When should I seek medical advice after a laparoscopy?

- Increasing abdominal pain: if you also have a temperature, have lost your appetite and are vomiting.
- Burning and stinging when you pass urine or passing urine frequently. This may be due to a urine infection.
- Continued redness, pain, or discharge from a wound site.
- A painful, red, hot leg which could be caused by a DVT (deep vein thrombosis).
- Chest pain or shortness of breath which could be caused by a blood clot on the lung (pulmonary embolism).

Contact details

If you have any queries or worries, please contact one of the following:

- Ward B4 on **0300 019 2414**
- Endometriosis nurse specialist on **0300 019 8432**
- Surgical clinical practitioner via switchboard: **0300 019 5511** between 8pm and 7.30am
- Your GP, if you feel it necessary
- Or if your condition warrants it, you may attend the Emergency Department.

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Laparoscopy for severe endometriosis - combined surgery

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What does surgery for severe endometriosis involve?

- Common areas affected by severe endometriosis are behind and next to the womb, the space between the vagina and bowel (known as the recto-vaginal septum), the bowel wall itself, the ureters (tubes running from the bladder to the kidneys), and the bladder. In combined surgery, a specialist gynaecologist and colorectal surgeon work together.

Surgery may involve:

- releasing the ovaries from other structures they are stuck to and removing endometriotic cysts (endometriomas) from the ovaries.
- identifying and releasing the ureters from any endometriotic tissue.
- separating all the structures in the pelvis that have become stuck together and excising (cutting away) any endometriosis or adhesions.
- if endometriosis affects the vagina, removing a small part of the top of the vagina and closing the wound with dissolvable stitches.

If endometriosis affects the bowel, how is it treated?

If endometriosis affects the bowel, depending on how deeply the endometriosis has grown the surgeons can remove it by:

- ‘shaving’ it from the bowel’s outer surface.
- ‘disc resection’ - removing a small disc of bowel wall and close the opening with stitches.
- ‘segmental resection’ - removing a section of bowel and joining the ends together.

- You may shower the day after your operation, but do not soak in the bath until a week after your operation. Ensure the wounds are dry after showering or bathing. The wound may be left exposed, or you may cover it with a small dressing if you wish.
- Stitches: the stitches used are dissolvable and you will usually find the outside stitch falls away after a week or two. If the stitches do not dissolve and your wounds are red or inflamed, please make an appointment with your practice nurse at your GP surgery.
- Vaginal loss: you may experience some vaginal bleeding/ discharge after surgery which is normal and should settle over the following week. Do not use tampons for one week after your operation.
- Sexual activity: you may resume sexual activity when you feel comfortable.
- Diet: try to eat a healthy, well balanced diet, including plenty of fibre and fresh fruit, with sufficient water to avoid constipation.
- Work: depending on the extent of your surgery, you may require two weeks off work. A sickness certificate is available if required.
- Tiredness: you may feel much more tired than usual after your operation. Every woman has different needs and recovers in different ways. Your own recovery will partly depend on how fit and well you were prior to the operation and how extensive the surgery was.
- Out-patient appointment: this will be arranged as appropriate.

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- There is a risk of accidental injury to the bowel, bladder, ureters (the tubes from the kidney to the bladder), uterus, and major blood vessels. If such complications occur, a larger incision (cut) may be required to do the necessary repair. This operation is called a laparotomy.
- With combined surgery, there is increased risk of damage to the bowel and the possibility of requiring a temporary stoma which will be discussed with you in clinic.
- As with all surgery there is a risk of infection, bleeding, deep vein thrombosis (blood clot in the leg) and pulmonary embolism (blood clot on the lung).

Investigations and medications before surgery

- Rarely a sigmoidoscopy (a procedure to look inside the bowel) may be required if a diagnostic laparoscopy has already shown severe endometriosis, or your systems indicate doing one. The colorectal surgeon will see you in clinic to discuss this further.
- Prior to surgery you will be required to have a minimum of three months zoladex injections. Zoladex works by reducing the amount of the natural hormone called oestrogen (produced by your ovaries) which in turn reduces symptoms such as pain and stops periods. Endometrial deposits become inactive and therefore bleed less during surgery.
- Prior to combined surgery you will have the opportunity to speak with the stoma care nurse, who will provide verbal and written information should you require a stoma.
- You will be advised to eat a low fibre diet 48 hours before surgery and take medication to empty the bowel (bowel prep). On admission you will be given a small enema prior to surgery. This will be explained to you in clinic.

