

Postoperative Symptoms Experienced by Patients after Gynecologic and Urogynecologic Outpatient Surgery – A Qualitative Study

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Abstract

Outpatient surgery implies a short period of hospital surveillance before discharge. This study explored post-discharge symptoms postoperative day 1 after gynecologic and urogynecologic outpatient surgery. In a descriptive qualitative design, thirty patients were individually interviewed according to a semi-structured interview guide. Using inductive content analysis, four main categories were identified: "Voiding difficulty" challenged patients, particularly after urogynecologic procedures;

"Postoperative pain" was prevalent and inhibited recovery; "Being unprepared for bowel problems" ie bloating, abdominal discomfort and constipation; and finally, "Unexpected fatigue affecting daily activities." Systematic and procedure-specific postoperative follow-up rather than the current "one-size-fits-all" approach appears relevant for ongoing quality development.

Keywords: Gynecological outpatient surgery, Recovery, Postoperative symptoms, Postoperative pain, Postoperative voiding, Postoperative fatigue, Postoperative bloating and constipation.

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Introduction

New anaesthetic and surgical technologies, along with economic and political initiatives continue to enable expansion of the number and complexity of surgical procedures performed in the outpatient setting [1, 2]. Outpatient surgery implies a short period of surveillance at the surgical unit before home discharge. Patients can therefore experience symptoms and concern related to the surgery after discharge from hospital, some of which may impact postoperative recovery and require intervention from health care professionals (HCPs) [1].

Pain, nausea, and headache are well-researched post-discharge symptoms which differ in prevalence and intensity across surgical procedures [3]. Symptoms such as fatigue, sleep disruption and dizziness remain less investigated despite their potential for protracting postoperative recovery [3,4]. Likewise, patients' experience of concern, insecurity, or anxiety post-discharge after outpatient surgery have received sporadic priority [5]. Although not life-threatening, postoperative concern, insecurity and anxiety may physically and mentally inhibit patients, and delay postoperative recovery [6,7]. Additionally, different surgical procedures are likely to generate distinct symptoms and experiences of concern and anxiety. Hence, assessment of post-discharge symptoms and concerns across different procedures is relevant for ensuring patient safety and quality of care [8,9].

Gynecologic outpatient surgical procedures are complex procedures which, in Denmark, are increasingly performed in the outpatient setting [10]. Studies indicate that patients undergoing these procedures experience multiple symptoms post-discharge, including discomfort, fatigue and pain [11]. Post-discharge telephone follow-up provided by the outpatient clinic appears to reduce urogynecology patients' concerns about for example vaginal bleeding, constipation, voiding difficulty and pathology tests while pain and insufficient pain management persist [12].

Currently, our outpatient clinic offers a one size fits all telephone

follow-up to all patients on postoperative day (POD) 1 regardless of the specific surgical procedures performed. This approach may not sufficiently catch patients' experiences of procedure-related symptoms and concerns. As recommended by the IAAS, we therefore embarked on improving the quality of our follow-up for the growing group of patients undergoing gynecologic and urogynecologic surgery (Patient satisfaction surveys (iaas-med.com)). As a first step, we aimed to assess post-discharge symptoms and concerns as perceived by patients' postoperative day (POD) 1 after gynecologic and urogynecologic outpatient surgery.

Materials and Methods

This was a descriptive qualitative study conducted according to the COREQ criteria for reporting qualitative studies [13]. Data were collected using individual telephone interviews. Interviews were conducted POD 1 using a semi-structured interview guide (Table 1) inspired by existing literature on patients' experiences of symptoms after outpatient surgery and incorporating the clinical experience of nurses and physicians in the outpatient clinic [12]. Prior to interviewing, we pilot-tested the interview guide to evaluate relevance and ease of understanding of the interview questions. During interviews, participants were encouraged to freely describe their experiences. The interviewer followed the participants' lead, asked probing questions, and continuously checked her understanding of the participants' statements whilst simultaneously ensuring coverage of the topics in the interview guide [14]. Interviews were digitally recorded and transcribed verbatim.

