Patient Information

Patient information and consent to laparoscopic cholecystectomy

**Key messages for patients**

- **Please read your admission letter carefully. It is important to follow the instructions we give you about not eating or drinking or we may have to postpone or cancel your operation.**

- **Please read this information carefully, you and your health professional will sign it to document your consent.**

- **It is important that you bring the consent form with you when you are admitted for surgery.** You will have an opportunity to ask any questions from the surgeon or anaesthetist when you are admitted. You may sign the consent form either before you come or when you are admitted.

- **Please bring with you any medications you use (including patches, creams and herbal remedies) and any information that you have been given relevant to your care in hospital, such as x rays or test results.**

- Take your medications as normal on the day of the procedure **unless** you have been specifically told not to take a drug or drugs before or on the day by a member of your medical team. If you have diabetes please ask for specific individual advice to be given on your medication at your Pre-Operative Assessment appointment.

- **Please call the upper gastrointestinal surgery specialist nurse or the consultant secretary on telephone number 01223 245151 ext 6383** if you have any questions or concerns about this procedure or your appointment.

After the procedure we will file the consent form in your medical notes and you may take this information leaflet home with you.

**Important things you need to know**

Patient choice is an important part of your care. You have the right to change your mind at any time, even after you have given consent and the procedure has started (as long as it is safe and practical to do so). You will be having a general anaesthetic and will have the opportunity to discuss this with the anaesthetist, unless the urgency of your treatment prevents this.

We will also only carry out the procedure on your consent form unless, in the opinion of the responsible health professional, a further procedure is needed in order to save your life or prevent serious harm to your health. However, there may be procedures you do not wish us to carry out and these can be recorded on the consent form. We are unable to guarantee that a particular person will perform the procedure. However the person undertaking the procedure will have the relevant experience.

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*It has been reported - training statistics of Bile Duct Injury*

All information we hold about you is stored according to the Data Protection Act 1998. **53% of BDI occurred during the surgeon’s first ten cases, 33% between case 11-50.**

Laparoscopic cholecystectomy, CF192, Version 5, December 2013
What is the gall bladder?
Your liver has many functions, one of which is to produce a substance called bile. This green liquid drains from the liver to the intestine via the bile duct (see diagram below). The gall bladder is a small reservoir attached to the side of the bile duct where bile can be stored and concentrated between meals. When we eat, particularly fatty foods, the gall bladder contracts and empties extra bile into the bile duct and then into the intestine to mix with the food. Bile has many functions, one of which is to allow us to absorb fat. The gall bladder sits just under the liver, which is in the right upper part of the abdomen, just under the ribs.

Why might I need my gall bladder removed?
Usually this is because it is giving you pain due to gall stones. These small stones form in the gall bladder and can cause a range of problems including pain, jaundice, infection and pancreatitis. They are very common but do not always cause symptoms. Gall stones that are not causing trouble can be left alone.

Intended benefits
The gallbladder and gallstones are removed to prevent pain and/or complications of these.

Who will perform my procedure?
This procedure will be performed by a consultant surgeon or by the team under the consultant’s care.

Before your procedure
Most patients attend a pre-admission clinic, when you will meet a member of the team who will be looking after you. At this clinic, we will ask for details of your medical history and carry out any necessary clinical examinations and investigations. You will also be informed by the doctor you see about where your operation will be carried out. Please ask us any questions about the procedure, and feel free to discuss any concerns you might have at any time.

We will ask if you take any tablets or use any other types of medication either prescribed by a doctor or bought over the counter in a pharmacy. Please bring any
This procedure involves the use of anaesthesia. We explain about the different types of anaesthesia or sedation we may use at the end of this leaflet. You will see an anaesthetist before your procedure. They will review your medical history. In particular, you will be asked about your medications and any health problems that you have. They will also ask you about previous anaesthetics you have had and whether you had any problems with these (for example, nausea). You will be asked if you are allergic to anything. They will also want to know about your teeth, whether you wear dentures, have caps or a plate. Your anaesthetist may examine your heart and lungs.

Occasionally you may be prescribed medication that you will be given shortly before your operation – this is known as ‘the pre-medication’ or ‘pre-med’. They relax you and may send you to sleep.

Most people who have this type of procedure will not need to stay in hospital overnight and the procedure is performed as a day case, although this may not be suitable for everyone. Whether your procedure will be carried out as a day case or not, you will almost always be admitted to hospital on the day of your operation. Your doctor will discuss the length of stay with you.

