You may expect some vaginal bleeding from time to time for anything up to two weeks after your operation. This is usually due to manipulation of the cervix at the time of surgery. If the bleeding becomes excessive you should seek medical help.

Some difficulty may be experienced in passing urine after the operation. This is because it is usual to ensure the bladder is empty by passing a catheter during the procedure. If you experience symptoms of cystitis, namely: passing urine frequently with burning discomfort, try drinking large amounts of fluid to “flush” through the urine. If your symptoms persist beyond a day or two your urine should be tested for infection, and if necessary, the appropriate antibiotics prescribed.

Depending on how you feel, you should get some light exercise during the first few days after surgery. You should be able to return to your regular activities two weeks after surgery. You should avoid sexual intercourse and use of tampons for one to two weeks after surgery.

FOLLOWING ANAESTHETIC

- Do not drive for 48 hours after a general anaesthetic. This may be longer depending upon the type of surgery/ operation you have had.
- After a general anaesthetic there is a period of time when your judgement and reaction times are impaired, even though you may feel normal.
- It is important that for the next 24 to 36 hours after surgery you remain in the company of a responsible adult.
- Do not drink alcohol.
- Do not make any important decisions or sign any important documents.
- Do not operate any machines, cookers or ride a bicycle.

FOLLOW-UP:

You will be advised if you need a follow-up appointment before you are discharged. Symptoms which require a call or visit to the doctor:

- Increasing pain
- Swelling or foul-smelling discharge from the incision sites
- Persistent fever or chills/shortness of breath
- Rigid abdomen
- Prolonged nausea and vomiting
- Excessive vaginal bleeding/vaginal discharge with foul odour
- Difficulty passing urine.

If you have any other questions or worries when you return home do not hesitate to contact the ward sister or member of staff at any time.

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PLEASE SCAN FOR THE LOCATION

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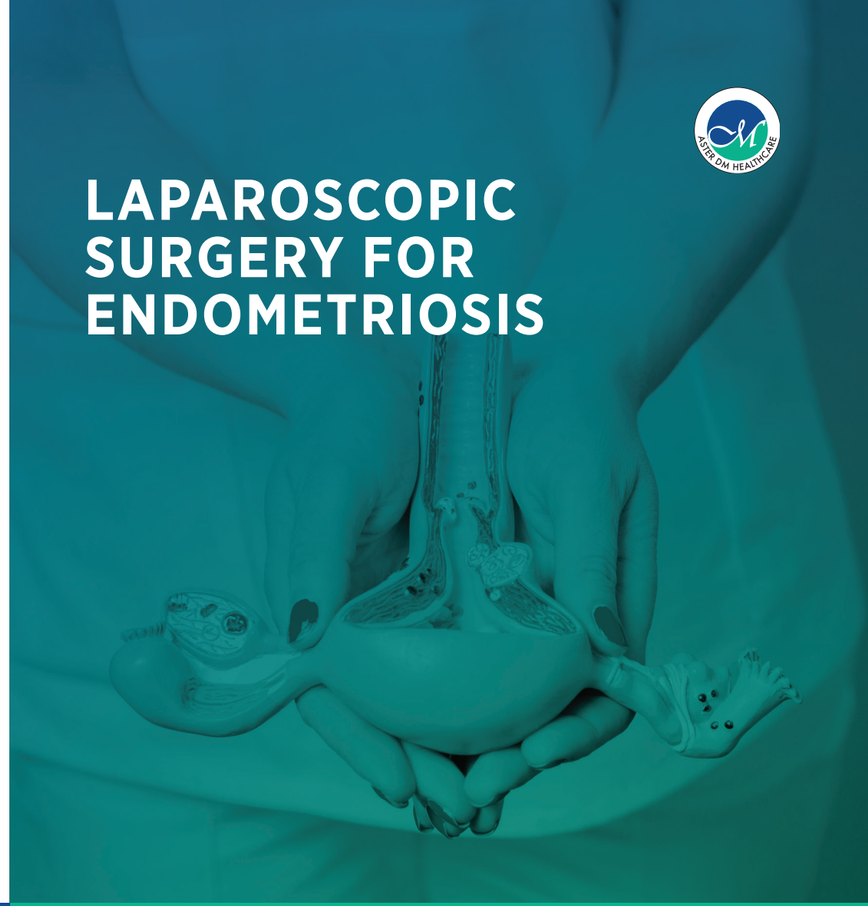
LAPAROSCOPIC SURGERY FOR ENDOMETRIOSIS



