

# Diagnostic Laparoscopy and hysteroscopy under general anaesthetic

Information for patients



Welcome to Leeds Fertility. This booklet explains diagnostic laparoscopy and hysteroscopy under general anaesthetic.

You can find further information at [www.leedsfertilityclinic.co.uk](http://www.leedsfertilityclinic.co.uk)

**How to contact us:**

Please see page 14 for urgent and non-urgent contact details.

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## What is a laparoscopy?

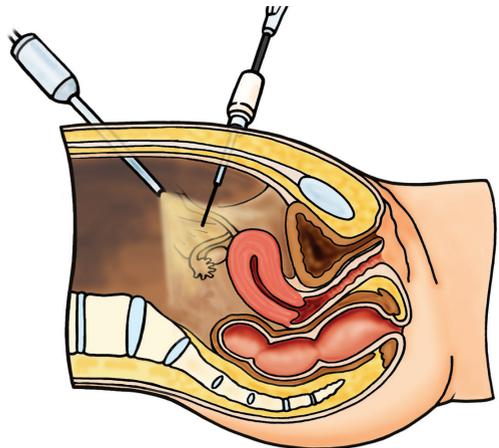
A laparoscopy is performed under general anaesthetic and allows a detailed inspection of the pelvic organs (womb/uterus, ovaries and fallopian tubes). A laparoscopy is a 'keyhole' procedure.

## Why is laparoscopy done?

A laparoscopy is often recommended to fertility patients as it is the most reliable way to check the health of the pelvic organs in preparation for pregnancy. It is offered to women who are troubled with pelvic pain of unknown cause. It may also be required in order to treat certain conditions, such as ovarian cysts, endometriosis and ectopic pregnancy. Fertility patients will also have their tubes checked with a dye test to make sure the tubes are open and healthy. Women who no longer wish to get pregnant may choose to have their tubes clipped (blocked for sterilisation purposes).

## How is laparoscopy done?

The laparoscope is a telescopic camera which is inserted in or just below the belly button (umbilicus) through a cut that is about 1cm long.

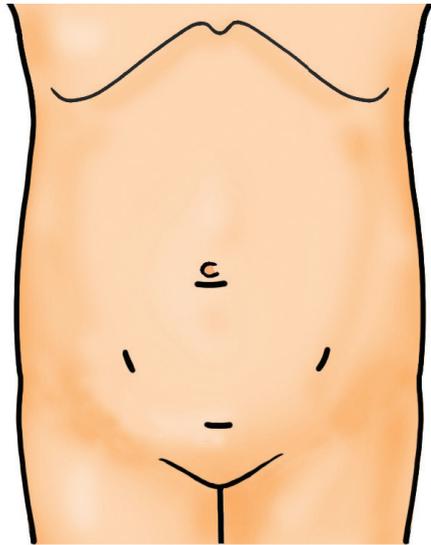


A further 1, 2 or 3 incisions are made lower down in the abdomen (tummy) about 0.5 - 1cm, through which the additional instruments can be inserted in order to enable careful inspection of the pelvic organs.

The pelvic organs may need to be manipulated and if problems are seen, they may be able to be treated at the same time as the diagnostic procedure.

*Approximate sites of the incisions*

You will be asked to sign your consent to the diagnostic procedure and also for treatment of simple problems such as mild endometriosis, ovarian cysts or adhesions/ scarring around the ovaries and fallopian tubes. If more severe problems are identified then treatment is usually discussed and a further operation may be required at a later date.



A laparoscopy takes between 20 and 40 minutes. Most women are admitted on the day of the operation and they go home later that day. The small incisions on the skin are usually closed with dissolving sutures. The sutures (stitches) may take 2 to 3 weeks to dissolve and therefore sometimes they are removed after a week, usually by a nurse at your general practitioner's surgery. It is quite common for there to be a small amount of bruising around these incisions.

The tummy cavity is inflated with carbon dioxide gas in order to be able to have a space in the tummy cavity to move the instruments that are being used for the diagnosis and treatment, during the laparoscopic procedure.

The gas is let out of the tummy cavity at the end of the operation. It is common for a small amount of gas to remain and for the tummy to feel bloated and distended for a few days. Sometimes, in addition, a small amount of fluid is left within the tummy cavity, which is thought to help with the healing process and to prevent adhesions/scar formation within the tummy cavity.

This will also result in a feeling of bloatedness and distension of the tummy for a few days. Sometimes a small amount of fluid can also leak through the incisions that are made in the skin. It is common also to feel discomfort in the shoulder tips for a day or two after the operation. Simple pain relief such as paracetamol and or ibuprofen may be taken for this.

It is preferable not to have a laparoscopy performed during a menstrual period if dye is being injected to check tubal patency.

**If you think your menstrual period is due when the laparoscopy is booked, please ring up the hospital to reschedule the operation.**

You are advised not to have unprotected sexual intercourse from the time of your last menstrual period to until the time of the operation, in order to minimise the chance that you could be pregnant etc. The nursing staff will always check a urine pregnancy test when you are admitted to the ward. Please be ready to tell the staff the date of your last period.

