NHS
Gloucestershire Hospitals
NHS Foundation Trust

Patient Information

Interval Debulking Surgery

Introduction

This leaflet gives you information about Interval Debulking Surgery (IDS) for ovarian cancer and answers some of the commonly asked questions.

What is IDS?

Debulking is a type of abdominal surgery with the goal to remove as much cancerous tissue from a patient's abdomen as possible. Some tumours may be completely removed; others are just reduced in size.

During this operation your surgeon will make a cut on your abdomen. This can be from the top of your abdomen down to your pelvis. This type of surgery allows the surgeon to explore the pelvic and abdominal area for cancer and remove any tumor masses.

During the operation, the surgeon will also remove your uterus (womb), cervix, ovaries, fallopian tubes and omentum (fatty lining of abdomen). The surgeon may also need to remove other organs such as your spleen, lining of the diaphragm (muscle dividing chest and abdominal cavity) and part of your bowel which may require a stoma.

Why am I having IDS?

Common reasons for IDS are to remove or reduce the size of cancerous tissues. This aims to improve patient survival rates and the effectiveness of chemotherapy treatment.

Will I need a stoma?

It may be necessary to have a stoma to divert stools (poo) away from the surgical join in the bowel until it heals. If this is the case, part of the bowel would be brought out onto the surface of your abdominal wall. Stools are then passed through the stoma and collected in a bag.

Reference No.
GHPI1564_06_23
Department
Gynaecology
Review due
June 2026

Before your operation, a stoma nurse will mark your abdomen with a skin marker pen (known as siting). This is to guide your surgeon to the best possible place to bring out the stoma if it is necessary. Your stoma nurse will also discuss with you, in more detail, what having a stoma will involve and answer any questions that you may have.

Before surgery

You should carry on taking your usual medications, unless told otherwise. We strongly advise that you stop smoking before your surgery. If you develop an illness before your surgery date or have any questions, please contact your consultant's secretary.

Pre-operative assessment

You will be invited to the hospital any time up to 2 weeks before your surgery for a pre-operative assessment. During this assessment we will check your fitness for general anaesthetic and surgery. This will include recording a full medical history, any current medication and arranging any investigations needed.

Please tell the nurse practitioner or doctor if you have had problems with any previous surgery, anaesthetic or if you have any allergies – this is very important.

At this visit you will have the opportunity to discuss what to expect before, during and after your surgery. We will also tell you what you will be able to do during your recovery time. Your admission details will be confirmed with you at this visit.

Will I have to sign a consent form?

You will be asked to sign a form giving your consent to the surgery. The consent form gives your doctor the right to do only what is written on this form. The only exception to this is if during the surgery there is an unforeseen problem. The form you will have signed does give the doctor the consent to correct any problems. Please feel free to ask any questions about the surgery that you do not understand before signing the consent form.

Patient Information

The medical terms commonly used on the consent form are:

- Total abdominal hysterectomy - removal of the womb which includes the cervix (neck of the womb)
- Oophorectomy - removal of one ovary
- Bilateral oophorectomy - removal of both ovaries
- Salpingectomy - removal of one fallopian tube
- Bilateral salpingectomy - removal of both fallopian tubes
- Salpingo-oophorectomy - removal of one ovary and fallopian tube
- Bilateral salpingo-oophorectomy - removal of both ovaries and fallopian tubes
- Splenectomy - removal of spleen
- Omentectomy - removal of part or all of the omentum (fatty tissue inside the abdomen)
- Diaphragmatic striping - removal of part or all of the lining of diaphragm muscle
- Bowel resection - removal of part of the large or small bowel
- Stoma formation - bringing the bowel through the abdominal wall to form an opening on the tummy.

When should I stop eating and drinking?

Detailed instructions will be given to you at your pre-operative assessment. This will include a prescription for a bowel preparation including clear written instructions on how to take it. This is to make sure that your bowel is empty before your surgery.

Day of your surgery

An anaesthetist and your surgeon (or a senior member of the team) will explain to you what will happen during your operation.

We want you to fully understand why you are having the surgery and the possible risks involved. You will be asked to sign a consent form, if you have not already done so and you will have the opportunity to ask any questions that you may have.

During the surgery

IDS is carried out under a general anaesthetic (while you are asleep). A narrow plastic tube called a cannula will be inserted into a vein in your arm or hand using a needle. This is used to give you fluids and medications. Before having the general anaesthetic, your anaesthetist will give you an epidural (small plastic catheter) into your spine (back bone) to help with pain control after your operation. After you have been given a general anaesthetic and you are asleep, a catheter (a tube to drain any urine) will be inserted into your bladder.