During surgery it is very unlikely you may lose blood. If you lose a considerable amount of blood your doctor may want to replace the loss with a blood transfusion as significant blood loss can cause you harm. The blood transfusion can involve giving you other blood components such as plasma and platelets which are necessary for blood clotting. Your doctor will only give you a transfusion of blood or blood components during surgery, or recommend for you to have a transfusion after surgery, if you need it.

Compared to other everyday risks the likelihood of getting a serious side effect from a transfusion of blood or blood component is very low. Your doctor can explain to you the benefits and risks from a blood transfusion. Your doctor can also give you information about whether there are suitable alternatives to blood transfusion for your treatment. There is a patient information leaflet for blood transfusion available for you to read on request; please do not hesitate to ask for it.

Hair removal before an operation
For most operations, you do not need to have the hair around the site of the operation removed. However, sometimes the healthcare team need to see or reach your skin and if this is necessary they will use an electric hair clipper with a single-use disposable head, on the day of the surgery. Please do not shave the hair yourself or use a razor to remove hair, as this can increase the risk of infection. Your healthcare team will be happy to discuss this with you.
During the procedure

- Before your procedure, you will be given a general anaesthetic. This is usually performed by giving you an injection of medication intravenously (i.e. into a vein) through a small plastic cannula (commonly known as 'a drip'), placed usually in your arm or hand.
- While you are unconscious and unaware your anaesthetist remains with you at all times, monitoring your condition and controlling your anaesthetic. At the end of the operation, your anaesthetist will reverse the anaesthetic and you will regain awareness and consciousness in the recovery room, or as you leave the operating theatre.
- Four small holes (between 0.5cm - 1cm long each) are made in the tummy wall. Through these, we inflate your tummy up with carbon dioxide gas which is completely harmless.
- We then use special long instruments to free up the gall bladder with its stones from underneath the liver and it is completely removed. This is all visualised on a TV screen by a miniature camera inserted through one of the four key-holes. In addition, it is sometimes necessary to perform a special X-ray during the operation called a cholangiogram. This is used to check for stones in the bile duct.
- At the end of the operation, before you wake up, all the puncture sites in your abdomen will be treated with local anaesthetic so that when you first wake up there should be very little pain. Some patients have some discomfort in their shoulders, but this wears off quite quickly.
- The cuts we have made will be covered with small waterproof dressings or absorbable glue.

After the procedure

Once your surgery is completed you will usually be transferred to the recovery ward where you will be looked after by specially trained nurses, under the direction of your anaesthetist. The nurses will monitor you closely until the effects of any general anaesthetic have adequately worn off and you are conscious. They will monitor your heart rate, blood pressure and oxygen levels too. You may be given oxygen via a facemask, fluids via your drip and appropriate pain relief until you are comfortable enough to return to your ward.

After certain major operations you may be transferred to the intensive care unit (ICU/ITU), high dependency unit (HDU), intermediate dependency area (IDA) or fast track/overnight intensive recovery (OIR). These are areas where you will be monitored much more closely because of the nature of your operation or because of certain pre-existing health problems that you may have. If your surgeon or anaesthetist believes you should go to one of these areas after your operation, they will tell you and explain to you what you should expect.

If there is not a bed in the necessary unit on the day of your operation, your operation may be postponed as it is important that you have the correct level of care after major surgery.
Eating and drinking. You will be able to drink immediately after the operation and if this is all right and you do not feel sick, then you will be able to eat something.

Getting about after the procedure. We will help you to become mobile as soon as possible after the procedure. This helps improve your recovery and reduces the risk of certain complications. If you have any mobility problems, we can arrange nursing or physiotherapy help.

Leaving hospital. You will be reviewed by the doctors and nursing staff on the ward after your operation. You will be allowed home after you have had something to drink and eat. We will also check that you are not feeling sick and have been able to pass urine. You will be given a supply of simple painkillers to take home. We recommend that you take these regularly for the first couple of days at home after your operation. You may feel discomfort for seven to ten days after, but simple painkillers taken by mouth are usually all that people need to enable them to be fully mobile at home.

Resuming normal activities including work. We expect you to return to normal activities in a matter of days following your procedure. You can drive again when you can comfortably make an emergency stop (generally about seven days, but must be checked in stationary car first!). Other more vigorous activities can be resumed after two weeks as you feel comfortable.

