DR MATLEY&PARTNERS
SPECIALIST SURGEONS
Practice Number: 4208293

Harfield House, Kingsbury Tel 021 683 3893 127 Vincent Pallotti Tel 021 506 5108

AORTIC ANEURYSM.

These notes give a guide to your stay in hospital. They also give an idea about what it will be like afterwards. They do not cover everything. If you want to know more, please ask.

What is an Aortic Aneurysm?

The aorta is a big artery, which carries blood from your heart to your legs. It runs deep in your tummy down to the level of your navel. There it branches into the 2 arteries, which run down to your legs. Sometimes the aorta forms a blowout like a balloon (an aneurysm). This is dangerous because the aneurysm can leak or burst, causing fatal internal bleeding. The aneurysm needs to be replaced by a new artery.

What does the operation consist of?

A cut is made in the skin of the tummy, usually from the breastbone to the pubis. A new artery made of a tube of very strong Dacron fabric is stitched in place inside the aneurysm. The cut in the tummy is then stitched up. Sometimes the 2 arteries, which run to your legs, have aneurysms as well. Then a new artery shaped like a pair of trousers is used. The bottoms of the trousers are stitched to the leg arteries. A cut in each groin is needed for this type of operation. The new arteries last for 20 years or more.

WHAT HAPPENS BEFORE THE OPERATION?

Reception

When registering at reception your medical aid details will be required. If you are not a member of a medical aid you will be required to pay a deposit or to sign an indemnity form. As far as possible we will try to advise you about hospital costs before your admission.

Welcome to the ward

You will be welcomed to the ward by the nurses or the receptionist and will have your details checked. Some basic tests will be done, such as pulse, temperature, blood pressure and urine examination. You will be asked to hand in any medicines or drugs you may be taking, so that your drug treatment in hospital will be correct. Please tell the nurses of any allergies to drugs or dressings. The surgeon will have explained the operation and you will be asked to sign your consent for the operation. If you are not clear about any part of the operation read this again and then ask for more details from the surgeon or from the nurses.

Visit by the anaesthetist.

The anaesthetist who will be giving your anaesthetic will interview and examine you. He will be especially interested in chest troubles, dental treatment and any previous anaesthetics you have had. He will put up a drip to give you fluid directly into your vein before the operation as you will not be able to drink for 12 hours.

Diet.

You will have your usual diet until the evening before the operation after which you will be asked to take only fluids. You will be given a laxative to drink to help to empty your bowel before the operation. From 6 hours before the operation you will not be allowed anything by mouth. This will let your stomach empty to prevent vomiting during your operation.

Shaving.

You will be shaved from chest to thighs to prevent hairs affecting the wound. You will be washed with an antiseptic solution to kill the skin germs in the vicinity of the cut.

Complications.

Complications may happen due to the very size of the operation. The chance of dying because of the operation is very small about 4 in a hundred but the risk of dying from the aneurysm bursting is considerably greater. Complications are rapidly recognized and dealt with by the nursing and medical staff. If you think that all is not well, please ask the nurses or doctors. Chest infections may arise, particularly in smokers. Co-operation with the physiotherapists to clear the air passages is important in preventing the condition. Do not smoke.

Occasionally the bowel is slow to start working again. This requires patience. Your food and water intake will continue through your vein tubing. Sometimes there is some discharge from the drain by the wound. This stops given time. Wound infection is sometimes seen. This settles down usually within a week or two. Aches and twinges may be felt in the wound for up to 6 months. Occasionally there are numb patches in the skin around the wound, which get better after 2 to 3 months.

A rare complication in males is impotence or retrograde (dry) ejaculation after the operation. This is due to interference with the nerves around the aorta and occurs even when no damage appears to have been done. It is unpredictable.

General advice.

The operation should not be underestimated. Some patients are surprised how slowly they regain their normal stamina - but virtually all patients are back doing their normal duties within 3 months.

If you have any problems or queries, please ask the nurses or doctors.

Washing.

You can wash the wound area as soon as the dressing has been removed. Soap and warm tap water are entirely adequate. Salted water is not necessary. You can shower or bath as often as you want.

How long in hospital?

You should plan to leave hospital within 2 weeks of the operation. You will be provided with an appointment to visit for a checkup as required, usually about one month after you leave hospital.

Sick notes.

