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Case report

Success of Medically Necessary Bilateral Salpingo-Oophorectomy without Uterine Manipulator or Urinary Catheter

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Abstract

A report of a young adult, transgender male patient who underwent removal of both ovaries and fallopian tubes, medically known as bilateral salpingo-oophorectomy. The procedure was effectively performed without the use of a uterine manipulator or urinary catheter using laparoscopic surgical techniques. These invasive and often humiliating instruments were easily avoided without impacting the risk of complication. Both the skill of the surgeon and intent preparation of the patient made this a successful procedure.

Keywords: Case report; Gynaecology; Key-hole; Laparoscopic; Minimally invasive surgery; Oophorectomy

Introduction

Urinary catheters [1-4] and uterine manipulators [5-9] have been documented to be "essential" instruments in performing pelvic surgical procedures. Laparoscopic surgeons are routinely balancing out the risks of these surgeries and their patients' preferences [10]. Although the absence of uterine manipulators and urinary catheters are not entirely novel [4,11-13], the currently available material either lacks details on the exact necessity of these instruments or the information is unknown, divided, obscure, or utterly false. Patients with gender dysphoria [14], young girls [15,16] sexual assault victims [17-19] or psychologically sensitive individuals [20] have the right to be treated in the least traumatic and most dignified way possible. This paper documents one of many successful clinical cases where a pelvic operation was performed without any insertion of a urinary catheter or uterine manipulator in the genital region.

Patient Background

Overview & Symptoms 24 year old transgender male suffering from painful periods from a young age (since 12 years old). Has been taking testosterone Hormone Replacement Therapy since 17 years of age where periods ceased. HRT was paused for 6 months in Jan-Jul 2018 (20 years old). Menstruation returned as expected. HRT was recommenced and patient has since been on continuous testosterone treatment for 4 years. Periods however never ceased and have been heavy, painful but regular. Having no future desire for pregnancy, patient has been seeking a surgical solution since 20 years of age.
Diet & Lifestyle Vegan, gluten-free, exercises regularly.
Physical Health BMI in healthy range (20.3). Has had no previous surgeries or other known co-existing physical health problems. History of low iron (either due to heavy periods or diet - undetermined).
Mental Health Diagnosed high-functioning autism[1], psychologically sensitive but generally mentally healthy.
Previous Treatments First-line ineffective treatments from past specialists included tranexamic acid, ibuprofen and progestin (Visanne®) [21]. Intrauterine Devices (IUD) were also suggested. Estrogen based birth control were also deemed unsuitable due to impacting on the patient's HRT. A surgical intervention was concluded to be the most pertinent option resulting in a permanent solution.
Diagnostics Previous pelvic ultrasound from 10th December 2020 had shown no abnormalities (Figure 1).
Prognosis Endometriosis was likely to be expected.

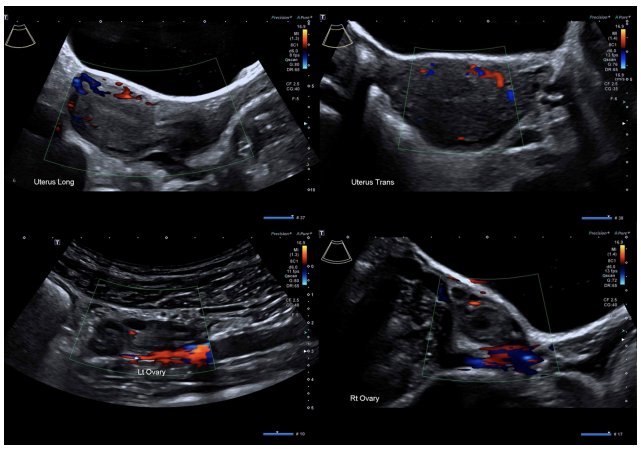

Figure 1: Ultrasound of the Pelvis from December 2020.

Historical Blood Results

Compiled is a table with all previous blood test results regarding hormone levels, in chronological comparison with HRT used and whether periods were occurring at the time (Table 1).

[1] Autistic individuals are known to be psychologically sensitive.