While under the general anaesthetic your surgeon will make a cut on your abdomen which can be from top of your abdomen down to your pelvis.

All the organs and cancer removed during your operation will be sent to the laboratory for examination to assess your likely response to chemotherapy.

The wound will be closed with dissolvable stitches, surgical glue or staples. The procedure can take 3 to 4 hours, but you should expect to be in theatre and recovery for longer.

After the surgery

You will normally wake up in the operating theatres recovery area, but you may not remember much. You will then be transferred to the Department of Critical Care (DCC). You might need medication to control your blood pressure which can only be given in the DCC. You will be moved to a ward once your blood pressure is stable and the Critical Care team are happy with your recovery.

Risks

Minor risks

- Infections (such as chest wound or bladder)
- Bruising to any wound on the abdomen or in the vagina
- Haematoma (blood collecting in the wound)
- Hernia
- Adhesions (tissues sticking together)
- Ileus (temporary bowel blockage)
- Constipation
- Delay in chemotherapy

More serious risks

- Bleeding
- Deep Vein Thrombosis (DVT), Pulmonary Embolism (PE) (blood clots in the legs or lungs) - you will be asked to wear special stockings during your stay in hospital. This is to help prevent any blood clots forming. You will be given daily blood thinning injections for 28 days following your surgery
- Injuries to the bowel, bladder, blood vessels, ureters (narrow tubes between the bladder and the kidneys), nerves
- Leak around the anastomosis (join in the bowel)
- Further surgery
- Permanent stoma

Anaesthetics carry a small risk and you will be asked by your doctors about any medical problems that might increase those risks.

When will the catheter be removed?

The epidural is usually removed on day 3 after your surgery. Once your epidural is removed you will gain control of your bladder and the catheter in your bladder will be removed.

When can I resume my normal diet?

How soon you will be able to resume your normal diet will depend mostly on the extent of your surgery. Food will be introduced gradually if you have had bowel surgery. If your bowel was not operated on you will be able to eat and drink within 1 to 2 days.

How long will I be in hospital?

You may be in hospital for 7 to 10 days after your surgery but this might be longer if you experience complications. If you have any concerns about going home after your surgery, please discuss these with the staff at the Pre-operative Assessment Clinic.

Follow up

Your next follow up appointment should be 3 to 4 weeks after your surgery and will be in the Oncology Department for chemotherapy.

Going home

You may still have some discomfort when you leave hospital but you will be given a supply of pain relief medication which you should take regularly for the best effect.

You may have some light vaginal bleeding (spotting) for up to 6 weeks after the surgery. This is normal, but if the bleeding becomes heavy, has a bad smell or if you are concerned, please contact your GP and let your oncologist know during your chemotherapy assessment.

Returning to normal

You may feel more tired in the weeks following your surgery. Further chemotherapy treatment can also make you feel tired.

You might experience a slight aching discomfort at the wound sites. This can persist for some months but most women are able to resume light daily activities and tasks within 6 to 12 weeks.

What about my sex life?

The area at the top of the vagina, where the cervix was, will have had stitches. The wound will need about 6 weeks to heal before intercourse is resumed. You will tend to know when you feel ready to resume intercourse. You should find that there is no alteration in the sensation but there may be slight discomfort if you are over enthusiastic. Please ask your specialist nurse or GP for advice if you experience any pain.

Patient Information

When can I drive?

You will be able to travel as a passenger but if you are travelling long distances, please make sure that you stretch your legs regularly.

You should not drive until you feel able to perform an emergency stop comfortably and are not taking regular pain medication. This usually means about 6 weeks without driving. We recommend you discuss this with your insurance company.

Contact information

If you have any problems or concerns after going home, please contact your GP for advice.

Content reviewed: June 2023

Making a choice

Shared Decision Making

If you are asked to make a choice, you may have lots of questions that you want to ask. You may also want to talk over your options with your family or friends. It can help to write a list of the questions you want answered and take it to your appointment.

Ask 3 Questions

To begin with, try to make sure you get the answers to three key questions if you are asked to make a choice about your healthcare.

1. What are my options?
2. What are the pros and cons of each option for me?
3. How do I get support to help me make a decision that is right for me?

These resources have been adapted with kind permission from the MAGIC Programme, supported by the Health Foundation

* Ask 3 Questions is based on Shepherd HL, et al. Three questions that patients can ask to improve the quality of information physicians give about treatment options: A cross-over trial. Patient Education and Counselling, 2011;84: 379-85

AQuA NHS https://aqua.nhs.uk/resources/shared-decision-making-case-studies/