The Christie NHS
NHS Foundation Trust

Risk-reducing salpingo-oophorectomy

This booklet has been written to answer some of your questions about risk-reducing salpingo-oophorectomy and help you decide whether this surgery is for you.

Your doctor has suggested this operation because you have an increased risk of developing ovarian/fallopian tube cancer due to your family history, or because you have been found to carry a faulty gene.

What is the surgery for and why is it necessary?
The aim of this operation is to reduce your risk of developing ovarian/fallopian tube cancer. Having this operation will not remove all your risk of developing ovarian/fallopian tube cancer. There will still be a very small risk of developing an ovarian-like cancer. Having your ovaries removed will reduce your risk greatly, but there will still be tissue left which surrounds the ovaries that has the potential to develop into an ovarian-like cancer.

This operation involves

- removal of both fallopian tubes
- removal of both ovaries

The ovaries are two small organs which form part of your reproductive system. They contain eggs and during the reproductive years they release an egg monthly. The ovaries also produce a variety of hormones including oestrogen, progesterone and testosterone. The production of these hormones reduces as a woman reaches the menopause. The fallopian tubes carry the eggs towards the womb as part of the reproductive cycle.

Ovarian/fallopian tube cancer affects approximately one in every 70 women during their lifetime. For the majority of women who are diagnosed with ovarian/fallopian tube cancer, this will be a lifetime event and not caused by an inherited factor. When there are two or more close relatives with ovarian cancer, or ovarian cancer linked with young onset breast or bowel cancer, the women in the family may be at an increased risk of developing ovarian cancer.

In this situation it is important that you are able to discuss your family history with a doctor or counsellor who specialises in hereditary diseases.

Do I need a salpingo-oophorectomy?
You need to be seen by your local genetics department who will look at your own risk of developing ovarian/fallopian tube cancer in relation to your family history. Other options will also be discussed at this time. You will also be able to meet with the gynaecologist to discuss what types of operation are available and any issues relating to the operation.

The genetic and gynaecology doctors and nurses will also be able to provide support and information to help you decide whether this operation is what you want and also to help you through the surgery. It is important that you have time to think about whether you would like this operation and have the opportunity to ask any questions or concerns you may have.

Agreeing to treatment:

Consent to treatment

We will ask you to sign a consent form agreeing to accept the treatment that you are being offered. The risks will be discussed with you when you complete your consent form. The basis of the agreement is that you have had The Christie's written description of the proposed treatment and that you have been given an opportunity to discuss any concerns. You are entitled to request a second opinion from another doctor who specialises in treating this cancer. You can ask your own consultant or your GP to refer you. Your consent may be withdrawn at any time before or during this treatment. Should you decide to withdraw your consent then a member of your treating team will discuss the possible consequences with you.

What are the benefits of this operation?

The aim of the operation is to remove safely both fallopian tubes and ovaries whilst there is no evidence of cancer present. This will help to reduce the risk of developing ovarian/fallopian tube cancer in the future. However, it is important to realise that risk-reducing surgery is not risk-eliminating surgery. There is still a small chance that you can develop ovarian or peritoneal cancer as microscopic cancer cells which are invisible to the naked eye may have started to grow in your abdomen or pelvis before your ovaries and tubes are removed.

Are there any alternatives to this operation?

There are no alternatives to this operation.

At present there is no effective way of screening to pick up early stage ovarian cancer in women who do not have symptoms. This means that we do not know of any screening tests that have been proven to be effective.

You may have heard of a blood test looking at a marker in the blood called CA125. Sometimes when a person has ovarian/fallopian tube cancer CA125 can be raised, but it can also be raised with other conditions that are not cancerous. Furthermore, it may not always rise in the early or treatable stages of ovarian/fallopian tube cancer. Therefore this test is not helpful for women at an increased risk of developing ovarian cancer.

What are the disadvantages of this operation?

- You will be unable to become naturally pregnant once your ovaries and tubes have been removed.
- You will have a sudden onset of menopause if you have not already reached it.
- There is an increased chance that you may develop osteoporosis (thinning of the bones).
- There is a small risk of complications with having surgery. This will be explained to you when you sign the consent form.

What are the risks of this operation?

As with any operation there are risks but it is important to realise that the majority of women do not have complications.

There can be risks associated with having a general anaesthetic and abdominal surgery. The risks include:

- Bruising or infection in the wounds.
- Internal bruising and infection may also occur, needing treatment with antibiotics. Occasionally, a second operation may be necessary.
- A blood transfusion is occasionally needed to replace blood lost during the operation. Occasionally, there may be internal bleeding after the operation, making a second operation necessary.
- Blood clots in the leg or pelvis (deep vein thrombosis or DVT). This can lead to a clot in the lungs (pulmonary embolism or PE). Moving around as soon as possible after your operation can help to prevent this. We will give you special surgical stockings (known as 'TEDS') to wear whilst you are in hospital and injections to thin the blood. The physiotherapist may visit you and show you some leg exercises to help prevent blood clots.