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Time	HRT	Period	E	T
Jul 2015		—	160	1.5
Aug 2015		—		
Sep 2015		—		
Oct 2015		—		
Nov 2015		—		
Dec 2015		—		
Jan 2016		—		45.9
Feb 2016		—		
Mar 2016				
Apr 2016				
May 2016				40.6
Jun 2016				
Jul 2016				
Aug 2016				
Sep 2016				
Oct 2016				
Nov 2016	Sustanon®			
Dec 2016	Black Market			
Jan 2017	250mg/1mL			
Feb 2017				
Mar 2017				
Apr 2017				
May 2017				
Jun 2017				
Jul 2017				
Aug 2017				
Sep 2017				
Oct 2017				
Nov 2017				
Dec 2017				
Jan 2018				
Feb 2018		—		
Mar 2018		—		
Apr 2018		—		
May 2018		—		
Jun 2018		—		
Jul 2018		—		
Aug 2018		—		
Sep 2018		—		
Oct 2018		—		
Nov 2018	Sustanon®	—		
Dec 2018	Black Market	—		
Jan 2019	250mg/1mL	—	129	5.3
Feb 2019		—		
Mar 2019		—		
Apr 2019		—		
May 2019		—		
Jun 2019		—	611	6.3
Jul 2019		—		
Aug 2019	Reandron®	—		
Sep 2019	GP Prescribed	—		
Oct 2019	1000mg/4mL	—	589	3.6
Nov 2019		—	564	4.1
Dec 2019		—		
Jan 2020		—	123	47.0
Feb 2020		—		
Mar 2020		—		
Apr 2020		—		
May 2020		—		
Jun 2020		—		
Jul 2020		—		
Aug 2020		—		
Sep 2020		—		
Oct 2020		—		
Nov 2020		—		
Dec 2020		—	404	200.0
Jan 2021		—		
Feb 2021		—		
Mar 2021	Testavan®	—		
Apr 2021	GP Prescribed	—	456	14.3
May 2021	23mg/1.25mL	—	502	16.0
Jun 2021		—	652	57.0
Jul 2021		—		
Aug 2021		—		
Sep 2021		—		
Oct 2021		—		
Nov 2021		—		
Dec 2021		—		
Jan 2022		—		
Feb 2022		—		
Mar 2022		—	159	1.9
Apr 2022		—		
May 2022		—		
Jun 2022		—		

Table1: Hormone Levels & Periods

Reproductive hormone levels were tested on the Siemens diagnostic immunoassay from various Australian pathology providers [22- 24]. Reference intervals supplied by these laboratories for an adult male are listed (Table 2).

Hormone	Min.	Max.	Unit
Oestradiol	0	190	pmol/L
Testosterone	11.5	32.0	nmol/L

Table 2: Estrogen & Testosterone Male Ranges

The patient's values with hormone ranges are visualised (Figure 2).

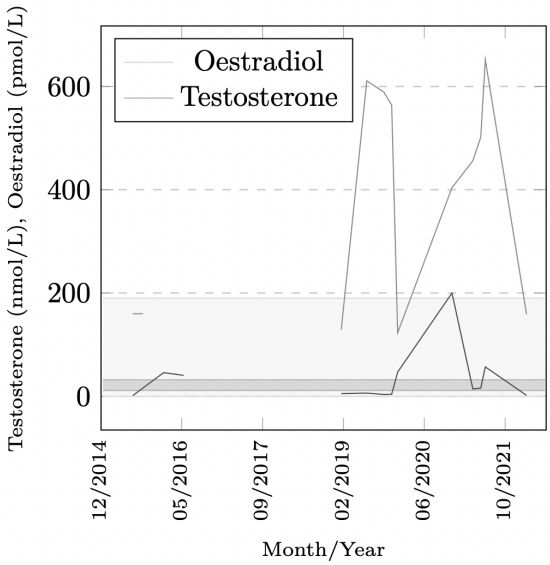

Figure 2: Estrogen & Testosterone Graph

The recorded values between Jan 2019 to Mar 2022 show unstable and extreme spikes in both reproductive hormones. This was likely due to a conversion of excess testosterone and a competing production of estrogen from the ovaries. Transgender patients are known to have difficulty finding the optimal amount of HRT for their bodies [25].

Procedure

The removal of at least estrogen producing organs – both ovaries, was expected to solve the cessation of periods and prevent production of estrogen which the testosterone was not suppressing. Also advised was removing the fallopian tubes to reduce future risk of cancer development [26].

