Patient Advice

Ovarian and fallopian tube surgery

(adnexectomy, partial resection of ovary, ovariectomy)

Ovaries, fallopian tube and their positions in the body

In normal conditions, the uterus is a hollow organ weighing about 80-100g, the function of which is to nurture the fertilized ovum developing into the fetus and to hold it till the baby is mature enough for birth; it serves reproductive purposes. In its upper corners, the uterus is connected on both sides with the fallopian tubes – hollow funnel-shaped tubes the only function of which is to transport the mature and released ovum/egg into the uterine cavity; the ovary is a pair, female hormones producing reproductive organ, four centimeters in size, attached below each fallopian tube. Ovaries are in direct control of the menstrual cycle, and in one of them, an ovum growing in a small cavity ripens every month so that it could be fertilized. Approximately in the middle of two menstrual cycles the ovum is released from the ovary. Ovaries and fallopian tubes are called uterine adnexa. In case of an ovarian or fallopian tube disease or in case of changes affecting the ovary or the fallopian tube, the unhealthy part of the ovary or the whole ovary, or the ovary together with the fallopian tube may require to be removed. When a fallopian tube fails to function normally, only the fallopian tube is removed. After the surgery, the empty space is filled by the surrounding organs of the abdominal cavity. The other ovary takes over the function in relation to hormone and ovum production of the ovary that has been removed.

The most common cause of ovarian disorders is the appearance of cysts filled with fluids of various types. The most common cause of fallopian tube surgery is the ectopic pregnancy in the fallopian tube or rarely in the ovary. The other surgery indications include inflammation processes with pus formation in ovaries or fallopian tubes. The surgery will occur only when other treatments have been unsuccessful. There are also other grounds for the removal of uterine adnexa which are very rare; they fall in the category of non-tumor changes.

Examinations before surgery

In addition to preoperative medicinal assessment, also ultrasound scan is made. Frequently blood test is made to determine the presence of substances that might indicate tumor proliferation, aiming to exclude possible malignant disease. However, it should be noted that it is not possible to exclude malignant tumor absolutely; this is only possible by a histology test (by examining the tissue under the microscope)!

Surgery

The surgery may be performed via anterior abdominal wall by an incision running either downwards from the belly button or transversally above the pubic bone. Laparoscopy is a modern type of this surgery, with a good esthetic effect (usually three small scars in the underbelly).

We will do our best to choose an acceptable and safe method of surgery. In case of complications during surgery, the surgeon may decide to change the procedure from endoscopic/laparoscopic to abdominal.
The surgery is performed in general anesthesia (after the patient falls asleep) following the necessary preparation. On the day of surgery, please, do not eat, drink or smoke. Before laparoscopy, inform the surgeon of any surgeries intervening with the abdominal cavity and inflammatory processes in the abdominal cavity (fallopian tubes, ovaries, gall bladder...) preceding the planned laparoscopy. Mention also any postoperative complications in these past procedures.

**Complications**

Surgical complications may be divided into:

- bleeding during surgery (damaged large blood vessels),
- damaging the organs close to the ovary and fallopian tube, (rectum, urinary bladder, urethra, urinary system), and the organs that may be injured when entering the abdominal cavity (intestine, stomach, blood vessels).

These complications occur very rarely, but when they occur, it may often be necessary to change laparoscopic to abdominal approach, and a follow-up surgery may also be required. Not even with the most experienced surgeons, these complications may be 100 percent avoided.

**Postoperative complications**

- postoperative bleeding (surgery may be repeated)
- potential thrombi (blood clots) formation especially in the veins of the lower extremity with possible pulmonary embolism and risk to life
- pus formation in the surgical wound
- possible postoperative urethral or intestinal fistula (abnormal connection between organs) – this complication requires further surgery treatment.

Antibiotics coverage and administration of anti-coagulants before surgery significantly reduce the occurrence of postoperative complications of thrombi and pus formation.

Quite seldom, urinary catheters are used for several hours after the surgery. Most commonly, a thin tube is temporarily used to drain the fluids formed in the abdominal cavity, and this tube is usually removed the next morning after the surgery. Postoperative pain is relieved by medication. Post-laparoscopy pain is quite mild. The length of hospital stay after laparoscopy does not exceed 24 hours.

Such surgery typically does not affect your next life; before leaving the hospital you may ask your attending physician about possible side effects.

In general, in case of surgery, only the organs necessary for the patient’s overall treatment are removed.
With your attending physician you will discuss also the schedule of the follow-up checkups.