Are there any long term complications?
If you have not already experienced the menopause you will have a premature menopause by having both your ovaries and tubes removed. This means that your periods will stop permanently and you will be unable to become naturally pregnant. You may also experience menopausal symptoms such as hot flushes, night sweats and vaginal dryness in the months and years following removal of their ovaries. This can lead to discomfort during sexual intercourse, and lack of interest in sex (loss of libido).

If you have already experienced the menopause, then by having your ovaries and tubes removed, you are unlikely to have any menopausal symptoms, although removal of the ovaries after the menopause can lead to loss of libido in some women.

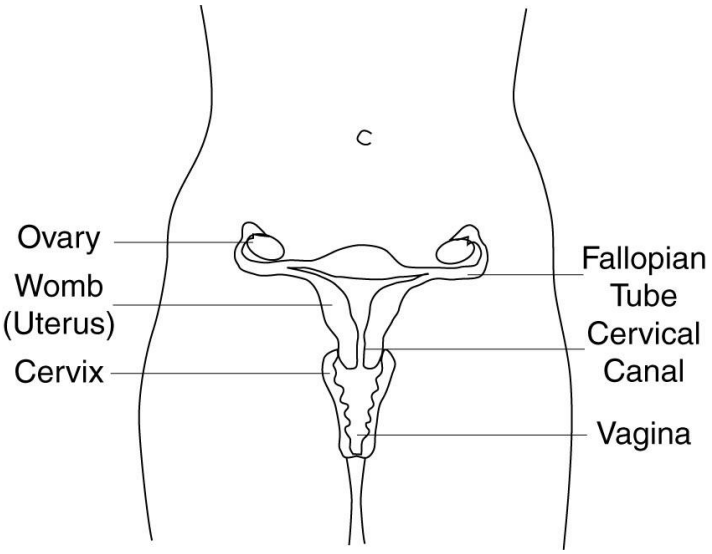
Will I need Hormone Replacement Therapy (HRT)?
Hormone replacement therapy will control the symptoms of the menopause but not all women need HRT after this surgery. Your doctor will discuss with you whether HRT is appropriate for you.

The operation

What is removed during my operation?

- Both fallopian tubes
- Both ovaries

See the diagram on following page.



What tests will I need before my operation?
Tests will be done to ensure that you are physically fit for surgery and help your doctor to choose the most appropriate treatment for the type and extent of your disease. Recordings of your heart (ECG) may be taken as well as a chest x-ray. An MRI or CT scan of your pelvis and abdomen will be needed. A blood sample will also be taken to check that you are not anaemic and to identify your blood group in case you need a blood transfusion.

We will take swabs from your nose, throat and perineum to find out whether you carry the bacterium known as MRSA. This is so we can identify whether you need any treatment for this infection during your stay in hospital. Do not worry; if you are carrying the bacterium this will not cause your operation to be cancelled.

You will also have the opportunity to ask the doctor and the specialist nurse any questions that you may have. It may help to write them down before you come.

Ultrasound scan
The scan looks at the size and shape of the ovaries. This can be done externally by moving the scanner over the abdomen (rather like when a woman is pregnant). However, the most effective type of scan is an internal or 'transvaginal' ultrasound scan.

During a transvaginal scan the ultrasonographer gently inserts a probe into the vagina to look at the ovaries. The scan takes about 10 minutes. Most women find that this is not particularly uncomfortable.

Why do I need to attend the pre-operative clinic?
Before your admission to hospital, you will be asked to attend the pre-operative clinic to make sure that you are fit for the operation. During the visit the staff will discuss your operation with you and what to expect afterwards. You will have the opportunity to ask any questions.

Your temperature, pulse, blood pressure, respiration rate, height, weight and urine are measured to give the nurses and doctors a base line (normal reading) from which to work.

When will I come in for my operation?
You will be admitted to the ward the day of your operation or the day before. You will meet the nurses and doctors involved in your care. The anaesthetist may visit you to discuss the anaesthetic. Any further questions you have can also be discussed at this time. Before your operation, you may be given some medication or an enema to help you open your bowels.

What happens on the day of my operation?

You will not be allowed to have anything to eat or drink (including chewing gum or sweets) for a number of hours before your operation. Each hospital has slightly different fasting times and the ward staff will tell you more about this.

Before going to the operating theatre, you will be asked to take a bath or shower and change into a theatre gown. All make-up, nail varnish, jewellery (except your wedding ring), dentures and contact lenses must be removed.

After the operation

What happens after my operation?

