Radical Trachelectomy

Information and advice for patients having surgery for early stage cercival cancer

The Pan Birmingham Gynaecological Cancer Centre

Introduction

This booklet has been written to give you information about having a radical trachelectomy and the care you will receive before, during and after your operation. We hope it will answer some of the questions that you or those who care for you may have at this time. It is not meant to replace the discussion between you and your surgeon but helps you to understand more about what is discussed.

If you have been recently diagnosed with cervical cancer, it is normal to experience a wide range of emotions. For some women it can be a frightening and unsettling time. Whatever you may be feeling at present, try talking about it with someone who specialises in dealing with this condition, such as your gynaecological clinical nurse specialist (CNS). They will listen, be able to answer any questions you may have and can put you in touch with other professionals or support agencies if you wish.

What is a radical trachelectomy?

The conventional treatment for early stage cancer of the cervix is complete womb removal (hysterectomy) or pelvic radiotherapy and chemotherapy. These treatments make a woman unable to conceive or carry a child. The aim of radical trachelectomy is to treat cervical cancer by removing the cervix, but leave behind the uterus so you could become pregnant and carry a child in future. Radical trachelectomy is a surgical technique that has been developed in recent years by skilled gynaecological oncologists in only a few specialist centres throughout the world. Although we have been performing this surgery for over fifteen years the number of women who have undergone this surgery is still relatively small.

Who is suitable for a radical trachelectomy?

A radical trachelectomy is only suitable for women whose cancer is small and confined to the cervix. It is essential that you have a desire for children and understand that you may need more treatment if we find out that not all the cancer has been removed. A careful physical and emotional assessment will be carried out to decide together if a radical trachelectomy is the best treatment choice for you.

This will include:

- An MRI scan to assess the size and position of the tumour
- A review of the investigations you have had at your local hospital to make sure that we understand how your tumour has been growing and your particular risk factors

The aim of the operation is to remove all the cancer. If there is any evidence that the cancer has spread, you may require additional treatment like chemotherapy and radiotherapy. This will be discussed with you when all the results are available.

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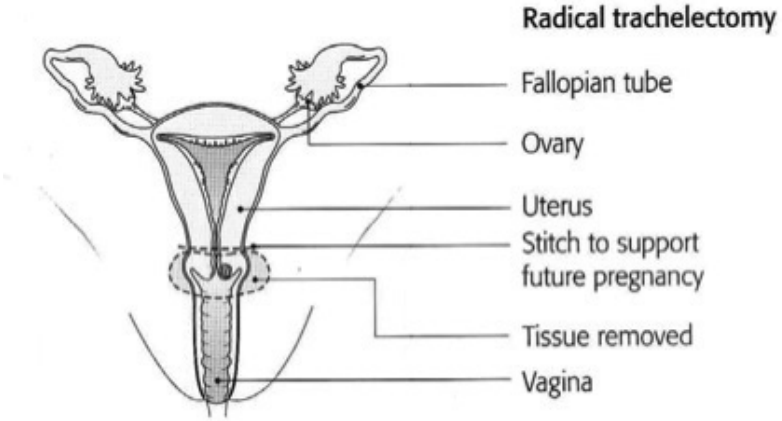
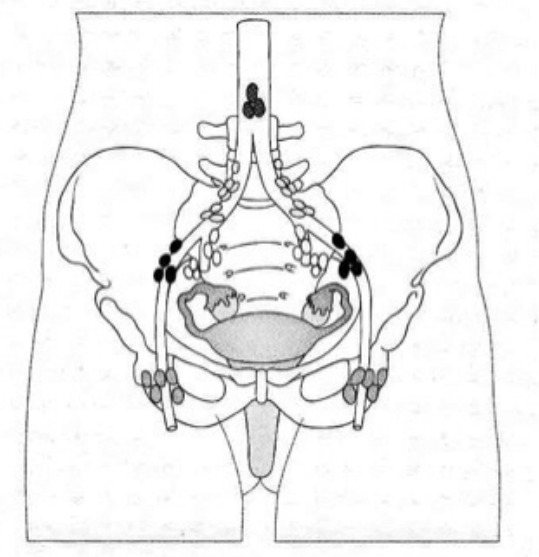
What happens during a radical trachelectomy?



