you have disability or work release forms that need to be completed, please scan them and send them through the patient portal as soon as possible.
- You can also fax them to the clinic site where you were seen. Label them "Attention: Disability Paperwork."
    - Von Voigtlander clinic (Ann Arbor): (734) 615-4270
    - West Ann Arbor clinic: (734) 998-7370
    - Northville clinic: (248) 305-4401

    - Chelsea clinic: (734) 896-4521
    - Brighton Center for Specialty Care: (734) 615-4270
    - MyMichigan Midland office: (989) 839-1840
- Send the forms at least 1 week before you need them completed. If you need to talk with us about your disability paperwork, send us a portal message or call and ask to speak with the person who handles disability and work release forms for your doctor.
- After your surgery, call or message us if you need a back-to-work note before your scheduled after-surgery visit.

Find someone to drive you and help you

- You need a responsible adult to drive you to and from the hospital for your surgery. You cannot drive yourself home from surgery. This adult also will need to help get you to the car and help you with getting inside your home after surgery.
    - If you are having outpatient surgery (without a hospital stay), your driver will need to drive you to the surgery, stay there while you have surgery, and drive you home after. They can expect to be there for 4-8 hours, so they should plan to bring food and entertainment with them to the hospital.
    - If you are having inpatient surgery (with a hospital stay), your driver will drive you to your surgery and then come back to the hospital around 10:00 AM the next morning. Then they'll help you get ready to leave and drive you home.
- We strongly recommend that someone stay with you the night after surgery and even for a few days after surgery. They should stay until you are both sure that you can safely go to the bathroom, get to a phone if you need to call for help, get food and drink, and take your medication.
- If you think you do not have a friend or family member you feel comfortable asking to help, please think again. While you may be used to

being the one who helps others, now is the time you can give them the gift of letting them help you. If no one can help, then call the Guest Assistance Program at (734) 764-6893 or (800) 888-9825.

- If you live more than a 4-hour drive away from the hospital, or if you live in an area without easy access to an emergency department, you may want to consider spending another night or two close to the hospital before you go home. For help with reservations, contact the Patient and Visitor Accommodations Program at (800) 544-8684.

Find someone to take over your caretaking duties

- If you care for someone on a regular basis, make sure someone else has promised to take on that care for you after your surgery. This a time where you should focus on healing your own body.
- Usually, you will not be able to lift, transfer, or push anyone for 6 weeks after your surgery. You will not be able to walk a dog on a leash, do more than light gardening, or take care of livestock. Check with your doctor if you have questions about this.

Go to your pre-surgery clinic visit

- Most of our patients have a visit at one of our pre-surgery clinics 2-3 weeks before their surgery. Often these appointments are virtual (meaning they're done on video). This visit is done by an **advanced practice provider or APP** (a nurse practitioner or physician assistant) who has a lot of experience in preparing patients for surgery. Your surgeon will not be at this visit.
- The APP will review your health history and the medications you take. We suggest having a list of your medical problems, past surgeries, and current medications ready before this appointment.

- The APP will give you more detailed education about your surgery, including whether you need to stop taking any of your medications before your surgery.
- If your visit is in person, you will review and sign the surgery consent form as part of your appointment. A sample consent form is included at the end of this section. You will sign a form specific to the surgery you are having, but we included this sample one so you can be prepared to ask questions.
- At your visit, you may get blood drawn for pre-surgery testing or have an electrocardiogram (EKG) done to look for signs of heart disease.
- Please note that this pre-surgery clinic visit is not for medical clearance. If you need medical clearance, you'll have other visits with one of your usual healthcare providers (like an internist or cardiologist).
- If you haven't yet, sign up for our online patient portal (called MiChart or MyUofMHealth) at MyUofMHealth.org. The portal is great to use for quick access to your test results, appointment scheduling, and messaging your doctor's office. Ask how to sign up at your pre-surgery clinic visit.

Figure out hotels and lodging

- Many of our patients are able to go home the same day as their surgery. Be aware that some surgeries end later in the day, which means you will only be ready to leave by 6:00 PM or later.
- Depending on where you live, you and your support person should discuss whether you want to stay locally in a hotel on one or more of the nights around the day of your surgery.
- Michigan Medicine Lodging helps patients and families find a place to stay overnight during their time at Michigan Medicine. We know finding the right place to stay can be challenging, and the Michigan Medicine Lodging team is here to help. If you think staying at a hotel would work best for you, here are some options:

    - Michigan Medicine Lodging team members will work with you to match your preferences with a local lodging option at the best rates possible. For example, if a free breakfast, disability access, or shuttle services are priorities for your family, they will work with you to find an option that meets your needs.
    - Michigan Medicine Lodging can make reservations for our 30-room on-site Med Inn hotel.
    - Michigan Medicine Lodging partners with more than 30 hotels and motels in the area (currently in Ann Arbor, Brighton and Livonia). We will take your information and preferences, make your reservations at the best rate, provide you with information about hotel amenities, give you directions to the hotel, and answer any questions you may have. Michigan Medicine Lodging can help you make reservations at many of the hotels and organizations often at a better cost rate than what you might get otherwise.
- For help making reservations for any of the options above, contact Michigan Medicine Lodging at (800) 544-8684 or (734) 936-0100. You can complete the online reservation request form and get more information at: UofMHealth.org/patient-visitor-guide/michigan-medicine-lodging

Plan for parking

- We know parking can be a challenge in Ann Arbor. If you are having surgery at Von Voigtlander Women's Hospital and C.S. Mott Children's Hospital in Ann Arbor, you have the option to park or use valet.
    - If you're going to park, we suggest using parking structure P4. This is located across East Hospital Drive from Von Voigtlander/Mott hospitals main entrance, and it is connected to the hospital by a pedestrian bridge (walkway) above the street. It is open 24 hours, 7 days a week.

- If you want to use the valet service, it is also open 24 hours, 7 days a week. You can use this by driving up to the front entrance of the hospital.

- We do surgeries at several other sites across southeastern Michigan as well, including Brighton Center for Specialty Care and East Ann Arbor Surgery Centers. Parking is free and on the street level at these sites. Here is a link to find maps for these other locations: UofMHealth.org/maps-directions/medical-center

Fill out Advance Directives

- Some patients find that having surgery brings up questions about **Advance Directives**. These are legal documents that provide instructions for your medical care in situations where you're not able to communicate or make those decisions yourself. We do not wish to create any worry by bringing up this topic, but you may wish to make this part of your preparations for surgery.
- Michigan has 2 kinds of Advance Directives. If either of these documents is missing certain parts, they may not be legally valid. However, the information in them could be used to show a patient's intent or wishes about treatment choices.
  - One is the **Durable Power of Attorney for Health Care (DPOA-HC)**, which can be used in both inpatient and outpatient settings within the University of Michigan hospitals and health centers.
  - The other is a **Do-Not-Resuscitate (DNR) Declaration**, which is for non-hospital settings.
- A document called a **living will** is not recognized as an Advance Directive that must be legally followed in Michigan. However, a living will is sometimes combined with a valid Durable Power of Attorney for Health Care to help the patient advocate named in the DPOA-HC to understand the patient's treatment choices.

- For more information or for help with Advance Directives, including DPOC-HC and DNR Declaration forms, visit: med.umich.edu/1libr/AdvanceDirectives/ADbooklet.pdf
- If you have these documents, please bring them to your pre-surgery clinic appointment or bring them with you on the day of your surgery so they can be scanned into your medical chart. You can also send them through the patient portal.

Sample surgical consent form:

MICHIGAN MEDICINE Obstetrics and Gynecology **Request and Consent to Vaginal Hysterectomy**	MRN: NAME: BIRTHDATE: CSN:

ENTER PATIENT INFORMATION or APPLY PATIENT LABEL TO ALL PAGES

1. I have spoken with my doctors. They have explained my diagnosis and condition (listed on page 3).
2. My doctors have recommended the procedures listed on page 3 to diagnose or treat my condition. They have explained the **POTENTIAL BENEFITS** of these procedures. They also have explained the **RISKS OF REFUSING** the procedures.
3. My doctors have explained the **RISKS OF THE PROCEDURES** and I understand them. The major risks are listed on page 3.
4. I understand the planned location of my procedures may be marked on my body before the procedures. It may also be marked on the diagrams on page 3.
5. I understand that if I am given **ANESTHESIA OR SEDATION ANALGESIA** there will be other risks. These risks include severe blood loss, infection, damage to teeth, mouth, throat, or vocal cords, nerve or eye damage, drug reaction, slowing or stopping of breathing, failure of the anesthetic or sedation analgesia, cardiac arrest, risks that cannot be predicted, permanent disability or even death. There may be other unknown risks. I understand these risks and I consent to the use of any anesthetic or sedation analgesia that my doctors or the anesthetists believe is necessary.
6. I understand that **blood and urine specimens** will need to be collected in order to determine my care. If I am a woman of childbearing age, this will include a **pregnancy test** unless I initial my refusal on page 3 or I have any of the following documented in the medical record:
   - I am currently pregnant;
   - I have had a prior hysterectomy or had both ovaries removed; or
   - I am known to be menopausal
7. My doctors have explained the **ALTERNATIVES** to the recommended procedures and their risks. I want to have the recommended procedures.
8. I understand that sometimes during a procedure or afterwards (for example if I am in an intensive care unit), my doctors may decide that **RELATED OR ADDITIONAL PROCEDURES** are also necessary. I request and authorize Michigan Medicine (MM) and the providers responsible for my treatment to perform any necessary additional procedures.
9. I **DONATE** and authorize Michigan Medicine to own, use, retain, preserve, manipulate, analyze, or dispose of any **excess tissues, specimens, or parts of organs** that are removed from my body during the procedures described above and are not necessary for my diagnosis or treatment. Michigan Medicine may use or retransfer these items to any entity for any lawful purpose, including education and research.
10. By signing this form, I give my permission for Michigan Medicine and any doctors, advanced practice providers, nurses, medical residents, and other trainees, technicians, assistants, or others who may be assigned to my case to participate in my diagnosis and treatment. I understand that representatives of companies that sell equipment used in my procedures may also be present and participate.
11. I understand that Michigan Medicine is a teaching institution. This means that medical and other students can and do participate in procedures as part of their education and they are supervised by the providers involved in my care. By signing this form, I give my permission for these students to participate in my procedures. This may include performing exams related to my procedure while I am under anesthesia. I understand that students, faculty or other personnel will not perform any genital, anal, rectal, prostate, or breast exams unrelated to my procedure while I am under anesthesia, unless I give them permission to do so before the procedure.
12. I understand that unexpected events may happen before or during a surgery or procedure. This may require changing the providers originally scheduled to perform or supervise my procedures.
13. I understand that the practice of medicine, surgery and dentistry is not an exact science. I have been told about the probability of success of the procedures. **NO PROMISES OR GUARANTEES** have been made or can be made to me about the success, outcomes, or side effects of the procedures.
14. I have been given a chance to ask questions about the procedures and this form and my questions have been answered.

List any exceptions under the Exceptions section located on page 3.

30-10209	VER: A/24 HIM: 06/24	Medical Record	M MICHIGAN MEDICINE	Consent – Procedure / Treatment / Evaluation

NOTE: Image ALL PAGES or send ALL PAGES to Health Information Management – including pages without a signature section

MICHIGAN MEDICINE Obstetrics and Gynecology **Request and Consent to Vaginal Hysterectomy**	MRN: NAME: BIRTHDATE: CSN:

ENTER PATIENT INFORMATION or APPLY PATIENT LABEL TO ALL PAGES

CONSENT FOR USE OF BLOOD OR BLOOD COMPONENTS

1. I understand I may need a transfusion during my procedure. Reasons for transfusion will be for one or more reasons that may include: to correct anemia, to increase oxygen delivery to my body, to treat a blood clot, or to prevent bleeding. My provider has told me what a blood transfusion is and how it will be done. The blood products that may be used include:
   (1) **Red Blood Cells** (3) **Plasma/cryoprecipitate** (5) **Stem cells**
   (2) **Platelets** (4) **Granulocytes** (6) **Mononuclear cells**
2. The risks of a transfusion include:
   (1) **Common Reactions that usually are not dangerous**: bruising, fever, chills, rash or hives
   (2) **Less Common But More Serious Reactions, especially if I have heart disease**: kidney failure, heart failure or shortness of breath (kidney or heart failure may lead to death).
   (3) **Very Rare But Possibly Life Threatening** (less than 1 in 100,000): getting an infectious disease, like hepatitis or HIV/AIDS, bacterial infection, breakdown of transfused blood by my immune system, lung injury or death.
3. My provider has explained the potential benefits of a transfusion, and the risks of refusing a transfusion. I understand there may be alternatives to allogeneic (blood bank) transfusion, depending on my condition and the time involved, and that each of these has its own risks, which also have been explained. These include:
   (1) **Growth factors or Iron**: these products take days or months to replace or increase blood cells.
   (2) **Autologous blood**: my own blood that I donate before surgery, or that is salvaged during surgery.
   (3) **Directed donors**: blood donated by people I choose (Requires at least 3-4 days and must be compatible with the patient and is not safer than volunteer donors. The directed donor's blood can pose additional risks if the direct donor is a first-degree relative. Additional risks may include acute lung injury, reactions due to antibodies and graft versus host disease.).
4. MM uses blood obtained from Food and Drug Administration licensed and registered blood establishments, who test for infectious agents. MM does not do its own testing and makes no guarantees about the blood products.
5. I understand the risks and potential benefits of a transfusion and I want to receive any medically necessary transfusions during my course of treatment unless I initial my refusal on page 3.

Provider: List any exceptions under the Exceptions section located on page 3.

CONSENT FOR TISSUE IMPLANTS

1. The procedures listed on page 3 may include replacement of lost or damaged tissue. Tissue might include: bone, ligaments, tendons, fascia, cartilage, cornea and sclera, skin, veins and arteries, heart valves, pericardium, or dura matter.
2. Each of the following options for replacement of lost or damaged tissue has risks. My provider has explained these risks. These include:
   (1) **Autograft** – tissue from another part of my body for repair. Risks include increased anesthesia time, infection, transfer failure, or two surgical sites.
   (2) **Allograft** – tissue obtained from a human donor. Risks include communicable disease such as hepatitis, HIV/AIDS, or CJD (the human form of mad cow disease), infection, or implant failure.
   (3) **Synthetic materials** – artificially prepared human and non-human based. Risks include communicable disease such as hepatitis, HIV/AIDS, or CJD (the human form of mad cow disease), infection, possible blood thinning medication, or foreign material rejection.
   (4) **Xenograft** – animal tissue. Risks include infection, immune rejection, or viral infection.
3. I understand that MM uses tissue obtained from Food and Drug Administration registered tissue establishments which must screen donors and perform testing for communicable disease. MM does not do its own testing and makes no guarantees about the tissue implants.
4. I understand the risks and potential benefits of a tissue implant. I want to receive any medically necessary tissue implants during my course of treatment.

Provider: List any exceptions under the Exceptions section located on page 3.

MICHIGAN MEDICINE Obstetrics and Gynecology **Request and Consent to Vaginal Hysterectomy**	MRN: NAME: BIRTHDATE: CSN:

ENTER PATIENT INFORMATION or APPLY PATIENT LABEL TO ALL PAGES

1. My diagnoses/conditions are:
2. My recommended procedures are: **Pelvic Exam, Vaginal Hysterectomy (remove the uterus and cervix through the vagina) and Cystoscopy (look inside the bladder).**
   Possible bilateral salpingectomy (remove both Fallopian tubes); Possible unilateral or bilateral oophorectomy (remove one or both ovaries).
   My procedures have been explained by: _____ ID#: _____
   My procedures will be performed or supervised by: _____ ID#: _____
3. My risks include:
   DURING SURGERY: Blood loss; transfusion; injury to bowel, bladder, ureters, blood vessels or nerves; laparotomy (larger abdominal incision).
   AFTER SURGERY (SHORT TERM): Intermittent self-catheterization or prolonged bladder drainage by catheter; infection requiring antibiotic treatment; hematoma (a clotted collection of blood); vaginal cuff dehiscence (separation of the closed vaginal incision); separation or slow healing of incision; slow return of bowel function; nerve pain or numbness; deep vein thrombosis (blood clot in a large vein) or pulmonary embolism (blood clot in lung).
   AFTER SURGERY (LONG TERM): Failure to relieve symptoms; new or recurrent adhesions; new pelvic pain; continued nerve pain or numbness; pain with intercourse.
4. I understand the approximate location of my procedure or surgical incision will be marked on my body prior to the procedure unless it is considered to be an excluded site below. For illustrative purposes, the approximate operative site may be marked on the diagrams provided.

I CONSENT TO THE FOLLOWING:

PROCEDURE(S)

☐ I **consent** to the procedure(s) listed in #2 above including any tissue implants (Please initial)

Exceptions (TO BE COMPLETED BY PROVIDER ONLY)

PREGNANCY TEST

☐ I **refuse** any pregnancy testing (Please initial)

BLOOD OR BLOOD COMPONENT TRANSFUSION - Choose One

☐ I **consent** to transfusion given during my hospitalization or course of treatment (Please initial)

OR

☐ I **refuse** transfusion during my hospitalization or course of treatment (Please initial)

Exceptions (TO BE COMPLETED BY PROVIDER ONLY)

I HAVE READ AND UNDERSTAND THE INFORMATION ON THIS FORM AND ON THE PREVIOUS PAGE(S) BEFORE I SIGNED IT.