The study was conducted at a surgical outpatient clinic in the Capital Region of Denmark. The clinic treats 3000 patients annually and covers 5 surgical specialties, gynecology/ urogynecology, gastroenterology, orthopedic, breast and plastic surgery, of which gynecologic and urogynecologic procedures comprise the majority. Current practice prior to discharge from the clinic is to offer all patients a consultation with a nurse to inform about the

Table 1 Semi-structured interview guide.

Theme	Sample questions
Patient background	How old are you? What is your family situation? Are you employed/retired/other? Which surgical procedure did you have?
Post-discharge recovery	Describe how you have been for the past 24 hours?
Post- discharge symptoms	What symptoms/problems – if any – have you experienced?
Postoperative pain	Have you experienced pain since discharge? Can you rate the worst pain you have experienced on a scale from NRS0-10 (0 =no pain - 10 =excruciating pain How would you describe your pain? (intensity, location) If yes to pain, did you take any pain medication? How has the pain affected you?
Postoperative nausea and vomiting	Have you had nausea and vomiting? If yes, how has this affected you?
Postoperative bleeding	Have you experienced vaginal bleeding? If yes, how has this affected you?
Voiding	Have you experienced problems in relation to voiding? If yes, can you describe the problems you have experienced (for example voiding difficulty– need to self- catheterize? – lacking control of your bladder function? – pain? – If you have experienced problem, how have they affected you?
Bowel function	Have you experienced bowel problems? If yes, how has this affected you?
Concerns and anxiety after discharge	Have you felt concerned or anxious after discharge? If yes, can you elaborate? Have you been in contact with the hospital staff due to any concerns/anxiety? If yes, why?
Daily activities after discharge	To what degree have you taken up usual activities? Have you needed support from family, friends or neighbors?

Table 2 Gynecological surgical procedures, anesthesia, local anesthesia, postoperative voiding schedules and recommended pain management.

Surgical procedure	Anesthesia	Local anesthesia	Postopera- tive voiding procedure	Recommended post- operative pain management	Recommended prn pain management
Colporrhaphia anterior, Colporrhaphia posterior Manchester Procedure	GA	U + L I	Voiding trial 1	Paracetamol 1000 mg x 4 Ibuprofen 400 mg x3	
Tension free Vaginal Tape (TVT)	S	U + L 0,25	Voiding trial 1	Paracetamol 1000 mg x 4 Ibuprofen 400 mg x 3	
Urethral Bulking	± S	U + L I	Voiding trial 1		Paracetamol 1000 mg Ibuprofen 400 mg
Botulinum Toxin A injection in the bladder	± S	U	Voiding trial 2		Paracetamol 1000 mg Ibuprofen 400 mg
Laparoscopic adnexal surgery	GA	B	Voiding trial 2	Paracetamol 1000 mg x 4 Ibuprofen 400 mg x 3	Morphine 10 mg
hysteroscopic surgery	GA or S	M	Voiding trial 2	Paracetamol 1000 mg x 4 Ibuprofen 400 mg x 3	

GA: General anesthesia: propofol (10 mg/ml) and ultiva (50 microgram/ml) + laryngeal mask for airway maintenance

S: Sedation: propofol (10 mg/ml and ultiva (50 microgram/ml) up to 8 ml/h + spontaneous breathing with oxygen on nasal catheter

L I: Infiltration: lidocaine 0,25% w/adrenaline 5 microgram/ml

L 0,25: Infiltration: lidocaine 0,25% w/adrenaline 2.5 microgram/ml

B: Bupivacaine 0.25%

M: Mepivacaine 2% w/adrenaline 10 microgram/ml

U: Urethral lidocaine-gel

Voiding trial 1: Intermittent catheterization is performed at the end of the operation where the bladder is emptied or up to 100 ml is left in the bladder on the discretion of the surgeon. 2-4 hours post-operative the patient is asked to void. If the patient voids at least 100 ml and the residual urine volume is less than 150 ml the patient passed the voiding trial, otherwise, the voiding is still observed. Intermittent catheterization is performed if the patient cannot void and has more than 400 ml in the bladder.

