

HYSTERECTOMY

Hysterectomy is the surgical removal of the uterus, most commonly performed for malignancies and certain nonmalignant conditions (e.g., endometriosis/tumors), to control life-threatening bleeding/hemorrhage, and in the event of intractable pelvic infection or irreparable rupture of the uterus. A less radical procedure (myomectomy) is sometimes performed for removing fibroids while sparing the uterus.

Abdominal hysterectomy types include the following:

Subtotal (partial): Body of the uterus is removed; cervical stump remains.

Total: Removal of the uterus and cervix.

Total with bilateral salpingo-oophorectomy: Removal of uterus, cervix, fallopian tubes, and ovaries is the treatment of choice for invasive cancer (11% of hysterectomies), fibroid tumors that are rapidly growing or produce severe abnormal bleeding (about one-third of all hysterectomies), and endometriosis invading other pelvic organs.

Vaginal hysterectomy or laparoscopically assisted vaginal hysterectomy (LAVH) may be done in certain conditions, such as uterine prolapse, cystocele/rectocele, carcinoma in situ, and high-risk obesity. These procedures offer the advantages of less pain, no visible (or much smaller) scars, and a shorter hospital stay and about half the recovery time, but are contraindicated if the diagnosis is obscure.

A very complex and aggressive surgical procedure may be required to treat invasive cervical cancer. Total pelvic exenteration (TPE) involves radical hysterectomy with dissection of pelvic lymph nodes and bilateral salpingo-oophorectomy, total cystectomy, and abdominoperineal resection of the rectum. A colostomy and/or a urinary conduit are created, and vaginal reconstruction may or may not be performed. These patients require intensive care during the initial postoperative period. (Refer to additional plans of care regarding fecal or urinary diversion as appropriate.)

CARE SETTING

Inpatient acute surgical unit or short-stay unit, depending on type of procedure.

RELATED CONCERNS

Cancer

Psychosocial aspects of care

Surgical intervention (for general considerations and interventions)

Thrombophlebitis: deep vein thrombosis

Patient Assessment Database

Data depend on the underlying disease process/need for surgical intervention (e.g., cancer, prolapse, dysfunctional uterine bleeding, severe endometriosis, or pelvic infections unresponsive to medical management) and associated complications (e.g., anemia).

TEACHING/LEARNING

Discharge plan considerations: DRG projected mean length of inpatient stay: 2.9–5.9 days
May need temporary help with transportation; homemaker/maintenance tasks
Refer to section at end of plan for postdischarge considerations.

DIAGNOSTIC STUDIES

Pelvic examination: May reveal uterine/other pelvic organ irregularities, such as masses, tender nodules, visual changes of cervix, requiring further diagnostic evaluation.

Pap smear: Cellular dysplasia reflects possibility of/presence of cancer.

Ultrasound or computed tomography (CT) scan: Aids in identifying size/location of pelvic mass.

Laparoscopy: Done to visualize tumors, bleeding, known or suspected endometriosis. Biopsy may be performed or laser treatment for endometriosis. Rarely, exploratory laparotomy may be done for staging cancer or to assess effects of chemotherapy.

Dilation and curettage (D&C) with biopsy (endometrial/cervical): Permits histopathological study of cells to determine presence/ location of cancer.

Schiller's test (staining of cervix with iodine): Useful in identifying abnormal cells.

Complete blood count (CBC): Decreased hemoglobin (Hb) may reflect chronic anemia, whereas decreased hematocrit (Hct) suggests active blood loss. Elevated white blood cell (WBC) count may indicate inflammation/infectious process.

Sexually transmitted disease (STD) screen: Human papillomavirus (HPV) is present in 80% of patients with cervical cancer.

NURSING PRIORITIES

1. Support adaptation to change.
2. Prevent complications.
3. Provide information about procedure/prognosis and treatment needs.

DISCHARGE GOALS

1. Dealing realistically with situation.
2. Complications prevented/minimized.
3. Procedure/prognosis and therapeutic regimen understood.
4. Plan in place to meet needs after discharge.

NURSING DIAGNOSIS: Self-Esteem, situational low

May be related to

Concerns about inability to have children, changes in femininity, effect on sexual relationship
Religious conflicts

Possibly evidenced by

Expressions of specific concerns/vague comments about result of surgery; fear of rejection or reaction of significant other (SO)
Withdrawal, depression

DESIRED OUTCOMES/EVALUATION CRITERIA—PATIENT WILL:

Self-Esteem (NOC)

Verbalize concerns and indicate healthy ways of dealing with them.
Verbalize acceptance of self in situation and adaptation to change in body/self-image.