_____
Signature of Patient or Legally Authorized Representative (if patient is a minor or unable to sign)

_____
Printed Name of Legally Authorized Representative (if patient is a minor or unable to sign)

Relationship: ☐ Spouse ☐ Parent ☐ Next-of-Kin ☐ Legal Guardian ☐ DPOA for Healthcare

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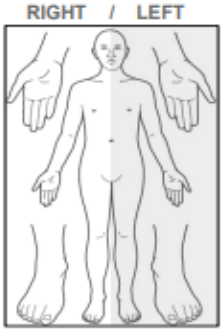

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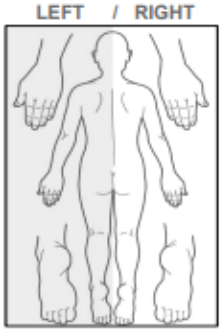


☐ Excluded Sites: Check here if the operative site is considered an excluded site.
Excluded sites are as follows:

- Mid-line sternotomy for a non-sided organ (e.g., CABG)
- Cesarean deliveries
- Surgery through a body orifice that does NOT involve laterality of the organ (e.g., Cystoscopy)
- Laparotomy, laparoscopy that does NOT involve laterality of the organ (e.g., splenectomy, laparoscopic cholecystectomy)
- Interventional procedures for which the site of insertion is NOT predetermined, such as cardiac catheterization procedures, angiography, and dialysis catheters
- Breast biopsy with wire localization
- Intra-oral and dental procedures
- Premature infants, for whom the mark may cause a permanent tattoo
- Marking for superficial cosmetic procedures using lasers (or similar energy-based devices) or injectables (such as neurotoxins and soft tissue fillers) when there are multiple sites and/or when marking would be impractical or pose a potential adverse outcome to the procedure.

_____ **Date:** _____ (mm/dd/yyyy) **Time:** _____ **A.M. / P.M.**
Consent Explained and Obtained by:

30-10209	VER: A/24 HIM: 06/24	Medical Record	Consent - Procedure / Treatment / Evaluation

NOTE: Image ALL PAGES or send ALL PAGES to Health Information Management – including pages without a signature section

The Day of Surgery

Our goal is for you to have a safe and successful surgery. As a referral center and a teaching hospital, we hold ourselves to very high standards. We want to provide the best care possible, and we know that working as a team is the way to do this.

Who will perform my surgery?

A team of doctors will perform your surgery. This team-based approach has been the same for many years and is very successful. Your surgical team members will include:

- **Attending surgeon:** Your attending doctor, or surgeon, is the lead surgeon. Your attending surgeon will be there throughout the entire surgery. They are always in charge of surgical planning and key decision-making. An attending surgeon is someone who has finished medical school, residency training, and often extra sub-specialty training (called fellowship).
- **Fellow:** A fellow is a doctor who has completed medical school and their 4-year residency training in obstetrics and gynecology. They are qualified to practice on their own and chose to get advanced training in a sub-specialty. They are supervised by the attending surgeon.
- **Resident**: A resident is a doctor who has graduated from medical school and is getting 4 years of advanced training in obstetrics and gynecology. They are always supervised by an attending surgeon or fellow.
- **Medical student**: A medical student has completed their undergraduate studies and is training to become a doctor. If a medical student participates in your surgery, you will meet them in the preoperative (pre-op) area.

- **Advanced practice provider (APP)**: An advanced practice provider has also completed specialized training. They may include nurse practitioners, physician assistants, or midwives. These staff members do not participate in the gynecology operating rooms, but you may see them in the office or talk to them on the phone.

On the day of surgery, you will also meet more members of our surgical team, including the team from anesthesiology and nursing who will be caring for you during surgery.

What can I expect in the preoperative (pre-op) area?

- When you arrive for surgery, we will take you to a **pre-op area**, where you'll wait and prepare before going into an operating room. In the pre-op area, you will meet your surgical team, including your anesthesiologist. An **anesthesiologist** is a health professional trained to give you medication (**anesthesia**) during surgery to make you sleep and prevent you from feeling pain. They will review your health history and medications.
    - Please be prepared to discuss any problems you've had with anesthesia in the past, such as nausea. You can ask questions and ask them about the plan for anesthesia and surgery before you become drowsy.
- If you have not already signed these forms, you will sign a consent form for the surgery you are having. This lists the possible complications (medical issues), which can be scary to hear, but we want to make sure you are well-informed about what is happening to you. There will also be forms to sign about possible blood transfusion, pain medication, or other needs you may have during surgery.
- You will talk about the plan for managing your pain after surgery with your surgical team. If your pain management plan includes a prescription

for narcotic pain medication, you will also need to sign a safety form required by the state of Michigan.
    - **Narcotics** (also called **opioids**) are strong pain relief medications with a risk for strong side effects and addiction if used over a long time. This is why you will need to sign a safety form, and why we will only give you a short-term prescription to manage your pain after surgery.
- After you have changed into a hospital gown and we have placed your IV (a needle in your arm to give you fluids during surgery), a friend or family member may come back and sit with you until it is time to go to the operating room.
- You can have a cell phone or book with you in this area. Your support person will take that with them as you enter the operating room.
- You will take a few medications by mouth. This might include acetaminophen (Tylenol®), a medication to help reduce nausea, and a medication that turns your urine (pee) an orange color.
- We may offer you a choice to take a relaxing medication on the way back to the operating room. This is up to you.
- Sometimes there can be long periods where you are just waiting. While we try to always run on time, it is not uncommon for surgeries to start later than the originally scheduled time. This is typical and does not mean anything is wrong. Consider bringing a book to read for these times.

What can I expect in the operating room?

- We will bring you from the pre-op area to the operating room on a wheeled stretcher.
- The operating room is often very brightly lit and the air temperature can feel cold. You can ask for a blanket if you need one.

- We will put a blood pressure cuff on your arm. We use sticky pads on your chest to monitor your heart.
- In the operating room, most patients will receive **general anesthesia** (medication that causes deep sleep, loss of feeling, and muscle relaxation). This often includes placing a breathing tube. There are different types of breathing tubes, which your anesthesia team will talk with you about.
    - For some surgeries, you may choose **spinal anesthesia** (medication injected near the spinal cord to produce loss of feeling from your stomach to your toes). The choice of anesthesia is a decision that you, your surgeon, and your anesthesiologist will make based on the planned surgery, your history, and your wishes.
- After you are asleep, we will usually place a tube (called a **catheter**) in your bladder to drain urine (pee) and measure the amount of urine coming out during surgery. We will usually remove the catheter before you go home after surgery. This type of catheter is a Foley catheter, so you may hear us call it a "Foley."
- We will put compression stockings on your legs to prevent blood clots in your legs from forming during surgery.
- You may also get a shot in your belly, upper arm, or thigh, with a small needle placed under your skin. This shot is a blood-thinning medication called heparin. The shot can leave a big bruise on your skin, which you might notice later in the day after surgery.
- We may give you antibiotics through an IV in your arm.
- At the start of your surgery, your surgeons will do a pelvic exam to finalize the plan for surgery and make sure that we are doing the best surgery for you.
    - If a medical student is part of your surgical team, we will have asked you in pre-op for your permission for the student to perform an educational pelvic exam. If you gave your permission, the

student will do this exam under the supervision of your surgical team.

What can my family and friends expect during my surgery?

- Coming with someone to surgery can be a long day of waiting, but the support your friends and family members provide is really important.
- Any support people you have with you will wait in the surgery family room. Wi-Fi is available there. They can also go get a snack or something to drink, and there is a chapel if they would like to visit.
    - They should check with staff at the check-in desk before leaving the waiting area. They will get messages (using their own cell phone or a pager) to let them know to when it is time to come back to speak with the surgeon.
- Often we will have your support person go to the pharmacy by the operating room to pick up the pain medications you'll need to take after surgery. They only need to bring their own ID to get these medications.
- After surgery, if you would like, your doctor will talk with your support person in the surgery family room. We will bring them back to a recovery area before you leave the hospital to review your discharge instructions (the care instructions you'll need to follow once you leave the hospital). They will push you in a wheelchair to the car.
- If you are staying overnight, we will tell your support person when you have a hospital room.

Recovery After Surgery

Most of our patients are able to go home the same day of their surgery. Some patients may need to spend the night in the hospital after surgery, but usually it's only for 1 night. Below are instructions for your immediate recovery after surgery, whether you're at home (**outpatient recovery**) or staying in the hospital (**inpatient recovery**).

What can I expect with outpatient recovery?

Before you leave the hospital:

- It's common that you may not remember most of the time between the pre-op area and recovery (because of the anesthesia).
- You will go to the recovery room where we will check on you until you are ready to go home. You will probably be in this area for about 1-3 hours before going home.
- We will check to see if your bladder empties normally. It is common to have trouble completely emptying your bladder after this surgery. We know that this can be disappointing or scary, but it is very common and most people do fine. Usually this is only for a short time.
- If you cannot empty your bladder normally, then either we will put the catheter put back in for a few more days and have you come back to our clinic to see the nurses for another check, or we will teach you how to catheterize yourself with a short, straight, narrow tube. You will do this after each time you pee (or after 4 hours if you cannot go) until you can empty your bladder normally. For most people, this is only for a few days, but for some it may take weeks.
    - Both of these choices will work to help you empty your bladder. Please ask if you have questions about which one is better for you.