Voiding trial 2: If the patient can void spontaneously after the surgery, the patient passes the voiding trial. The voided volume and the residual urine volume are not measured.

expected postoperative recovery course, recommendations for pain management, voiding schedules and the option to be discharged with a catheter a demeure. Additionally, all patients are contacted 24 hours after discharge by a nurse from the outpatient clinic to inquire about any potential problems or uncertainties.

Inclusion criteria were patients scheduled for gynecologic and urogynecologic outpatient surgery, 18 years of age, and sufficient Danish language proficiency.

We used purposeful sampling to recruit participants undergoing the following gynecologic procedures: colporrhaphia anterior/posterior/Manchester surgical procedure, Tensionfree Vaginal Tape (TVT), Urethral Bulking, Botulinum Toxin A injection in the bladder, Laparoscopic adnexal surgery and hysteroscopic surgery [15]. Table 2 illustrates, the gynecologic procedures, anesthesia, local anesthesia, postoperative voiding schedules and recommended pain management.

Data analysis

Interview data were imported into Nvivo software (Version 11, QSR International, Pty Ltd, Victoria, Australia) and analyzed using inductive content analysis as described by Elo and Kyngäs (16). The first author (LB) conducted the initial coding of the interview data and subsequently all authors met to discuss and agree on the final categories.

Ethics

Eligible patients were informed in writing and orally of the voluntary nature of participation, confidentiality and freedom to withdraw at any time. Participants provided written informed consent prior to interviews. According to Danish law, the study is exempt from approval from The Regional Ethics Committee. The Danish Data Protection Agency approved the study (j. nr.: 2012-58-0004).

Results

From November – December 2018, we approached 36 eligible patients. A total of 30 patients accepted participation in the study. Two patients did not wish to participate, one due to lack of time, one due to a previous complicated postoperative course, one failed to answer the phone at the scheduled interview time, and one patient chose to withdraw from the study when called. Patient characteristics are shown in Table 3.

Table 3 Data characterising the participants. Data are presented as median (min-max) or as numbers.

Data	Median /numbers
Age (years)	56 (33-89)
Employed	16
Retired	10
Unemployed	4
Living alone	12
Cohabiting	18
Duration of interviews median (range)	18 minutes (8-22)

We identified the following 4 categories through analysis of the data: Voiding difficulty, postoperative pain, being unprepared for bowel problems, and unexpected fatigue limiting daily activities.

Voiding difficulty

Voiding difficulty was a general experience and overall trigger of anxiety and concern among participants. One participant described it

in the following way:

”It was a bit hard in the beginning – nothing really happened, only this stinging sensation... I had to go to the bathroom several times... I could not really sense if I had emptied my bladder. I thought I was done and then I could feel more coming. It was as if I had lost all control which made me really nervous.” (P 14).

The participants described symptoms resembling cystitis with pain, a feeling of having to go to the bathroom all the time and an intense stinging sensation in relation to voiding attempts. The symptoms drove participants back and forth to the bathroom constantly to attempt voiding. Some participants experienced that they could not empty their bladder, which led them to self-catheterize and in turn question whether the surgical procedure had been successful and even worthwhile. They lacked control of their bladder and voiding was difficult which resulted in considerable frustration and concern. Some went as far as to monitor their urine output in cups or mugs just to keep abreast of their urine output. Participants felt insufficiently informed about the voiding difficulties they experienced post-discharge. For example, they were uncertain about whether it was normal to experience symptoms resembling cystitis and not being able to urinate. Not being prepared for these symptoms resulted in anxiety with some participants contacting the outpatient surgical clinic for information and guidance. A younger participant who had received Botulinum Toxin A injection in the bladder said:

”I was really nervous, I couldn’t urinate when I got home, oh. I didn’t know what to do because I hadn’t been told how to use a catheter” (P 21)

According to her, the information she had received was that voiding might be difficult and catheterization therefore needed, however she had received no concrete instruction on how to self-catheterize.