ACTIONS/INTERVENTIONS	RATIONALE
<p>Self-Esteem Enhancement (NIC)</p> <p>Independent</p> <p>Provide time to listen to concerns and fears of patient and SO. Discuss patient's perceptions of self related to anticipated changes and her specific lifestyle.</p> <p>Assess emotional stress patient is experiencing. Identify meaning of loss for patient/SO. Encourage patient to vent feelings appropriately.</p>	<p>Conveys interest and concern; provides opportunity to correct misconceptions, e.g., women may fear loss of femininity and sexuality, weight gain, and menopausal body changes.</p> <p>Nurses need to be aware of what this operation means to patient to avoid inadvertent casualness or oversolicitude. Depending on the reason for the surgery (e.g., cancer or long-term heavy bleeding), the woman can be frightened or relieved. She may fear loss of ability to fulfill her reproductive role and may experience grief.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p>Self-Esteem Enhancement (NIC)</p> <p>Independent</p> <p>Provide accurate information, reinforcing information previously given.</p> <p>Ascertain individual strengths and identify previous positive coping behaviors.</p> <p>Provide open environment for patient to discuss concerns about sexuality.</p> <p>Note withdrawn behavior, negative self-talk, use of denial, or overconcern with actual/perceived changes.</p> <p>Collaborative</p> <p>Refer to professional counseling as necessary.</p>	<p>Provides opportunity for patient to question and assimilate information.</p> <p>Helpful to build on strengths already available for patient to use in coping with current situation.</p> <p>Promotes sharing of beliefs/values about sensitive subject, and identifies misconceptions/myths that may interfere with adjustment to situation. (Refer to ND: Sexual dysfunction, risk for.)</p> <p>Identifies stage of grief/need for interventions.</p> <p>May need additional help to resolve feelings about loss.</p>

<p>NURSING DIAGNOSIS: Urinary Elimination, impaired/Urinary Retention [acute]</p> <p>May be related to</p> <p>Mechanical trauma, surgical manipulation, presence of local tissue edema, hematoma</p> <p>Sensory/motor impairment: nerve paralysis</p> <p>Possibly evidenced by</p> <p>Sensation of bladder fullness, urgency</p> <p>Small, frequent voiding or absence of urinary output</p> <p>Overflow incontinence</p> <p>Bladder distension</p> <p>DESIRED OUTCOMES/EVALUATION CRITERIA—PATIENT WILL:</p> <p>Urinary Elimination (NOC)</p> <p>Empty bladder regularly and completely.</p>
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ACTIONS/INTERVENTIONS	RATIONALE
<p>Urinary Elimination Management (NIC)</p> <p>Independent</p> <p>Note voiding pattern and monitor urinary output.</p> <p>Palpate bladder. Investigate reports of discomfort, fullness, inability to void.</p>	<p>May indicate urinary retention if voiding frequently in small/insufficient amounts (<100 mL).</p> <p>Perception of bladder fullness, distension of bladder above symphysis pubis indicates urinary retention.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p>Urinary Elimination Management (NIC)</p> <p>Independent</p> <p>Provide routine voiding measures, e.g., privacy, normal position, running water in sink, pouring warm water over perineum.</p> <p>Provide/encourage good perianal cleansing and catheter care (when present).</p> <p>Assess urine characteristics, noting color, clarity, odor.</p> <p>Collaborative</p> <p>Catheterize when indicated/per protocol if patient is unable to void or is uncomfortable.</p> <p>Decompress bladder slowly.</p> <p>Maintain patency of indwelling catheter; keep drainage tubing free of kinks.</p> <p>Check residual urine volume after voiding as indicated.</p>	<p>Promotes relaxation of perineal muscles and may facilitate voiding efforts.</p> <p>Promotes cleanliness, reducing risk of ascending urinary tract infection (UTI).</p> <p>Urinary retention, vaginal drainage, and possible presence of intermittent/indwelling catheter increase risk of infection, especially if patient has perineal sutures.</p> <p>Edema or interference with nerve supply may cause bladder atony/urinary retention requiring decompression of the bladder. <i>Note:</i> Indwelling urethral or suprapubic catheter may be inserted intraoperatively if complications are anticipated.</p> <p>When large amount of urine has accumulated, rapid bladder decompression releases pressure on pelvic arteries, promoting venous pooling.</p> <p>Promotes free drainage of urine, reducing risk of urinary stasis/retention and infection.</p> <p>May not be emptying bladder completely; retention of urine increases possibility for infection and is uncomfortable/painful.</p>

