The true intention of this document is to obtain consent by deception, misrepresentation and deliberate crafted concealment of all side effects risks and alternative non-surgical treatment options, in preference to treatment options resulting financial gain for the surgeon.

**LAPAROSCOPIC GALLBLADDER SURGERY**

Deliberately under estimated, figures are really 10 to 15%, 20% in over 60 years olds

The presence of gallstones is one of the most common problems of the digestive system. About one adult in every 10 has gallstones.

In people who have pain and other symptoms caused by gallstones, removal of the gallbladder is usually the best treatment. In people with complications due to gallstones, prompt treatment is important.

The most common way to remove the gallbladder is by using a modern surgical technique called laparoscopic surgery or “key-hole” surgery. As shown in the illustrations (right and on page 3), the surgeon inserts special instruments into the abdomen through small cuts and then removes the gallbladder. This is called a “laparoscopic cholecystectomy” (pronounced lap-ar-oh-skop-ic co-lee-sis-teck-toe-me). You will hear your surgeon use this term.

Laparoscopy is the technique of looking into the abdomen using a laparoscope and miniature video equipment. Cholecystectomy is the surgical removal of the gallbladder.

Laparoscopic cholecystectomy is generally a safe and effective treatment for most people who have symptoms due to gallstones. It has become the treatment of choice for most patients who need their gallbladder removed.

Surgical removal of the gallbladder is the safest way to treat serious gallbladder disease.

**THE GALLBLADDER AND HOW IT WORKS**

The gallbladder is a small, pear-shaped organ attached to the underside of the liver in the upper part of your abdomen. The gallbladder stores bile, a fluid produced by the liver. Bile aids digestion by breaking down fats in food.

When you eat, the gallbladder squeezes bile through the bile duct into the small intestine. Usually, bile moves smoothly from the gallbladder into the small intestine.

However, if gallstones form, the flow of bile may be blocked. This can cause pain and, sometimes, may lead to serious complications.

If your pain is likely to be due to gallstones and your gallbladder is not working properly, removal of the gallbladder is then usually recommended.

Symptoms may get worse and complications can develop if you do not have treatment.

*Once your gallbladder has been removed, bile will still flow (as it always has) from the liver to the small intestine.*

**Surgeons claimed protection clause, if sticker on file, informed consent was really provided!**

In other words, this document will not provide information required to make an informed consent. A verbal, non documented, non-witnessed discussion is required with your Surgeon, Or seek advice from another surgeon ONLY.
GALLSTONES AND THE PROBLEMS THEY CAN CAUSE

When the amounts of bile and other fluids inside the gallbladder become unbalanced, some of the chemicals solidify and form gallstones. Most gallstones are made primarily of cholesterol.

Although doctors do not know exactly why some people get gallstones and others do not, gallstones are linked to:
- multiple pregnancies
- obesity or rapid weight loss
- ageing
- some ethnic groups
- gender (more women than men get gallstones).

There is no known treatment or diet that can prevent gallstones.

If the gallstones stay deep within the gallbladder, they may not cause major problems.

Out right deception

Surgeons refuse to provide alternative treatment other than do nothing, guaranteeing an eventual client, or (financial interest) surgery

Although symptoms due to gallstones may go away, they tend to come back if the condition is left untreated. Such patients are more likely to develop complications.

PRINCIPLES OF TREATMENT

After you have a thorough examination, your surgeon can discuss the diagnosis with you. The decision to have treatment is made after discussion with your surgeon. If gallstones are present and are thought to be causing trouble, your surgeon will recommend the best treatment for you.

If surgery is suggested, laparoscopic cholecystectomy may be an option. However, laparoscopic cholecystectomy may not be appropriate for a number of reasons, including, among others:
- major scarring from previous surgery
- bleeding disorders (such as haemophilia)
- pregnancy (especially in the third trimester)
- any condition that will make it hard for your surgeon to see with the laparoscope. Your surgeon can give you more information about whether a laparoscopic cholecystectomy is suitable for you.