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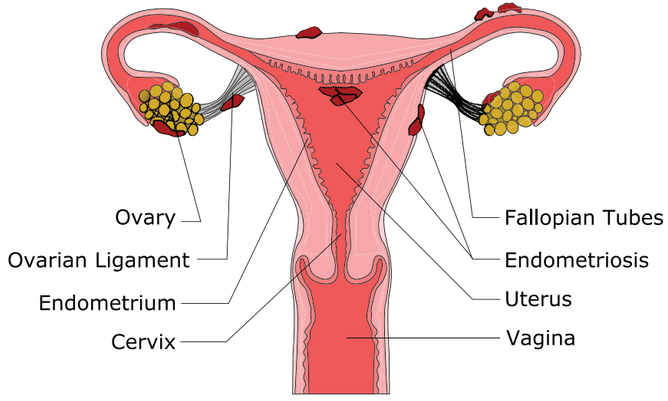
Digital Version



WHAT IS ENDOMETRIOSIS?

Endometriosis is a condition in which the endometrium, the lining of the uterus (womb), grows in locations outside the uterus.

These may be the ovaries, fallopian tubes, ligaments supporting the uterus or less commonly the appendix, bowel, bladder, ureters (the small tubes that carry urine from the kidneys to the bladder) or outside the pelvis.

WHY HAS LAPAROSCOPY BEEN RECOMMENDED FOR YOU?

- To view the internal organs to look for signs of endometriosis and other possible problems. This is the only way that endometriosis can be diagnosed with certainty. However, a "no endometriosis" diagnosis is never entirely certain - growths (implants) can be tiny or hidden from the surgeon's view.
- To remove any visible endometriosis implants and scar tissue that may be causing pain or infertility. If an endometriosis cyst is found growing on an ovary (endometrioma), it is likely to be removed.

WHAT DOES IT INVOLVE?

Laparoscopy is done under general anesthesia (you are asleep). Instead of making a large incision in your abdomen (tummy), the surgeon uses a laparoscope (a thin telescope with light) through a keyhole incision. For a laparoscopy, the abdomen is inflated with gas (carbon dioxide). If needed the surgeon makes one or two more small incisions for inserting other surgical instruments.

If endometriosis or scar tissue needs to be removed, the surgeon will use one of various techniques, including cutting and removing tissue (excision) or destroying it with electric current (electrocautery)

or vaporization with laser.

After the procedure, the surgeon closes the abdominal incisions with a few stitches. Usually there is very little scarring. At the end of the procedure some fluid may be left in your tummy to try to prevent the formation of scar tissue and organs sticking together.

PAIN RELIEF

As with hormone therapy, surgery relieves endometriosis pain for most women, but it does not guarantee long-lasting results.

- Approximately 70% of women report pain relief in the first months after surgery.
- About 45% of women have symptoms return within the first year after surgery. This number increases over time.

INFERTILITY

Most drug treatments for endometriosis affect women's ability to conceive. Surgery may therefore be recommended when there is a concern of delayed conception in relation to a diagnosis of endometriosis. If infertility is your main concern:

- Research has proven that removing mild endometriosis improves fertility.
- For moderate to severe endometriosis, surgery may improve your chances of pregnancy.
- In some cases, a fertility specialist may recommend omitting surgical treatment and using invitro fertilization (IVF).

Overall, pregnancy rates are highest in the 6 to 18 months after surgery.

