



# CENTER FOR WOMEN'S CARE AND REPRODUCTIVE SURGERY

*Gynecologic Endoscopic Surgery*

## *Questions and Answers... or FAQ's (Frequently asked Questions)*

The questions listed below are frequently asked questions of the center. If you have a more specific question that is not answered on this page, please submit it to us for review by emailing Dr. Lyons at [cwcrs@mindspring.com](mailto:cwcrs@mindspring.com).

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What is a hysterectomy?

Hysterectomy is the surgical removal of the uterus. The procedure is indicated most often for abnormal uterine bleeding, uterine fibroids, chronic pelvic inflammatory disease, endometriosis and uterine or ovarian malignancies.

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What are the different types of hysterectomies?

Four surgical options are currently available for a woman who needs a hysterectomy:

- Abdominal Hysterectomy, which is performed by making a large incision in the lower abdomen and surgically removing the uterus. The tubes and ovaries can also be removed with this procedure, if indicated.
- Vaginal Hysterectomy, which is often indicated when the uterus is low in the pelvis. The surgeon enters the abdominal cavity through an incision in the vagina next to the cervix. The uterus is surgically removed through this incision. It can be combined with a vaginal repair for problems of urinary incontinence, cystocele or rectocele. Vaginal hysterectomy is not possible if the patient's ovaries must be removed, if the patient has had previous pelvic surgery or if the surgeon must treat related disorders near the uterus.
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Many patients are not considered for vaginal hysterectomy due to a history of pelvic scar tissue (adhesions); a uterus that is too large; or the condition of endometriosis, which makes vaginal removal of the uterus more difficult.

- Laser Laparoscopic Assisted Vaginal Hysterectomy is a procedure which can be used with any of the indications for hysterectomy except when advanced disease is present. It is performed through the laparoscope by detaching the uterus with the assistance of electrocautery, lasers and other minimally invasive technologies. After the uterus is detached it is removed through the vagina. Tubes and ovaries can also be removed with the laser laparoscopic assisted vaginal hysterectomy, if necessary.
- Supracervical Laparoscopic Hysterectomy, a laser surgery procedure developed by Dr. Lyons, leaves the woman's cervix intact. The procedure causes less trauma to the patient and leaves the pelvic floor intact as a further deterrent to pelvic prolapse or urinary stress incontinence later on. In addition to less discomfort and an even quicker recovery than the other alternatives, the patient can resume normal activity within two days and intercourse within two weeks, compared to a six to eight week resumption with abdominal hysterectomy.

A 30- year study conducted by Pent Killiku, M.D., in Finland, documents that sexual function is enhanced post-operatively because of decreased scarring and trauma to the vagina. In the study, preoperatively 76% of the patients were orgasmic, and six months after surgery 78% were orgasmic.

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What is the recovery time for these procedures?

- Abdominal Hysterectomy: a three to five day hospital stay with approximately six weeks recovery at home.
- Vaginal Hysterectomy: a three to five day hospital stay with approximately four weeks recovery at home.
- Laser Laparoscopic Assisted Vaginal Hysterectomy: a one to two day hospital stay with one to two weeks recovery at home.
- Supracervical Laparoscopic Hysterectomy: an outpatient procedure which enables the patient to leave the hospital after approximately 18 hours, and be back to normal activity within two days to a week.

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What is a laparoscopy?

Laparoscopy is a surgical procedure in which the surgeon makes a small incision in the patient's abdomen which allows the insertion of an instrument called a laparoscope. Using this instrument allows the surgeon to see the inside of the abdomen.

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What is a laparoscope?

The laparoscope is a thin, long, rigid tube in which light travels along glass fibers to light up internal organs. A periscope-like attachment allows the surgeon to see into the abdomen and pelvis. Other instruments used with the laparoscope allow the surgeon to take photographs, obtain biopsies of tissue and now, with the addition of the laser, to cut, coagulate or vaporize tissue.

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How will I feel following a laparoscopy?

Following any laparoscopic procedure, some discomfort is normal and to be expected. Patients commonly report pain in the shoulders, neck and abdomen. This may occur because gas used during the procedure to expand the abdomen cannot be fully removed. These symptoms usually resolve within 12-24 hours with bed rest.

Nausea may occur and can be related to abdominal distention and/or manipulation of the bowel during the procedure. Some patients develop post-surgical nausea from anesthesia.

The incision and stitches may be tender for a few days. Most of these minor discomforts subside quickly. While each patient is different, most will recover within a few hours or a day after the procedure. Improvement is continuous.

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What is a laparoscopic bladder procedure?

This surgical procedure, developed by Dr. Lyons, is used in the management of urinary stress incontinence, which is the involuntary loss of urine-- usually during some physical activity such as lifting, sneezing, laughing, jogging, bending or stooping. Childbirth and loss of estrogen associated with menopause--conditions that can weaken muscles supporting the bladder--are common causes for the condition.

Surgical therapy is indicated after conservative therapies have been proven ineffective, or if the condition is interfering with daily activities. The procedure takes one to two hours based on the patient's anatomy, and has an eighty per cent success rate.

