Laparoscopic endometriosis Surgery

What is endometriosis?

Endometriosis is a very common condition found in women where cells typically found inside the uterus (womb) are located outside of the uterus and surrounding pelvic area including; pelvis, ovaries, fallopian tubes and occasionally the bladder and bowel. Every month these cells react in the same way to those inside the uterus building up then breaking down to bleed which inside the uterus is known as menstruation (period). Although, unlike periods, endometriosis has no way to escape; therefore leading to inflammation, pain and the formation of scar tissue.

Who gets endometriosis?

Endometriosis can affect any females who have started their periods. One in ten women of childbearing age have some degree of endometriosis with symptoms presenting themselves between the ages of 25-40 years old.

What causes endometriosis?

The cause for this condition remains unknown. Retrograde menstruation is a possible explanation, and this is where some of the blood shed from the womb during your period travels down the fallopian tube or back tracks. Though some professionals feel this condition could be hereditary (runs in the family).

What are the symptoms of endometriosis?

Some women can experience all of the symptoms below, some of them or none at all.

Common Symptoms:

- Pain before a period begins
- Pain during a period
- Pain during sexual intercourse
- Heavy periods
- Rectal symptoms/pain: particularly when opening your bowels
- Infertility: difficulties in becoming pregnant
- Back pain
- Pelvic pain.

Uncommon Symptoms:

- Pain in the lower abdomen: particularly when passing urine
- Blood in your urine or faeces
- Fatigue
- Endometriosis can be found in other areas of the body causing pain when your period is due and throughout.

How is endometriosis diagnosed?

Endometriosis can be difficult to diagnose immediately as the symptoms experienced are similar to those of other conditions, an example being irritable bowel syndrome.

A formal diagnosis of endometriosis is made through performing a diagnostic laparoscopy (keyhole surgery). This usually is a day case procedure, performed under a general anaesthetic (putting you to sleep) where a small camera is

inserted into your belly button to look inside the abdomen and pelvis.

The diagnosis of this can then be made by the doctor sometimes just by visualising the endometriosis. Often a small piece of endometriosis known as a biopsy is sent for testing with results relayed to you when they are back. If fertility has been a concern then the doctor may also flush your tubes to make sure they are clear and patent checking for any blockages/signs of endometriosis.

How can endometriosis progress?

Untreated endometriosis becomes worse in approximately four out of ten women; however in about three out of ten women it will improve. For the remainder the condition and symptoms remain the same. Women with severe untreated endometriosis are at risk of complications such as; obstruction or blockage of the ureter (the tube between the kidney and bladder).

Can endometriosis be treated, and how?

Treatment is not required if no pain and fertility not an issue. Mild endometriosis evident during a diagnostic laparoscopy may be treated at the same time.

In more severe cases there are many options available and these are divided into medical management and surgical management. The option that is best for you will be discussed with your doctor and will depend on personal individual factors including: age, pregnancy status and thoughts on future pregnancies, how you feel about undergoing surgery, how effective previous treatment has been and what symptoms you want to try and manage.

Medical Management

- **The combined oral contraceptive pill**: This does not make endometriosis disappear but may mask symptoms experienced by usually lightening the blood flow and reducing pain experienced when having a period. This is temporarily done by preventing ovulation. This management is usually effective in managing symptoms such as pain and heavy periods
- **Intrauterine system (mirena coil):** This is a T shaped device that is inserted into the womb via the cervix and shaped in that particular way to fit into the lining of the womb. Having a coil inserted is an option to managing heavy periods as one in five women with coils stop having periods all together due to the fact the hormone being released by the coil thins the lining of the womb. The coil can be inserted as an outpatient/at the GP surgery, acts as a contraceptive and lasts for five years. Adenomyosis (this is where endometrial tissue which normally lines the womb is found growing into the muscular wall) is another reason how the coil device can help symptoms of endometriosis
- **Depo Provera:** This is a progestogen administered as an injection every three months. Progestogens are hormones and the injection works by stopping your periods whilst having the injections
- **GNRH Analogues:** This is an injection and works by stopping your ovaries from producing the hormone oestrogen. It mimics a temporary state of menopause and has shown to be effective in reducing the deposits of endometriosis found outside of the womb. Sometimes if having an operation is an option the doctors might recommend this treatment prior to the operation date as they want to shrink as much as possible so minimal pelvic tissue is excised. This treatment will only be used for a maximum of six months as the side effects can be unpleasant.

- **Surgical Management**

    - **Keyhole surgery:** This will involve being put to sleep and through small incisions in your abdomen your endometriosis will be destroyed or endometriotic tissue cut out to try and restore normal pelvic anatomy where possible. This treatment often reduces pelvic pain and improves fertility rates
    - **Hysterectomy:** (+/- Bilateral Salpingoophrectomy BSO) This involves removing the womb, fallopian tubes and often ovaries. This operation is not a guaranteed way to make you pain free as you may still have evidence of endometriosis on your bladder and bowel, organs which are not removed as part of this surgery. This operation should only be considered in women who are certain they have no further plans to become pregnant and where other previous treatment has been tried and failed. Your tubes and ovaries may be removed at the same time.