    - **We know no one wants to go home with a catheter, but it is important to protect your bladder.**
- We will talk with you about a prescription for MiraLAX® to keep your stool (poop) soft like toothpaste to prevent constipation. We suggest using this 1-2 times a day to start. You should not strain or have discomfort with bowel movements. If the MiraLAX® causes you to have diarrhea or discomfort, use it less often.
- We will ask you to rate your pain on a scale of 0 (no pain at all) to 10 (the worst imaginable pain). Please be as honest as possible with these questions so that we can help you.
- We will give you some liquids to drink and light food before you go home.
- Before you leave the hospital, ask your doctor when you can start taking aspirin or any blood thinning medications. If you use vaginal estrogen (cream or tablets), or any other creams or ointments near the vaginal opening, ask when you should start using these again.
- Before you leave the hospital, your nurse will go over your discharge information with you. This will include what medications you already took that day.
- We will bring your support person back to the recovery area before you leave to review your discharge instructions. They will push you in a wheelchair to the car.

When you go home after surgery:

- Unless your doctor tells you otherwise, you can start back on your usual medication schedule as soon as you get home after surgery.
- It's okay to eat whatever foods sound good to you, but we suggest eating something light and bland until you know you aren't nauseous from the anesthesia.

- Expect to feel sleepy after the anesthesia. Please don't make any major life decisions during this time!
- The next day, you might have a sore throat from the breathing tube. Your lips might also feel dry and chapped.
- It's okay to shower the day after your surgery, unless you are instructed not to. Avoid taking a bath until your surgeon says it's okay.
- You might see a large bruise on your shoulder or stomach. This is where we injected a blood thinner medication to help prevent blood clots from forming during surgery. This bruise will go away with time.

What can I expect with inpatient recovery?

Some patients spend the night in the hospital after surgery. This might happen if you are feeling sleepy or nauseous after anesthesia. In this case, you will usually be ready to go home the next day. You may stay longer if your doctor decides this is needed.

While you are in the hospital:

- It's common that you may not remember most of the time between the pre-op area and recovery (because of the anesthesia).
- You can start eating a regular (solid food) diet. If you have special dietary needs, please tell us.
- You will take medications for pain and nausea if needed.
- We will give you a shot, using a small needle placed under your skin, of a blood thinning medication.
- You can start taking your regular medications again.
- We encourage you to start walking as soon as possible to help with healing and recovery.
- We will put compression stockings on your legs to prevent blood clots. The stockings will stay on your legs until you are up and walking.

- We will ask you to rate your pain on a scale of 0 (no pain at all) to 10 (the worst imaginable pain). Please be as honest as possible with these questions so that we can help you.
- We will check to see if your bladder empties normally. It is common to have trouble completely emptying your bladder after this surgery. We know that this can be disappointing or scary, but it is very common and most people do fine. Usually this is only for a short time.
- If you cannot empty your bladder normally, then either we will put the catheter put back in for a few more days and have you come back to our clinic to see the nurses for another check, or we will teach you how to catheterize yourself with a short, straight, narrow tube. You will do this after each time you pee (or after 4 hours if you cannot go) until you can empty your bladder normally. For most people, this is only for a few days, but for some it may take weeks.
    - Both of these choices will work to help you empty your bladder. Please ask if you have questions about which one is better for you.
    - **We know no one wants to go home with a catheter, but it is important to protect your bladder.**
- We will talk with you about a prescription for MiraLAX® to keep your stool (poop) soft like toothpaste to prevent constipation. We suggest using this 1-2 times a day to start. You should not strain or have discomfort with bowel movements. If the MiraLAX® causes you to have diarrhea or discomfort, use it less often.
- We may have you use an **incentive spirometer** (a plastic device with a tube that you inhale air through) while you're in bed in the hospital. This helps prevent the small airways in your lungs from collapsing and helps prevent you from getting pneumonia (a lung infection).
    - If you stay in bed the first day you get home, continue to use this spirometer once an hour the way you were taught. Once you are up

and moving about, you will automatically breathe more deeply on your own and you do not need to keep using the spirometer.

- The next day, you might have a sore throat from the breathing tube. Your lips might also feel dry and chapped.

Pain Management After Surgery

What pain can I expect after surgery?

- It is normal to have some pain after surgery. Your care team will talk with you about your pain control options, and we may prescribe you opioid or non-opioid (such as acetaminophen and ibuprofen) medication to help reduce your pain.
- The goal of managing your pain after surgery is to reduce your pain so you feel comfortable enough to get up, take deep breaths, wash, get dressed, and do simple tasks in your home. Some discomfort is likely. We do not expect you to be completely free of pain, but we want it to be controlled and tolerable.
- The pain from these surgeries often feels more like cramping or pressure (rather than sharp or stabbing). Fatigue is also very common.
- Pain is usually worst during the first 24-48 hours after surgery. You should feel a little better every day after that. You may also start to notice more pain or discomfort as you become more active.

What can I do to relieve pain without medications?

- Use a warm compress, hot water bottle, or heating pad. Do not put anything hot directly on your skin or lie on top of anything hot.
- Use a cold gel pack, bag of frozen peas, or crushed ice. Wrap it in a soft cloth or towel before you put it on your skin.
- Do not push or press on your **incision** (the cut made during surgery). It is normal for the incision to feel sore when pushed or pressed for up to 6 weeks. You may also notice a firm ridge forming underneath the incision. This is normal and part of your body's healing process.

What pain medications will I take?

- Unless your doctor gives you a different plan, ibuprofen (Advil® or Motrin®) and acetaminophen (Tylenol®) are the main medications you will use to manage your pain.
    - One dose of ibuprofen is 600 milligrams (mg). To take 600 mg of ibuprofen, you can take 1 prescription pill or 3 over-the-counter (non-prescription) pills which are 200 mg each.
    - One dose of acetaminophen is 650 mg. To take 650 mg of acetaminophen, you can take 2 over-the-counter pills which are 325 mg each.
    - We recommend eating something when you take ibuprofen to lower the risk of stomach irritation and indigestion.
- You may also get a prescription for an opioid medication, such as oxycodone or hydrocodone. You should only take the opioid as needed to reduce pain that is not controlled by ibuprofen and acetaminophen.
    - Norco® contains hydrocodone and acetaminophen.
    - Percocet® contains oxycodone and acetaminophen.
    - Oxycodone and hydrocodone do not contain any acetaminophen.
- If you cannot take acetaminophen (Tylenol®), ibuprofen (Motrin®), oxycodone, or hydrocodone, please talk to your doctor about this.
- **Do not take more than 3000 mg of acetaminophen in a 24-hour period. Remember that many pain relievers, like Norco® and Percocet®, also contain acetaminophen.**

What is my schedule for taking pain medication?

Research has shown that taking pain medication on a set schedule is much more effective than waiting and taking medication after you are in pain. There are 2 non-opioid medication plans to consider for safely and effectively managing your pain after surgery. You will work with your healthcare provider to decide what pain control option works best for you.

Schedule option 1: Taking your medications together

Most people will take their doses of acetaminophen and ibuprofen together every 6 hours. An example schedule starting at 6:00 AM is included below:

Time:	Medications taken:
6:00 AM	Acetaminophen (650 mg) and ibuprofen (600 mg)
12:00 PM (noon)	Acetaminophen (650 mg) and ibuprofen (600 mg)
6:00 PM	Acetaminophen (650 mg) and ibuprofen (600 mg)
12:00 AM (midnight)	Acetaminophen (650 mg) and ibuprofen (600 mg)
Continue to take your medications together every 6 hours.	

Schedule option 2: Alternating your medications

Another option is to **alternate** your doses of acetaminophen and ibuprofen every 3 hours (meaning you take different medications at different times). An example schedule starting at 6:00 AM is included below:

Time:	Medications taken:
6:00 AM	Acetaminophen (650 mg)
9:00 AM	Ibuprofen (600 mg)
12:00 PM (noon)	Acetaminophen (650 mg)
3:00 PM	Ibuprofen (600 mg)
6:00 PM	Acetaminophen (650 mg)
9:00 PM	Ibuprofen (600 mg)
12:00 AM (midnight)	Acetaminophen (650 mg)
3:00 AM	Ibuprofen (600 mg)
Continue to alternate your medications every 3 hours.	

You do not need to set an alarm clock to wake you at night, but if you do wake up, stay on a schedule of alternating medications every 3 hours.

What if this schedule does not control my pain?

- Some people may need opioid pain medication to control their pain at home. You will work together with your doctor to decide what total number of prescribed opioid pills is right for you.
- Your pain should improve each day, allowing you to reduce how much pain medication you're taking as your body heals. The table below is a guide for choosing the appropriate number of opioid pills for each type of surgery. The minimum, average, and maximum pill numbers can be used as standards to help you decide what your total prescribed amount might be.

Surgery type	Minimum	Average	Maximum
Vaginal or laparoscopic hysterectomy	0 pills	6 pills	15 pills
Abdominal hysterectomy	0 pills	9 pills	20 pills

What are my instructions for taking opioid medications?