A radical trachelectomy is performed by vaginal and laparoscopic (keyhole) surgery, that is through the vagina and small incisions in the abdomen. Occasionally, the operation is done through a scar into the abdomen.

The diagram shows you how the vagina, cervix and uterus are arranged - they are all hollow organs connected together- and then what happens during your operation.

The surgery involves a narrow telescope called a laparoscope being inserted through a small cut in the belly button. This allows the surgeon to see inside the tummy. Keyhole instruments are then inserted into the abdomen through small cuts in the abdominal wall. The cervix is removed through a small incision at the top of the vagina and passed through the vagina to leave the body. The small abdominal incisions are sutured and these stitches will dissolve a few weeks after the operation. Your pelvic lymph glands will also be taken out (pelvic lymphadenectomy) to remove any free cancer cells that may have been carried into the lymph glands in the lymph fluid. Please see diagram of lymph nodes in the pelvis below.



Radical Trachelectomy

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The Pan Birmingham Gynaecological Cancer Centre

It is obviously important to cut out all the tissue that may be cancerous, so as well as the cervix, the top 2-3 cm of the vagina and the tissue from around the cervix (the parametrium) are removed. A stitch is inserted in the cervix to keep it closed but a small opening is left for menstruation. The remaining portion of the vagina is then attached to the remaining part of cervix and uterus

After a radical trachelectomy you will be able to resume sexual intercourse after it has healed up, usually after 12 weeks. It is advisable to have an examination by the hospital doctor before resuming sexual intercourse just to ensure that sufficient healing has taken place.

Whilst you are recovering from your operation a histopathologist will carefully examine the tissue and lymph glands removed during the operation to confirm that all the cancer has been removed. If cancer cells are found in the edges of the tumour removed or in the lymph glands then the need for further treatment is very likely.

Are there any alternatives to this operation?

Yes, but they vary from patient to patient. This is the only treatment that aims to remove the cancer and retains the potential to have a child.

Are there any risks?

There are risks, but it is important to understand that most women do not have complications after this operation.

As with any operation, there is a risk associated with having a general anaesthetic. Your surgeon will discuss these risks with you. The identified risks associated with this surgery are – bleeding, infection of wound, urine or chest, clots in legs or lung, injury to neighbouring organs or structures like bowel, bladder, blood vessels, nerves.

A blood transfusion may be required to replace the blood lost during the operation. Very occasionally, there may be internal bleeding after the operation, making a second operation necessary.

Patients occasionally suffer from blood clots in the leg or pelvis (known as deep vein thrombosis or DVT). This can lead to a clot in the lungs. Moving around as soon as possible after your operation can help prevent this. We will give you special surgical stockings (known as 'TED stockings') to wear whilst you are in hospital and a small daily injection of heparin to thin the blood. This all helps to prevent a clot. We will teach you how to give the heparin injections as these will need to be given for 28 days after your operation.

After the operation your bladder and bowels may take some time to begin working properly. Some women have loss of feelings in the bladder that may take some months to get better.

Radical Trachelectomy

Information and advice for patients having surgery for early stage cercival cancer

The Pan Birmingham Gynaecological Cancer Centre

During this time they may need to take special care to empty their bladder regularly. Rarely, a hole may develop in the bladder or in the tube bringing urine to the bladder (ureter). If this happens it is generally identified at the time of surgery. If it happens later this may result in leakage of urine into the vagina. The hole may close without surgery, but another operation may be necessary to repair this.

Are there any long-term complications associated with this operation?