Special measures after the procedure:
What happens with my dressings? All the wounds are closed with dissolvable stitches under the skin and therefore nothing needs to be done to these after the operation. Each of the wounds is covered with a small waterproof dressing which we ask you to keep intact for five days if possible. It is shower proof but will come off in a hot bath. We suggest that you get into a hot bath on day five and gently remove the dressings and leave the wound open to the air. If they rub on your clothing you may find it more comfortable to put a small Elastoplast dressing over each wound. If you have any worries about your wounds, you should contact your GP. If you have glue then you can have a shower the following day and a bath four days after the procedure and the glue will dissolve/disappear over the coming weeks.

Check-ups and results: Before you leave hospital you will be advised about your expected recovery. We do not need to see you routinely for a check up in the clinic but are always happy to do so if you have any problems.
How is this different from the traditional operation for gall bladder problems?

The actual operation is the same. The only thing that differs is the way in which we get to the gall bladder to remove it. Traditionally, we make a cut underneath the ribs (15cm long). This takes longer to heal than the four little holes of keyhole surgery and the recovery is slower.

Is there a guarantee that keyhole surgery can be done?

No, there is no guarantee that the operation can be completed by keyhole surgery. If there is some technical difficulty with removing the gall bladder then a traditional cut would be needed to remove it. The time in hospital would be a little longer (about three to five days) and the recovery at home would be between six to eight weeks. The risk of having to convert to open surgery is small, about 1-3%.

Can I manage without my gall bladder?

Yes. The gall bladder is a reservoir for bile and we are able to manage without it. Rarely patients notice that their bowels are a little looser than before the operation but this is uncommon. You will be able to eat a normal diet after your operation, assuming that there is nothing else wrong with you.

9.1% to 20% of patients reported post-cholecystectomy diarrhoea as a troublesome problem

Significant, unavoidable or frequently occurring risks of this procedure

Removal of the gallbladder is a very common and a very safe procedure. However, like all operations there are small risks involved. We believe that it is very important that you are fully aware of these risks as this is important in your understanding of what the operation involves. The possible complications below are particularly important as they can mean that you need to stay in hospital for longer and that further operations or procedures are required.

- **Bleeding** – this very rarely occurs after any type of operation. Your pulse and blood pressure are closely monitored after your operation as this is the best way of detecting this potential problem. If bleeding is thought to be happening, you will require a further operation to stop it. This can usually be done through the same keyhole scars as your first operation.

- **Infection** – this can affect your scars (‘wound infection’) or can occur inside your tummy. Again this can happen after any type of abdominal operation. Simple wound infections can be easily treated with a short course of antibiotics. Infection inside your tummy will also usually settle with antibiotics. Occasionally, it may be necessary to drain off infected fluid from inside your tummy. This is most frequently performed under a local anaesthetic by our colleagues in the X ray department.

- **Leakage of bile** – When we remove the gallbladder, we put special clips on the tube that connects the gallbladder to the main bile duct draining the liver. Despite this, sometimes bile fluid leaks out. If this does occur, we have a number of different ways of dealing with this. Sometimes the fluid can simply

Consent obtained through deception - No evidence based medical study known to mankind
be drained off by our colleagues in the X-ray department. In other cases we will ask some other colleagues to perform a special test called an ERCP. This is a procedure where you are made very sleepy (using sedative injections) and a special flexible camera (‘an endoscope’) is passed down your gullet and stomach to allow the doctor to see the lower end of your bile duct. The doctor then injects a special dye that allows them to see where the bile has leaked from. If they see where the bile is leaking from, they will insert a plastic tube (called a ‘stent’) into your bile duct to allow the bile to drain internally. This stent is usually removed six to eight weeks after it is put in. Rarely, if a patient develops a bile leak, an operation is required to drain the bile and wash out the inside of the abdominal cavity. This can usually be performed as a keyhole procedure.

**False Claim**

- **Injury to bile duct** – Injury to the main bile duct draining bile from the liver to your intestine is a rare (1 per 400 cases) complication of gallbladder surgery. We use a number of techniques during the operation to prevent this happening. If an injury occurs, it requires immediate repair so that you recover smoothly from the operation. Repair of this injury requires an open cut to be made under your ribs.