- If you were prescribed opioids, take them as instructed. For example, prescriptions for oxycodone usually say, "Take 1-2 pills every 4-6 hours as needed for pain."
- If your prescription is for Norco® or Percocet® (opioid medications that contain acetaminophen), substitute it for the acetaminophen doses in the schedule tables above.
- Opioids are prescribed for short-term use, and you should stop taking them as soon as possible after surgery.
- Use the smallest amount of opioid medication that you need to control your pain. Reduce the number and frequency of opioid use as soon as

you can. Do not take more opioid medication than your doctor has prescribed.

- Never mix opioids with alcohol, sleep medications, or anti-anxiety medications. These are dangerous combinations that increase the harmful effects of opioid pain medication. Many overdose deaths from opioids also involve alcohol or at least one other drug.

What else should I know about using opioid medication?

- Common side effects and risks of opioids include drowsiness, mental confusion, dizziness, nausea, constipation, itching, dry mouth, and slowed breathing.
- Opioids can make constipation worse after surgery. Please be sure you are using the MiraLAX® or other bowel medications to help avoid this.
- Keep opioid medications locked away from the reach of children. This also helps prevent others from stealing opioid medications.
- Never sell or share an opioid with another person without a prescription from a licensed healthcare prescriber. It is illegal under Michigan law.

Should I worry about becoming addicted to opioids?

Anyone can become addicted. However, addiction is rare if opioids are used for less than 1 week. You can reduce your risk by doing the following:

- Only use opioids for pain that is not controlled with acetaminophen and ibuprofen
- Use fewer opioids and increase the time between doses as your pain lessens
- Decrease and stop opioids before decreasing or stopping acetaminophen and ibuprofen
- Be careful and talk with your care team if:
    - You are taking opioids at the same time as other sedating medications (there is an increased risk of overdose)

- You have depression or anxiety, long-term (chronic) pain, or a history of alcohol, tobacco, or previous prescription drug use or abuse (there is an increased risk of developing dependence or addiction)

What is the best way to stop taking pain medications once my pain starts to improve?

1. Stop taking opioid medications.
2. Stop taking acetaminophen.
3. Gradually decrease how often you take ibuprofen.
    - It is a good idea to take a 600 mg pill before you start a more tiring activity, such as going shopping or going for a long walk.
    - Once you get more active, you may have a day when your pain gets a little worse. This is your body letting you know you did a lot of activity. If this happens, take ibuprofen. If ibuprofen does not relieve the pain, also take acetaminophen.

How do I safely dispose (get rid of) opioid medications?

- There are 4 main ways to safely dispose of any unused opioids:
    - **Medication deactivation bags** (special bags that destroy the medication so it can be put into the trash safely)
    - **Mail-back envelopes** (these allow you to send unused medications back to an organization that will destroy them safely for you)
    - **Permanent disposal locations** (places like pharmacies, police stations, and hospitals that will accept and safely destroy unused medications)
    - **Medication take-back programs and events** (places where you can drop off medications for safe disposal at a specific date, time, and location)

- Dropping off medications at permanent disposal locations or at take-back events is the safest way to get rid of old medications.
    - Many pharmacies and police stations have lockboxes where you can drop off unused prescriptions. Search “medical disposal near me” online to find your nearest permanent disposal sites.
    - To find a take-back program or event near you in Michigan, visit: Michigan.gov/EGLEDrugDisposal. This will take you to a map that shows all the take-back program locations in Michigan. You can find the one nearest to you by typing in your town’s name or your zip code. If you do not have access to the internet, call your county health department, local police department, or the state police.
    - To find take-back programs in other states, visit: safe.pharmacy/drug-disposal
- If you aren’t able to do any of the 4 disposal methods listed, use your household trash as a final option. Put the opioids in a plastic bag and mix them with something unappealing, like coffee grounds or kitty litter. Do not crush the pills. Scratch out personal information on the prescription label and dispose of the original medication container.
- Do not flush opioids down the toilet. We do not recommend flushing medications down the drain or toilet unless absolutely necessary, because they can pollute our water and harm animals and people.

Home Care After Surgery

Shortly after you go home from the hospital, you should get a phone call from one of the nurses from your clinic. They will ask you specific questions about how you are feeling and how your recovery is going so far. Please call us if you need to before this call – you don't need to wait if you are concerned about anything.

When should I call my doctor?

Call your surgeon's office right away, any time of the day or night (including on weekends and holidays), if you have any of these signs or symptoms:

- A temperature higher than 100.4 ˚F (38 ˚C)
    - If you don't have one, please buy a thermometer before your surgery.
- Heavy bleeding
    - If you still have your uterus, heavy bleeding means soaking a regular pad in an hour or less.
    - If you had a hysterectomy, heavy bleeding means soaking a regular pad in 1 hour or less or have bleeding similar to a menstrual period.
- Severe pain in your stomach or pelvis that the pain medication is not helping
- Chest pain or difficulty breathing
- Swelling, redness, or pain in your legs
- Your incision opens
- Your incision is red or feels hot
- Fluid or blood leaking from your incision
- New bruising after leaving the hospital that is large or spreading (a little bit of bruising around an incision is normal)

- Nausea or vomiting
- Heavy vaginal discharge (spotting and light discharge are normal)
- Skin rash
- Not being able to pee at all
- Pain, burning, or stinging when you pee
- Blood or cloudiness in your pee
- A constant urge to pee, but only dribbling when you try to go
- A sense that something is wrong

Please be aware that we do not check the patient portal (MiChart) messages on nights and weekends. We are still available 24 hours a day, every day to help if you need us! If you are having a problem during those times, please call us at (734) 763-6295.

What can I eat?

- You can eat your regular diet after you go home. Frequent small meals are easier to digest than a few big meals, and can also help you prevent nausea.
- Eat high protein foods to help with healing, such as:
    - Beans and lentils
    - Nuts, including nut-based milks
    - Eggs
    - Dairy products (for example, Greek yogurt is very high in protein)
    - Chicken and other meats
- Eat foods that are rich in vitamins to help with healing, such as:
    - Bell peppers
    - Dark green, leafy vegetables like kale and spinach
    - Broccoli
    - Sweet potatoes
    - Carrots

    - Squash
    - Tomatoes
    - Citrus fruit (oranges, grapefruit, lemons)
    - Berries
    - Kiwi
    - Cantaloupe
    - Apricots
    - Mangos
- **If you have diabetes, it is very important to keep your blood sugar under good control.** Follow your diet and take your medications on time. Check your blood sugar every day, and call the doctor who helps you manage your diabetes if your blood sugar is too high.
- Watch a short video on how healthy eating can help you be strong for surgery: michmed.org/v15gk
- Read the handout "Increasing Protein in Your Diet" to learn more: med.umich.edu/1libr/Nutrition/IncreasingProtein.pdf
- Discover hundreds of delicious recipes at: mhealthy.umich.edu/recipes

How do I care for my incisions?

For incisions inside the vagina:

- Incisions inside the vagina are closed with dissolvable stitches. When they dissolve, you may see little bits of material that look like thin pieces of string on your underwear or on the toilet paper after wiping. This is normal.
- Do not put anything inside the vagina, including tampons or your fingers, and a void sexual activity that involves putting anything inside your vagina until your doctor checks you at a follow-up visit and tells you when it will be okay.
- Do not douche (clean or rinse the inside of your vagina).

For incisions on your skin:

- Wait 24 hours after your surgery before showering.
- If there are clear dressings (bandages) over the incisions, remove them 2 days after surgery. Leave the slim Steri-Strips™ that are under the dressings in place. During the week after surgery, they will usually curl up at the edges and then come off on their own. If they are still there a week after surgery, gently remove them.
- Your incisions will heal best if they are kept clean and dry.
    - To clean the incisions, first wash your hands and then get your hands sudsy with soap. Gently wash the incisions or let the soapy water run down over the incisions.
    - After washing, dry the incisions well by gently patting them with a clean towel. You may use a blow dryer to help dry the incisions, but it must be on a low heat setting.
- Do not put any lotion, oil, gel, or powder on or near your incisions.
- Wear loose-fitting clothing for a few weeks to avoid rubbing or irritating the incisions.

Do I need to worry about my stitches?

- Most people who have vaginal surgery will have some stitches (also called **sutures**) in the vagina. Sometimes these are near the opening, but there is no need to check or inspect them.
- Any stitches you have in the vagina will dissolve over time. Some of these deeper stitches might take even 5-6 months to completely dissolve. Other stitches dissolve a few weeks after surgery. Sometimes you might see a little pink spotting as they dissolve.
- Sometimes the stitches near the vaginal opening will loosen slightly as time passes after surgery. This is normal.

- You might see the stitches drop into your underwear or the toilet bowl. As long as there is not heavy bleeding with this, it's completely okay. They can look like thread.
- It is common for you to see or feel the ends of the incision stitches on your skin or in the vagina. This is not dangerous. Please call if this happens and you have concerns.

What kind of vaginal bleeding and discharge can I expect?

- It's normal to have spotting of pink or red blood from the vagina after surgery. The spotting can stop and then return once you become more active.