- Nerves in the pelvis run very closely alongside the tissue that is being removed. Sometimes these nerves can be bruised creating a numbness that may affect the top of the legs or the inside of the thighs. This nearly always gets better in six to twelve months.
- There is a small risk of swelling of the legs or lower abdomen (lymphoedema). Normally, lymphatic fluid circulates throughout the body, draining through the lymph glands. As the pelvic lymph glands are removed during the operation to prevent the spread of cancer cells, the lymphatic drainage system may become restricted, resulting in the build-up of fluid in one or both legs or in the genital area. The problem can be treated, but preventative measures can also be taken to reduce the risk of this happening. You can discuss this further with any of the nurses or doctors or ask to see a leaflet on the subject.
- Very occasionally the scar at the top of the vagina heals over and blocks the passageway out of the uterus. This would mean that your menstrual flow cannot leave your body. Please contact us if your monthly periods do not resume as normal after your surgery.

Will I have a scar?

Yes, 4 very small laparoscopy scars on your tummy, which will fade.

Is there anything I should do to prepare for the operation?

Yes, make sure that all of your questions have been answered to your satisfaction and that you fully understand what is going to happen to you. You are more than welcome to visit the ward and meet the staff before you are admitted to hospital. Just ask your CNS to arrange this for you.

If you are a smoker, it would benefit you greatly to stop smoking or cut down before you have your operation. This will reduce the risk of chest troubles as smoking makes your lungs sensitive to the anaesthetic.

You should also eat a well-balanced diet and if you feel well enough, take some gentle exercise before the operation, as this will also help your recovery afterwards.

Your GP, the practice nurse at his/her surgery or the doctors and nurses at the hospital will be able to give you further advice about this.

Radical Trachelectomy

Information and advice for patients having surgery for early stage cercival cancer

The Pan Birmingham Gynaecological Cancer Centre

Before you come into hospital for your operation, try to organise things for when you come home. If you have a freezer, stock it with easy-to-prepare food. If you have any concerns about your finances whilst you are recovering from your operation, you can also discuss this with your CNS. You can do this either before you come into hospital or whilst you are recovering on the ward.

What tests will I need before my operation?

You will be asked to attend a pre-admission clinic one or two weeks before your operation. Tests will be arranged to ensure you are physically fit for surgery. Depending on your age you may need recordings of your heart (ECG) as well as a chest X-ray. A blood sample will also be taken to check that you do not have anaemia. The nurses in pre-admission will then take some details and ask some questions about your general health.

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

The nurses will explain to you about the post-operative care following your operation. You will have the opportunity to ask any questions that you or your family may have. It may help to write them down before you come to the clinic.

When will I come in for my operation?

You will be admitted to D6 at 7.30am on the day of your operation. On your arrival the ward clerk or one of the nurses will greet you and show you to your bed or chair.

You will meet the ward nurses and doctors involved in your care. The anaesthetist will visit you to discuss the anaesthetic.

You will not be allowed to have any solid food from 3am on the morning of surgery. You will be provided with pre-op nutritional drinks which will be given to you when you attend your pre-admission appointment with instructions of when to drink them. If you are on any medication you may need to take your tablets in the morning with a little water. The nurses in pre-admission will tell you which medication you need to take.

What will happen the day of the operation?

Before going to the operating theatre, you will be asked to change into a theatre gown. All make-up, nail varnish, jewellery (except wedding rings which can be taped over), contact lenses, must be removed.

What happens after the operation?

One of the nurses will collect you from recovery (where you wake up after your surgery) and escort you back to the ward D27.

Radical Trachelectomy

Information and advice for patients having surgery for early stage cercival cancer

The Pan Birmingham Gynaecological Cancer Centre

When you return from theatre please tell us if you are in pain or feel sick. We have tablets/ injections that we can give to you to relieve these symptoms as and when required. Above all we want you to 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 how to use it will be explained to you. Alternatively an epidural may be inserted in your back for pain relief. The anaesthetist will discuss the choices for pain control with you before surgery.

You may still be very sleepy and be given oxygen through a clear mask to help you breathe comfortably immediately after your operation. You will be allowed to start drinking and then eating very soon after returning to the ward. You may have a drip attached to your arm or hand to give you fluids for a short time after the operation.

