Endometriosis Surgery Information

EXPPECT Edinburgh is an accredited British Society of Gynaecological Endoscopy (BSGE) Endometriosis Centre. www.exppectedinburgh.co.uk

The proposed operation will be carried out under a general anaesthetic (with you fully asleep). The operation performed is usually laparoscopy ('keyhole surgery'). This is carried out through 3 or 4 small cuts on your tummy around 0.5-1cm in size. Once you are asleep a tube called a catheter is placed in your bladder. This is usually removed on the first or second day following surgery but may be kept in for longer. A special device (uterine manipulator) is placed in your womb at the start of the operation to make the surgery easier. You will have a drip running to give you fluids during and immediately after the surgery until you are able to drink. You are usually in hospital for 1-2 nights. We may require expertise from our colorectal (bowel) +/- urology (bladder) colleagues to support us with your surgery depending on the extent and complexity of the endometriosis.

Endometriosis involving bowel/bladder

Endometriosis can affect many organs including the bowel, bladder and tubes coming from the kidneys (ureters). Disease on the bowel may be 'shaved off' the surface or we may need to intentionally cut into the bowel to successfully remove the disease if it is deeper. This would be repaired with stitches. We may need to remove a portion of the bowel. *Very rarely* a colostomy/stoma may be needed. This is usually temporary and reversed a few months later. Whilst surgery for endometriosis on the bowel is likely to help your symptoms you may develop new issues e.g. needing to get to the toilet in a hurry.

Removing severe disease from the bladder would involve intentionally making a hole in the bladder to allow us to cut the disease out. This is repaired with stitches and can usually be done laparoscopically (with keyhole surgery). We would then need to leave a catheter in your bladder for around 10 days followed by a special x-ray test (cystogram) to check that the bladder is watertight before removing the catheter.

Sometimes we insert stents (small tubes) into the ureters (tubes which drain the kidneys) prior to surgery (often a few weeks before) as a safety measure to protect the ureters if we anticipate the surgery to be particularly complex.

Risks and complications of surgery for endometriosis

We take the greatest of care to ensure that your surgery goes smoothly but all operations have a risk of complications. With endometriosis there are often adhesions (tissues stuck to other tissues).This makes the operating difficult, and therefore the risks higher.

Common minor complications

- pain around the keyhole cuts on the skin
- shoulder tip pain (from the gas that distends tummy)
- urinary/bladder infections associated with the catheter

Uncommon minor complications

- perforation (a hole) in the muscle of the womb from the uterine manipulator. This usually requires no treatment and heals itself
- ileus: after surgery, there is a small risk that your bowels may temporarily 'go on strike'. This may take a few days to resolve. The symptoms are feeling or being sick and a distended (bloated) tummy
- hernia: a bit of bowel or fat which gets stuck in one of the cuts on the tummy. This may need a small operation to fix it. To minimise this risk we advise you to avoid strenuous activity or heavy lifting for a few weeks after your operation.

More serious complications

- Risk of conversion to open surgery (laparotomy). This may be a bikini cut or larger up and down cut. This may happen if there were technical difficulties or complications.

- Bleeding/haemorrhage: heavy bleeding is not common with laparoscopy (keyhole surgery). When bleeding occurs we can usually manage it with heat (cauterisation) or stitches. The need for a blood transfusion is unlikely. Please let us know if you have any objections to blood transfusion. There is a small risk of developing some bleeding post operatively which may form a collection (blood clot/haematoma) in your tummy. This could become infected so we may give you antibiotics. Any significant bleeding after the operation would mean returning to theatre for a second procedure.

- Infection: we aim to prevent infection by operating in a sterile environment and by giving antibiotics when indicated. Unfortunately infection can still occur and can affect a number of areas within the body including the pelvis, bladder (UTI) and lungs (chest infection).

- Fistula: an abnormal connection between the bowel and vagina. Bowel content and wind can then be passed through the vagina and further major surgery would be required.

