

CONSENT TO LAPAROSCOPIC SURGERY and HYSTEROSCOPY

Laparoscopy is a surgical procedure which allows the Surgeon to see and operate on the organs inside the pelvis and abdomen. A general anaesthetic is usually required.

A small cut is made in the umbilicus (navel or belly button) through which a laparoscope (telescope) is inserted with a video camera attached. Further instruments are inserted through more incisions (5-10mm), usually placed in the lower abdomen. Carbon dioxide gas is used to distend the abdomen. This is inserted through a needle via the umbilicus, but this may not be possible in all cases. A larger incision through the umbilicus may be required, or a needle may be placed just below, or between the left lower ribs.

An instrument is passed into the uterus to allow it to be moved around by the Surgeon or his Assistant.

Hysteroscopy – a telescope is inserted through the vagina into the uterus to visualise the uterine cavity. This is usually performed with a laparoscopy to determine:

The size and depth of the uterine cavity, the presence of congenital abnormalities, polyps, or fibroids, the appearance of the endometrium (lining of the uterus).

Dilatation and curettage (D & C) may be performed if indicated.

A video and/or photographs may be taken during surgery, and used to aid discussion at your post-operative visit.

Complications

Complications from laparoscopic surgery are not common. Usually an overnight hospital stay is not necessary, but some patients experience sufficient nausea, drowsiness, or pain to require it.

Very rarely, the gas that is distending the abdomen gets into the circulation (gas embolism). This is a very serious complication, and one of the reasons your operation is performed with the assistance of a Specialist Anaesthetist.

Any operation can be complicated by bleeding. Blood transfusion or re-operation, may be necessary. The risk of severe bleeding from a major vessel is 3 per 10,000. This requires immediate open surgery.

Infection may occur after any operation, particularly of the umbilicus after laparoscopic surgery.

The risk of bowel damage is 3 to 6 per 1,000. If recognised at the time of surgery, the bowel is repaired either through the laparoscope, or by an open procedure. Longer hospitalisation will be required. There is a small risk of peritonitis and re-operation because of infection, or failure of the bowel to heal. If the damage is not recognised at the time of surgery, re-operation will be necessary some days later when it may not be possible to simply repair the bowel. A segment may need to be removed and/or temporary colostomy (opening of the bowel on the abdomen) made to allow healing. This is rare.

Surgery for rectal endometriosis, or severe adhesions carries a risk of bowel involvement, and therefore bowel surgery may be necessary.

The risk of bladder damage is rare (1%) unless hysterectomy is performed. The bladder is repaired at the time of operation, but hospitalisation will be prolonged. If the hole is not detected at the time of surgery, urine may leak from the bladder into the vagina or abdomen, and a more complicated operation will be required at a later date.

Initial/date:...../.....

The risk of damaging the ureter (tube connecting bladder to kidney) is rare, unless hysterectomy or extensive endometriosis surgery is performed. If recognised, the ureter is repaired at the time of operation, but hospitalisation will be prolonged. If the damage is not detected at the time of surgery, leakage of urine into the vagina or abdomen, or back pressure on the kidney, may result and require further surgery at a later date. During surgery it may be necessary to place plastic tubes up the ureters via the bladder to more clearly outline them.

Other rare complications include skin burns from electrosurgical instruments, blood clots in the pelvis and lungs, and allergic reactions to drugs.

With respect to loss of life, this surgery is 16 times safer than driving a car, and 2-3 times safer than having a baby.

The alternative procedure to laparoscopic surgery is major incisional surgery. This alternative method also carries similar risks, but with a longer, and more painful recovery. Although I cannot, and do not, guarantee the success of this surgery, it is recommended in your best interest.

CONSENT

I understand that during the course of the operation or the treatment – unforeseen circumstances may be revealed requiring an extension of the original procedure, or different procedures to those specifically discussed.

The operation may be terminated at any stage if no progress is being made. If complications occur or previous permission has been obtained from me, an open procedure may proceed. I hereby authorise Raphael Kuhn, and/or his associates to perform any other surgical procedures deemed necessary, or medically desirable, as determined by his professional judgement.

My signature below constitutes my acknowledgement that:

1. I have read or have had read to me the contents of this form.
2. I understand and agree to the foregoing.
3. The proposed operational procedure has been satisfactorily explained to me, including the possible risks and alternatives.
4. I have all the information I desire and have had ample opportunity to ask questions on specific points, and these have been answered or explained to me in a satisfactory manner.
5. I hereby give my authorisation and consent.

DO NOT SIGN THIS FORM UNLESS YOU HAVE READ IT, UNDERSTOOD IT, AND AGREE WITH WHAT IT SAYS.

Date **Patient** Signature
(please print Surname)

Date **Witness** Signature
(please print Surname)

Please initial and date preceding page and forward both pages to the Rooms NOT the Hospital.

NAME: **DOB:**