DIAGNOSTIC LAPAROSCOPY (KEYHOLE EXAMINATION OF THE ABDOMINAL CAVITY)

Information about your procedure from
The British Association of Urological Surgeons (BAUS)

This leaflet contains evidence-based information about your proposed urological procedure. We have consulted specialist surgeons during its preparation, so that it represents best practice in UK urology. You should use it in addition to any advice already given to you.

To view the online version of this leaflet, type the text below into your web browser:

http://www.baus.org.uk/_userfiles/pages/files/Patients/Leaflets/Diagnostic laparoscopy.pdf

Key Points

- Diagnostic laparoscopy is usually reserved for situations where non-invasive tests have not provided you with an accurate diagnosis for your symptoms
- Laparoscopy requires a general anaesthetic
- It is not necessary in most patients and is very rarely used in urology
- There is a small risk of conversion to open surgery, as there is with any "keyhole" procedure
- We can, if appropriate, biopsy or treat any abnormality found at the same time
- Shoulder-tip pain and abdominal (tummy) bloating are common but other complications are rare

What does this procedure involve?

It involves putting a telescope through a small (keyhole) incision into your abdominal (tummy) cavity, after inflating it with gas (carbon dioxide) so that the surgeon can see inside. We may put in other instruments, through additional incisions, to help take biopsies or treat any abnormality found.

What are the alternatives?

- **Observation** – if your symptoms are not troublesome, you may decide not to do anything further

- **Ultrasound scanning** – special ultrasound techniques may help to establish a diagnosis
- **CT or MRI scanning** – may also help in establishing a diagnosis

What happens on the day of the procedure?

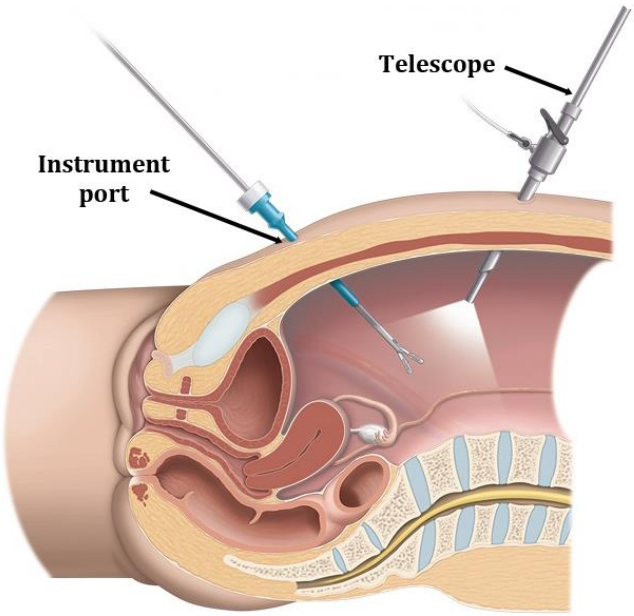
Your urologist (or a member of their team) will briefly review your history and medications, and will discuss the surgery again with you to confirm your consent.

An anaesthetist will see you to discuss the options of a general anaesthetic or spinal anaesthetic. The anaesthetist will also discuss pain relief after the procedure with you.

We may provide you with a pair of TED stockings to wear, and we may give you a heparin injection to thin your blood. These help to prevent blood clots from developing and passing into your lungs. Your medical team will decide whether you need to continue these after you go home.

Details of the procedure

- we normally carry out the procedure under a general anaesthetic
- we may give you an injection of antibiotics before the procedure, after you have been checked for any allergies
- we inflate your abdominal cavity with carbon dioxide gas through a special needle
- through a small incision (port), we put in a telescope to see your internal organs (pictured); the position of the telescope will depend on which area of the abdomen your surgeon wishes to inspect



- we sometimes put a catheter in your bladder if the area of interest is in your pelvis
- we may make further small incisions to introduce additional instruments
- we use these instruments to take biopsies or to treat any abnormality we may find

- we close the incisions with absorbable stitches which usually disappear after two to three weeks
- if you have had a temporary bladder catheter put in, we remove it at the end of the procedure
- the procedure takes from 30 minutes to two hours, depending on what is found or needs to be done
- you can expect to be in hospital for up to two days

Are there any after-effects?