A catheter (tube) will be inserted into your bladder in theatre to drain urine away. As the bladder is positioned close to the cervix, uterus and vagina, where the surgery has taken place, the catheter will allow the area to recover and heal. The catheter will need to stay in for approximately ten days. You will be discharged with the catheter attached to a bag to your leg and the nurses will teach you how to care for the catheter prior to discharge. After you have had the catheter in for ten days you will be re-admitted to D27 for the day and the catheter is removed in the morning. The nurses will monitor how much urine you are passing to ensure you are emptying your bladder properly.

Very occasionally some women are unable to pass urine after their catheter has been removed. If this happens you will be sent home for a further week with the catheter in to help rest the bladder and then we would repeat the process of taking it out again and monitoring how well you pass urine.

You may have discomfort due to the build-up of wind for the first few days following surgery. This is temporary and we can give laxatives if needed and hot peppermint water to help relieve wind pain.

You may have some vaginal bleeding for the first few days following surgery. The bleeding normally turns to a red/brownish discharge before disappearing. This can take between a few days to a few weeks.

When can I return to work?

If you work then this will depend upon the type of work you do, how well you are recovering and how you feel physically and emotionally. It also depends on whether you need further treatment, after your operation.

Most women need approximately four to six weeks away from work to recover fully before returning to work or their usual routine. However, this will depend upon your recovery, and you can discuss it further with your doctor, specialist nurse or GP.

Radical Trachelectomy

Information and advice for patients having surgery for early stage cercival cancer

The Pan Birmingham Gynaecological Cancer Centre

Remember – the return to normal life takes time, it is a gradual process and involves a period of readjustment and will be individual to you.

What about exercise?

Take short walks, gradually building up distance and time. If you were attending a gym before, please wait until 6 weeks after surgery before resuming low impact exercise. Please avoid swimming for the first six weeks also.

When can I have sex?

After a radical trachelectomy for cancer, you may not feel physically or emotionally ready to start having sex again for a while. It can take at least 10-12 weeks for the vagina to heal and even longer for the energy and sexual desire to improve. Initially you may have a small amount of pinkish and then brown discharge from your vagina which is quite normal; if this becomes smelly you should contact your GP as you might need antibiotics for an infection. You should avoid full penetrative sex and the use of tampons for about 10-12 weeks to allow the top of the vagina to heal.

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 after the 10-12 week period after surgery and this can feel like a positive step. If you have any individual worries or concerns, please discuss them with your CNS.

There may be certain sexual positions that are more comfortable when you first resume having intercourse, but having a shortened vagina does not usually affect sexual enjoyment in the long term. We will discuss this further with you. We would ask you to wait 6 months before trying to conceive a baby and we will discuss contraception choices with you.

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 a radical trachelectomy.

Please do not hesitate to contact your CNS if you have any queries or concerns about your sexuality, change in body image or your sexual relationship either before or after surgery.

When can I start driving again?

You are advised not to start driving for 4-6 weeks after surgery.

Radical Trachelectomy

Information and advice for patients having surgery for early stage cercival cancer

The Pan Birmingham Gynaecological Cancer Centre

Will I need to visit the hospital again after my operation?

Yes. It is very important that you attend any further appointments arranged either at City Hospital or back at the hospital that referred you for treatment.

An early appointment for the outpatients clinic will be made for you to discuss the results. You will be asked to attend follow-up appointments at 6 monthly intervals for the first 2 years after your surgery.

Will I need further treatment?

Your medical team will discuss this with you further, if necessary, once the histology (tissue analysis) results are known. If the results are negative and all the cancer tissue has been removed you will not usually require further treatment.

Should I continue to have cervical smears?

As your cervix has been removed you will not have a routine cervical smear however we will take a smear from the area around the permanent stitch. This is called an isthmic smear. It is important to come for regular examinations in the outpatient clinic.

