

Nursing Compendium: Hysterectomy

ABIDE BALLI

Alliance University

NUR 493 C

Professor Grace Samuel

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Healthcare is highly dynamic. Emerging healthcare trends and illnesses require innovative treatment methods to make medical interventions more efficient and effective in promoting patient safety and better health outcomes. Hysterectomy is among the most controversial medical procedures in health. A hysterectomy is a medical procedure for removing the uterus via an incision in the abdominal wall. However, after undergoing a hysterectomy, the patient can no longer become pregnant, and those who have not gone through menopause can never have periods again, regardless of their age. Various studies have examined hysterectomy and provided extensive information regarding its effectiveness in healthcare practice. This paper is a literature review on hysterectomy to determine how different researchers perceive it in healthcare and provide future recommendations for using hysterectomy in healthcare practice.

Patient Assessment and Interventions

Patient SS is a 69 years old female diagnosed with Mild Persistent Hernia after undergoing a hysterectomy. Her family history includes her father with bladder cancer and congestive heart failure (CHF), her sister having Type 2 Diabetes, and her mother having hypertension. The patient was given Midazolam injection 2 mg IV, Fentanyl 100 mcg IV, Dexamethasone injection 4 mg/ML IV, Acetaminophen injection 1000mcg IV, and Cefazolin injection 1g IV. The assessment revealed that patient SS indicates vital signs of body temperature of 98.4°F and blood pressure of 145/64. The patient's pulse rate is 68, respiration is 15, and Oxygen saturation 95 %, with a pain scale of 5. The laboratory test results of patient SS indicate blood in the urine (trace), BUN / Creatinine 22.5, AST 30, ALT 22, Protein 7.1, WBC 6.2, RBC 4.5, Lymphocytes 14.8, PTT 10.7, and INR 29. Upon assessment, SS lungs sounds clear bilaterally without adventurous sounds, heart sounds S1S2 symmetrical and regular, pedal pulse

strong and regular and no edema on extremities, incision site skin is dry and intact, no tenderness around the area. Some of the interventions include monitoring vital signs every 15 minutes, monitoring urine output, performing neuro assessments, assess for pain, provide comfort measures, encouraging deep breathing using incentive spirometer, providing warm blankets to avoid hypothermia, assessing for nausea, vomiting, and respiration not less than 10. These interventions were done so that our patient display core temperature within normal range upon discharge and be able to identify signs and symptoms of infection to report to the provider upon discharge.

Literature Review

National Health Service (2022) defines hysterectomy as the surgical procedure for removing the uterus. After undergoing the procedure, the patient can no longer become pregnant. Moreover, for persons who have not undergone menopause, a hysterectomy can prevent them from having periods regardless of age. National Health Service (2022) reports that hysterectomy is highly common for women between 40 and 50 years old. Hysterectomy is a surgical procedure for treating health problems affecting the female reproductive system, such as long-term pelvic pain, heavy periods, fibroids, womb cancer, ovarian cancer, cancer of the fallopian tube, or cervical cancer. National Health Service (2022) recognizes that a hysterectomy is a primary operation with a long recovery period and is usually considered after less invasive treatments have failed to yield better health outcomes.

Bossick et al. (2018) describe hysterectomy as the most common no obstetric surgical procedure among women in the United States. However, the author reports that despite the high rates of hysterectomies in the United States, no evidence-based guidelines for clinical care regarding patient-centered outcomes exist. Therefore, Bossick et al. (2018) suggest that a

hysterectomy is a highly controversial clinical procedure. The existing guidelines on hysterectomy include clinical factors like length of hospital stay, blood loss, and complications, which do not include patient concerns (Bossick et al., 2018). According to Bossick et al. (2018), despite hysterectomy using standardized quality-of-life measures, the approach does not facilitate the development of guidelines related to patient-centered outcomes. Besides, Bossick et al. (2018) report that the recovery period post-surgery requires women to change their daily activities, while some women experience complications like a hernia.