Bilateral Salpingo-Oophorectomy

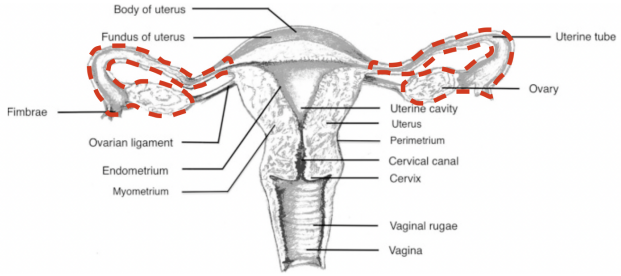

Figure 3: The removal of both ovaries and fallopian tubes.

A full hysterectomy was suggested but would mean a longer healing time and a slightly more complex surgery. Both the surgeon and patient agreed that laparoscopic removal of ovaries along with the fallopian tubes would be the most minimally invasive treatment option – a procedure medically known as bilateral salpingo-oophorectomy.
Preferences No urinary catheter, no uterine manipulator, no overnight hospital stay [27].
Risks Modern day pelvic surgical operations carry low risk of complications [28]. For this patient's age, health, condition and the surgeon's experience, the risks involved in performing such procedure were basically zero. Two studies cited earlier each report back on a large number of pelvic operations that were successfully performed without a uterine manipulator. A. Kavallaris, et. al. reported on 67 total laparoscopic hysterectomies between 2008-2009 without any uterine manipulation having zero complications [12]. While D. Zygouris, et. al. reported on 1023 cases between 2011-2020 of the exact same procedure having zero conversions of laparoscopy to laparotomy [13]. After two appointments with the surgeon, the patient felt confident in the procedure and went ahead with scheduling an operation date on Friday 17th June 2022. The consent form was concisely filled out as attached in the appendices.

Cost Estimate

Residing in New South Wales, Australia the patient had the option to select to undertake the procedure in a public or private hospital [29]. Public route meant being on a waitlist for one year and having the costs covered by the Australian government Medicare system. While private route meant a shorter wait period (about 1-2 months) and fees were the responsibility of the patient or a private health insurer. The patient weighed out the benefits of both routes and selected the private hospital as a self-funded patient. Entire costs of appointments, procedure fees, anaesthesia, hospital facilities and pharmaceuticals including all Medicare rebates in 2022 [30] are listed (Table 3).

Date	#	Item	Cost
2022 Apr 13	00104	Initial Appointment	-$300
2022 Apr 13	00104	Medicare Rebate	+$76.80
2022 Apr 26	35631	Operative Laparoscopy	-$2351.25
2022 Apr 26	51303	Assistance at Operation	-$426.75
2022 May 16	-	Anaesthesia	-$1820
2022 Jun 02	00105	Subsequent Appointment	-$180
2022 Jun 02	00105	Medicare Rebate	+$38.60
2022 Jun 03	-	Hospital Procedure Fee	-$2909
2022 Jun 03	-	Hospital Day Accommodation	-$778
2022 Jun 03	-	Hospital Pharmacy	-$50
2022 Jun 17	-	Hospital Rapid Antigen Test	-$14.30
2022 Jun 17	-	Hospital Painkillers	-$11
2022 Jun 23	35631	Medicare Rebate	+$555.30
2022 Jun 27	72824	Tissue Pathology	-$390
2022 Jun 27	73924	Pathology Collection/Handling	-$36
2022 Jul 18	17610	Medicare Rebate	+$34.05
2022 Jul 18	20806	Medicare Rebate	+$108.15
2022 Jul 18	23075	Medicare Rebate	+$108.15
2022 Jul 19	-	Anaesthesia Refund	+$364
2022 Jul 28	00105	Subsequent Appointment	$0
2022 Jul 28	55065	Pelvic Ultrasound	$0
2022 Aug 26	-	Hospital Balance Refund	+$136
Total (AUD)			-$7845.25

Table 3: Total Cost of Pelvic Operation in 2022

Preparation

A pre-operative appointment on Thursday 2nd June 2022 finalised and confirmed all details of the surgical procedure. Starting Tuesday 14th June 2022, the patient began clearing his bowels by fasting 3 days prior along with taking PicoPrep® laxative solution the night before operation.