- Injury to organs: there is a small risk of injury to the bowel, bladder, ureter or blood vessels.

Bowel injury - the risk with endometriosis surgery is around 1%. It is usually recognised at the time of surgery. This is a serious complication that could require a surgeon to operate through a large up-and-down incision (laparotomy) to fix the damage. A temporary colostomy/stoma may be required but this is usually reversed a few months later. With an unrecognised bowel injury, there is a risk of the bowel content leaking into your tummy after surgery and you developing peritonitis .You would develop increasingly severe abdominal pain and need a further operation with the general surgeons.

Bladder injury - this is repaired with stitches and can usually be done laparoscopically (with keyhole surgery). We would then need to leave a catheter in your bladder for around 10 days followed by a special x-ray test (cystogram) to check that the bladder is watertight before removing the catheter.

Ureter injury - this could require stents (tubes inserted into the ureters to allow them to heal) or further surgery to repair the damage.

Extremely rarely life-threatening complications can occur.

Safety

- Clot prevention: to reduce the risk of DVT (deep vein thrombosis, which are clots in the leg veins that can move to the lungs), you will receive a daily injection of blood thinning medication. You will be given compression stockings to wear whilst you are in hospital.

- Bowel Preparation: if we are planning to operate on or near your bowel you will be given enemas (medicine into the back passage/rectum) before your surgery to clean out your bowel. This minimises the risks of further complications if your bowel is injured or intentionally opened up.

- Anti-adhesion treatments: at the end of the operation we may use a special anti-adhesion gel to try to prevent scar tissue in the pelvis from forming (tissues or organs sticking together).

After the surgery

- Pain relief: most patients manage with tablet pain relief after they have started eating again. Before this point pain relief may be given by injection or through your drip.

- Catheter and drain: you will have a catheter (small tube) in your bladder when you wake up as you will be unable to immediately mobilise to the toilet and also this helps us to monitor how much urine you are passing. You may have a drain in place (small tube coming from the abdomen). Both of these are usually removed on the first or second day after your operation.

- Mobilising: we will encourage and assist you to mobilise as soon as possible after the surgery. This has been proven to improve recovery.

- Going home: you should steadily improve day by day. Take pain killers as required. Rarely some complications of the surgery do not become apparent until after you are home. These late complications would usually be 3-5 days after the operation but could be later. If you have a fever, vomiting or worsening abdominal pain you should seek medical advice promptly. During normal day time hours you can call your GP. Out of hours, call NHS 24 on 111 or attend A&E.

- Stitches: these are dissolvable but if they are bothering you after 7-10 days you could ask your practice nurse to remove them.

- HRT: we may have discussed HRT with you if your ovaries are being removed. If you have opted for tablet HRT we would usually advise waiting around one month before commencing this to minimise the risk of post operative blood clots (DVT/PE-see above). HRT given through the skin (patch or gel or spray) can be started right away after the surgery.

Symptom improvement

Many women report an improvement in their symptoms after surgery. Unfortunately, not all women get better after surgery even when the endometriosis is completely removed. Some patients may experience new pain following surgery; others may only experience a temporary improvement in symptoms. Endometriosis can sadly recur and it does so in 20% of patients after two years and in 50% of patients after five years.

Fertility

Not all patients with endometriosis will suffer from fertility problems. There is reasonable evidence that the fertility of patients with mild endometriosis is improved by surgery for those having difficulty falling pregnant. The evidence is unclear whether treatment to severe endometriosis offers any benefit to fertility.

If there is a cyst on the ovary which needs to be removed, there is a risk of losing some normal ovarian tissue and therefore decreasing ovarian reserve (the capacity of the ovary to provide eggs in the future). There is a very small risk (less than 1%) of completely losing an ovary if during the removal of a cyst we are unable to stop the bleeding.

Useful web sites:
www.exppectedinburgh.co.uk
www.endometriosis-uk.org
www.bsge.org.uk

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