Pregnancy

If your results are all normal after your appointment at 6 months, you may actively start trying to conceive if you wish to do so. Pregnancy after a radical trachelectomy is classed as 'high risk' because of the increased risk of miscarriage, or early rupture of membranes (waters breaking). You should be cared for by a specialist obstetrician who should communicate with your surgeon here. Together they may advise measures to reduce the risks in pregnancy such as antibiotics as a precautionary measure, prenatal steroid therapy to support lung development in the baby and a planned caesarean section at 37-38 weeks via an 'up and down' scar.

It is important that you make a list of all medicines you are taking and bring it with you to all your follow-up clinic appointments. If you have any questions at all, please ask your surgeon, oncologist or nurse. It may help to write down questions as you think of them so that you have them ready. It may also help to bring someone with you when you attend your outpatient appointments.

Radical Trachelectomy

Information and advice for patients having surgery for early stage cercival cancer

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Glossary of medical terms used in this information

Anaemia: a condition in which the blood is lacking in red blood cells.

Catheter: a flexible tube used to drain fluid from the bladder.

Cervix: the narrow outer end of the uterus or womb.

Chemotherapy: the treatment of cancer with drugs.

ECG: also known as an electrocardiogram, is a test which measures the electrical activity of the heart.

Epidural: a pain relieving injection into the spinal column.

Fallopian tubes: one of a pair of long, slender tubes that transport eggs released from the ovary to the womb.

Histology: the study of cells and tissues on a microscopic level.

Lymph nodes: hundreds of small oval bodies that contain lymph. These act as a first line of defence against infections.

Ovary: one of two small oval bodies in which eggs and hormones are developed.

Physioterapist: a therapist who treats injury or dysfunction with exercises and other physical treatments of the disorder.

Radiotherapy: X-ray treatment that uses high energy rays to damage or kill cancer cells.

Uterus: a hollow muscular organ in the female pelvis, in which a fertilised egg develops into an embryo.

Local sources of further information

The Looking Forward Gynae-Oncology Support Group. For further information and dates of group meetings please call 0121 507 5511 or ask your Clinical Nurse Specialist.

You can visit any of the health/cancer information centres listed below:

Birmingham Women's NHS Foundation Trust
Health Information Centre
Birmingham Women's Healthcare NHS Foundation Trust
Metchley Park Road
Edgbaston
Birmingham B15 2TG
Telephone: 0121 627 2608

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Heart of England NHS Foundation Trust
Health Information Centre
Birmingham Heartlands Hospital
Bordesley Green
Birmingham B9 5SS
Telephone: 0121 424 2280

Cancer Information and Support Centre
Good Hope Hospital
Rectory Road
Sutton Coldfield B75 7RR
Telephone: 0121 424 9486

Sandwell and West Birmingham Hospitals NHS Trust
The Courtyard Centre

Sandwell General Hospital (Main Reception)
Lyndon
West Bromwich B71 4HJ
Telephone: 0121 507 3792
Fax: 0121 507 3816

University Hospital Birmingham NHS Foundation Trust
The Patrick Room
Cancer Centre
Queen Elizabeth Hospital
Edgbaston
Birmingham B15 2TH
Telephone: 0121 697 8417

Walsall Primary Care Trust
Cancer Information & Support Services
Challenge Building
Hatherton Street
Walsall WS1 1YB
Freephone: 0800 783 9050

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About this information

This guide is provided for general information only and is not a substitute for professional medical advice. Every effort is taken to ensure that this information is accurate and consistent with current knowledge and practice at the time of publication.

We are constantly striving to improve the quality of our information. If you have a suggestion about how this information can be improved, please contact us on 0121 507 5511

This information was written by Macmillan Clinical Nurse Specialists and Consultants in Gynaecological Oncology

If you would like to suggest any amendments or improvements to this leaflet please contact the communications department on 0121 507 5303 or email: **swb-tr.swbh-gm-patient-information@nhs.net**

Health & care information you can trust

The Information Standard Certified Member

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