<p>NURSING DIAGNOSIS: Constipation/Diarrhea, risk for</p> <p>Risk factors may include</p> <p>Physical factors: abdominal surgery, with manipulation of bowel, weakening of abdominal musculature Pain/discomfort in abdomen or perineal area Changes in dietary intake</p> <p>Possibly evidenced by</p> <p>[Not applicable; presence of signs and symptoms establishes an <i>actual</i> diagnosis.]</p> <p>DESIRED OUTCOMES/EVALUATION CRITERIA—PATIENT WILL:</p> <p>Bowel Elimination (NOC)</p> <p>Display active bowel sounds/peristaltic activity. Maintain usual pattern of elimination.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p>Bowel Management (NIC)</p> <p>Independent</p> <p>Auscultate bowel sounds. Note abdominal distension, presence of nausea/vomiting.</p> <p>Assist patient with sitting on edge of bed and walking.</p> <p>Encourage adequate fluid intake, including fruit juices, when oral intake is resumed.</p> <p>Provide sitz baths.</p> <p>Collaborative</p> <p>Restrict oral intake as indicated.</p> <p>Maintain nasogastric (NG) tube, if present.</p> <p>Provide clear/full liquids and advance to solid foods as tolerated.</p> <p>Use rectal tube; apply heat to the abdomen, if appropriate.</p> <p>Administer medications, e.g., stool softeners, mineral oil, laxatives, as indicated.</p>	<p>Indicators of presence/resolution of ileus, affecting choice of interventions.</p> <p>Early ambulation helps stimulate intestinal function and return of peristalsis.</p> <p>Promotes softer stool; may aid in stimulating peristalsis.</p> <p>Promotes muscle relaxation, minimizes discomfort.</p> <p>Prevents nausea/vomiting until peristalsis returns (1–2 days).</p> <p>May be inserted in surgery to decompress stomach.</p> <p>When peristalsis begins, food and fluid intake promote resumption of normal bowel elimination.</p> <p>Promotes the passage of flatus.</p> <p>Promotes formation/passage of softer stool.</p>

<p>NURSING DIAGNOSIS: Tissue Perfusion, risk for ineffective (specify)</p> <p>Risk factors may include</p> <p>Hypovolemia</p> <p>Reduction/interruption of blood flow: pelvic congestion, postoperative tissue inflammation, venous stasis</p> <p>Intraoperative trauma or pressure on pelvic/calf vessels: lithotomy position during vaginal hysterectomy</p> <p>Possibly evidenced by</p> <p>[Not applicable; presence of signs and symptoms establishes an <i>actual</i> diagnosis.]</p> <p>DESIRED OUTCOMES/EVALUATION CRITERIA—PATIENT WILL:</p> <p>Tissue Perfusion: (Specify) (NOC)</p> <p>Demonstrate adequate perfusion, as evidenced by stable vital signs, palpable pulses, good capillary refill, usual mentation, individually adequate urinary output.</p> <p>Be free of edema, signs of thrombus formation.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p>Circulatory Care (NIC)</p> <p>Independent</p> <p>Monitor vital signs; palpate peripheral pulses, and note capillary refill; assess urinary output/characteristics. Evaluate changes in mentation.</p> <p>Inspect dressings and perineal pads, noting color, amount, and odor of drainage. Weigh pads and compare with dry weight if patient is bleeding heavily.</p> <p>Turn patient and encourage frequent coughing and deep-breathing exercises.</p> <p>Avoid high-Fowler's position and pressure under the knees or crossing of legs.</p> <p>Assist with/instruct in foot and leg exercises and ambulate as soon as able.</p> <p>Check for Homans' sign. Note erythema, swelling of extremity, or reports of sudden chest pain with dyspnea.</p>	<p>Indicators of adequacy of systemic perfusion, fluid/blood needs, and developing complications.</p> <p>Proximity of large blood vessels to operative site and/or potential for alteration of clotting mechanism (e.g., cancer) increases risk of postoperative hemorrhage.</p> <p>Prevents stasis of secretions and respiratory complications.</p> <p>Creates vascular stasis by increasing pelvic congestion and pooling of blood in the extremities, potentiating risk of thrombus formation.</p> <p>Movement enhances circulation and prevents stasis complications.</p> <p>May be indicative of development of thrombophlebitis/pulmonary embolus.</p>
<p>Collaborative</p> <p>Administer IV fluids, blood products as indicated.</p> <p>Apply antiembolus stockings.</p> <p>Assist with/encourage use of incentive spirometer.</p>	<p>Replacement of blood losses maintains circulating volume and tissue perfusion.</p> <p>Aids in venous return; reduces stasis and risk of thrombosis.</p> <p>Promotes lung expansion/minimizes atelectasis.</p>