  Brown-colored, strong-smelling discharge that slowly changes to a light yellow or cream color is also normal. This change in discharge color can last for up to 8 weeks. The brown color comes from old, dried blood. **Call us if your discharge becomes heavier or starts smelling bad.**

When will my bladder function get back to normal?

- You received extra fluid through your IV while you were in the hospital, so it is normal to urinate (pee) more than usual when you first get home.
- It is normal for your bladder function to be different after surgery. You may notice a pause before your pee stream starts or that you pee more slowly. This will get better, but it may take up to 6 months before you are back to normal. Be patient, relax, and sit on the toilet a little longer.
    - Drinking more water than usual will not help your bladder recover faster.

What do I need to know about bowel movements?

- Starting as soon as you get home, take 17 grams (or 1 capful) of MiraLAX® once or twice a day to keep your stool soft and prevent constipation. You can mix this with any liquid that you want.

    - It is important to prevent constipation because straining during a bowel movement can damage your stitches. Your stool (poop) should be soft like toothpaste. If your stool gets too loose or you have a lot of bloating or cramping, reduce your MiraLAX® use to only once a day or stop using it.
- If you used a bowel prep before surgery, it is common not to have a bowel movement for 1-2 days after surgery.
- If you have not had a bowel movement by 7:00 PM on the third day after surgery even while using MiraLAX®, try doing **only one** of the following things at bedtime:
    - Drink 1 ounce (2 tablespoons) of milk of magnesia (MOM). If you have used MOM before and know you need to take 2 ounces for it to work for you, it is OK to do this.
    - Drink 1 cup of Smooth Move® tea
    - Take 2 Senokot-S® pills
- Go for short walks. Walking and being active will help you have a bowel movement.
- If you have not had a bowel movement by 12:00 PM (noon) on the fourth day after surgery, call and ask to speak with a nurse.

What energy and activity levels can I expect after surgery?

It is normal to have a decreased energy level after surgery. Our best piece of advice is to listen to your body. If you need to rest, do it. Give yourself permission to take it easy. Once you settle into a normal routine at home, you will find that you slowly begin to feel better. Walking around the house and taking short walks outside will also help you get back to normal.

What kind of exercise can I do?

- Exercise is important for a healthy recovery. We encourage you to start normal physical activity, like walking, within hours after surgery. Start

with short walks, and slowly increase the distance and length of time that you walk.

- Ask your doctor when you can start specific exercise activities like bicycling, swimming, or dancing. Often activities like bike riding, where a seat might put pressure on the vaginal opening, is one of the last things we suggest returning to after surgery.
- Allow your body time to heal. Do not restart a difficult exercise routine until you have had your follow-up visit and your doctor says it is okay.
- If you feel pain when you do something, stop doing it. Try again in another week when you've had more time to heal.

What activities can I do?

- Overall, listen to your body and slowly increase the activities you do. If you start to feel tired, sore, or in pain, lie down to rest. This is your body telling you you're doing too much.
- You may shower starting 24 hours after your surgery. You may also take a short bath, but do not soak for more than 10 minutes.
    - When sitting in the tub, do not fill the tub above hip level. Do not get in or out of a tub without help. **It is very important to avoid doing anything that could cause you to slip and fall.**
- You may be told to do a **sitz bath** (a warm water bath you sit in to help with pain or discomfort). You can buy a sitz bath that sits on the toilet seat for less than $15 at stores that sell home medical equipment, or you can use a bath tub. If you use a tub, fill it to sitting hip level with warm water and mix a tablespoon of plain epsom salt into the water. Do not stay in the tub for more than 10 minutes.
- Do not douche.
- Walking up or down stairs is okay, but you should start out slowly and use the railing. You may need some help at first until you know you are steady on your feet.

- Do not drive while you are taking prescription opioid pain medications. After you stop them, you may drive when you are sure you can react as quickly as you need to in an emergency without hurting yourself.
    - Before you drive, sit behind the wheel and practice slamming on the brakes and turning to look over your shoulder. If this hurts, wait and check again in a few more days.
- Unless you are given other instructions, start by only lifting things that you can easily hold in one hand. Avoid doing any heavy, repeat lifting for 6 weeks or as instructed by your surgeon.
- Avoid any sexual activity involving your vagina until your follow-up visit with your doctor. They will tell you when it is okay to start having sex after your surgery.
    - When you do start having sex, expect that things may feel different than they did before your surgery. The first few times may be uncomfortable. Go slowly and use lots of lubricant. In time, you will get back to normal.
- It is best if you do not travel far away from home in the first few weeks after surgery. If you have travel plans, talk with your doctor about this before your surgery. You cannot lift suitcases or other bags for 6 weeks after surgery.
- How long you'll be off work after surgery depends on both your surgery and your job. Talk with your doctor about this before surgery. If you have any questions about this, call your doctor.

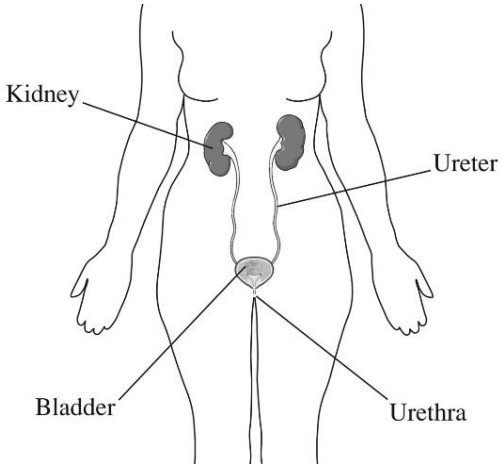
Clean Intermittent Self-Catheterization (CIC)

Some patients need help emptying their bladder after surgery for a short time. There are 2 ways this may be done: clean intermittent self-catheterization or an indwelling catheter.

What is clean intermittent self-catheterization (CIC)?

Clean intermittent self-catheterization (CIC) is a way to empty your bladder by using a short, straight tube called a **catheter**. You will insert the catheter into your bladder through the urethra to allow pee to drain out. You will empty your bladder on a regular schedule until it is emptying normally.

What is a post-void residual (PVR)?



- Urine (pee) is made in the kidneys and flows down the ureters to the bladder. Urine leaves the bladder, and your body, through the urethra. It is normal for some urine to be left in your bladder every time you pee. This is called the **post-void residual, or PVR**.
- After your surgery, a nurse will measure your PVR by either placing a device on your lower belly to do an ultrasound bladder scan or by placing a catheter through your urethra into your bladder to drain the remaining urine. If the PVR is too large, it can cause health problems.
- CIC is a way to drain the PVR from your body.

Why do I need to do CIC?

- Sometimes, the bladder and pelvic floor muscles are not ready work properly just after gynecology surgery. Your muscles will recover, but

this may take a few hours to a few weeks. Without normal bladder muscle movements and pelvic floor relaxation, the bladder can get too full and stretched out. The PVR will also be higher than normal. This can damage the bladder, lead to infections, or cause urine to back up into the kidneys.

- To prevent this, you will learn how to do CIC to drain out extra urine. You will do this until your bladder function is back to normal. We know this isn't something anyone wants to do, but we will teach you how and make sure you feel comfortable with the plan for CIC before you go home.

How do I do CIC?

Gather your supplies

You should receive these supplies from your nurses after surgery. Set out these supplies on a clean surface near the toilet so you can easily reach them:

- 2 catheters (1 to use and 1 for backup in case you need it)
- 2 lubricant packets (1 to use and 1 for backup)
- 2 towelettes (1 to use and 1 for backup)
    - If you run out of towelettes, you can use a soft washcloth with unscented antibacterial soap.
- Mirror
- Urine collection and measuring hat (or other container to collect urine)

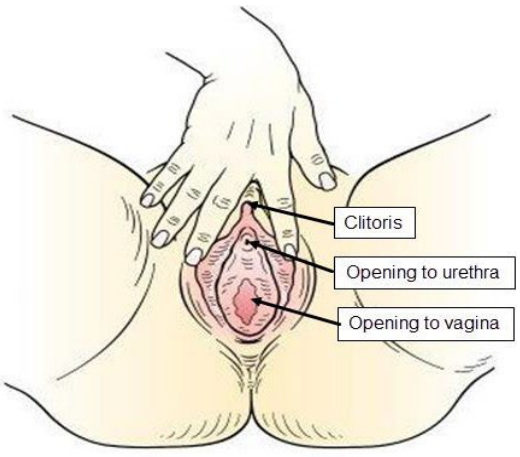
    - If you cannot easily drain into the hat while sitting on the toilet, and you are going to drain into a different container (such as a cup) placed between your legs, set out that container.
    - Even if you do not drain directly into the hat, you will still use it to measure the amount of urine you drain, so make sure to put it out with the other supplies.
- CIC diary (included at the end of this section) and pen or pencil

Try to pee on your own

1. Place the hat under the toilet seat, sit down, and try to pee.
    - Give yourself a few minutes to relax and let your bladder do its job.
    - Straining to pee will probably not help. Instead, focus on relaxing. You can also try turning on the water if there is a sink nearby.
    - Do not put toilet paper in the hat.
2. Measure how much pee is in the hat, then dump the urine into the toilet and rinse out the hat. Replace it under the toilet seat.
3. Wash your hands well with soap and water, and dry them with a clean towel.
4. Record the date, time, and amount of pee in the diary.

