for patients

NHS
East Suffolk and North Essex
NHS Foundation Trust

Advanced surgical treatment for endometrosis

Obstetrics and Gynaecology Department
Colchester Hospital

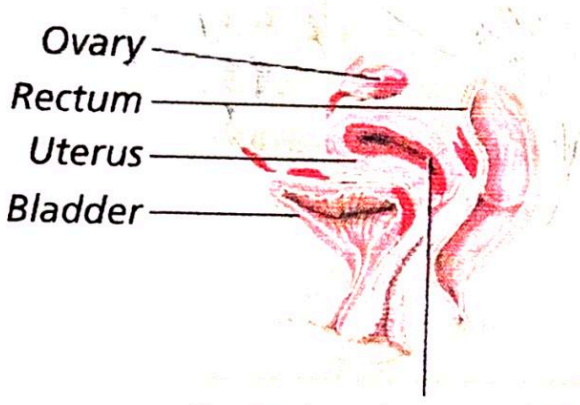
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What is endometriosis?

Endometriosis is a condition that affects 1 in 10 women and up to 50% of women with pelvic pain, discomfort or infertility. It entails the lining of the uterus or womb (endometrium) being located in areas other than the uterus, such as on the ovaries, bladder, ureter (tube from the kidney to the bladder), bowel or rectum.

Common sites for endometrial growths are shown in red



Normal endometrial lining

What is laparoscopy?

Laparoscopy is a procedure to look inside the abdomen using a telescope. A laparoscope is like a thin telescope with a light. The laparoscope is passed into the abdomen through a small incision (cut) in the skin, often referred to as a port. It is used to light up and magnify the structures inside the abdomen. The laparoscope is then connected to a television monitor for the surgeon to see clearly inside the abdomen.

A laparoscopy may be done to find the cause of your symptoms (such as painful periods or pain during intercourse) or to see a specific area within the abdomen or pelvis.

What is laparoscopic surgery?

In addition to simply looking inside, the surgeon can use fine instruments to perform operations. These are also passed into the abdomen through three or four small incisions in the skin. These instruments are used to cut, trim, take a biopsy, or repair organs inside the abdomen.

Consent

By law we must obtain your written consent before any operation and some other procedures. Staff will explain all the risks, benefits and alternatives before they ask you to sign the consent form. If you are unsure about any aspect of your proposed procedure or treatment, please ask us to explain again.

How is it done?

Colchester Endometriosis Centre is one of only 26 such centres in the UK accredited by the British Society of Gynaecological Endoscopy. We perform joint laparoscopies, sometimes with gynaecologists and colorectal/urological surgeons.

The abdominal skin surface is cleaned. Under general anaesthetic the surgeon makes a small incision (cut) about 1–2 centimetres long near to the navel (belly button). Carbon dioxide gas is introduced through the incision to slightly distend the abdominal wall. This makes it easier to see the internal organs with the laparoscope, which is gently pushed through the incision into the abdominal cavity. The surgeon views the end of these instruments through the laparoscope and manipulates them to perform the required procedure.

If any endometriosis is seen, a further 1–3 incisions are made to allow treatment in the affected areas. The surgeon will then either burn out or remove (cut out) the affected areas.

You may be required to have medications before surgery (to ease your symptoms until your operation) or if you have a large cyst of endometriosis on an ovary, your surgery may entail partial treatment, then medication and a second planned procedure. In other words, your surgery will be undertaken in two stages to optimise complete removal of the disease.

Identification wristbands

Wristbands are used to identify hospital inpatients. When you are in hospital it is essential that you are given and wear your wristband, which carries your name, date of birth, NHS number and hospital number. This ensures that staff can identify you correctly and give you the right care.

Your photographic records

As part of your treatment, a photographic record may be made, such as X-ray(s), clinical photographs or digital images, which will be kept confidentially in your health records and seen only by people involved in your care or quality checking. They are also extremely important for teaching or medical research so we may ask for your written consent to use your images, in which case your personal details will be removed so you cannot be identified.

Your NHS number

When you attend hospital you will be asked for your NHS number and other information, such as your address. Please be patient with this procedure – it is to ensure our records are kept up to date and to protect your safety. If you do not know your NHS number, please don't worry, you will still receive care.

After laparoscopic surgery

You may feel a little sore around the abdominal incisions and may have some pain in your shoulder tip. This is caused by the gas which had been pumped inside, irritating the diaphragm, which has the same nerve supply as the shoulder tip.

This pain gradually eases, particularly once you are up and moving around.

The length of time it takes to recover can vary depending on the specific operation, although you should feel better each day. If you are feeling worse, you should contact your GP or phone Stanway Ward on **01206 742035** or, if you have had an excision of the rectum, we will give you the mobile telephone number of the enhanced recovery team.