Endometrioma (an ovarian cyst caused by endometriosis)

There are various ways of surgically treating an endometrioma, including draining it, cutting out part of it or removing it completely (cystectomy). These treatments bring pain relief for most women, but not all. However, cystectomy is most likely to relieve pain for a longer time, prevent an endometrioma from growing back and prevent the need for further surgery.

ANAESTHETIC RISKS

The risks of anaesthesia for elective surgery under modern conditions are very small. You will be carefully monitored throughout the operation by a trained anaesthetist (usually a consultant). However, there are risks with all anaesthetics and if you wish to discuss them please feel free to do so when you meet your anaesthetist before the operation.

SURGICAL RISKS

The risk of surgery includes:

- Minor damage to blood vessels leading to bleeding that can usually be dealt with using laparoscopic surgical techniques.
- Damage to major blood vessels has been recorded.
- Damage to the urinary tract - uncommon during diagnostic procedures, but can occasionally happen, particularly if the bladder is full prior to surgery. It can be repaired laparoscopically but a laparotomy may be required (cut to the abdomen). The risk is increased if there has been previous surgery.
- Bowel damage. This is by far the most common complication. If recognized and dealt with promptly there are few complications, but difficulties can arise if the damage is not quickly dealt with. Repair may involve laparotomy and colostomy.
- Damage and scarring to gynecological organs, which may create fertility problems in the future. This includes damage to small nerves within the pelvis.
- Serious complications occur in about 2/3 in 1000 cases. The risk is increased in complex cases for example women who are obese or significantly underweight and women who have had previous abdominal surgery, peritonitis or inflammatory bowel disease. In severe endometriosis risk can be up to 3 to 5 in 100 cases.

WHAT TO EXPECT BEFORE THE OPERATION?

Your doctor may request some of the following tests depending on the extent of disease:

- Ultrasound,
- Pelvic MRI
- Sigmoidoscopy(fine camera test of lower bowl, Chest X ray, barium Intravenous pyelography (imaging the kidneys) will be done if required.
- Patients with severe rectal-vaginal disease will be discussed at Endometriosis MDT and will require a surgical review.

Your operation will be discussed with you and written consent taken. Before signing the consent form, it is important that you fully understand why you need the operation and the potential complications. You will need to be assessed as medically fit to receive an anaesthetic and will be asked to attend Pre-operative clinic some weeks before your operation.

HOW SHOULD YOU PREPARE?

Laparoscopy is usually done as a day case procedure. Sometimes surgery requires a hospital stay of one to two days. You are expected to fast overnight or at least for six hours before the operation. You should have a bath the night before or on the day of surgery. You may be prescribed an enema if you have problems moving your bowels.

If you are taking any medications, you should discuss this with your doctor.

Most medication will not interfere with surgery and can be continued without a problem. However, if you are on blood thinners or aspirin you should discuss with your surgeon when to discontinue use. You should be able to resume these medications soon after the surgery.

POST-OPERATIVE CARE

After the operation you may experience nausea and vomiting as well as a certain amount of pain. This is not unusual. You may experience pain in the shoulder. This is common and is due to small amounts of gas left in the abdomen which are slowly absorbed. You will be prescribed pain relief medication which should be taken as instructed. The pain should lessen and resolve within 24 to 48 hours. You may experience a sore throat (due to anesthesia) which can be relieved by gargling or sucking ice cubes. You should have someone to take care of you for at least first 24 hours after discharge from hospital.

The puncture incisions are usually closed with a stitch, which will dissolve, but can be removed in five to seven days. We will ask you to make an appointment with the practice nurse to have your stitches removed.

The plasters placed over the wounds at the end of the operation should be removed after 24 hours and air allowed to get to the skin. It is quite usual for the wound itself to become a little reddened and inflamed. Quite often it will weep a little and even discharge some pus. This will settle providing the wound is kept clean and dry.

Normal bathing is allowed. For the first 48 hours you are advised to take showers only. The wound should be dried and left open unless it is uncomfortable next to clothing, or moist in which case a dry dressing such as gauze can be placed over it.