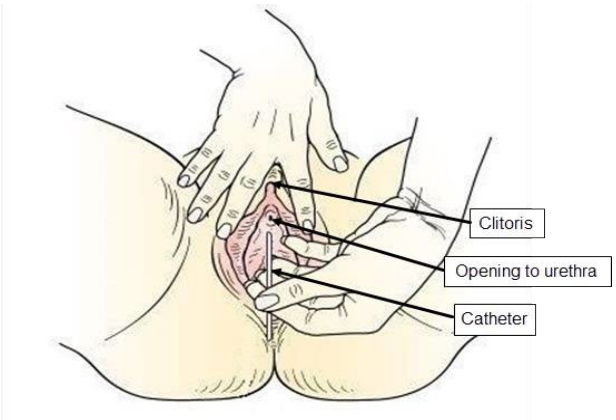
Insert the catheter and drain urine

1. Open a lubricant packet so it is ready to be used.
2. Take the catheter out of its package and check it. Do not use if it is damaged.
3. Put the tip of the catheter into the opened lubricant packet. Leave this on a clean surface within easy reach.
4. Position yourself so that you are seated comfortably with your legs apart. Most patients sit on the toilet so that they can drain the urine into the hat under the toilet seat.
    - You may find it easier to sit on a chair or the edge of a bed and drain the urine into a container held between your legs.



5. Put a mirror on a chair or stool in front of you, positioned so that you can easily adjust it to see the opening to your urethra. Remember that the urethral opening is between the clitoris and the vaginal opening.

6. Use one hand to separate the labia (the folds of skin around the urethral opening and vagina) as shown in the picture. Adjust the mirror as needed so that you can see the opening to the urethra. Hold an opened towelette or wash cloth in the other hand and use it to wipe the skin clean, starting above the urethral opening and wiping toward the anus. Do not wipe from the anus toward the urethral opening.



7. Pick up the catheter and remove it from the lubricant packet. Insert the catheter into the urethra and gently push it into the bladder until urine begins to flow. Position the catheter so the urine will flow into the hat under the toilet seat or into the container between your legs.
8. When the urine flow stops, gently move the catheter around a little (slightly in and out of the urethra and also in small circles) to see if more urine will come out. If it does, wait until it stops. Then slowly remove the catheter.
    - If urine flow restarts while removing the catheter, wait until it stops, and then continue to remove the catheter.
    - If you drained the urine into a container held between your legs instead of the hat, pour the urine into the hat to measure it.
9. Wash your hands and the catheter with soap and water. Rinse the catheter well and store it in a clean, dry place.
    - It is okay to use a catheter more than once each day. When you are re-using a catheter, wash it with soap and water and rinse it well both before and after each use.
10. Measure the PVR (the amount of urine you drained with the catheter) and write it down in the diary.

11. Add together the amount your urinated and the PVR amount. Record this total amount in the diary.

Visit this link or scan the QR code to watch a video demonstration of how to do CIC: SGSOnline.org/a-guide-to-female-clean-intermittent-self-catheterization • Please be aware that the video is not animation and shows a real person doing CIC on themselves.	

What do I do if no urine comes out during my CIC?

Use the hand mirror to find the vaginal opening and the urethral opening and check to see where you placed the catheter.

- If the catheter is in the urethra, gently push it farther in until urine comes out. You may need to move it around and change the angle a little.
- If you accidentally put the catheter in the vagina instead of the urethra, leave it there so you don't do it again. Open a new catheter and lubricant packet, dip the tip of the catheter in the lubricant, and then insert the catheter through the urethral opening. After you're done draining urine, remove both catheters.

When can I stop doing CIC?

You can stop when the amount you urinate is 150 mL (milliliters) or more and the amount of the PVR is less than 150 mL, 2 times in a row.

How often should I go to the bathroom?

- Go to the toilet when you feel the urge to pee. Always try to pee on your own before doing CIC. Give yourself time to relax.
- If it has been 4 hours since the last time you peed, and you still do not feel any urge to pee, try sitting on the toilet.

    - If no urine comes out, put 0 (zero) in the diary in the "Amount you urinated" column. Then do CIC. Measure how much you drained with the catheter and put this amount in the "PVR" column.
- Do not wait more than 4 hours in between emptying your bladder. If the amount you urinated plus the PVR amount is more than 500 mL, shorten the time in between emptying your bladder by an hour (for example, 3 hours instead of 4 hours). The goal is to prevent your bladder from getting too full.

Should I do CIC before I go to bed?

Yes, you should try to pee and do CIC before you go to bed. If the total of the amount you urinate plus the PVR is usually more than 500 mL when you first get up in the morning, set an alarm to get up once during the night to pee and do CIC.

What color should my urine be?

- During the first few days after surgery, your pee may be orange. This is caused by medication we may have given you during your surgery.
- After 1-2 days, your urine should be light yellow. If it is very dark yellow, drink more water. If your urine looks like clear water, drink less.

How much should I drink?

- Do not drink more than 60 ounces (oz) of fluids (about a half gallon) per day. This includes all kinds of fluids such as coffee, tea, water, juice, and soda pop.
- Your bladder needs time to recover from surgery. Drinking more liquid does not help your bladder get better faster. Drink and eat normally.

When should I call for help?

Call us at (734) 763-6295 if:

- Your urine is bloody, has a bad smell, or is cloudy.
- Your temperature is over 100.4 ˚F (38 ˚C).
- You cannot easily push the catheter into the urethra or bladder.
- You have a very strong urge to pee that does not go away after you urinate, no matter how many times you go.
- You suddenly start leaking urine.

What if I run out of catheters?

- Hopefully you will only be catheterizing for a short time, but sometimes you run out of catheters and need more. If that happens, please find the phone number of a medical supply store near you and call us for a prescription. Please do this early, since it can be a few days before they can get you more.
- It's also completely safe to wash the catheters in warm, soapy water and reuse them as many times as you want. This can be a good option if you are running low and can't find a medical supply store.

Clean Intermittent Self-Catheterization (CIC) Diary

Date	Time	Amount you urinated	PVR (amount you drained with the catheter)	Total amount (amount you urinated plus PVR)

Caring for Your Indwelling Catheter

Some patients need help emptying their bladder after surgery for a short time. There are 2 ways this may be done: clean intermittent self-catheterization or an indwelling catheter.

What is an indwelling catheter?

- An **indwelling catheter** (sometimes called a **Foley catheter**) is a tube placed into your bladder and left there for a period of time. This could be a few hours (like during surgery) or a few days if you are having trouble emptying your bladder.
- The tube connects to a drainage bag to collect your urine. You'll have a **leg bag** that you'll wear during the day and an **overnight bag** (which is larger) at night. If you go home with an indwelling catheter, we will review the parts of the catheter and bags with you and teach you how to use them.

Why do I need an indwelling catheter?

We know that no one wants to go home with a catheter, but it is important to protect your bladder while it is healing. This is a temporary step in your recovery.

How can I make sure the catheter keeps working properly?

- Always keep the urine (pee) collection bag below the level of your bladder.
- Wear the leg bag below your knee. If you place it above the knee, the urine will not drain into the bag as it should.
- Make sure the tube is not kinked (folded) and that urine is flowing into the bag.

When should I drain the leg bag?

Drain the leg bag when:

- It is a little more than half full.
- It feels heavy on your leg.

How do I drain the leg bag?

1. Wash your hands with soap and water.
2. Take the bag off your leg.
3. Aim the drainage tube on the bag toward the toilet. Then open the clamp and let the collected pee drain into the toilet.

4. When the bag is empty, close the clamp.
5. Dry the end of the drainage tube with some clean toilet paper.
6. Put the bag back on your leg.

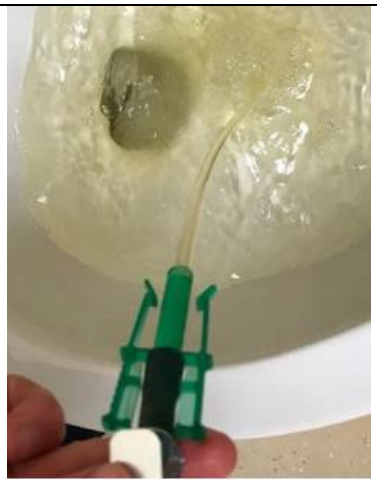
When should I drain the overnight bag?

- Drain the overnight bag when you first get up in the morning.
- Usually you will change to the leg bag after you drain the overnight bag. If you continue to use the overnight bag while you are awake, drain it when it is a little more than half full or when it feels heavy to lift.

How do I drain the overnight bag?

1. Wash your hands with soap and water.
2. Lift the bag up and hold it near the toilet.
3. Squeeze the hard, plastic pieces on either side of the drainage tube and pull the tube out of the clear holder.

