Diagnostic Laparoscopy

Diagnostic laparoscopy is usually performed to investigate the cause of abdominal or pelvic pain. It is important to realise that one-third to one-half of diagnostic laparoscopies will be negative (i.e. fail to identify a cause) and much of the pathology identified is not necessarily the cause of pain. The surgery is usually performed as a day case in the day procedure unit.

The operation

Diagnostic laparoscopy is performed while you are asleep under general anaesthetic. Bladder will be emptied and you will be examined vaginally before starting the laparoscopy. Being able to manipulate the womb from side to side also enhances the view of the pelvic organs. This is achieved by placing a probe into the cavity of the womb at the time of vaginal examination. The probe is then attached to the cervix (neck of the womb) and manipulated from below.

A small incision is made at the umbilicus (navel) and a slim telescope is inserted into the abdomen so that the uterus (womb), ovaries and fallopian tubes can be clearly visualised. To create space inside, carbon dioxide gas is introduced to lift the wall of the abdomen away from the internal organs.

A small probe is usually inserted through a second, smaller, abdominal incision and this allows a more careful inspection of the pelvic organs.

Complications

Occasionally there may be difficulties or complications.

The overall risk of serious complications from diagnostic laparoscopy is uncommon (approximately 2 women in every 1000). These include -

- Damage to bowel, bladder, uterus or major blood vessels which would require immediate repair by laparoscopy or laparotomy (uncommon). However up to 15% of bowel injuries might not be diagnosed at the time of laparoscopy
- Failure to gain entry to abdominal cavity and to complete intended procedure
- The risk of death as a result of complications in women undergoing laparoscopy is very rare (3-8 women in every 100 000)
- Hernia at site of entry (less than 1 in 100; uncommon)
- Thromboembolic complications (rare or very rare)

Frequent risks include

- Bruising
- Shoulder-tip pain
- Wound gaping
- Wound infection

Finally, if there is any possibility that you might be pregnant please mention this to the doctor or nurse.

Stitches

The skin incision will be closed by a dissolving stitch, which does not need to be removed. You may bath or shower as usual following the operation and can remove any dressings in a couple of days.

After the operation

You can expect some swelling or bruising at the wound site(s). This is not unusual and there will be some discomfort and tenderness where the incision(s) have been made. You will have some discomfort in your abdomen or occasionally in your shoulder for the first day or two. You may need to take a simple painkiller such as paracetamol. Your abdomen may seem a little swollen but this will settle.
You may have a little vaginal bleeding for a few days after the operation. We advise the use of sanitary towels rather than tampons.

If however you experience any of the following problems during the first week, you should seek medical advice.

- Increased abdominal pain, redness, swelling or discharge of the wound(s).
- Persistent bleeding from the wound(s).
- Difficulty in passing urine.
- High temperature.
- Nausea or vomiting.

If any of these occur or you need advice please contact the Day Procedure Unit on **01603 286008** during daytime till 7 PM or the Cley Gynaecology ward on **01603 287242** after 7 PM. Alternatively, you may be able to see your General Practitioner.

Activity

You are advised not to drive for 24 hours. As soon as the discomfort settles you can return to normal activity. You may feel tired for a few days as a result of the anaesthetic, but can return to work after a few days.

Follow-up

This varies and you will be advised of any follow-up arrangements before you leave the hospital.

Videos about coming into hospital that are available on Youtube -
https://www.youtube.com/watch?v=2nW8khbB8gA

IN TRAN communication for all