## What are the risks of a diagnostic laparoscopy?

All surgical procedures have risks but these are relatively minor in this routine diagnostic procedure.

### Bleeding and blood transfusion

The risk of very heavy bleeding is very low. Bleeding can usually be managed with keyhole surgery techniques but rarely (less than 1 in 100 operations) the operation needs to be extended into a larger incision called a laparotomy to be able to stop the bleeding from becoming dangerous. The transfusion of blood is not commonly needed but it will be done if necessary to top up heavy blood loss.

### Infection

Infection does sometimes happen in the skin wounds as they are trying to heal afterwards. It is important to keep the wounds clean and follow your aftercare instructions.

### Damage to nearby structures

The pelvic organs (bladder, womb, tubes, ovaries and intestines) are all close to each other in the surgical area. The ureter is the tube that connects the kidneys to the bladder. This tube is also in the area, close to the blood vessels going to and from the legs. All these structures are vulnerable to damage as a result of surgery close to them. These complications are not common but they can be serious if they do occur. Damage to the bowel (small pin-prick or tear) can lead to infection as the contents leak out. The chance of this complication is lower than 1 in 2000 operations. Sometimes it is obvious and can be fixed at the time but sometimes it is hidden and does not cause problems until a couple of days after the surgery.

If you do not feel much better or if you have pain and a temperature (sweats and shivers) by the third day after your operation you should contact the ward and attend for a check-up.

### **Blood clots (deep vein thrombosis, pulmonary embolus)**

Blood clots in the deep veins of the legs can happen when you are lying or sitting still for a long time. Most diagnostic laparoscopy operations are short (45-90 minutes) and the risk of clots is low. People who smoke and / or are overweight and / or are taking oestrogen hormones are more at risk.

You will wear compression stockings during your admission and will be encouraged to get up and get moving soon afterwards to keep the blood in your legs flowing. You should continue to get up and about at home as well. Hydration is important and you should keep drinking plenty of water even if you do not feel like eating much in the day or so after your operation. Some people judged to be at increased risk will be given blood-thinning injections as well.

### **General anaesthetic**

The risk of serious problems with general anaesthetics is low in younger women. Allergic reactions are rare and can be managed. You should discuss any particular concerns you have when the anaesthetist visits you before the operation to explain what they will be doing for you to keep you comfortable during and after the procedure.

Your consultant will discuss any specific risks for you when you sign your consent for your procedure.

## Treatment of Endometriosis

Endometriosis is a condition where small amounts of the endometrium (lining of the womb) spill backwards through the fallopian tubes and can settle in the pelvic cavity, usually around the ovaries and womb. This is a condition that can cause pain during periods and can sometimes cause inflammation and scar tissue, which can affect fertility. Endometriosis may be treated using diathermy (electrocautery or heat treatment) at the time of the diagnostic laparoscopy.

## Adhesions

Adhesions may result from endometriosis or infection. Pelvic infection can sometimes occur without realising that it has happened. Adhesions are a bit like sticky spider webs that can cause the ovaries, fallopian tubes and womb to be stuck together. This may cause pain and also affect fertility. Adhesions can sometimes cause the bowel to stick to the back of the womb. Adhesions can be divided using laparoscopic surgery. Adhesions do have a tendency to reform. There are certain fluids that can be left within the tummy cavity that may help reduce the risk of adhesions coming back again after initial surgery.

## Ovarian cysts

The ovaries produce cysts every month under normal conditions so an ovarian cyst is not necessarily abnormal. Cycle cysts should go away on their own. Cysts that do not disappear sometimes need a closer look and removal. These are usually detected by ultrasound scan prior to a laparoscopy.

Ovarian cysts can often be removed with keyhole surgery but sometimes a laparotomy (bigger cut) is needed. Your consultant will discuss whether this is likely for you.

The usual aim is to remove a cyst and preserve normal ovary. Sometimes however, cysts can occupy the whole of the ovary leaving no normal egg-containing ovarian tissue behind. In this situation, the whole ovary may need to be removed.

Again this will be discussed with you by your consultant. If one ovary is removed, the remaining ovary will usually function to provide a monthly menstrual cycle.

## Ectopic pregnancy

An ectopic pregnancy occurs when a pregnancy fails to develop within the womb, but develops outside the womb, most commonly within the fallopian tube. This may require surgery to either remove the ectopic pregnancy from the fallopian tube, or remove the entire fallopian tube.

The decision as to which operation is the most appropriate can often not be made until the laparoscopy is actually being performed and the fallopian tube being inspected. The surgeon will do what is needed to remove the ectopic pregnancy and preserve normal organs for future fertility.

## Tubal surgery

If the tubes have been damaged by past infection or endometriosis, then laparoscopic surgery can sometimes help to open up the fallopian tubes and try and improve the situation.

