LAPAROSCOPIC GYNECOLOGIC SURGERY
(COMPLICATIONS AND DIFFICULTIES)

"ESSAY"

Submitted for the Partial Fulfillment of Master Degree in Gynecology and Obstetrics

By

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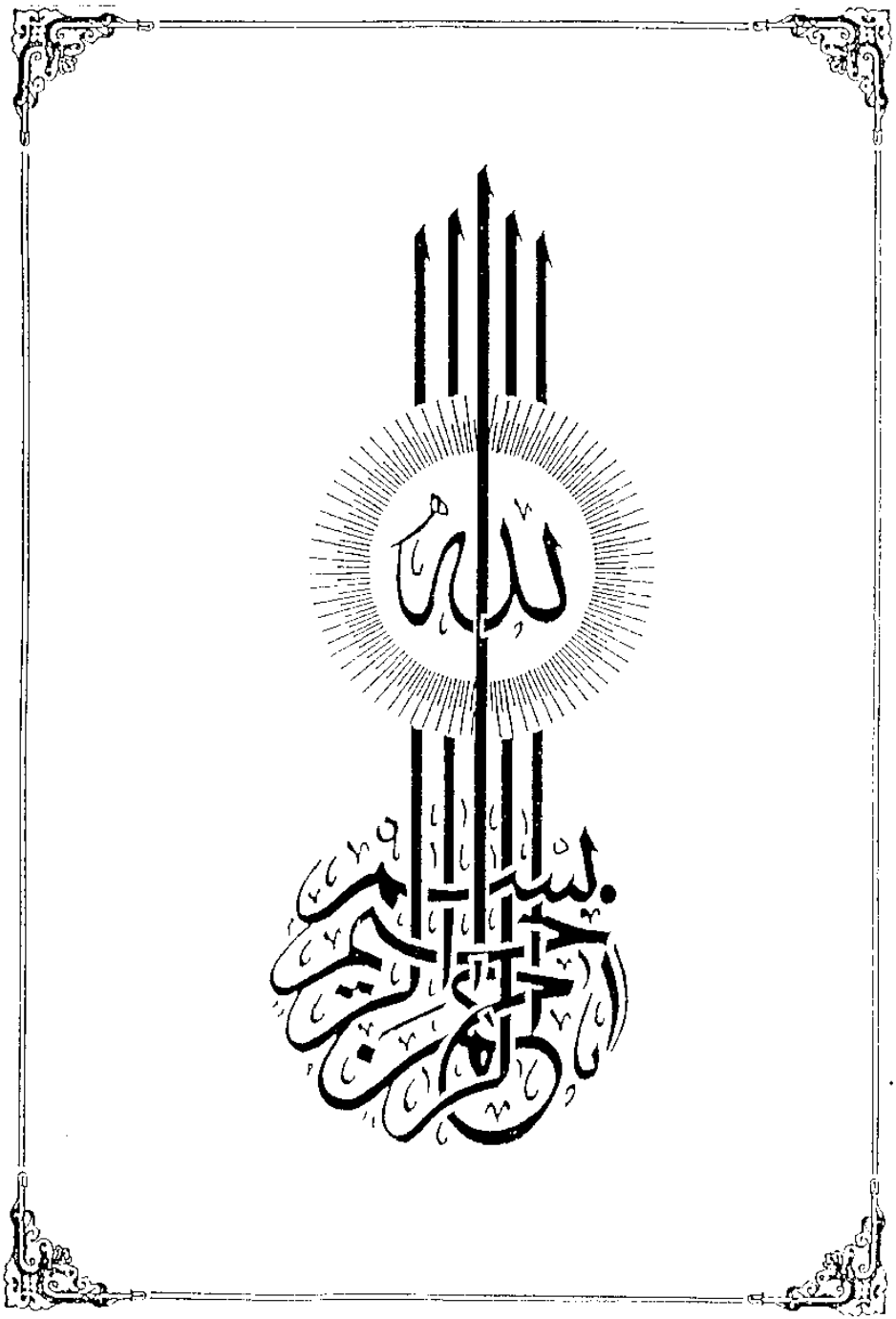

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Emad Mahmoud
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INTRODUCTION

Although modern laparoscopic surgery dates back to the early 1900s, it is only in recent years that it has enjoyed a real renaissance. Modern technologic advances have led to the production of sophisticated, precision quality laparoscopic instruments, which have, in turn revolutionized the surgical procedures ***(Schaer, et al., 1995)***.