Postoperative pain

Postoperative pain was prevalent and affected participants’ post-discharge recovery negatively. Nineteen of the thirty participants described having moderate to severe pain post-discharge with pain scores 5 on the Numerical Rating Scale. Participants undergoing diagnostic laparoscopy, gynecological prolapse surgery and Tensionfree Vaginal Tape (TVT) experienced the most severe pain. One participant described it as follows:

”Cramps... really bad cramps in my abdomen, I couldn’t do anything, just lie in my bed. I would say the pain was 9 (on the NRS) and maybe... I felt it was really intense.” (p 12)

Another participant described her pain as:

”I’d describe it like when you have just given birth, if you’d had stitches or really intense menstrual pain – the pain felt a bit like that. Aching with stabbing pangs.” (P 14)

The pain described by participants was mostly located to the surgical site. Participants also described pain that was not directly related to the surgical site and this worried them. Several described an intense stinging sensation when voiding or a feeling of heaviness in their abdomen. A participant said:

”It wasn’t so bad pain-wise when I was with you in the outpatient clinic. It was first after I got home that it (the pain) became worse, and I became worried. I felt this very intense stinging sensation especially when I had to urinate. NRS 7-8” (P 2)

A younger participant who had a Tension free Vaginal Tape (TVT) described her postoperative pain in the following way:

”...of course, it is painful, it feels like cystitis... so I thought the operation had gone wrong. The urine catheter was the worst -NRS 8.” (P 30)

Despite being informed about pain management and the importance of taking pain medication, this participant chose not to take the recommended pain killers because she was afraid of becoming too doped and therefore unable to look after herself. Another participant who had a laparoscopy adnexal surgery did not take the prescribed morphine medication despite having severe pain, because she was afraid of becoming addicted to the medicine.

Like the voiding problems experienced by participants, pain reinforced feelings of unease and concerns. Furthermore, pain reduced participants' ability and motivation to engage in daily activities and physical activity. One participant emphasized that her anxiety was easily curbed after calling the outpatient clinic and being reassured that everything was normal and that it was safe to take pain killers. Participants stressed the important role of informal caregivers in comforting and supporting them and helping with everyday practical issues.

Being unprepared for bowel problems

Bowel problems such as bloating, feeling unwell due to abdominal discomfort or constipation were common symptoms which the participants felt uninformed about. Lack of bowel movements and confusion regarding which medications to take to ease abdominal symptoms was distressing. A participant who had a colporrhaphia posterior said:

“I didn't expect to feel so bloated . . . and now I'm afraid that I won't be able to go to the toilet. In the pamphlet that I was given it says that you can take different kinds of laxative therapy but what's best – pills or liquid medicine?” (P 22)

Another participant said:

“I'm most worried about not having bowel movements and I daren't press too much. If I do, I'll have to take some more laxative medicine” (P 10)

Having bowel problems after outpatient surgery that so significantly affected well-being surprised patients and was something, they recommended patients be better informed and prepared for beforehand.

Unexpected fatigue limiting daily activities

Fatigue was common and a surprising symptom for participants. Many had difficulty sleeping due to pain, abdominal discomfort and voiding difficulties. A participant who lived alone expressed:

“After I got home, I had a lot of pain, nausea and I was so tired – I kept thinking who's going to do the shopping for me?” (P 9)

Another participant expressed:

“I'm tired and really worn out – I was surprised that I didn't have any energy at all. My husband had to take the children to kindergarten.” (P 17)

All participants were preoperatively independent in activities of daily living and able to take care of themselves. Postoperatively, at home, fatigue inhibited uptake of normal, daily activities. The participants had many questions about uptake of daily activities and found the written information pamphlets handed out at discharge, insufficient, confusing and overall unhelpful in preparing them for how to resume daily activities and when to return to work.

Discussion

Voiding problems, postoperative pain, bowel problems and fatigue limiting daily activities and causing considerable anxiety and worry were commonly experienced post-discharge symptoms after

outpatient gynecologic and urogynecologic surgery. The findings resonate with similar studies in the field [17].