  1 per 300 cases accepted rate - reported as higher as 1.4%

- **Injury to intestine, bowel and blood vessels** – Injury to these structures can, very rarely, occur during the insertion of the keyhole instruments and during the freeing up of the gallbladder particularly if it is very inflamed. Usually this injury can be seen and repaired at the time of the operation, but occasionally may only become clear in the early postoperative period. If we suspect that you may have sustained such an injury, a further operation will be required. This will be performed as a keyhole operation but will need conversion to an open operation if necessary.

- **Blood clots in the legs (DVT)** – Before your operation, you will be fitted with some stockings that you wear during your operation to help prevent blood clots developing in the veins of your legs. You may also be given an injection in the skin of your tummy - this is a blood thinning medicine (Heparin) that also helps prevent blood clots.

**COMPLETE lie and informed consent fraud - Alternative treatment options do exist**

**Alternative procedures that are available**

Unfortunately no alternative exists. The only successful treatment is to remove the gall bladder and gall stones completely. The results of this operation are very good and most patients can then return to eating a normal diet.

**Information and support**

If you have any questions or anxieties about your procedure, do not hesitate to discuss these with your surgeon or one of the senior trainees. Please telephone 01223 217421.
Anaesthesia

Anaesthesia means ‘loss of sensation’. There are three types of anaesthesia: general, regional and local. The type of anaesthesia chosen by your anaesthetist depends on the nature of your surgery as well as your health and fitness. Sometimes different types of anaesthesia are used together.

Before your operation

Before your operation you will meet an anaesthetist who will discuss with you the most appropriate type of anaesthetic for your operation, and pain relief after your surgery. To inform this decision, he/she will need to know about:

- your general health, including previous and current health problems
- whether you or anyone in your family has had problems with anaesthetics
- any medicines or drugs you use
- whether you smoke
- whether you have had any abnormal reactions to any drugs or have any other allergies
- your teeth, whether you wear dentures, or have caps or crowns.

Your anaesthetist may need to listen to your heart and lungs, ask you to open your mouth and move your neck and will review your test results.

Pre-medication

You may be prescribed a ‘premed’ prior to your operation. This is a drug or combination of drugs which may be used to make you sleepy and relaxed before surgery, provide pain relief, reduce the risk of you being sick, or have effects specific for the procedure that you are going to have or for any medical conditions that you may have. Not all patients will be given a premed or will require one and the anaesthetist will often use drugs in the operating theatre to produce the same effects.

Moving to the operating room or theatre

You will usually change into a gown before your operation and we will take you to the operating suite. When you arrive in the theatre or anaesthetic room and before starting your anaesthesia, the medical team will perform a check of your name, personal details and confirm the operation you are expecting.

Once that is complete, monitoring devices may be attached to you, such as a blood pressure cuff, heart monitor (ECG) and a monitor to check your oxygen levels (a pulse oximeter). An intravenous line (drip) may be inserted. If a regional anaesthetic is going to be performed, this may be performed at this stage. If you are to have a general anaesthetic, you may be asked to breathe oxygen through a face mask.

General anaesthesia

During general anaesthesia you are put into a state of unconsciousness and you will be unaware of anything during the time of your operation. Your anaesthetist achieves Laparoscopic cholecystectomy, CF192, Version 5, December 2013
this by giving you a combination of drugs.

While you are unconscious and unaware your anaesthetist remains with you at all times. He or she monitors your condition and administers the right amount of anaesthetic drugs to maintain you at the correct level of unconsciousness for the period of the surgery. Your anaesthetist will be monitoring such factors as heart rate, blood pressure, heart rhythm, body temperature and breathing. He or she will also constantly watch your need for fluid or blood replacement.

**Regional anaesthesia**

Regional anaesthesia includes epidurals, spinals, caudals or local anaesthetic blocks of the nerves to the limbs or other areas of the body. Local anaesthetic is injected near to nerves, numbing the relevant area and possibly making the affected part of the body difficult or impossible to move for a period of time. Regional anaesthesia may be performed as the sole anaesthetic for your operation, with or without sedation, or with a general anaesthetic. Regional anaesthesia may also be used to provide pain relief after your surgery for hours or even days. Your anaesthetist will discuss the procedure, benefits and risks with you and, if you are to have a general anaesthetic as well, whether the regional anaesthesia will be performed before you are given the general anaesthetic.

**Local anaesthesia**

In local anaesthesia the local anaesthetic drug is injected into the skin and tissues at the site of the operation. The area of numbness will be restricted. Some sensation of pressure may be present, but there should be no pain. Local anaesthesia is used for minor operations such as stitching a cut, but may also be injected around the surgical site to help with pain relief. Usually a local anaesthetic will be given by the doctor doing the operation.