Operative laparoscopy has been termed "minimally invasive surgery". This is a misnomer. Adnexectomy or hysterectomy are equally invasive irrespective of the approach. A more realistic term for the laparoscopic approach is "minimal access surgery", since only the access route has been minimized. The term minimally invasive surgery also creates the perception that the operation is minor. This may swing decision in favour of an intervention in the face of doubtful indications ***(Gomel, 1995)***.

In the last 15 years, there has been an explosion of interest in minimal access surgery both from patients and doctors. That has been due to an increase in the

awareness of the advantages that laparoscopic surgery can offer: a smaller scar, less post-operative morbidity, less post-operative pain, a shorter hospital stay and a quicker return to normal life ***(Zaki et al., 1995)***.

Operative endoscopy can be modified for application to almost any existing cavity in the body and as instruments and techniques continue to improve, endoscopy will become more practical ***(Nezhat et al., 1995)***.

Laparoscopy has been used to perform all gynecological operations, ranging from simple procedures such as tubal sterilization and removal of ectopic pregnancy to the more complex techniques required to remove the ovaries, the uterus or pelvic lymph nodes.

Most gynecologists and some professional colleges, such as the American college of Obstetricians and Gynecologists, have agreed that laparoscopic surgery is a suitable, and in most cases, a preferable alternative to laparotomy for tubal sterilization, ectopic pregnancy, endometrioma, and ovarian cystectomy. However, laparoscopic oophorectomy and hysterectomy, and laparoscopic surgery for stage III and IV endometriosis are not performed by the majority of gynecologists,

although a small minority have used these techniques extensively. Laparoscopic techniques for genital prolapse and pelvic cancer are still under trial ***(Wood & Maher, 1996)***.

Laparoscopy is essentially a safe surgical procedure and complications are relatively rare ***(Gordon & Magos, 1989)***.

The rapid expansion of laparoscopic surgery was not achieved without attendant complications. Each of the individual instruments and procedures that are part of operative laparoscopic is associated with a variety of complications ***(Painvain et al., 1995)***.

Regardless of the degree of care and caution exercised, complications can occur. Timely recognition of a complication is essential to proper management. As laparoscopic surgery becomes more complex, the ability to handle an increasing number of complications associated with operative laparoscopy appear to be low when procedures are performed by an experienced laparoscopist. The known rate of intra-operative and post-operative complication is less than 1%. The incidence of complication is related directly to the severity of pelvic and

abdominal pathology. Adhesions and endometriosis are contributing factors to urinary tract and intestinal injury ***(Nezhat et al., 1995)***.

To perform laparoscopic operations successfully and with the least frustration, the surgeon and surgical team need to understand how the laparoscopic equipment works, and they must be able to diagnose, manage and prevent the most common technical problems ***(Duh, 1995)***.

A surgeon who is poorly trained or has minimal skills and experience, finds that many cases are "difficult". Nevertheless, even those with appropriate skill and experience encounter intellectual and technical challenges in laparoscopy ***(Halpern, 1996)***.

There are some difficulties during laparoscopy. The cause of these difficulties can be categorized in two ways:

1- Pre-existing difficulties.

2- Difficulties that develop intra-operatively.

Pre-existing difficulties include abdominal wall scars or intra-abdominal adhesions, body build characteristics and abnormal tissue characteristics or relationship.