The possible after-effects and your risk of getting them are shown below. Some are self-limiting or reversible, but others are not. We have not listed very rare after-effects (occurring in less than 1 in 250 patients) individually. The impact of these after-effects can vary a lot from patient to patient; you should ask your surgeon's advice about the risks and their impact on you as an individual:

After-effect	Risk
Shoulder tip pain due to irritation of your diaphragm by the carbon dioxide gas	 Almost all patients
Wound discomfort which last a few days	 Almost all patients
Abdominal bloating	 Almost all patients
Hernia at one of the port sites which requires further treatment	 Between 1 in 10 & 1 in 50 patients
Inadvertent or accidental injury to adjacent structures requiring further surgery	 Between 1 in 10 & 1 in 50 patients
Conversion to open surgery due to unexpected pathology, failure to progress, bleeding or recognised adjacent organ damage	 Between 1 in 10 & 1 in 50 patients

Bleeding or infection in the wounds requiring further treatment		Between 1 in 10 & 1 in 50 patients
Anaesthetic or cardiovascular problems possibly requiring intensive care (including chest infection, pulmonary embolus, stroke, deep vein thrombosis, heart attack and death)		Between 1 in 50 & 1 in 250 patients (your anaesthetist can estimate your individual risk)

What is my risk of a hospital-acquired infection?

Your risk of getting an infection in hospital is approximately 8 in 100 (8%); this includes getting *MRSA* or a *Clostridium difficile* bowel infection. This figure is higher if you are in a "high-risk" group of patients such as patients who have had:

- long-term drainage tubes (e.g. catheters);
- bladder removal;
- long hospital stays; or
- multiple hospital admissions.

What can I expect when I get home?

- any discomfort you may have can normally be relieved by simple painkillers such as paracetamol
- you may get some mild bruising around the port incisions
- if you had a catheter put in temporarily, you may get some mild pain on passing urine
- you will be given advice about your recovery at home
- you will be given a copy of your discharge summary and a copy will also be sent to your GP
- any antibiotics or other tablets you may need will be arranged & dispensed from the hospital pharmacy
- a follow-up appointment will be made for you if necessary

General information about surgical procedures

Before your procedure

Please tell a member of the medical team if you have:

- an implanted foreign body (stent, joint replacement, pacemaker, heart valve, blood vessel graft);
- a regular prescription for a blood thinning agent (warfarin, aspirin, clopidogrel, rivaroxaban or dabigatran);

- a present or previous MRSA infection; or
- a high risk of variant-CJD (e.g. if you have had a corneal transplant, a neurosurgical dural transplant or human growth hormone treatment).

Questions you may wish to ask

If you wish to learn more about what will happen, you can find a list of suggested questions called "Having An Operation" on the website of the Royal College of Surgeons of England. You may also wish to ask your surgeon for his/her personal results and experience with this procedure.

Before you go home

We will tell you how the procedure went and you should:

- make sure you understand what has been done;
- ask the surgeon if everything went as planned;
- let the staff know if you have any discomfort;
- ask what you can (and cannot) do at home;
- make sure you know what happens next; and
- ask when you can return to normal activities.

We will give you advice about what to look out for when you get home. Your surgeon or nurse will also give you details of who to contact, and how to contact them, in the event of problems.

Smoking and surgery

Ideally, we would prefer you to stop smoking before any procedure. Smoking can worsen some urological conditions and makes complications more likely after surgery. For advice on stopping, you can:

- contact your GP;
- access your local NHS Smoking Help Online; or
- ring the free NHS Smoking Helpline on **0800 169 0 169**.

Driving after surgery

It is your responsibility to make sure you are fit to drive after any surgical procedure. You only need to contact the DVLA if your ability to drive is likely to be affected for more than three months. If it is, you should check with your insurance company before driving again.

What should I do with this information?

Thank you for taking the trouble to read this information. Please let your urologist (or specialist nurse) know if you would like to have a copy for

your own records. If you wish, the medical or nursing staff can also arrange to file a copy in your hospital notes.

What sources have we used to prepare this leaflet?

This leaflet uses information from consensus panels and other evidence-based sources including:

- the Department of Health (England);
- the Cochrane Collaboration; and
- the National Institute for Health and Care Excellence (NICE).

It also follows style guidelines from:

- the Royal National Institute for Blind People (RNIB);
- the Information Standard;
- the Patient Information Forum; and
- the Plain English Campaign.

Disclaimer

We have made every effort to give accurate information but there may still be errors or omissions in this leaflet. BAUS cannot accept responsibility for any loss from action taken (or not taken) as a result of this information.

PLEASE NOTE

The staff at BAUS are not medically trained, and are unable to answer questions about the information provided in this leaflet. If you do have any questions, you should contact your urologist, specialist nurse or GP.