Tuesday 14 June 2022
9:00am Started fasting from solid food. Low calorie consumption, clear liquids such as electrolytes, water and tea.
Wednesday 15 June 2022
9:00am Continued fasting with liquid consumption only.
Thursday 16 June 2022
9:00am Continued fasting with liquid consumption only.
6:00pm PicoPrep® laxative solution.
8:00pm Stopped all liquid consumption.
Friday 17 June 2022
5:00am Shower, comfortable clothes.
5:30am Paused medication (Testavan® gel).
6:00am Arrived at hospital. Checked-in.
6:30am COVID-19 Rapid Antigen Test (negative).
6:40am Admitted. Changed into surgical gown.
6:50am Vitals checked. Emptied bladder.
7:00am Pregnancy test (negative).
7:15am Pre-anaesthesia consultation.
7:25am Ultrasound of bladder to confirm emptiness.
7:30am Patient placed on operating table.
7:32am Anaesthesia administered.
7:35am Operation commenced.

Operation

A lead surgeon, assistant surgeon and anaesthetist were present along with nurses/technicians.
7:35am Patient placed in supine position. Lower abdomen draped and prepared for surgical incisions.

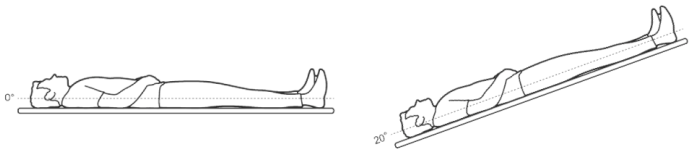

Figure 4: Supine vs. Trendelenburg

7:45am Hasson entry made by inserting a 10/12mm port at the umbilicus then three 5mm ports at the LLQ, RLQ and suprapubic abdominal regions.

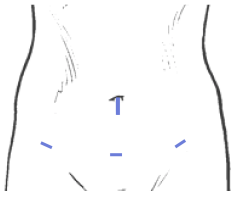

Figure 5: Laparoscopic Port Incisions

Pneumoperitoneum is achieved at an intra-abdominal pressure of 12 to 15 mm Hg.

8:00am Systematic inspection of pelvis conducted. Uterus, ovaries and fallopian tubes appeared normal. Appendix, liver and sub-diaphragmatic surfaces also normal. Uterus was propped up by the assistant with forceps through the suprapubic port (Figure 6).

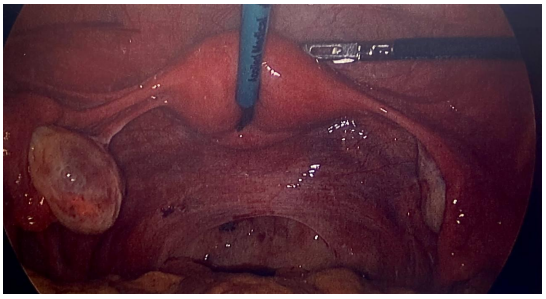

Figure 6: Before Bilateral Salpingo-Oophorectomy

8:10am Two gunpowder patches consistent with endometriosis identified on left pelvic side wall and in Pouch of Douglas (Figure 7). Both excised and sent for histopathology.

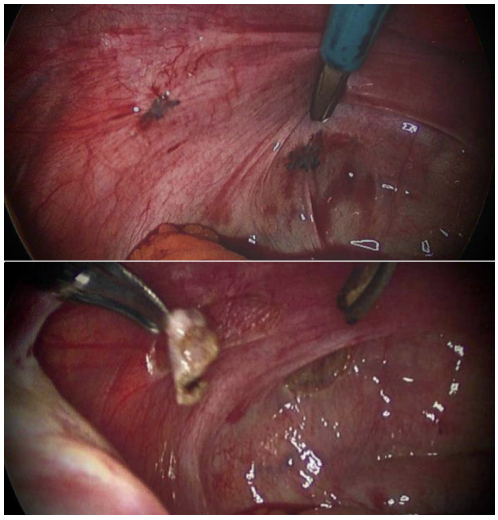

Figure 7: Endometriosis

8:15am Bilateral salpingo-oophorectomy commenced. Ovarian ligaments and infundibulo-pelvic ligaments cauterised and transected. Base of fallopian tubes with ovaries attached were separated from uterus.
8:35am Tissue delivered with EndoCatch™ via umbilicus port. Bilateral salpingo-oophorectomy complete (Figure 8).