Voiding dysfunction after urogynecologic surgery occurs frequently and is considered a routine occurrence by health professionals. For patients however, voiding dysfunction requiring self-catheterisation or an indwelling catheter is far from routine. A recent study found that patients having to self-catheterize (CISC) or have an indwelling catheter (IFC) experienced substantial catheter burden following urogynecologic surgery when measured using the Short-Term Catheter Burden Questionnaire (STBC) [18]. The STBC assesses catheter burden in relation to difficulty of use and embarrassment [18]. The burden was high regardless of type of catheterization, CISC or IFC [18]. Elkadry et al similarly found that postoperative catheterization was perceived by patients as worse than the pre-existing condition necessitating surgery [19]. Like other studies, the participants expressed that they were not informed and not sufficiently prepared for voiding problems and ill-prepared for having to self-catheterize post-discharge [19].

Even though patients are informed and instructed about voiding problems and how to deal with them post-discharge while in the outpatient clinic, they nevertheless still feel ill-prepared and bewildered when problems arise [20]. It therefore seems appropriate to consider alternative routes of information that reinforce patients' feelings of security and coping post-discharge. A way forward could be through active involvement of patients in developing the content, route of delivery, and duration of information and communication regarding postoperative recovery. Alternative channels of communication, using interactive digital platforms would appear relevant to include [21].

Pain is reported to be the most frequent complication after surgery, including ambulatory surgery [4]. Our study likewise indicates that a substantial number of participants experienced moderate to severe pain, specifically patients undergoing diagnostic laparoscopy, urogynecological prolapse surgery and TVT surgery. Pain after ambulatory surgery as reported by HCPs is mostly assessed to be mild [22]. A newly published study showed that patients' self-reported pain scores from 4 hours after gynecologic surgery until POD 1 were generally higher than when assessed by nurses [23]. There appears to be persistent difficulty in managing postoperative pain optimally, suggesting that HCPs need to prioritize communication with patients in relation to pain assessment along with more detailed pathways of pain assessment [23].

Insufficient pain management after hospital discharge can lead to anxiety, depression, fatigue and immobility with the risk of further complications [4]. This in turn can delay uptake of habitual activity and return to work and therefore could have considerable individual as well as societal impact [3].

There may be several underlying reasons for the relatively high number of participants reporting moderate to severe pain. First, the current strategy as presented in Table 1 for pain management may be insufficient. Alternatively, participants might not have been relevantly informed about pain management, and the importance of taking pain medications, or maybe they did not fully comprehend or could not remember the information after discharge. Some participants specifically chose not to take pain killers as recommended for fear of becoming lethargic or disoriented. This was also reported by Brix [4] who found that ambulatory surgical patients had a low consumption of pain killers despite reporting moderate to severe postoperative pain [4]. Others were confused about how much and for how long they should continue taking pain killers. According to Yang et al. [23], information about postoperative pain management needs to incorporate generic information about surgical pathways

overall as well as information tailored to specific surgical procedures, including procedure-specific symptoms. Insufficient knowledge of pain management, whether due to lack of relevant and focused information or lack of understanding, may leave patients confused about when to take which medications. It seems that clearer recommendations for postoperative pain management are needed. This could include provision of pre-packed medicine to patients at discharge [24]. Also, postoperative follow-up calls used as an intervention to ensure adequate pain control and pain management seem to have a positive effect on patients' compliance [12].

Improving postoperative pain management is a complex process requiring knowledge, a positive managerial attitude ensuring that HCPs have adequate training, and development and implementation of evidence-based clinical guidelines [23].

Bloating and constipation were frequent symptoms which took participants by surprise. Herling and colleagues similarly found that bloating and constipation were frequent symptoms after robotic-assisted hysterectomy and, furthermore, that patients were unsure of what type of laxative to take [25]. Close observation and focus on prevention of postoperative constipation is of utmost importance after outpatient surgery. The frequency and duration of constipation after outpatient procedures should be systematically monitored and research into effective interventions is warranted. Currently, the importance of preventing constipation is emphasized only in selected information pamphlets in the outpatient unit, more precisely pamphlets for anal or urogynecologic procedures. However, the pamphlets do not include specific instructions on how to prevent or treat constipation, leaving patients without concrete solutions for how to deal with the problem after discharge. Hand-out materials for patients therefore need to be scrutinized closely and the information aligned to include clear and specific information on constipation, including both preventive and treatment options.