After your operation you will wake up in the recovery room before returning to the ward. You may still be very sleepy and be given oxygen through a clear face mask to help you breathe comfortably immediately after your operation. An intravenous infusion also called a **'drip'** will be attached to your hand or arm to give you fluids and prevent dehydration for the next 24-48 hours.

During your operation a **catheter** (tube to drain urine away) will be put into the bladder. The catheter will need to stay in until you are walking around.

The doctor will see you after your operation to explain the details of your surgery. You may also have trouble opening your **bowels** or have some discomfort due to wind for the first few days after the operation. This is temporary and we can give you laxatives and painkillers if you need them.

How will I feel after my operation?

You can expect to be extremely sleepy or sedated for the first few hours. This will allow you to rest and recover. **Please tell us if you are in pain or feel sick.** We have tablets or injections that we can give you as and when needed, so that you remain comfortable and pain free. You may have a device that you use to control your pain yourself. This is known as a PCA (Patient Controlled Analgesia) and the staff will show you how to use it. Alternatively, an you may have an epidural inserted in your back for pain relief (a local anaesthetic injection into the spine which will produce a loss of sensation below your waist). The anaesthetic will discuss these choices (PCA or an epidural) with you before surgery.

You may have some vaginal bleeding or a blood stained discharge but this does not usually last for more than a few days. The wounds will have dressings on to keep them clean and dry. The sutures or clips will be removed 5-10 days later.

We will encourage you to do gentle leg and breathing exercises to help your circulation and prevent a chest infection.

Convalescence

If you have had laparoscopic surgery (keyhole surgery performed in your abdomen through small incisions) then you will usually be able to go home the same day or the next day of your operation and will usually need two weeks' convalescence. Otherwise you will be able to go home about three days after an abdominal bilateral salpingo-oophorectomy through a laparotomy (tummy cut).

Following an abdominal bilateral salpingo-oophorectomy you are advised not to return to work for a month. You should avoid strenuous exercise and heavy lifting during the time you are off work. You will not be able to drive for up to four to six weeks dependent on the type of surgery that you have had.

Sex life

It is quite common for women to ask about their sex life. There is no reason why you should not resume sexual activity as soon as you are comfortable to do so. We normally advise women not to have intercourse for 6 weeks following surgery.

During this time, it may feel important for you and your partner to maintain intimacy, despite refraining from sexual intercourse. However, some couples are both physically and emotionally ready to resume having sex much sooner and this can feel like a positive step. However, some women do experience emotional changes. These are natural and understandable, particularly in younger women where the loss of ovaries results in an early surgical menopause and anxieties related to the loss of fertility.

You may find it helpful to talk to a sympathetic friend, your GP or a counsellor about these feelings. You also may find it helpful to use a vaginal lubricant such as KY Jelly (available at the chemist) the first few times you have intercourse following surgery, or you may prefer to use a vaginal moisturiser such as Replens (also available at the chemist) which plumps up vaginal tissue in preparation for intercourse. This is obviously dependent on the type of surgery you have had. Hormone replacement therapy with or without testosterone may help.

It can be a worrying time for your partner. He or she should be encouraged to be involved in discussions about the operation and how it is likely to affect your relationship afterwards.

If you do not have a partner at the moment, you may have concerns either now or in the future about starting a relationship after having this surgery. Please do not hesitate to contact the gynaecology cancer nurse specialist if you have any queries or concerns about your sexuality, change in body image or your sexual relationship either before or after surgery.

Follow-up appointments

An appointment will be made for you to attend clinic in a few weeks' time to discuss your recovery and histology (tissue analysis) results.

Further information

The team involved in your care is:

Consultant: ……....

Tel no: ……....

Genetic counsellor: ……..

Tel no: ……

If you require additional information or advice, please contact your consultant's secretary on the numbers below. They are available Monday to Friday 9am to 5pm:

Mr Slade and Mr Winter-Roach	**0161 446 3367**
Mr Smith and Miss Myriokefalitaki	**0161 446 8045**
St Mary's Hospital Genetic Service	**0161 276 6506**

If you need information in a different format, such as easy read, large print, BSL, braille, email, SMS text or other communication support, please tell your ward or clinic nurse.

We try to ensure that all our information given to patients is accurate, balanced and based on the most up-to-date scientific evidence. If you would like to have details about the sources used please contact **patient.information@christie.nhs.uk**

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For more information about The Christie and our services, please visit **www.christie.nhs.uk** or visit the cancer information centres at Withington, Oldham or Salford.

The Christie NHS Foundation Trust
Wilmslow Road
Withington
Manchester M20 4BX
Tel: 0161 446 3000
www.christie.nhs.uk

The Christie Patient Information Service
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Health & care information you can trust
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