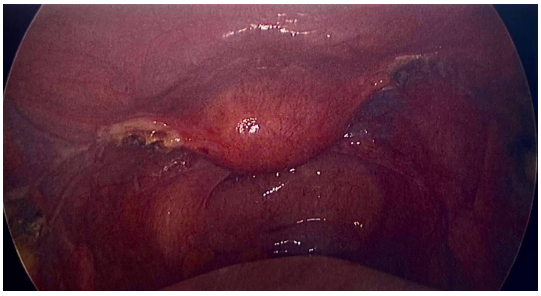

Figure 8: After Bilateral Salpingo-Oophorectomy

8:40am Peritoneal lavaged and haemostasis secured.
8:45am Trocars removed. Incisions closed with polydioxanone and Vicryl Rapide™ absorbable sutures. Marcaine with 1% adrenaline infiltrated into skin wounds. Lastly bandaged with waterproof Comfeel® dressings.
8:55am Anaesthesia stopped. Tissue sent to pathology.

Recovery

9:20am Patient went into shock upon waking up. Fentanyl was administered. Monitored in recovery unit.
10:30am Patient stabilised then moved to ward/room.
10:40am Rested further.
11:20am Awake and conscious. Reported pain from pressure in abdomen from insufflation. Wounds were normal.
1:00pm Lunch. Eating food as usual. Struggled sitting upright with abdominal pain and internal pressure. Nurse applied hot pack to ease internal pressure and assist in dissolving excess CO2. Effective after further resting.
2:30pm Up and walking. Changed clothes. Bathroom use normal. No significant pain, mild abdominal pressure.
3:00pm Post-operative surgeon visit. Debrief on findings and checked on wellbeing. All-clear to be discharged with after-care instructions and pain medication.
3:50pm Discharged home.
4:00pm Tapentadol IR 50mg (Palexia® IR) 4 day course dispensed from hospital pharmacy.

Post-Operative Instructions No heavy lifting or straining for 3-6 weeks. Leave waterproof wound dressings on for 7-10 days. Sutures will dissolve on their own. Shower as usual. Normal diet as tolerated starting with light meals and slowly building up. Natural laxatives such as psyllium husk to be used for assisting gentle bowel movements. Stay hydrated and empty bladder regularly to avoid over-distension. Time off physical work is 4 weeks while studies can be returned to within few days. Monitor for any abnormal bleeding. Continue Hormone Replacement Therapy as usual (Testavan® gel). Request GP blood tests to confirm healthy hormone levels and adjust if necessary. Follow up appointment with surgeon at 4-6 week mark.

Surgical Dressings

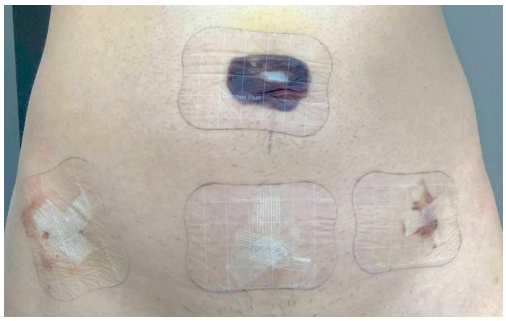

Figure 9: Post-Operative Bandages

Saturday 18 June 2022 Bed rest and sleeping at home.
Sunday 19 June 2022 Eating, drinking, resting at home.
Monday 20 June 2022 Mild walking, resting at home.
Tuesday 21 June 2022 Driving, walking, resting.

Pathology Results

Histopathology was reported on 21st June 2022. Macroscopic examination noted multiple small benign cysts having a maximum diameter of 6-8mm present on both ovaries and fallopian tubes. Microscopic examination of the ovaries and fallopian tubes appeared normal with no endometriosis being identified. A small benign paratubal serous cyst was identified on the right ovarian specimen. Both peritoneal biopsies had endometriosis, minor adhesions and chronic inflammation. No further concerns.

Initial Scars

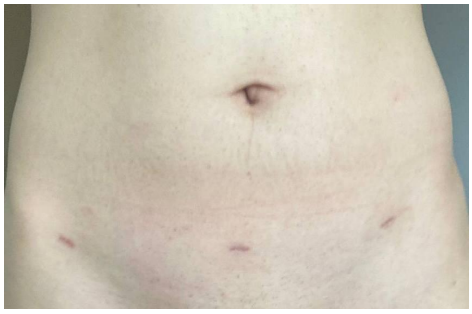

Figure 10: Scars on 11 July 2022

Despite the blood soaked bandages after operation, the scars revealed to be very minimal in comparison (Figure 10).