Consent

By law we must obtain your consent to any operation before carrying it out. Staff will explain the risks, benefits, and alternatives, before they ask you to sign a consent form. If you are unsure about any aspect of the treatment proposed, please do not hesitate to speak with a senior member of staff.

Getting over the general anaesthetic

- We would advise you not to drink alcohol, drive, operate machinery, or sign any legal documentation for a minimum of 24-48 hours after the operation.
- You will be able to eat and drink normally straight after the procedure. If you have any feelings of nausea (sickness), stick to clear fluids until you feel better.

Specific post-operative care

- From theatre you will be taken to the recovery room where staff will monitor your pulse, blood pressure, pain, sickness, and wound sites.
- You may have an intravenous infusion (drip) in your arm.
- If you experience any nausea (sickness) or pain, medication can be given to help relieve these symptoms.
- You will be able to drink and eat as you feel able to and gradually increase your intake.
- Initially you may experience some shoulder tip discomfort, which is due to trapped gas from the operation. This will settle as the gas is absorbed. Gentle mobilisation may also help, once you are able. If you have had an epidural, you will need to wait until the feeling in your legs returns.
- You may have some vaginal bleeding and need to use sanitary pads. This should settle within a week.

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- You will normally have a urinary catheter in place when you wake up following your operation. This is usually removed at around 10pm on the day of surgery or early the following morning.
- A minimum of one night stay in hospital is required.
- Pre-operative assessment will provide an information leaflet on post-operative exercises to aid your recovery.
- You will be reviewed by a doctor early the following day. If you are eating and drinking, passing urine and gently mobilising, you will be able to go home to continue your recovery.
- Your stay in hospital will be extended if 'stoma formation' is required and you will be supported by the stoma nurse team.

Discharge information

- Pain killers: you will need to take painkillers to relieve any discomfort. It is best to have a good supply of paracetamol and ibuprofen (if you can take these), ready at home.
- Fluid leakage: after some operations one litre of a special solution called' Adept' may be left in your abdomen (tummy). This is to try to reduce any adhesions (scar tissue) forming after surgery. It is designed to stay in the abdomen for 2-3 days. You may notice some fluid leaking from your wounds, which may be blood stained. This is nothing to worry about. You may also be aware of a 'sloshing' feeling in your tummy which settles as the fluid is absorbed.
- Activity: you will feel rather sore across your abdomen and wound sites. It is advisable to take regular pain killers so you can move around more easily. Most women are back to normal activity including work, in around two weeks.
- Lifting/exercise: avoid heavy lifting and aerobic workouts or strenuous exercise for 2-4 weeks. You may start again gently when you feel comfortable.

The colo-rectal surgeon will speak to you about the potential need for a temporary stoma where a loop of bowel is brought out through the skin onto the abdomen (tummy). A bag is worn to collect faeces (poo) while healing takes place. This can then be reversed at a later date.

How is the operation performed?

Laparoscopy is a minimally invasive or keyhole operation which allows the surgeon to look inside your abdomen (tummy) and pelvis.

Laparoscopy is performed under a general anaesthetic. In addition to a general anaesthetic, the anaesthetist will see you before your operation and discuss the benefits and risks of having a spinal anaesthetic. This can aid recovery by providing good pain relief.

At the start of the operation the bladder is emptied using a catheter. A small telescope, called a laparoscope, is passed through a small cut on the abdomen (usually on the tummy button). The abdomen is gently filled with carbon dioxide gas to separate the tissues and allow space within the pelvis to operate.

Usually three or four further small incisions (cuts) are made to allow instruments to be passed into the abdomen to perform the operation. These cuts will leave small scars on your tummy.

The gas is expelled at the end of the operation. The incisions are closed with dissolvable stitches and covered with a small dressing.

What are the risks?

As with any operation under general anaesthetic, there is a risk of complications. These will be discussed with you when you are asked to sign the consent form.

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