Laparoscopy

Laparoscopy is a common gynaecological procedure which I perform in the operating theatre under general anaesthetic.

The procedure uses small incisions in the abdomen (usually 2-5) to visualize abdominal and pelvic organs and to perform surgical procedures if necessary. The operation is done via a "laparoscope" – a camera on a long instrument with visualization on a screen. During the operation CO_2 gas is insufflated into the peritoneal cavity to enable the operation; this is removed at the end of the procedure.

Usually one incision is made inside the umbilicus. The placement of other ports is very much dependent on the individual situation. The size of these varies from 5-15mm.

Many gynaecological procedures can be performed through this method including but not limited to:

- "Diagnostic laparoscopy" - a simple inspection
- Resection of endometriosis
- Division of adhesions
- Tubal and ovarian operations (eg tubal ligation, removal of cysts or whole ovaries and/or tubes)
- Hysterectomy
- Removal of fibroids
- Prolapse and incontinence surgery etc

Depending on the extent of the internal surgery performed laparoscopy may either be a day procedure or involve admission for one or more nights.

Pain and discomfort afterwards will depend on the actual procedure performed. However the CO_2 gas used during the surgery can commonly cause a bit of discomfort for several days including shoulder discomfort.

Although the external signs of surgery may be minimal, the procedure inside can be extensive. Laparoscopy certainly carries some risks which in rare cases may be serious:

- Infection
- Bleeding
- Blood transfusion
- Visceral trauma (bowel, bladder, major blood vessels etc)
- Anaesthetic risks
- Laparotomy – this is a big abdominal incision which sometimes becomes unavoidable:
    - - When a serious complication develops during the surgery (eg major haemorrhage)

- o – When the goal of the operation cannot be accomplished via laparoscopy (despite the initial preoperative plan) and a return to the operating theatre at another date under another anaesthetic is unreasonable

Please understand that upto 50% of serious risks can occur even with simple diagnostic laparoscopy. This should be kept in mind when deciding whether or not to proceed with surgery. This is especially so when the likelihood of finding treatable cause for symptoms is unlikely.

Occasionally it is safer and more appropriate to abandon the procedure and repeat it some weeks or months later after a more specialized preparation and/or discussion. This would be done if continuing surgery on the day would pose unreasonable risk with a safer option potentially available.

Once you are able to eat, drink, pass urine, mobilize and have reasonable pain control you are able to go home.

The following symptoms and signs are important to be aware of and report after the operation:

- Worsening and/or uncontrollable pain,
- Bright vaginal bleeding which is becoming heavier,
- Persistent nausea and/or vomiting.

Endometriosis

I perform a 1 or 2 stage laparoscopy depending on the severity of endometriosis. In severe endometriosis the initial laparoscopy aims to divide adhesions and drain endometriotic cysts. After that a 3 months course of Zoladex medication would aim to suppress endometriosis. A 2nd laparoscopy after that would aim to safely excise any residual endometriosis.

Ovarian cysts

Occasionally it is safer and more appropriate to remove the whole ovary and not just the cyst. Sometimes this is because the cyst takes over the whole ovary making it impossible to remove one without the other. The remaining ovary in such a case would take over the hormonal and ovulatory function. Fertility or timing of menopause in such a case would remain close to normal.

Hysterectomy

The uterus is ultimately removed through the vagina. If it's very bulky a special procedure called morcellation is performed to be able to remove it in fragments through one of the abdominal laparoscopic incisions. The vaginal vault is closed with absorbable sutures. Avoiding pessaries, tampons and penetrative vaginal intercourse for 6 weeks afterwards is vital in avoiding complications.

I would discuss more specific issues regarding your particular circumstances with you at your appointment. Please feel free to ring me afterwards and/or make an appointment for further clarification.

In general I review patients in my office 1 and 6 weeks after discharge to discuss the results and progress.