**Sedation**

Sedation is the use of small amounts of anaesthetic or similar drugs to produce a ‘sleepy-like’ state. Sedation may be used as well as a local or regional anaesthetic. The anaesthesia prevents you from feeling pain and the sedation makes you drowsy. Sedation also makes you physically and mentally relaxed during an investigation or procedure which may be unpleasant or painful (such as an endoscopy) but where your co-operation is needed. You may remember a little about what happened but often you will remember nothing. Sedation may be used by other professionals as well as anaesthetists.

**What will I feel like afterwards?**

How you will feel will depend on the type of anaesthetic and operation you have had, how much pain relieving medicine you need and your general health.

Most people will feel fine after their operation. Some people may feel dizzy, sick or
have general aches and pains. Others may experience some blurred vision, drowsiness, a sore throat, headache or breathing difficulties. You may have fewer of these effects after local or regional anaesthesia although when the effects of the anaesthesia wear off you may need pain relieving medicines.

**What are the risks of anaesthesia?**

In modern anaesthesia, serious problems are uncommon. Risks cannot be removed completely, but modern equipment, training and drugs have made it a much safer procedure in recent years. The risk to you as an individual will depend on whether you have any other illness, personal factors (such as smoking or being overweight) or surgery which is complicated, long or performed in an emergency.

**Very common (1 in 10 people) and common side effects (1 in 100 people)**
- Feeling sick and vomiting after surgery
- Sore throat
- Dizziness, blurred vision
- Headache
- Bladder problems
- Damage to lips or tongue (usually minor)
- Itching
- Aches, pains and backache
- Pain during injection of drugs
- Bruising and soreness
- Confusion or memory loss

**Uncommon side effects and complications (1 in 1000 people)**
- Chest infection
- Muscle pains
- Slow breathing (depressed respiration)
- Damage to teeth
- An existing medical condition getting worse
- Awareness (becoming conscious during your operation)

**Rare (1 in 10,000 people) and very rare (1 in 100,000 people) complications**
- Damage to the eyes
- Heart attack or stroke
- Serious allergy to drugs
- Nerve damage
- Death
- Equipment failure

Deaths caused by anaesthesia are very rare. There are probably about five deaths for every million anaesthetics in the UK. For more information about anaesthesia, please visit the Royal College of Anaesthetists’ website: [www.rcoa.ac.uk](http://www.rcoa.ac.uk)
Information about important questions on the consent form

1  Creutzfeldt Jakob Disease (‘CJD’)

We must take special measures with hospital instruments if there is a possibility you have been at risk of CJD or variant CJD disease. We therefore ask all patients undergoing any surgical procedure if they have been told that they are at increased risk of either of these forms of CJD. This helps prevent the spread of CJD to the wider public. A positive answer will not stop your procedure taking place, but enables us to plan your operation to minimise any risk of transmission to other patients.

2  Photography, Audio or Visual Recordings

As a leading teaching hospital we take great pride in our research and staff training. We ask for your permission to use images and recordings for your diagnosis and treatment, they will form part of your medical record. We also ask for your permission to use these images for audit and in training medical and other healthcare staff and UK medical students; you do not have to agree and if you prefer not to, this will not affect the care and treatment we provide. We will ask for your separate written permission to use any images or recordings in publications or research.

3  Students in training

Training doctors and other health professionals is essential to the NHS. Your treatment may provide an important opportunity for such training, where necessary under the careful supervision of a registered professional. You may, however, prefer not to take part in the formal training of medical and other students without this affecting your care and treatment.

4  Use of Tissue

As a leading bio-medical research centre and teaching hospital, we may be able to use tissue not needed for your treatment or diagnosis to carry out research, for quality control or to train medical staff for the future. Any such research, or storage or disposal of tissue, will be carried out in accordance with ethical, legal and professional standards. In order to carry out such research we need your consent. Any research will only be carried out if it has received ethical approval from a Research Ethics Committee. You do not have to agree and if you prefer not to, this will not in any way affect the care and treatment we provide. The leaflet ‘Donating tissue or cells for research’ gives more detailed information. Please ask for a copy.

