PATIENT INFORMATION LEAFLET

This document is intended to assist patients in their understanding of a common gynaecological procedure or condition. It does not replace discussions with the health care team and individualised clinical care.

Developed and endorsed by SASOG as part of the BetterGYN® programme

LAPAROSCOPIC GYNAECOLOGICAL PROCEDURES

Introduction

Many gynaecological operations that were traditionally performed through an open midline or transvers incision, can nowadays be performed through laparoscopic surgery or minimally invasive access surgery. When laparoscopic surgery is performed, small incisions (0,5 to 1,2 cm) are made in the abdominal wall. A lens connected to a camera is placed through the first incision (usually in or around the umbilicus), after which two or three additional incisions are made through which laparoscopic instruments are placed. These instruments are used to perform the procedure. The camera is connected to monitors that are used to visualise the abdomen, pelvis and surgical field.

Benefits of minimally invasive surgery (MIS) include less pain, shorter hospital stay and a quicker recovery. Surgeons performing MIS require additional skills training and the facilities where these procedures are performed need to acquire the necessary technology and instruments. Laparoscopic surgery should generally not be performed in day hospitals, due to difficulty to manage unexpected complication.

Gynaecological procedures that can be performed laparoscopically

The following procedures are examples of gynaecological operations that can be performed using laparoscopic surgery:

Diagnostic investigations for possible infertility, treatment of endometriosis, removal of symptomatic or abnormal benign ovarian cysts or tumours, surgical treatment of ectopic pregnancy, removal of uterine fibroids, female sterilisation, benign reasons for removal of ovaries, hysterectomy, and corrective surgery for female pelvic organ prolapse. This is not an exhaustive list, and what can be done through laparoscopic surgery will depend on the skills of the gynaecologist performing the procedure, the patient and the available facilities.

How is the procedure performed?

The first skin incision is usually made inside the umbilicus, but sometimes it is made in the midline above the umbilicus and in cases of previous abdominal surgery, the first incision is made 2 cm below the left lower rib. A needle (Veress needle) is placed through the incision and the abdomen is then insufflated with carbon dioxide gas,

after which a laparoscopic trocar (primary trocar) is inserted through the abdominal wall. The trocar is an instrument sleeve that allows access through the abdominal wall and the camera lens and instruments are placed through these trocars. The sizes of the trocar usually vary from 5 mm to 12 mm. Some gynaecologists do not use a Veress needle and place the primary trocar directly through the skin incision, while other gynaecologists might prefer an open access technique, where a hole is made in the abdomen before the trocar is inserted. These different access techniques are equally safe. After insufflation and insertion of the camera, the rest of the trocars (secondary ports) are placed through small skin incisions under direct vision to limit the risk of organ injury. After placement of the ports, the operation table is tilted with the patient's head down and feet up to allow safe access to the pelvis for the specific procedure to be performed.

Possible complications

As with all gynaecological procedures, the risk of complications exist. Procedures done laparoscopically requires general anaesthesia and involves abdominal access. The non-exhaustive list of possible complications are the same as those associated with other abdominal operations, including:

- Damage to the bowel, bladder, ureters (kidney pipes) or major blood vessels
- Reaction to one of the drugs or complications of anaesthesia
- Bleeding in the abdominal wound or pelvis
- Blood clot in the legs, pelvis or even lungs
- Improper wound healing or infection
- Continued pelvic or abdominal pain
- Conversion from laparoscopy to laparotomy (open surgical procedure performed through a larger incision)

Factors that increase the risk of complications following laparoscopic surgery include a history of previous pelvic or abdominal surgery, obesity or diabetes and other co-existing medical conditions.

Some laparoscopic surgery complications such as injury to the bowel, bladder and ureter (kidney pipe) are not always detectable at the time of the operation, and will only be diagnosed a few days to weeks after the operation.

Post-operative recovery expectations

Hospital stay will depend on the specific procedure, and will range from discharge on the same day to discharge from hospital one or two days after the procedure.

Early discharge is one of the major benefits of laparoscopic surgery, but it can

contribute to poor outcomes when a patient experience a complication after discharge but it is not recognised and the patient does not seek help in time.

Following discharge from hospital, patients should anticipate a rapid recovery. This means patients should feel better the next morning after the procedure, and should feel better that evening compared to the morning.

Failing to improve from day to day, should immediately prompt patients to contact the gynaecologist who performed the procedure. Important warning signs of possible complications include fever, shivers, nausea and vomiting and abdominal distension. Pain related to the procedure can be expected, but should get better every day and should not worsen. Referred pain in the right shoulder tip is caused by trapped CO_2 gas, is frequently experienced and is not a danger sign. It can be alleviated by blowing through a straw that is placed in a bottle of water and by anti-inflammatories.

What to do when recovery is not as expected?

When recovery is not as expected or if the patient or care givers are concerned, it is essential to inform the gynaecologist who performed the operation. This is the person best informed about potential difficulties experienced during the procedure, and should therefore preferably be involved in the further investigations and care.

If you cannot reach your surgeon you could go back to the hospital where you were operated, or you should seek help elsewhere. This second health care provider, or hospital should then attempt to make contact as soon as possible.

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