YOUR FULL MEDICAL HISTORY

Inform your surgeon about any health problems you may have had. Some may interfere with surgery, anaesthesia and aftercare. This information is confidential.

Tell the surgeon, before surgery, if you have had:
- allergies or bad reactions to antibiotics, anaesthetic drugs, any other medicines, surgical tapes or dressings
- a recent or long-term illness or digestive disorder
- keloid scars or poor healing after previous surgery.

Give your surgeon any medicines you are taking that may increase the risk of bleeding after surgery. Tell your surgeon if you take aspirin, anti-inflammatory medications (such as ibuprofen), vitamin E, herbal medications or garlic tablets. If you are taking a medication to help prevent a blood clot (aspirin, warfarin, clopidogrel or similar medicines), ask your surgeon and prescribing doctor whether the dose should be changed before surgery.

You may need to stop smoking at least two weeks before surgery. It is best to quit.

ANAESTHESIA

Surgery to remove the gallbladder is performed under general anaesthesia. Modern anaesthesia is safe and effective, but can pose risks. Rarely, side effects from anaesthetic can be life threatening. Ask your surgeon and anaesthetist for advice on anaesthesia.

The only side effect likely to affect patients quality of life disclosed they the surgeon, is 'some people', when specifically eating 'too much fat', 'may' experience diarrhoea', THAT'S ALL!

DIET

Most people who have their gallbladder removed can return to a normal diet following recovery. Avoid fatty foods at first and slowly add them to the diet, as you prefer. In a few people, too much fatty food may contribute to bloating, indigestion and stomach discomfort. In such cases, a low-fat diet may be helpful.

Surgeon will never mention about the risks of developing food allergies or intolerance once the gallbladder is removed.
REMOVAL OF THE GALLBLADDER USING LAPAROSCOPIC SURGERY

The surgery is performed through several (usually four) very small incisions in the abdomen. A laparoscope (a thin telescope-like tube) is inserted through an incision in the navel. A small video camera attached to the laparoscope allows your doctor to view your gallbladder on a video monitor and remove it. The gallbladder is then withdrawn through one of the incisions.

BENEFITS OF LAPAROSCOPIC CHOLECYSTECTOMY

For most people, laparoscopic cholecystectomy has benefits over open surgery, including:
- less discomfort after surgery
- less time in hospital
- a recovery of days instead of weeks
- small incisions instead of a large incision
- small scars instead of a large scar.

OPEN SURGERY (LAPAROTOMY)

Although your surgeon has recommended laparoscopy to remove the gallbladder, the surgeon may find, after starting the procedure, that a laparoscopy is not safe due to unexpected findings or events.

If your surgeon believes that it is not safe to continue with the laparoscopic procedure, your gallbladder will be removed through a larger incision in the abdomen. This is known as open surgery or laparotomy.

Conversion to open surgery may become necessary in some patients with:
- chronic or acute infection of the gallbladder
- a gangrenous gallbladder
- abnormal anatomy
- many scar-tissue adhesions due to previous surgery
- other problems that obscure the view of, and access to, the gallbladder.

Open surgery is safe and effective, but does have risks (see page 4 for possible complications).

Conversion from a laparoscopic cholecystectomy to open surgery is not a complication of the procedure but rather is done to protect the patient. The decision to convert to open surgery should be considered to be sound judgement.

A patient may be very disappointed that he or she had open surgery instead of laparoscopy, but open surgery is done in the interests of the patient’s safety and well-being.

Conversion to open surgery occurs in about five patients in 100.

Carbon dioxide gas is blown into the abdominal cavity to lift the abdominal wall clear of the liver, gallbladder, small intestine, pancreas, stomach and other organs. The objective is to improve the surgeon’s access to, and vision of, the area.

A laparoscope (a thin telescope-like tube) is inserted through an incision near or in the navel. A small video camera attached to the laparoscope allows your surgeon to view the abdominal organs on a video monitor. Surgical instruments are inserted into the abdomen through the other small incisions.