Follow Up

A follow up appointment with the surgeon on Thursday 28th 2022 checked on the general condition and healing of the operative procedure. The removal of ovaries had succeeded in stopping the menstrual cycle. A quick pelvic ultrasound was conducted showing no abnormalities. Both surgeon and patient were satisfied with the outcome of the procedure. Hormone levels were to be monitored over the next few months.

New Blood Results

New hormone levels from 5th August 2022 are graphed (Figure 11).

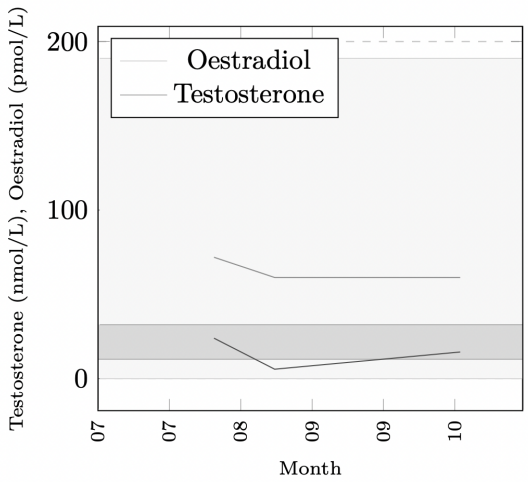

Figure 11: New Estrogen & Testosterone Graph

Estrogen levels are consistently within range, while testosterone on 22nd August 2022 fell slightly below recommended laboratory minimum. The general practitioner advised patient to increase his daily Testavan® gel dosage to 69mg (3 actuations) to increase the levels. Hormone values from 13th October 2022 are since within range.

Conclusion

A successful bilteral salpingo-oophorectomy was performed without a uterine manipulator or urinary catherisation. The intended outcome was to cease the menstrual cycle and stablise reproductive hormonal levels typical for an adult male. The surgery was deemed medically necessary due to the patient's prior heavy and painful menses which during the operation was found to be a cause of endometriosis. The treatment also resulted in gender affirming aspects for the transgender patient but was a secondary feature. Some improvements to the process are suggested such as fasting few days prior to surgery without the PicoPrep® laxative solution. Another suggestion is replacing the post-operative opioid painkillers to a medicinal cannabis oil such as Althea™ CBD10:THC5 [31]. The patient reports medicinal cannabis to be a more effective pain relief with a milder comedown period [32]. Overall the experience has been a great success due to the patient's preparation and an experienced surgeon.