What are the risks?

Medical Management
Some risks associated with choosing medical management are:

- May not be effective
- Will not remove endometriosis
- May be contraindicated in women who wish to become pregnant
- May reduce long term fertility
- Side effects of individual drugs with a high non-compliance rate.

Surgical Management

What are the risks?

There are risks with any operation but these are small. The main risks associated with a laparoscopy are:

Common risks:

- Postoperative pain including abdominal and shoulder tip pain
- urinary infection, retention and/or frequency
- wound infection, bruising and delayed wound healing.

Uncommon risks:

- Damage to blood vessels
- damage to the bladder
- damage to the bowel
- pelvic abscess or infection
- venous thrombosis and pulmonary embolism (a blood clot in your leg or lung)
- Failure to gain entry to abdominal cavity and to complete procedure
- hernia at site of entry
- haemorrhage requiring blood transfusion
- return to theatre i.e. because of bleeding
- unexpected laparotomy (abdominal incision).

In order for you to make an informed choice about your surgery please ask one of the doctors or nurses if you have any questions about the operation before signing the consent form.

What can I expect after the operation?

As you come round from the anaesthetic you may experience episodes of pain and/or nausea. Please let the nursing staff know and they will assess you and take appropriate action. We will use a pain score to assess your pain 0-10; 0 = No Pain, 10 = Very Strong Pain.

Your nurse will also check your blood pressure, pulse, breathing and temperature and monitor the laparoscopic ports and any vaginal bleeding.

You may have a drip attached (intravenous infusion); once you are fully awake you will be able to start drinking and eating. Your drip will then be discontinued. You can expect pain and discomfort in your lower abdomen for the first few days after the operation. You may also experience shoulder tip pain from the gas and water that is used through the telescope which may get trapped under your rib cage, this is common with laparoscopic surgery. You will be given pain killers to alleviate this.

You will have 4 small dressings on the cuts in your abdomen. You may experience trapped wind which can cause discomfort, peppermint water and getting up and walking around will help this.

What about going home?

A diagnostic laparoscopy is usually a day case procedure and you should be able to go home within 3-4 hours. Before you go home you need to have had something to eat and have passed urine. When you go home, make sure you are not alone and someone can stay with you overnight.

If you have had a simple procedure as part of an operative laparoscopy, you should be able to go home on the same day or you may be asked to stay in hospital overnight.

The anaesthetic is short-lasting. You should not have, or suffer from, any after-effects for more than a day after your laparoscopy. During the first 24 hours you may feel more sleepy than usual and your judgement may be impaired. You should avoid drinking any alcohol during this time as it will affect you more than normal. You should have an adult with

you during this time and should not drive or make any important decisions.

Tiredness:

You may feel much more tired than usual after your operation as your body is using a lot of energy to heal itself. You may need to take a nap for the first few days. Very often feeling tired is the last symptom to improve. Avoid crossing your legs when you are lying down.

Vaginal bleeding:

You can expect to have some vaginal discharge/bleeding for 24-48 hours after surgery. Sanitary towels should be used not tampons to reduce the risk of infection.

Stitches:

Your cut will initially be covered with a dressing that will need to be removed in 48 hours. Your cut will be closed by stitches which are usually dissolvable. If after 7 days you notice the stitches have not dissolved then they will need to be removed. This is normally done by your practice nurse and you will need to make an appointment. We advise that you shower daily and keep the wound clean and dry. There is no need to cover the wound with a dressing.

Exercise:

The day after your operation you should be able to go for a short 10 to15 minute walk in the morning and the afternoon. You should be able to increase your activity levels quite rapidly over the first week. Most women should be able to walk slowly and steadily for 30 to 60 minutes by the middle of the first week and will be back to their previous activity levels by the second week.

If you have had other procedures with the laparoscopy you may need to avoid contact/power sports for a few more weeks.

Preventing DVT:

There is a small risk of blood clots forming in your legs (DVT) after any operation. These clots can travel to your lungs (pulmonary embolism) which can be serious. Reduce these risks by:

- Being mobile
- Leg exercises
- Blood thinning injections
- Compression stockings

This will be discussed with you prior to leaving the hospital.

Diet:

A well balanced nutritious diet with a high fibre content is essential to avoid constipation. Your bowels may take some time to return to normal after your operation and you may need to take laxatives.

You should include at least 5 portions of fruit and vegetables per day. You should aim to drink at least 2 litres of water per day.

Sex:

It is safe to have sex when you feel ready. You may experience dryness which is common if you have had your ovaries removed at the time of the laparoscopy. You may wish to try a vaginal lubricant from your local pharmacy. If after this time you are experiencing pain or any problems with intercourse then you should see your GP.

Returning to work:

Depending on the surgery you will need 1-3 weeks off work. Most women are able to return to work after 1. If you have a procedure as part of an operative laparoscopy, such as removal of an ovarian cyst, you may need 2 to 3 weeks off after your operation please discuss this with the doctor or nurse.

Driving:

It is usually safe to drive after 24 hours but this will depend on your level of concentration and ability to perform an emergency stop. Each insurance company will have their own conditions for when you are insured to start.