Laparoscopic surgery for Endometriosis

Introduction

This leaflet aims to explain what laparoscopic surgery for endometriosis involves and the pros and cons of this surgery

Definition

Endometriosis is a common problem affecting 10% of women. It occurs when cells which normally line the womb (endometrium) are found outside the womb. This may be anywhere in the pelvis or abdomen.

Symptoms patients commonly experience are: increasingly painful periods, pain with intercourse, pelvic pain which may come after the period and be associated with opening the bowels, irregular bleeding and sometimes difficulty conceiving.

What do we do?

During a laparoscopy the patient is anaesthetised (a general anaesthetic) and a small instrument is inserted through a 1cm incision (cut) in the umbilicus ('belly button'). Gas (carbon dioxide) is put into the abdomen and then a telescope (laparoscope) is inserted. This allows us to look at the outside of the womb, ovaries and the rest of the pelvis as well as the outside of the bowel. A 2nd, and sometimes 3rd or 4th additional incisions are made according to how much surgery is involved. These are usually less than 1cm long.

There are two main types of surgical treatment for endometriosis. If there are multiple tiny small spots of endometriosis they can be destroyed using electrosurgical heat treatment using a small ‘wand-like’ instrument. Deeper deposits are surgically removed from the body through the same incisions.

Although we aim to complete your surgery as a ‘key-hole’ procedure, occasionally open surgery is necessary (laparotomy). If this happens you may need another surgical procedure at a later date following further detailed explanation.

Why do we do it?

Endometriosis can only be diagnosed by a laparoscopy. Removing it at time of surgery is considered by most gynaecologists the best way to treat significant endometriosis. By removing endometriosis significant improvements in pain and irregular bleeding patterns **can** be made. These improvements are not necessarily permanent and repeat surgery **may** be required. Up to 70% of patients will have some or a lot of improvement in pain but about 25% of patients

will have recurrence of symptoms and endometriosis later on. A few patients have surgery to treat endometriosis but their pain may not get better. This may be because endometriosis may not have been the cause of the pain after all.

What to expect afterwards

Some abdominal pain is normal after surgery; you will be prescribed suitable painkillers. Some patients also experience discomfort in their shoulder. This is due to the gas used during the operation and is quite common. Your body gets rid of it naturally and the pain subsides usually over a period of hours. Bruising around the cut (incision) sites may occur and will gradually disappear.

Most patients will be able to go home the same day. Some patients however, may need to stay in longer. The likelihood of this will be discussed with you before surgery.

Your gynaecologists will explain before the operation if you will need to have stitches removed or not. If this is the case they are usually removed on about the 5th day after your surgery with your practice nurse at the GP surgery

You will be told what was done before you are discharged home and given a follow-up clinic appointment.

Complications

All surgery has possible complications.

During surgery injury can occur to any of the structures inside the abdomen i.e. bowel, bladder, blood vessels and ureters (the tubes passing from the kidneys into the bladder). The chance of injury occurring is very small when the instruments are first inserted into the abdomen (about 1-4 per 1000 cases). This risk increases, however according to how severe the endometriosis is and which organs are affected (Making surgery more difficult). For all cases of endometriosis it is about 1%.

If injury to bowel or blood vessels occurs it may need to be repaired by an open operation. If severely endometriotic bowel is removed or bowel is injured a temporary colostomy may be necessary. 2% of patients with severe bowel endometriosis require a colostomy.

Adhesions (internal scar tissue) can occur after any surgery but are probably reduced following laparoscopic surgery.

Consent

Your gynaecologist will ask you to sign a consent form before your operation. This will say you understand the risks of:

1. Bowel injury
2. Bladder or ureteric injury

3. Vascular/blood vessel injury
4. Adhesions
5. An open operation (laparotomy)
6. Temporary colostomy

Great care is always taken to avoid these complications but they can still occur. If you do not feel able to accept these very small risks then you should choose not to have the operation done.

At home

You should make a very quick recovery from your laparoscopy. However very rarely complications become apparent after discharge home. You should seek medical advice if you have increasing pain, problems with breathing, feeling increasingly unwell or persistent vomiting.

Alternatives

Gynaecologists also use medical (hormonal) treatment for endometriosis. These work by making the deposits of endometriosis less active. This can help with pain symptoms but is not helpful for fertility problems. Some patients experience side-effects on hormone treatment. When this treatment stops and normal monthly oestrogen cycles return the endometriosis commonly flares up again. Hormonal treatment does not help symptoms due to scarring or adhesions caused by endometriosis.