If you wish to withdraw your consent on the use of tissue (including blood) for research, please contact our Patient Advice and Liaison Service (PALS), on 01223 216756.
Privacy & dignity

Same sex bays and bathrooms are offered in all wards except critical care and theatre recovery areas where the use of high-tech equipment and/or specialist one to one care is required.

We are currently working towards a smoke free site. Smoking is only permitted in the designated smoking areas. For advice and support in quitting, contact your GP or the free NHS stop smoking helpline on 0800 169 0 169

Help with this leaflet

If you would like this information in large print, another language or in audio format, please ask the department to contact Patient Information on 01223 216032 or patient.information@addenbrookes.nhs.uk

Document history

Authors
Upper GI Surgeon

Department
Cambridge University Hospitals NHS Foundation Trust, Hills Road, Cambridge, CB2 0QQ www.cuh.org.uk

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The gallbladder and gallstones are removed to prevent pain and/or complications of these.

b) the possible risks involved. Addenbrooke's always ensures any risks are minimised. However all procedures carry some risk and I have set out below any significant, unavoidable or frequently occurring risks including those specific to the patient

- Bleeding
- Infection
- Leakage of bile
- Injury to Bile Duct
- Injury to intestine, bowel and blood vessels
- Blood clots in the legs (DVT)

FRAUD CONFIRMED -
Non disclosure of likely ongoing post complications - impairment to quality of life

c) what the treatment or procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient:
Patient Information

Laparoscopic cholecystectomy

CF192 v5 December 2013

FRAUD CONFIRMED - No truthful information about long term risks or alternative options provided

"if NHS has lied about - " not need", "can live a normal life', 'eat a normal diet'

Consent Form

Laparoscopic cholecystectomy

Version, reference and date:  CF192 v5 December 2013

or  I have offered the patient information about the procedure but this has been declined.

This procedure will involve:

☐ General and/or regional anaesthesia  ☐ Local anaesthesia  ☐ Sedation  ☐ None

Signed (Health professional):  Date:  D D M M Y Y Y Y

Name (PRINT):  Time (24hr):  H H : M M

Designation:  Contact/bleep no:

"if NHS has lied about - " not need", "can live a normal life', 'eat a normal diet'

Consent of patient / person with parental responsibility  - I can sue for damages OK?"

I confirm that the risks, benefits and alternatives of this procedure have been discussed with me and that my questions have been answered to my satisfaction and understanding.

Important: please read the patient information about this procedure and then put a tick in the relevant boxes for the following questions:

FRAUD CONFIRMED - No truthful information about long term risks or alternative options provided

1. Creutzfeldt Jakob disease (CJD)
   Have you ever been notified that you are at risk of CJD or variant CJD for public health purposes? If yes, please inform your health professional.
   ☐ Yes ☐ No

2. Photography, Audio or Visual Recording
   a) I agree to the use of any of the above type of recordings for the purpose of diagnosis and treatment.
   ☐ Yes ☐ No
   b) I agree to unidentified versions of any of the above recordings being used for audit and medical teaching in a healthcare setting.
   ☐ Yes ☐ No

3. Students in training
   I agree to the involvement of medical and other students as part of their formal training.
   ☐ Yes ☐ No

FRAUD CONFIRMED - 'advised risk being higher for bile duct injury'
Use of Tissue

a) I agree that tissue (including blood) not needed for my own diagnosis or treatment can be used and stored for ethically approved research which may include ethically approved genetic research.

☐ Yes  ☐ No

b) Where additional clinical information is needed for the purposes of ethically approved research, I agree that relevant sections of my medical record may be looked at by researchers or by relevant regulatory authorities. I give permission for these individuals to have access to my records.

☐ Yes  ☐ No

I have listed below any procedures that I do not wish to be carried out without further discussion.


I have read and understood the Patient Information about this procedure and the above additional information. I agree to the procedure or treatment.

Signed (Patient): .......................................................... Date: ___/___/___

Name of patient (PRINT): ..................................................

If signing for a child or young person; delete if not applicable.

I confirm I am a person with parental responsibility for the patient named on this form.

Signed: ........................................................................ Date: ___/___/___

Relationship to patient:

If the patient is unable to sign but has indicated his/her consent, a witness should sign below.

Signed (Witness): .......................................................... Date: ___/___/___

Name of witness (PRINT): ..................................................