4. Aim the drainage tube toward the toilet.
5. Open the clamp and let the urine drain into the toilet.



6. When the bag is empty, close the clamp and push the drainage tube back into the clear holder.

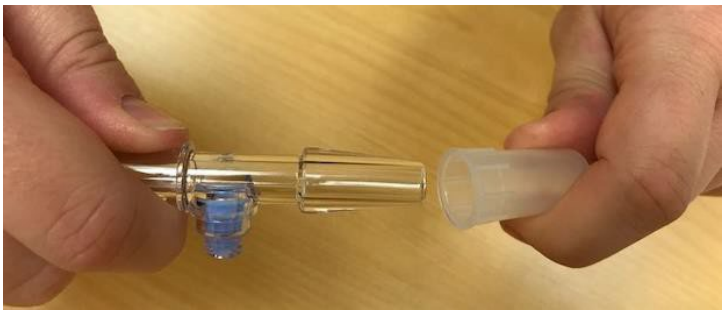
How do I change collection bags from a leg bag to an overnight bag?

You will go home with the catheter attached to a leg bag. Before bedtime, switch to an overnight bag so that you are using a bag that will stay below the level of your bladder while you are in bed. It is important to keep the ends of the tubes clean while changing bags to lower the risk of infection.

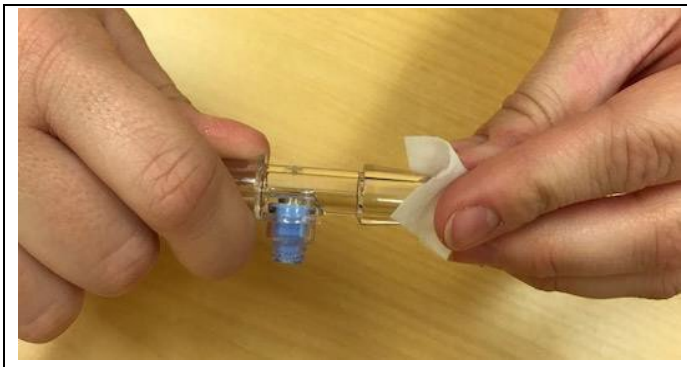
Follow these steps to change from a leg bag to an overnight bag:

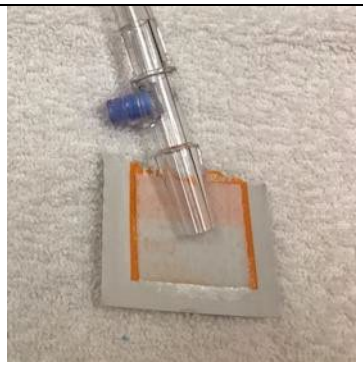
1. Wash your hands with soap and water.
2. Put a clean towel down on a counter or flat surface.
3. Put out the supplies you'll need on the towel:
    - 1 overnight bag
    - 3 alcohol swabs (open the packets and put the swabs on top of the packets)
    - 1 alcohol swab packet that has been opened wider to create a pouch (with the alcohol swab still inside it)
    - Pink plastic bin
    - Baby wipes or clean washcloths

4. Remove the cap from the connector on the overnight bag. Put it in the pink plastic bin.

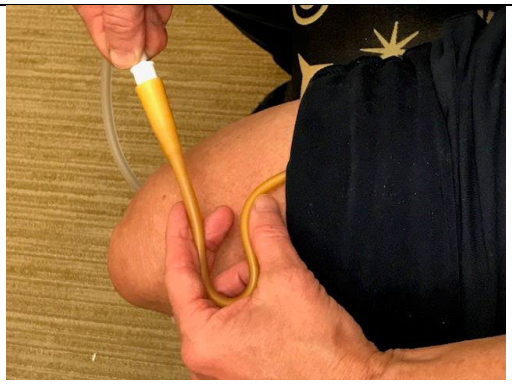


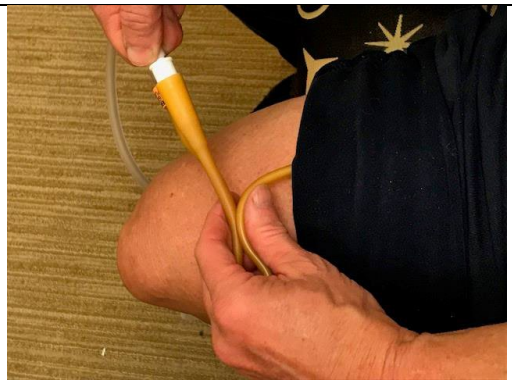
5. Clean the connector with one of the alcohol swabs, and then lay it down on top of one of the other alcohol swabs.





6. Pinch the catheter tubing closed.





7. Remove the connector from the leg bag and place it between your fingers (so you can hold it while you do the next steps).

8. Push the connector on the overnight bag into the catheter tubing.

9. Put the overnight bag on the floor. Remember to always keep it below your knee to make sure the urine drains properly.
10. Clean the connector on the leg bag with an alcohol swab.
11. Put the connector on the leg bag into the pouched open alcohol swab packet. Tighten the packet around it.

12. Wipe the outside of the leg bag and the tubing with a clean baby wipe or wet soapy washcloth. Then dry it with a clean cloth and put it in the pink plastic bin.

Please note the steps for changing from an overnight bag to a leg bag are the same except for Step 11. Because the overnight bag comes with a cap for the connector, you can put the cap back on (instead of using the alcohol wipe pouch) after cleaning the connector with an alcohol swab.

How do I clean my catheter?

It is very important to keep your catheter clean to lower the risk of infection. Clean your skin around the catheter and the catheter tubing 2 times each day. Use the following supplies each time:

- 2 clean, soft washcloths
- Soap that will not irritate your skin (an unscented soap is best)

Follow these cleaning steps:

1. Wash your hands with soap and water.
2. Wet one of the washcloths with soap and water, then gently clean the skin where the catheter leaves your body.
3. Rinse the washcloth with water until the soap is gone, and then clean the soap off your skin with the wet washcloth.
    - If you are in the shower, you can let the shower water flow over your skin to rinse off the soap.
4. Wet the second cloth with soap and water, then clean the catheter tubing. Start near where it leaves the body, and continue cleaning it down to where it attaches to the urine collection bag.
    - Handle the tube gently - do not pull or tug the tubing.
5. Rinse the tubing with a wet cloth or shower water.

How do I shower with my collection bag?

- It is best to shower while you are still using the overnight bag (instead of the leg bag).
- Drain the bag before you get into the shower.
- Put the bag on the floor of the shower or tub, near where you are standing.
- Be careful not to twist or pull on the tubing or bag while you are showering.
- Pick up the bag before you step out of the shower. Put it on a clean towel

on the floor. Dry yourself, the tubing, and the bag.

What color should my urine be?

- During the first few days after surgery, your pee may be orange. This is caused by medication we may have given you during your surgery.
- After 1-2 days, your urine should be light yellow. If it is very dark yellow, drink more water. If your urine looks like clear water, drink less.
- If you see red blood in the collection bag, or if your urine (pee) looks cloudy, please call us.

How much should I drink?

- Do not drink more than 60 ounces (oz) of fluids (about a half gallon) per day. This includes all kinds of fluids such as coffee, tea, water, juice, and soda pop.
- Your bladder needs time to recover from surgery. Drinking more liquid does not help your bladder get better faster. Drink and eat normally.

When should I call for help?

Call us at (734) 763-6295 if:

- Your urine is bloody, has a bad smell, or is cloudy
- Your temperature is over 100.4 ˚F (38 ˚C)
- Your catheter falls out
- Your catheter is not draining

Your Follow-Up Visit

- Most of our patients have a follow-up visit scheduled about 3-6 weeks after their surgery. Usually this is scheduled as part of the process of scheduling the surgery itself. Check your patient portal account or the printed surgery discharge information for the day and time of your follow-up visit with your doctor.
    - If you are not able to find this information, call us at (734) 763-6295 on the first business day (Monday-Friday) after you are home.
    - If you have not already done so, sign up for an online patient portal account at MyUofMHealth.org. Benefits of the portal include quick access to test results, appointment scheduling, and messaging your doctor's office. Instructions for how to sign up are included in your printed discharge information.
- If you go home with an indwelling catheter, you will come back within a week (7 days) after surgery to see how your bladder is working. We will schedule this appointment for you. If you have an indwelling catheter and you do not have an appointment for this, please call the day after surgery to speak with our nurses about this.
- If we removed any organs or tissue during your surgery, we will have sent them to the pathology lab for analysis. Pathology lab results take about a week to come back, and you can see them in your patient portal. It can be confusing to read this report, but your doctor will also read it (sometimes after you do) and give you instructions if needed. If you have questions about this, ask your surgeon at your follow-up appointment.
- Ask for a return-to-work letter, if you need one.
- We constantly work to make your surgical experience the best possible one. Share your thoughts with your surgeon at your follow-up visit, or

use the survey in the patient portal that you'll complete ahead of your visit. We want to hear from you.

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