Using the laparoscope and other instruments, the surgeon inspects the area and carefully dissects tissue away from the gallbladder, isolating it from other nearby organs.

A small tube called a catheter may be inserted into the cystic duct. The catheter allows an X-ray examination (called a “cholangiogram”) of the bile ducts so your surgeon can tell whether any gallstones have passed out of the gallbladder. If gallstones are in the bile ducts, they may be removed at this time or during a later procedure.

Clips are used to close off the cystic duct and the cystic artery at the base of the gallbladder. These clips stay in your body. The surgeon will detach the gallbladder using electrocautery or a laser.

When the gallbladder is empty, it is like a deflated balloon. The surgeon can then pull it through one of the incisions, with the gallstones still inside it. All instruments are removed from the abdomen, and the carbon dioxide gas is allowed to escape. The incisions are closed with sutures or surgical tape, and protected with small bandages.
Why would a surgeon make this statement in an informed consent document, unless he had something to hide? Especially when the only side effect disclosed, is simply a slight possibility of ‘diarrhea’.

**POSSIBLE COMPLICATIONS OF LAPAROSCOPIC GALLBLADDER SURGERY**

All surgery has some risk. It is not usual for a surgeon to dwell at length on every possible side effect or rare but serious complication of any operation. However, it is important that you have enough information to weigh up the benefits, risks and limitations of surgery.

If you have concerns about possible complications, discuss them with your surgeon. The following possible complications are listed to inform you, not to alarm you. There may be other complications that are not listed.

**General risks of surgery**
- Heavy bleeding may require a blood transfusion and, uncommonly, a return to theatre to control bleeding.
- Short-term nausea following general anaesthesia.
- Allergic reaction to medications, dressings, or antiseptic solutions.
- Formation of a large blood clot (haematoma) near the operative site may require further surgery.
- Cardiovascular complications such as heart attack, pulmonary embolism or stroke can be life threatening.
- Deep vein thrombosis (DVT) in a leg. To reduce the risk, you may be given a blood-thinning medication while in hospital. Exercising your legs regularly can help to prevent DVT.
- Chest infection; deep breathing exercises, physiotherapy and antibiotic treatment can help.
- Delayed healing of the wound.
- Raised, itchy and reddened scars (keloid or hypertrophic scars). These can be annoying but are not a threat to health. Scarring from the small incisions is variable. Most incisions heal well, and few people will develop keloids.

**Specific risks of laparoscopic cholecystectomy**
- An injury to a bile duct can cause leakage or obstruction of the duct. A return to theatre and more surgery may be needed to repair the problem.
- Infection of the wound may occur due to bacteria, resulting in redness and pain. Pus and an abscess may form. Antibiotic treatment is needed. Some sutures or staples may need to be renewed, and the pus drained. Care of the wound and clean dressings are important.
- During the procedure, injury can uncommonly occur to nearby organs, such as the small intestine, pancreas, stomach, major blood vessels or spleen. This risk is slightly greater with laparoscopic surgery than open surgery.
- Bile may leak from the remnant of the cystic duct or the common bile duct.
- Rarely, a bubble of carbon dioxide may get into a blood vessel (gas embolism) and may travel to the heart; this can be life threatening but is treated quickly and effectively.

**Re-operation**
If a complication after surgery does not resolve, your surgeon may have to operate again to control the situation. The reoperation may be done with the laparoscope or using open surgery.

**REPORT TO YOUR SURGEON**
Let your surgeon know at once if you have any of the following signs or symptoms:
- Fever greater than 38°C or chills
- Redness, swelling, increasing pain or bleeding, or discharge from the incisions
- Yellow skin or eyes, or dark urine
- Cough, shortness of breath, chest pain, severe nausea or vomiting
- Pain or swelling in your feet, calves or legs
- Inability to eat or drink
- Persistent weakness or dizziness
- Any other pains or concerns.