Open fallopian tubes are not necessarily tubes that will function normally and if any surgery has been performed to the fallopian tubes, there is an increased risk of an ectopic pregnancy with future pregnancies. This means that if you conceive after laparoscopic surgery, it is important to get an early ultrasound scan to confirm the site of the pregnancy (at 6-7 weeks from the last menstrual period date).

## Laparoscopic sterilisation

A laparoscopy may be performed in order to achieve sterilisation of the fallopian tubes (block them off). This is usually achieved by placing a 'Filshie' clip across each of the fallopian tubes. Once a sterilisation has been performed it should be considered to be permanent.

Whilst there are operations to reverse sterilisation, these have about a 50% chance of working and are not funded by the National Health Service. Furthermore, if a sterilisation has been performed, damage is inevitably caused to the fallopian tube and therefore reversal of the sterilisation is not always successful.

**You should not agree to a sterilisation unless you are sure you will not regret it later. There are many other alternative safe, reliable methods of reversible contraception. Please ask your doctor for more information.**

If pregnancy does occur after a sterilisation, there is also a risk of an ectopic pregnancy (see above). Sometimes the clips come off the fallopian tube. The risk of sterilisation failure (unplanned pregnancy) is 1 in 200 operations.

Therefore, if you miss a period and think you might be pregnant, even if you have been sterilised, it is important to have a pregnancy test and get an ultrasound scan if you are pregnant in order to determine the site of the pregnancy.

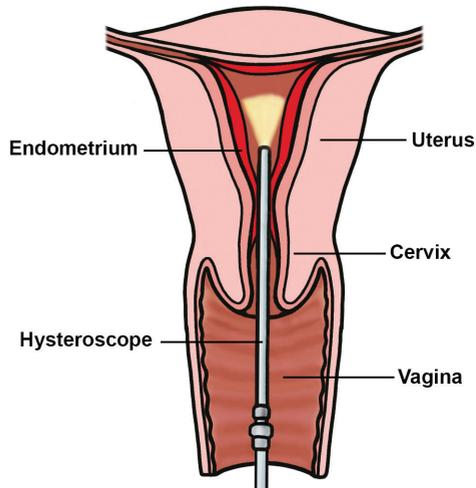
Some women notice a change in the nature of their menstrual periods after a sterilisation operation. This is probably because they have stopped some hormonal contraception which was keeping their periods at bay. It is not the sterilisation but the change in hormones which makes the periods different.

## Diagnostic hysteroscopy

A hysteroscopy is often performed at the same time as a diagnostic laparoscopy especially when the examination is for fertility purposes.

### What is hysteroscopy?

A hysteroscopy is a telescopic camera examination of the cavity of the womb. The camera is passed from the vagina, through the cervix and into the cavity of the womb to inspect the lining and openings of the fallopian tubes from the inside.



## What are the risks of hysteroscopy?

### *Bleeding*

The risk of heavy bleeding is rare.

### *Infection*

This is not common. You should report any bad smelling discharge from the vagina and / or worsening pain after your procedure. It is common to have some discharge soon after and when you stand up, as a watery solution is used to flush the area in order to be able to see properly inside. You should wear a sanitary towel and not tampons until this has settled.

### *Damage to nearby structures*

Perforation of the womb does happen occasionally but it is not common. Usually this may cause a little bleed which settles by itself. The womb heals and recovers normally. Occasionally a course of antibiotics will be given to make sure infection does not set in. It is rare for perforation to damage the bladder or bowels beyond the womb.

Whilst it is important to appreciate the risks of surgery, fortunately, serious problems are very rare. Your surgeon will come and speak to you before you go home to explain what was seen and done and what the next steps in your care should be.

Your general practitioner will be sent a full summary of your operation, which should be received within a week of the procedure taking place.

## Contact us

### Leeds Centre for Women's Health Gynaecology Acute Treatment Unit

**If you have had a hysteroscopy / laparoscopy operation recently and have a question or concern about how you feel, or you think you should see a doctor please call 0113 206 5714 (24 hours)**

## Leeds Fertility

### By post

- Leeds Fertility, Leeds Teaching Hospitals NHS Trust, Seacroft Hospital, York Road, Leeds, LS14 6UH

### By Email

- leedsth-tr.leedsrmenquiries@nhs.net

### Online

- Web: [www.leedsfertilityclinic.co.uk](http://www.leedsfertilityclinic.co.uk)

### By telephone

#### *Mon-Fri 08.00-17.00*

- For all NHS appointments: 0113 206 3100
- For clinical queries: 0113 206 3102

#### *Sat-Sun 08.00-12.00*

- Clinical queries only: 0113 206 3102

### In an Emergency

#### *During working hours*

- Please call appointments or clinical queries as needed on the above numbers

#### *Outside working hours*

- Please call Leeds Teaching Hospitals Switchboard on **0113 243 3144** and request to be put through to the Duty Nurse / Dr for Leeds Fertility.
- If necessary, attend your local Accident & Emergency department.

