

Laparoscopy Surgery Information Sheet

Laparoscopy

The laparoscope, a surgical instrument similar to a telescope, is inserted through a small cut in the belly button. The abdomen is distended with a gas called carbon dioxide. The scope allows the doctor to see the pelvic organs and allows other instruments to be used under direct vision. Small second, third and fourth cuts are occasionally made at the pubic hairline for scissors, coagulator, or laser to perform major closed surgery at laparoscopy.

Hysteroscopy (the use of a small optical tube that is inserted through the vagina into the uterus without incision to visualize the uterine cavity) is performed with laparoscopy in order to determine: (1) the size and depth of the uterine cavity, (2) the presence of congenital abnormalities within the uterus such as a septum that divides the inside of the uterus or a double uterus, (3) the presence of polyps or fibroid tumours in the uterine cavity, (4) whether specific abnormalities of the endometrium (lining of the uterus) are present eg., hyperplasia (build-up of the lining of the uterus), tuberculosis or cell changes that indicate early cancer. D&C (dilatation and curettage) may also be performed if indicated.

Video and/or pictures may be taken during surgery and used to show you what was seen and done. They are also used for teaching other patients and other surgeons these techniques.

Antibiotics, anticoagulants and other medications may be used with surgery to aid in healing.

Although laparoscopic is generally a day only procedure you may be asleep from 1-4 hours or occasionally longer. About 1 in 40 patients are admitted for overnight stay due to nausea, drowsiness or pain.

Robotic Surgery

In recent years surgical robots such as the Da Vinci system have been increasingly used to assist with surgery. Associate Professor Michael Cooper has been using these systems and believes they are a potentially significant advance. The port placement is slightly different to traditional laparoscopic procedures. Large scale data appear to display a probable decrease in complications with similar efficacy to traditional laparoscopic surgery. He anticipates rapid developments in this area and single port surgery is likely to become routine soon.

Complications

Complications from laparoscopic surgery are very uncommon, but they do sometimes occur. It is also possible that because of complications, or because of the discovery of life-threatening abnormalities, immediate major abdominal surgery might be necessary. The chance of severe complications such as hysterectomy (removal of the uterus), colostomy (bowel bag on the side), paralysis, or death is rare. With respect to your life, this operation is six times safer than driving a car and two to three times safer than being pregnant.

Potential complications include bleeding (sometimes needing blood transfusion); infection, particularly of the belly button; generalised disease; inflammation of the lining of the abdomen; injury to the stomach or intestines; gas bubbles to the lung and brain from the carbon dioxide; abnormal gas collections underneath the skin and in the chest; ruptures of hernias in the surgical wound and through the breathing muscles (diaphragm); burns on the skin and inside the abdomen; damage to the ureter (tube carrying urine from the

kidney to the bladder) and urinary system; blood clots in the pelvis and lungs; and allergic and other bad reactions to one or more substances used in the procedure.

Some of the complications of this procedure may require further surgery; some can cause poor healing wounds, scarring and permanent disability, and very rarely, some of the complications can even cause death.

The alternative procedure to laparoscopic surgery is incisional (large cut) surgery. However, this alternative method also carries the same risks and a much longer period to recover and more pain and discomfort. Therefore, in those patients in whom laparoscopic surgery is possible, the procedures provide the patient with diagnosis and treatment at low risk and less discomfort. Your doctor cannot and does not guarantee the success of this procedure, i.e., that pain will be totally resolved, but believes that the procedure is in your best interest.

The complication rate increases if you have had previous surgery and if your doctor is not experienced with this type of surgery.

Preoperative Instructions:

- No aspirin (Nurofen, Naprogesic etc) for 2 weeks
- Preferably, stop the oral contraceptive pill
- Day before surgery: Preferably clear fluids only (black tea/coffee, water, cordial, minimal food, fizzy drinks, juices) & bowel preparation Fleet (Drink 1 bottle the afternoon before surgery with plenty of water. This takes 1 hour to work and is usually completed within 4 hours)
- For operations in the morning fast from midnight, or 0600 for operations in the afternoon

Postoperative Instructions:

- Shoulder pain from the carbon dioxide gas and abdominal distension are common. Your throat may be sore from the endotracheal tube. You may have some troublesome vaginal bleeding or discharge that may continue for one to two weeks. This should not be very heavy. You may initially have some difficulty passing urine or opening your bowels.
- Plan to avoid any activities that will require concentration for at least 2 days.
- You can usually return to work at 5-7 days and moderate activities by the third day.
- You may need 1-3 weeks to return to heavy activities and for full recovery.
- If you are worried after the surgery ring your doctor. Things to be concerned about include increasing abdominal pain, fever, significant bleeding or severe nausea and vomiting.