Kwon et al. (2022) conducted a case report of a 47-year-old woman with a history of several abdominal surgeries. The patient had a small bowel hernia following an anterior abdominal wall peritoneal defect (Kwon et al., 2022). Kwon et al. (2022) recognize that hysterectomy is associated with low rates of hernia formations and low mortality rates. Hernia in hysterectomy usually occurs if the surgeons fail to close the peritoneum via a surgical approach. Inflammation following hysterectomy and multiple surgeries are the primary contributors to herniation following surgery. As a result, nurses must thoroughly assess the surgical site to prevent patients from developing an infection after a hysterectomy.

Panda et al. (2022) conducted an observational study to analyze hysterectomy's different routes of hysterectomy and complications. The decision tree of the study is based on uterine size, pelvic pathology, pelvic adhesion, vaginal access, patient choice, surgeon competency, and complication of the various routes of hysterectomy (Panda et al., 2022). The researchers collected data from preoperative, intraoperative, and postoperative records. Panda et al. (2022) state that hysterectomy is widely applied in treating many gynecologic conditions. According to Panda et al. (2022), the surgical procedure of hysterectomy is the most significant factor that causes postoperative complications. For instance, postoperative fever is highly common

following abdominal hysterectomy than in vaginal and laparoscopic hysterectomy. Generally, a hysterectomy may lead to complications like hernia that may require further medical attention.

Madhvani et al. (2022) report that most surgeons undertaking hysterectomies recognize patient characteristics that can cause complexity and complications following surgery. Madhvani et al. (2022) state that race, older age, diabetes mellitus, raised body mass index (BMI) fibroids, increased uterine weight, adhesions, and endometriosis are predictors of complications among patients undergoing hysterectomy for mild conditions. As a result, patients should be given information on the potential risks before undergoing a hysterectomy to manage their expectations. Patient education is usually necessary if surgery is an option for a mild condition since nonsurgical alternatives are usually available (Madhvani et al., 2022). According to Madhvani et al. (2022), abdominal hysterectomy has a higher chance of complication than laparoscopic hysterectomy. Hence, individuals considering a hysterectomy should understand the risks following the procedure before undergoing surgery.

Recommendation for Best Evidence-Based Practice in Hysterectomy

Hysterectomy needs standardized postoperative pain management in early postoperative stages. However, Lirk et al. (2019) discourage using analgesic interventions for pain management during the postoperative period due to a balance between their efficacy and potential risks. Postoperative pain management in hysterectomy should include a non-steroidal anti-inflammatory drug (NSAID) and acetaminophen continued into the postoperative period because they can minimize opioid use. Dexamethasone can act as an antiemetic and reduce analgesic use (Lirk et al., 2019). Filson et al. (2018) recommends taking postoperative vital signs to detect deviations early. Nurses should take the vitals every 15 minutes for 30 minutes during admission, 1.5 hours after admission, 4 hours post-admission, and then every 4 hours for 20

hours (Filson et al., 2018). Taking vital signs facilitates early interventions to prevent deviations postoperatively.

Unintended perioperative hypothermia (UPH) is common in surgical patients who are not warmed and is associated with increased morbidity and mortality. Therefore, the best evidence-based practice to prevent UPH in postoperative patients, according to Hart et al. (2011), is to monitor body temperature and conduct passive and active warming measures. Hart et al. (2011) report that warming measures are vital in preventing complications of UPH that may include delayed wound healing, surgical site infection, increased bleeding, and adverse myocardial outcome. According to Hart et al. (2011), a uniform application of evidence-based perioperative warming measures effectively reduces adverse outcomes and enhances patient satisfaction. Hence, temperature monitoring is an evidence-based way of preventing UPH in postoperative patients.

Conclusion

Emerging healthcare trends and illnesses require innovative treatment methods to make medical interventions more efficient and effective in promoting patient safety and better health outcomes. Hysterectomy is among the most controversial medical procedures in healthcare. Most American women undergo hysterectomy despite the procedure having numerous complications. For instance, the patient developed Mild Persistent Hernia after undergoing a hysterectomy. The literature review explores various studies about hysterectomy and its complications. Despite the high rates of hysterectomy in the United States, no evidence-based guidelines for clinical care regarding patient-centered outcomes exist. Therefore, nurses should educate patients on signs and symptoms to report immediately to the health care provider.

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