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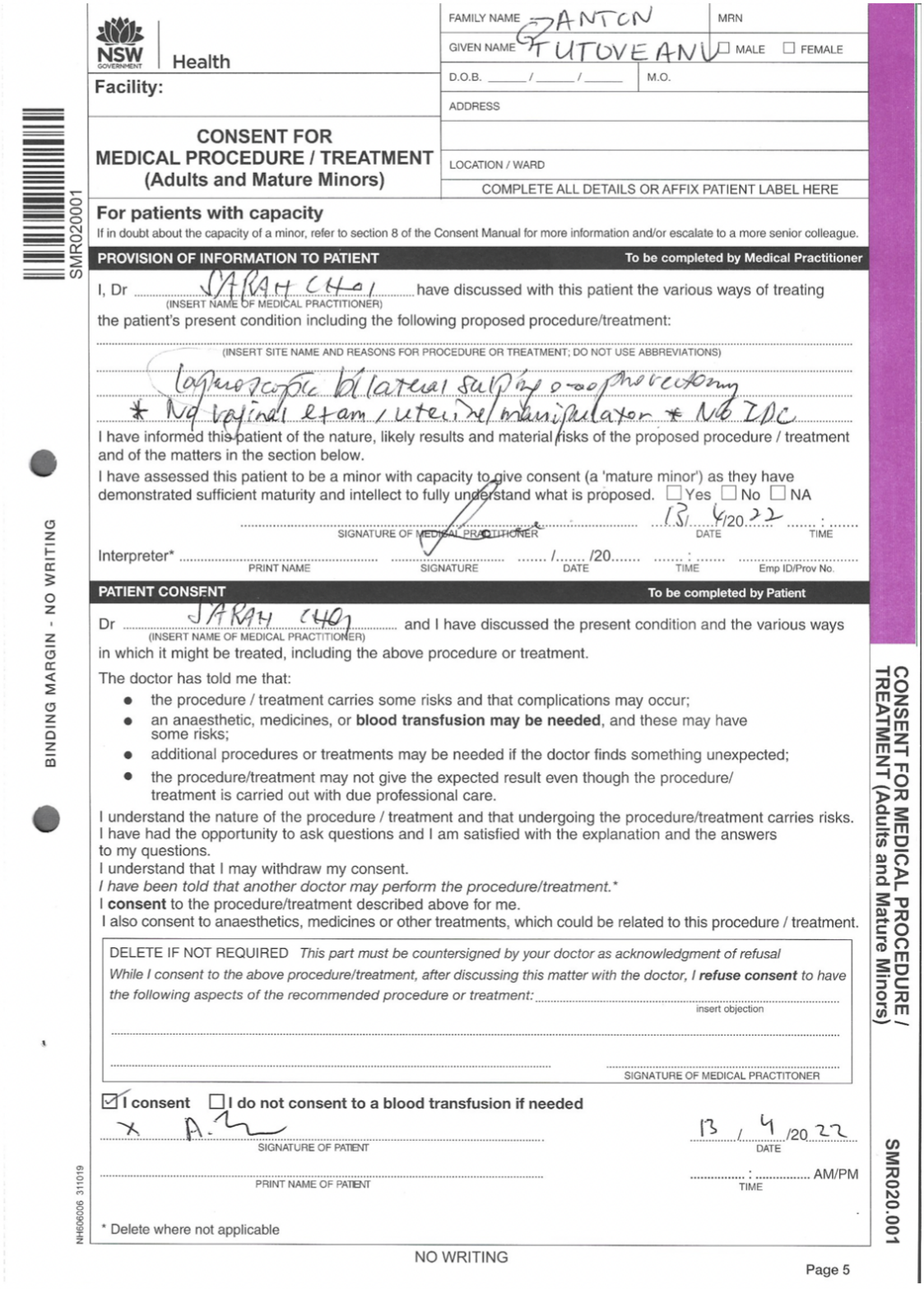
Appendix A - Consent Form (Public Hospital)



NSW GOVERNMENT Health

Facility:

FAMILY NAME ANTON | MRN

GIVEN NAME TUTOVEANU ☐ MALE ☐ FEMALE

D.O.B. _____ / _____ / _____ M.O.

ADDRESS

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

SMR020001

CONSENT FOR MEDICAL PROCEDURE / TREATMENT (Adults and Mature Minors)

For patients with capacity

If in doubt about the capacity of a minor, refer to section 8 of the Consent Manual for more information and/or escalate to a more senior colleague.

PROVISION OF INFORMATION TO PATIENT — To be completed by Medical Practitioner

I, Dr SARAH CHOI (INSERT NAME OF MEDICAL PRACTITIONER) have discussed with this patient the various ways of treating the patient's present condition including the following proposed procedure/treatment:

(INSERT SITE NAME AND REASONS FOR PROCEDURE OR TREATMENT; DO NOT USE ABBREVIATIONS)

laparoscopic bilateral salpingo-oophorectomy

* No vaginal exam / uterine manipulator * No IDC

I have informed this patient of the nature, likely results and material risks of the proposed procedure / treatment and of the matters in the section below.

I have assessed this patient to be a minor with capacity to give consent (a 'mature minor') as they have demonstrated sufficient maturity and intellect to fully understand what is proposed. ☐ Yes ☐ No ☐ NA

SIGNATURE OF MEDICAL PRACTITIONER 13/4/2022 DATE TIME

Interpreter* PRINT NAME SIGNATURE /20 DATE : TIME Emp ID/Prov No.

PATIENT CONSENT — To be completed by Patient

Dr SARAH CHOI (INSERT NAME OF MEDICAL PRACTITIONER) and I have discussed the present condition and the various ways in which it might be treated, including the above procedure or treatment.