Initial management of the problem can include weight reduction to help lessen intraabdominal pressure, behavior modification (i.e. changing posture), estrogen replacement therapy in menopausal and perimenopausal women, Kegel exercises, and electrostimulation to strengthen the pelvic floor. Medication to help constrict the muscles in the bladder may also be prescribed.

In keeping with a total approach to pelvic floor defects, including pelvic prolapse, Dr. Lyons has also developed procedures for posterior pelvic floor relaxation. The procedure for rectocele (a defect in the rectum, which causes severe constipation) is also performed laparoscopically in a similar fashion to the laparoscopic bladder suspension. By performing these procedures via laparoscope, the patient experiences a significant decrease in post-operative pain. Once again, she is able to resume her normal activities, including elimination of bodily wastes, more quickly than if the surgery had been performed using a scalpel.

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What is endometriosis?

Endometriosis is a condition which occurs when endometrial tissue, the tissue that lines the uterus and is shed during menstruation, grows outside the uterus. When this growth occurs outside the uterus, endometrial tissue can develop painful implants which are most common on the ovaries, the fallopian tubes and the ligaments that support the uterus. Other possible sites for endometrial growths are the bladder, bowel and vagina.

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What causes endometriosis?

One of the most puzzling conditions affecting women, the cause of endometriosis is not yet known. The most common theory, however, is that "retrograde menstruation" causes some of the menstrual tissue to back up through the fallopian tubes and implant in the abdomen. Endometrial cells in the menstrual fluid may then attach themselves to various sites in the pelvic cavity and cause growths.

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What are the symptoms of endometriosis?

Approximately 15% of all women during the childbearing years develop some degree of endometriosis before reaching menopause. The most common symptoms of the disease are pre-menstrual and menstrual pain, heavy or irregular bleeding, pain during sexual intercourse and urinary or bowel problems in conjunction with menstruation. In more serious cases, scar tissue may form on the ovary or fallopian tube, thus causing infertility.

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How is endometriosis diagnosed?

A physician can only definitively diagnose endometriosis using a surgical procedure called laparoscopy. During this minor outpatient surgical procedure, a slender light-transmitting microscope, the laparoscope, is inserted through a tiny incision in the abdomen, often the navel so the scar will be invisible. Before insertion of the laparoscope, the abdomen is filled with carbon dioxide or nitrous oxide to help separate the intestines from the pelvic organs. This way, organ surfaces are viewed easily and the physician can check the size and extent of endometrial growths. This method also allows the physician to rule out other conditions with similar symptoms, such as ovarian cancer.

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What treatments are available?

Although endometriosis is not curable, the condition does tend to disappear when the woman reaches menopause, due to hormonal changes at that time. Treatment options may include surgery, drug therapy or a combination of the two. The objective of surgical treatment is to remove the endometrial implants and/or the organs that have been affected by the disease. The objective of drug therapy is to suppress a woman's levels of estrogen and progesterone, which stimulate the endometrial growths.

In most cases, the physician should be able to treat endometrial implants during the laparoscopy. Using minimally invasive procedures through small incisions, the surgeon can remove scar tissue, destroy endometrial implants using a laser, and/or drain fluid. Less conservative procedures such as hysterectomy may be considered for patients who have no success with other treatments and who no longer want to have children.

In choosing a treatment for endometriosis, the best approach is to review all treatment options with a physician, and pursue the choice with confidence.

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What is a myomectomy?

Myomectomy is the surgical procedure performed to remove uterine fibroid tumors, which are the most common tumor in women with a prevalence of between 20-50%. These benign fibroid tumors, or myomas, appear to grow in relation to their exposure to estrogen. Symptoms can range from excessive or dysfunctional uterine bleeding, severe pain, anemia of undetermined origin, or pressure-related symptoms from enlarged fibroids. Infertility or recurrent miscarriage have been associated with fibroids that significantly distort the uterus.

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What therapies are available?

Therapies can include progesterone therapy, oral contraceptive therapy and/or other drug therapy to reduce the size of the fibroid or multiple fibroids. The length of therapy with these drugs varies; however, it is known that cessation of the drugs will usually result in reoccurrence of the fibroid's growth.

Surgical therapy can be conservative or more radical. For women who do not wish to have the uterus removed, myomectomy is an option available for continued fertility. Women who have completed childbearing may want to consider removal of the uterus because of the awareness that multiple fibroids have a reoccurrence rate as high as 50%; however, solitary fibroids return in only 10-20% of reported studies.

Myomectomy can be performed either via hysteroscopy or via an abdominal approach. Patients who opt for myomectomy should be aware of potential pregnancy-related complications if they do conceive, including possibility of a necessary cesarean section.

Only a fraction of patients with fibroids are candidates for surgical therapy, and for those who are candidates, minimally invasive surgical techniques may be desirable. The physician's goal is always to choose the most efficient and least problematic and painful alternative for patients undergoing treatment for this extremely common gynecologic disorder.

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