Minor surgery

Although 1 in 10 women suffer with endometriosis, a small number of these require minor surgery that involves inspection and burning or cutting away away the endometriosis tissue or spots:

- adhesions (scar tissue) are divided or removed
- an endometrioma or chocolate cyst (cyst filled with endometriotic fluid) will be opened and drained. The cyst will then be treated (burned away or stripped out). Care will be taken to preserve as much normal ovarian tissue as possible and to reconstruct the ovary where required. This will usually significantly reduce pain in the majority (70 out of 100) women, although 30 out of 100 women will not get improvement in pain and 10–30 in 100 may get a recurrence of the cyst in the future. Stripping out the cyst seems to reduce the chance of recurrence, although it carries a small risk (less than 5 in 100) of the ovary failing to function in the future
- you may require a catheter (tube in the bladder) overnight
- you may also have a PCA (patient controlled analgesia) overnight where you have the control of pain relief medication which you administer yourself by pressing a button
- usually, you will be discharged the following day but the duration of stay depends on the extent of endometriosis.

Major surgery

Sometimes the endometriosis is more advanced (1 in 100 women) and hence the complication rate is a little higher. Extensive surgery is usually achieved through the laparoscope, though a slightly longer duration of stay may be needed. This involves:

- cutting away the tissue affected by endometriosis
- releasing ovaries
- releasing adhesions and removing the tissue affected by endometriosis around the back and the side of the uterus, around the bladder and ureter and the space between the rectum and the vagina
- dissecting the ureter (tube that carries urine from the kidney to the bladder) to be able to remove endometriosis tissue and possibly inserting a tube (stent) into the ureter for six weeks or so, then removing it as a day case procedure under local anaesthetic.

Bladder disease

If severe endometriosis affects the bladder or is found close to the bladder:

- a cystoscopy (inspecting the bladder with a scope) may be carried out
- the bladder may need to be opened to remove the endometriosis
- a catheter may be retained inside the bladder and the bladder rested for about 14 days
- the consultants will advise you how long the catheter is required.

Bowel disease (rectovaginal endometriosis)

Your consultant should be able to tell you if this is likely to apply to you: often if you pass blood via your rectum during your periods or have pain passing your motions during your periods or if felt during an internal examination or seen on an MRI scan.

The bowel may sometimes be involved with endometriosis. The surgical treatment involves cutting the bowel free and assessing the degree of endometriosis. Sometimes nothing more need be done but at other times the endometriosis may need to be cut away. This may require taking off the surface layer of the bowel or taking out a small disc of bowel and sewing up the resulting hole.

Sometimes, if the involvement is extensive, a small section of the bowel needs to be removed and the bowel rejoined.

These procedures are done with the laparoscopic bowel surgeons. The surgery may require an additional 3cm cut in the pubic hairline or in the umbilicus (tummy button).

Occasionally, if the bowel join is very low (near the anus) or the operation has been technically difficult, a stoma bag is required (ileostomy/colcostomy). The risk of this is about 1 in 10. This effectively diverts the faeces into a bag on the abdomen or stomach, thus protecting the join lower down, allowing it to heal. The stoma bag is usually left for three months and then requires a smaller operation to return the bowel into the abdomen. This usually requires a hospital stay of 2–3 days.

Rarely, leakage of bowel fluid at the site where the bowel was stitched or stapled back together may occur. The risk of this is 4–8 in 100.

Bowel preparation

Before surgery you will be asked to stick to a low residue diet (mainly starchy foods, such as potatoes, bread and/or rice) and to avoid fibre. You may be given an enema the day before surgery to clean out your bowels. This will help with the surgery and may reduce the risk of complications if the bowel is involved.

Surgical risks

The risk of a major complication from a laparoscopy is only about 1–2 per 1,000. The risk from the most major type of laparoscopic surgery for endometriosis is up to 1 in 10.

All the risks listed below will be discussed in detail by the surgical team before you are asked to sign the consent form for the operation. The risks include:

- possible damage to bladder and ureter, needing a stent (tube) passed via a telescope. This is usually removed as a day case six weeks later
- if the ureter is cut, it is possible that a cut will be required in the abdomen to rejoin it
- extensive surgery in the pelvis may delay the return of bladder function. Occasionally, you may need to self-catheterise in the short term and very rarely in the long term
- extensive surgery may also result in delay (or overactivity) of bowel function
- damage to the bowel. This can be in the form of a leak from the join, resulting in an abscess. This may require draining with a small tube. Occasionally, it will require a

larger cut in the abdomen to correct the problem

- damage to nerves and blood vessels
- infection (bladder infection risk 1 in 10)
- risk of delayed complications that can occur up to two weeks after the procedure include bowel leak up to 4–8 in 100 and if this happens the mortality rate is estimated to be 3 in 100); ileus (bowel is temporarily paralysed, leading to distension and vomiting) – the risk is 5–10 in 100; haematoma (collection of blood in the abdomen) is 2–5 in 100.