NURSING DIAGNOSIS: Sexual dysfunction, risk for

Risk factors may include

Altered body structure/function, e.g., shortening of vaginal canal; changes in hormone levels, decreased libido
Possible change in sexual response pattern, e.g., absence of rhythmic uterine contractions during orgasm;
vaginal discomfort/pain (dyspareunia)

Possibly evidenced by

[Not applicable; presence of signs and symptoms establishes an *actual* diagnosis.]

DESIRED OUTCOMES/EVALUATION CRITERIA—PATIENT WILL:

Sexual Functioning (NOC)

Verbalize understanding of changes in sexual anatomy/function.

Discuss concerns about body image, sex role, desirability as a sexual partner with SO.

Identify satisfying/acceptable sexual practices and some alternative ways of dealing with sexual expression.

ACTIONS/INTERVENTIONS	RATIONALE
<p>Sexual Counseling (NIC)</p> <p>Independent</p> <p>Listen to comments of patient/SO.</p> <p>Assess patient's/SO's information regarding sexual anatomy/function and effects of surgical procedure.</p> <p>Identify cultural/value factors and conflicts present.</p> <p>Assist patient to be aware of/deal with stage of grieving.</p> <p>Encourage patient to share thoughts/concerns with partner.</p> <p>Problem-solve solutions to potential problems, e.g., postponing sexual intercourse when fatigued, substituting alternative means of expression, using positions that avoid pressure on abdominal incision, using vaginal lubricant.</p>	<p>Sexual concerns are often disguised as humor and/or offhand remarks.</p> <p>May have misinformation/misconceptions that can affect adjustment. Negative expectations are associated with poor overall outcome. Changes in hormone levels can affect libido and/or decrease suppleness of the vagina. Although a shortened vagina can eventually stretch, intercourse initially may be uncomfortable/painful.</p> <p>May affect return to satisfying sexual relationship.</p> <p>Acknowledging normal process of grieving for actual/perceived changes may enhance coping and facilitate resolution.</p> <p>Open communication can identify areas of agreement/problems and promote discussion and resolution.</p> <p>Helps patient return to desired/satisfying sexual activity.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p>Sexual Counseling (NIC)</p> <p>Independent</p> <p>Discuss expected physical sensations/discomforts, changes in response as appropriate to the individual.</p> <p>Collaborative</p> <p>Refer to counselor/sex therapist as needed.</p>	<p>Vaginal pain may be significant following vaginal procedure, or sensory loss may occur because of surgical trauma. Although sensory loss is usually temporary, it may take weeks/months to resolve. In addition, changes in vaginal size, altered hormone levels, and loss of sensation of rhythmic contractions of the uterus during orgasm can impair sexual satisfaction. <i>Note:</i> Many women experience few negative effects because fear of pregnancy is gone, and relief from symptoms often improves enjoyment of intercourse.</p> <p>May need additional assistance to promote a satisfactory outcome.</p>