Participants were surprised by the level of postoperative fatigue and its impact on uptake of normal activities. Cox & O'Connell [26], similarly found that 51% of gynecologic outpatient surgical patients reported persistent fatigue and difficulty concentrating up to as long as 5-10 days postoperatively. Postoperative symptoms such as pain, bleeding, and anxiety negatively affect sleep quality and daily activities [27]. A previous study found a 33% reduced level of activity POD 1 which was associated with pain in 54% of gynecological, orthopedic and breast cancer patients and with fatigue in 17% [28]. Postoperatively, participants in the current study depended on family or friends for shopping, cleaning, and picking up children because they were too tired to do so themselves. A previous qualitative study of patients undergoing ambulatory shoulder surgery likewise described the importance of family in helping with daily chores and activities, indicating the considerable support provided by informal caregivers' post-discharge [29]. There are few studies on fatigue after ambulatory surgery. As with constipation, postoperative fatigue and the impact on postoperative recovery should be monitored systematically in outpatient surgical patients, preferably taking the specific surgical procedure into account. The knowledge gained would qualify preoperative provision of information to patients and family about what to expect after discharge in relation to daily tasks, returning to work, independent activities of daily living and implications for family members supplying care.

Participants in the present study appeared unprepared for postoperative symptoms of voiding difficulties, pain, fatigue and bowel problems, despite receiving routine information. This indicates that both the timing and route of information provision to patients should be reconsidered [30]. Individual preoperative consultations to elicit patients' symptoms and expectations followed by telephone consultation POD 1-7 post-discharge, might serve

to align expectations, and prevent unnecessary worry. It could be an advantage to use a self-reporting digital instrument with a mutual communication with HCP's [30,31]. This is also in line with recommendations for follow-up by telephone for outpatient surgery [12] and recommended by the IAAS (Patient satisfaction surveys (iaas-med.com)).

Systematic monitoring of postoperative symptoms is also essential for increasing our knowledge of the patient experience, for providing relevant guidance and for ongoing quality development.

Strengths and limitations

The size and variation in our sample regarding different types of gynecological surgical procedures allowed us to gain sufficient information power to capture the breadth of participants' experience of symptoms the first day after outpatient surgery [32]. This strengthens the transferability of the findings. We collected data using telephone interviews. Telephone interviews are logistically less demanding than face-to-face interviews and they may be less intimidating for some than face-to-face interviews, thereby facilitating openness [33]. On the other hand, we cannot rule out that face-to-face interviews might have uncovered other aspects of patients' symptoms. Researcher triangulation involving the first author (LB) and 2 outpatient surgery nurses (ACT, SL) with different clinical and academic positions and therefore also distance to the phenomenon of interest, in the analysis of data increases the validity and relevance of the findings [32]. Throughout the conduct of the study, the author group continuously discussed the different preconceptions brought into the study as recommended by Malterud [32].

Data from a single site is a potential limitation of the study as the findings may reflect characteristics specific to this outpatient surgery unit. However, we consider the findings to be transferable to gynecology and urogynecology patients at other outpatient surgical sites. We only interviewed participants POD 1. Longitudinal data with repeated interviews for example POD 5-10 would have generated deeper knowledge of the participants' recovery course. Sampling of participants requiring readmission due to postoperative complications might similarly have uncovered other nuances.

Conclusions

The participants in the present study experienced numerous burdensome symptoms in the first 24 hours after discharge. Symptoms were voiding difficulty, postoperative pain, bowel problems and fatigue. These symptoms led to concern, anxiety and worry and affected daily activities. Systematic follow-up of symptoms and interventions focusing on prevention as well as early reduction of symptoms, especially prevention of postoperative pain after discharge, is important for successful outpatient surgery, both clinically and personally for the individual patient. Active involvement of patients in the development of tailored information and follow-up services is suggested as a path towards quality improvement.

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Conflicts of interest

The authors declare that they have no conflicts of interest.

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