Address: ........................................................................
Consent Form

Laparoscopic cholecystectomy

D Confirmation of consent

Confirmation of consent (where the treatment/procedure has been discussed in advance)
On behalf of the team treating the patient, I have confirmed with the patient that she/he has no further questions and wishes the treatment/procedure to go ahead.

Signed (Health professional): ________________________________ Date: ____________
Name (PRINT): __________________________________________ Job title: ________________________________

Please initial to confirm all sections have been completed:

E Interpreter’s statement (if appropriate)

I have interpreted the information to the best of my ability, and in a way in which I believe the patient can understand:

Signed (Interpreter): ________________________________ Date: ____________
Name (PRINT): __________________________________________

Or, please note the language line reference ID number:

F Withdrawal of patient consent

☐ The patient has withdrawn consent (ask patient to sign and date here)

Signed (Patient): ________________________________ Date: ____________
Signed (Health professional): ________________________________ Date: ____________
Name (PRINT): __________________________________________ Job title: ________________________________
More on - Informed Consent FRAUD Confirmed here.

Postcholecystectomy syndrome

From Wikipedia, the free encyclopedia

Postcholecystectomy syndrome describes the presence of abdominal symptoms after surgical removal of the gallbladder (cholecystectomy). 2 years after the surgery.

Symptoms of postcholecystectomy syndrome may include:
- Dyspepsia, nausea, and vomiting,
- Flatulence, bloating, and diarrhea.
- Persistent pain in the upper right abdomen.

Symptoms occur in about 5 to 40 percent of patients who undergo cholecystectomy[3] and can be transient, persistent, or lifelong. The chronic condition is diagnosed in approximately 10% of postcholecystectomy cases.

The pain associated with postcholecystectomy syndrome is usually ascribed to either sphincter of Oddi dysfunction or to post-surgical adhesions.[6][7] A recent study[7] shows that postcholecystectomy syndrome can be caused by biliary microthiasis.

Approximately 50% of cases are due to biliary causes such as remaining stone, biliary injury, dysmotility, and choledocolithiasis. The remaining 50% are due to non-biliary causes. This is because upper abdominal pain and gallstones are both common but are not always related.

Chronic diarrhea in postcholecystectomy syndrome is a type of bile acid diarrhea (type 3). This can be treated with a bile acid sequestrant like cholestyramine,[5] colestipol[4] or colesvelam,[8] which may be better tolerated.[9]

Postcholecystectomy syndrome (PCS)

S.S. Jaunoo*, S. Mohandas, L.M. Almond

Department of General Surgery, Worcestershire Royal Hospital, Worcester, UK

1. Introduction

Since its introduction by Muhe in 1986, laparoscopic cholecystectomy has rapidly gained in popularity and is now considered the treatment of choice for symptomatic gallstones disease. The advantages over laparotomy including reduced hospitalisation, pain, morbidity, better cosmesis and financial savings. There are over 50,000 performed annually in the UK and Ireland and more than half a million annually in the USA. Overall, cholecystectomy is an established successful operation which provides total relief of preoperative symptoms in more than 90% of patients.

2. Postcholecystectomy syndrome (PCS)

2.1. Definition

Post-cholecystectomy syndrome is defined as the recurrence of symptoms similar to those experienced before the cholecystectomy. This usually takes the form of upper abdominal pain (mainly right upper quadrant) and dyspepsia, with or without jaundice.

2.2. Incidence

The incidence of postcholecystectomy syndrome has been reported to be as high as 40% in one study, and the onset of symptoms may range from 2 days to 25 years. There may also be gender-specific risk factors for developing symptoms after cholecystectomy. In one study, the incidence of recurrent symptoms among female patients was 43%, compared to 28% among male patients.

2.3. Aetiological theories

The most common cause of postcholecystectomy syndrome is an overlooked extrabiliary disorder such as reflux esophagitis, peptic ulceration, irritable bowel syndrome or chronic pancreatitis. The biliary aetiologies include:

1. Biliary strictures
2. Bile leakage
3. Retained calculi
4. Dropped calculi
5. Chronic biloma or abscess
6. Long cystic duct remnant
7. Stenosis or dyskinesia of the sphincter of Oddi
8. Bile salt-induced diarrhea or gastritis

Bile duct injuries are the most serious complications associated with laparoscopic cholecystectomy, with a rate of occurrence as low as 0.2% but usually ranging from 0.4% to 4% for most surgeons. Many injuries may go unrecognized until the patient gets referred with symptoms of abdominal pain, sepsis or jaundice soon after...