The doctor has told me that:

- the procedure / treatment carries some risks and that complications may occur;
- an anaesthetic, medicines, or **blood transfusion may be needed**, and these may have some risks;
- additional procedures or treatments may be needed if the doctor finds something unexpected;
- the procedure/treatment may not give the expected result even though the procedure/ treatment is carried out with due professional care.

I understand the nature of the procedure / treatment and that undergoing the procedure/treatment carries risks.
I have had the opportunity to ask questions and I am satisfied with the explanation and the answers to my questions.
I understand that I may withdraw my consent.
*I have been told that another doctor may perform the procedure/treatment.**
I **consent** to the procedure/treatment described above for me.
I also consent to anaesthetics, medicines or other treatments, which could be related to this procedure / treatment.

DELETE IF NOT REQUIRED *This part must be countersigned by your doctor as acknowledgment of refusal*
While I consent to the above procedure/treatment, after discussing this matter with the doctor, I ***refuse consent*** *to have the following aspects of the recommended procedure or treatment:* ..... insert objection

SIGNATURE OF MEDICAL PRACTITONER

☑ **I consent** ☐ **I do not consent to a blood transfusion if needed**

X A. SIGNATURE OF PATIENT 13 / 4 /2022 DATE

PRINT NAME OF PATIENT : AM/PM TIME

* Delete where not applicable

NH606006 311019

NO WRITING

Page 5

BINDING MARGIN - NO WRITING

CONSENT FOR MEDICAL PROCEDURE / TREATMENT (Adults and Mature Minors) SMR020.001

J Reprod Med Gynecol Obstet ISSN: 2574-2574, Open Access Journal
DOI: 10.24966/RMGO-2574/100126

Appendix B - Consent Form (Private Hospital)

RAMSAY HEALTH CARE

CONSENT FOR TREATMENT

PLEASE PRINT

Patient Name: TUTOVEANU, ANTON DOB: 21/12/97

Insert patient label

Admission Date (Required): 17/6/22 Procedure Date: (Required): 17/6/22

Treating Accredited Practitioner: SARAH CHOI

Referring General Practitioner: VISWANATHAN MAHADEV (optional)

PART A to be completed by the TREATING RAMSAY HEALTH CARE ACCREDITED PRACTITIONER

I have informed Mr. Anton Tutoveanu and / or ..... / .....

Print name of patient *Guardian / Person responsible (if applicable)* *Relationship (father, mother / wife etc)*

of his / her present condition, alternative treatments available and have explained the nature, purpose, likely results and the material risks of the following recommended operation / procedure(s).

Procedure / Reason for Admission: *(Please print)*

laparoscopic bilateral salpingo-oophorectomy

(No) Avoid bladder catheterization.

- Procedure site no uterine manipulator / vaginal access
- Procedure side of body: Right ☐ Left ☐ Not Applicable ☐

☐ Patient does ***NOT*** consent to having a blood or blood products transfusion.

☐ Interpreter used: Name of RHC accredited Interpreter: ..... *(Please print)* Language: .....

Sight Translated ☐ (NSW) Verbally Interpreted ☐ (NSW)

Treating RHC Accredited Practitioner / Doctor

Signature	Print Name	Date
	SARAH CHOI	21/6/2022

PART B to be completed by the PATIENT / Person Responsible

I acknowledge that:

Doctor Sarah Choi and I have discussed the teatment of my / patients condition

Print name of Treating RHC Accredited Practitioner / Doctor

- I have consented to the Operation / Procedure as described above.
- Ramsay employees / contractors will administer care / treatment under my treating Doctors direction, or in an emergency, medical and nursing care will also be delivered as required.
- I understand the explanation the Doctor gave me as to the need, benefits, risks and complications related to this admission / operation / procedure(s) as discussed by my Doctor above.
- I have had the opportunity to ask questions and these have been answered in a way I understand by my Doctor above.
- I have read / seen / heard and understand the following where applicable.

☒ Information sheet(s) laparoscopy

Name of information sheet(s)

☐ Multimedia presentation(s) .....

Name of multimedia presentation(s)

Where applicable which explains the operation / procedure(s) and the risks involved.

- I am able to withdraw this consent in writing at anytime prior to the commencement of treatment / procedures.

Patient / Responsible person(s) Signature	Date
	2/6/2022

Print name of patient / person responsible	If person responsible signs, state relationship to patient eg; mother / father / husband

CONSENT FOR TREATMENT

10