<p>NURSING DIAGNOSIS: Knowledge, deficient [Learning Need] regarding condition, prognosis, treatment, self-care, and discharge needs</p> <p>May be related to</p> <p>Lack of exposure/recall Information misinterpretation Unfamiliarity with information resources</p> <p>Possibly evidenced by</p> <p>Questions/request for information; statement of misconception Inaccurate follow-through of instructions, development of preventable complications</p> <p>DESIRED OUTCOMES/EVALUATION CRITERIA—PATIENT WILL:</p> <p>Knowledge: Disease Process (NOC) Verbalize understanding of condition and potential complications. Identify relationship of signs/symptoms related to surgical procedure and actions to deal with them.</p> <p>Knowledge: Treatment Regimen (NOC) Verbalize understanding of therapeutic needs.</p>
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ACTIONS/INTERVENTIONS	RATIONALE
<p>Teaching: Disease Process (NIC)</p> <p>Independent</p> <p>Review effects of surgical procedure and future expectations; e.g., patient needs to know she will no longer menstruate or bear children, whether surgical menopause will occur, and the possible need for hormonal replacement.</p> <p>Discuss complexity of problems anticipated during recovery, e.g., emotional lability and expectation of feelings of depression/sadness; excessive fatigue, sleep disturbances, urinary problems.</p> <p>Discuss resumption of activity. Encourage light activities initially, with frequent rest periods and increasing activities/exercise as tolerated. Stress importance of individual response in recuperation.</p> <p>Identify individual restrictions, e.g., avoiding heavy lifting and strenuous activities (such as vacuuming, straining at stool), prolonged sitting/driving. Avoid tub baths/douching until physician allows.</p> <p>Review recommendations of resumption of sexual intercourse. (Refer to ND: Sexual dysfunction, risk for.)</p> <p>Identify dietary needs, e.g., high protein, additional iron.</p> <p>Review hormone replacement therapy (HRT).</p> <p>Encourage taking prescribed drug(s) routinely (e.g., with meals).</p>	<p>Provides knowledge base from which patient can make informed choices.</p> <p>Physical, emotional, and social factors can have a cumulative effect, which may delay recovery, especially if hysterectomy was performed because of cancer. Providing an opportunity for problem solving may facilitate the process. Patient/SO may benefit from the knowledge that a period of emotional lability is normal and expected during recovery.</p> <p>Patient can expect to feel tired when she goes home and needs to plan a gradual resumption of activities, with return to work an individual matter. Prevents excessive fatigue; conserves energy for healing/tissue regeneration. <i>Note:</i> Some studies suggest that recovery from hysterectomy (especially when oophorectomy is done) may take up to four times as long as recovery from other major surgeries (12 mo versus 3 mo).</p> <p>Strenuous activity intensifies fatigue and may delay healing. Activities that increase intra-abdominal pressure can strain surgical repairs, and prolonged sitting potentiates risk of thrombus formation. Showers are permitted, but tub baths/douching may cause vaginal or incisional infections and are a safety hazard.</p> <p>When sexual activity is cleared by the physician, it is best to resume activity easily and gently, expressing sexual feelings in other ways or using alternative coital positions.</p> <p>Facilitates healing/tissue regeneration and helps correct anemia when present.</p> <p>Total hysterectomy with bilateral salpingo-oophorectomy (surgically induced menopause) requires replacement hormones. The long-term benefits of HRT (particularly estrogen) include a decreased incidence of cardiovascular disease, protection against osteoporosis, improved mood and cognition.</p> <p>Taking hormones with meals establishes routine for taking drug and reduces potential for initial nausea.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p>Teaching: Disease Process (NIC)</p> <p>Independent</p> <p>Discuss potential side effects, e.g., weight gain, increased skin pigmentation or acne, breast tenderness, headaches, photosensitivity.</p> <p>Recommend cessation of smoking when receiving estrogen therapy.</p> <p>Review incisional care when appropriate.</p> <p>Stress importance of follow-up care.</p> <p>Identify signs/symptoms requiring medical evaluation, e.g., fever/chills, change in character of vaginal/wound drainage; bright bleeding.</p>	<p>Development of some side effects is expected but may require problem solving such as change in dosage or use of sunscreen.</p> <p>Some studies suggest an increased risk of thrombophlebitis, myocardial infarction (MI), cerebrovascular accident (CVA), and pulmonary emboli associated with smoking and concurrent estrogen therapy.</p> <p>Facilitates competent self-care, promoting independence.</p> <p>Provides opportunity to ask questions, clear up misunderstandings, and detect developing complications.</p> <p>Early recognition and treatment of developing complications such as infection/hemorrhage may prevent life-threatening situations. <i>Note:</i> Hemorrhage may occur as late as 2 wk postoperatively.</p>

POTENTIAL CONSIDERATIONS following acute hospitalization (dependent on patient's age, physical condition/presence of complications, personal resources, and life responsibilities)

In addition to surgical and cancer concerns (if appropriate):

Sexual dysfunction—altered body structure/function; changes in hormone levels, decreased libido; possible change in sexual response pattern; vaginal discomfort/pain (dyspareunia).

Self-Esteem, situational low—concerns about inability to have children, changes in femininity, effect on sexual relationship; religious conflicts.