In addition, if a piece of bowel has had to be removed there may be changes to the way the bowels work in the future.

You may become either more constipated or the opposite may occur and, very rarely, you may become incontinent. These changes usually resolve over a period of weeks or months:

- risk of a fistula (abnormal connection between the bowel or other organ and the vagina)
- loss of a tube or ovary due to bleeding
- risk of adhesion formation (where organs can stick together and sometimes cause pain or discomfort)
- risk of recurrence of endometriosis or pelvic pain.

If any of these complications occur, a laparotomy (open surgery through a larger cut) may need to be undertaken to correct the damage or to stop the bleeding.

If you experience sudden or increasing pain at home or are vomiting or feel unwell, please seek medical advice immediately.



Other complications that can sometimes happen include:

- small areas of the lungs may collapse, which increases the risk of chest infection and may need antibiotics and physiotherapy
- clots in the legs (deep vein thrombosis [DVT]) with pain and swelling. Rarely, part of this clot may break off and go to the lungs (pulmonary embolism [PE]), which is more serious and can be fatal
- people who are obese are at increased risk of wound and chest infections, thrombosis (blood clots) or heart and lung and circulatory complications
- the procedure or subsequent complications can be fatal. The risk of death from a normal laparoscopy for minor endometriosis is 1 in 10,000 (similar to that of driving your car).



Recovering from your operation

After your operation the nursing staff will watch you closely until you have recovered from the anaesthetic. You may even be cared for in the intensive care unit immediately following your surgery, although this is rare.

The recovery period after bowel surgery varies. It usually involves a stay in the hospital of 3–10 days in uncomplicated cases.

Immediately after your operation, the following are usually in place for your care and wellbeing:

- intravenous fluids via a cannula (fine plastic tube) in your neck or arm to keep you hydrated until you are able to drink enough. You may also be given medication via this tube
- a catheter (plastic tube) draining urine from your bladder into a collection bag so we can accurately measure the amount.

These are removed as soon as possible after your operation, depending on your condition and rate of recovery. You will be discouraged from spending long periods of time in bed and given the help you need to carry out your daily hygiene, dietary and exercise routines until you gradually become stronger and more independent.

Diet

During the first few days of recovery you will be able to eat but will probably have a reduced appetite. It is important to choose small amounts at more frequent intervals at first.

Meals can be supplemented with nourishing soups and snacks, and with high-energy drinks. The body will use a lot of calories during the healing process.

Bowel actions

The bowel may take a little while to recover and work normally. This will vary but you will know it is beginning to work when you pass wind and/or have a bowel movement.

It is perfectly normal for the bowels to be more erratic and less predictable after this type of operation. Sometimes it is necessary to use medicines to slow down the gut or to use a gentle laxative to encourage bowel actions.

Your lungs and blood supply

It is likely that on your return from surgery you will be wearing elastic (anti-embolism) stockings. These are tight-fitting stockings that are used to reduce the risk of blood clots forming in your legs.

It is very important after surgery that you start moving as soon as possible. This helps to prevent blood clots forming in your legs and possibly going to your lungs, which could be fatal.

You need to do your deep breathing exercises. Take 10 deep breaths every hour during the day for the first week to prevent secretions collecting in the lungs because if this happens you may develop a chest infection.

Avoid smoking after surgery at all costs because this increases your risk of a chest infection.

Coughing is painful after abdominal surgery.

Exercise

Expect to feel tired for some time after surgery. You need to take things easy and gradually return to normal activities and work as you feel able. The time taken to recover from surgery is variable and depends on you as a person and the type of operation you have had. In most cases, this should take no longer than 2–6 months.

Driving

Check with your insurance company about whether there are any exclusions to your driving. This includes being under the influence of some pain medication. Ensure you can do an emergency stop and wear a seat belt before you drive.

Lifting after surgery

The best advice is 'if it hurts, don't do it'. Lifting heavy weights is not advisable until about four weeks after your operation.

Further information

If you have any further concerns or worries, please phone the department on **01206 742455**.

For more information visit, www.esneft.nhs.uk/service/womens-health/

We value your feedback

To find out how to give us feedback on your visit or healthcare experience, please visit www.esneft.nhs.uk and search for 'PALS' or 'Your views matter', or speak to a member of staff on the ward or department you are in.

Please ask if you need this leaflet in an alternative format.

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