Please ask the doctor for sick notes, certificates etc.

After you leave hospital.

You are likely to feel very tired and need rests 2 or 3 times a day for a month or more. You will gradually improve so that by the time 3 months has passed you will be able to return completely to your usual level of activity.

Driving.

You can drive as soon as you can make an emergency stop without discomfort in the wound, i.e. after about 3 weeks.

What about sex?

You can restart sexual relations within 4 to 6 weeks when the wound is comfortable enough.

Work.

You should be able to return to a light job after about 12 weeks and any heavy job within 6 months.

Timing of the operation.

The timing of your operation is usually arranged the day before so that the nurses will tell you when to expect to go to the operating theatre. Do not be surprised, however, if there are changes to the exact timing.

Bladder catheters.

Patients usually have a fine rubber tube passed into the bladder through the front passage during the anaesthetic. This lets the bladder stay empty and small during the operation and helps us control your body fluids afterwards.

Premedication.

You may be given a sedative injection or tablets about 1 hour before the operation.

Transfer to theatre.

You will be taken on a trolley to the operating suite by the ward staff. You will be wearing a cotton gown, wedding rings will be fastened with tape and removable dentures will be left on the ward. There will be several checks on your details on the way to the operating room where your anaesthetic will begin.

Coming round after the anaesthetic.

You are unlikely to remember anything for several hours after the operation. You will be taken to the Intensive Care Unit on a trolley and will wake up in a bed there. It is quite likely that you will be connected to an anaesthetic ventilator for a day or two to help your recovery. This means that there will be a tube passing into your windpipe, and the machine will be pumping oxygen in and out for you. You will not be able to speak because of the tube, but you will be able to hear and see and communicate with the nurses by means of movement. You will have sedatives to help you relax if you need them. There will be lots of other tubes and wires connecting part of you to various gadgets. For instance, there will be a tube down the back of your nose to keep your stomach empty. There will be a tube in your bladder to collect urine. This may make you feel that you want to pass urine all the

time, but the feeling will pass off. You will have one or more plastic tubes in the veins of your arms and on the side of your neck to give you necessary liquids. There will be several wires attached to your chest to check your heart action. You will have a cuff on one arm, which squeezes automatically every few minutes to measure your blood pressure. The ventilator is rather noisy, making a pumping noise. There will be several nurses working around you. They will talk to you and tell you what is happening and how you are doing, what day it is, what time it is, and what they are going to do next and ask you if there is anything you want in the way of pain relief, positioning, relatives, etc. You will be able to have visitors during this time.
You will have x-rays, physiotherapy and attention to your tubing and wires. As you improve the various tubes are removed so that after a day or two you will be able to go back to your original surgical ward without any tubing. By this time you should be starting to drink liquids. You should be on a soft diet within a week and onto a normal diet in two weeks.

Will it hurt?

The wound is painful and this may be controlled by an injection in your back called an epidural, which the anaesthetist will usually insert during or just before the anaesthetic. Ask him about this. You will also be given injections and later tablets to control this. Ask for more if the pain is still unpleasant. You will be expected to get out of bed after 2 days. You will not do the wound any harm and the exercise is very helpful for you.
The fourth day after operation you should be able to spend an hour or two out of bed. By the end of a week you should have little pain.

Drinking and eating.

The operation causes the bowel to stop working for a day or two. Until the bowel starts up again, you will be given water, salts and sugar solutions into your arm vein. The tube in your nose will be used to draw off any build-up of stomach juices. The first signs of returning bowel activity are noises in your tummy and passing wind out of your back passage. Once these have happened you will be able to start drinking - a little at a time. When you are able to drink freely, the arm drip tubing is removed. You should be eating normally after 4 or 5 days.

Opening bowels.

It is quite normal for the bowels not to open for 3 or 4 days after the operation. Often there is diarrhoea for up to a week, but this settles down by itself. If

you have not opened your bowels after two days and you feel uncomfortable, ask the nurses for a laxative.

Passing urine.

Because of the drainage tube (catheter) in the bladder, passing urine is not a problem. Sometimes there is a feeling that there is a leakage all the time, but this is just an irritation by the tubing and it passes off. Once you can walk about in reasonable comfort, the catheter is taken out.

Sleeping.

You will be offered painkillers and, if necessary, sleeping pills to help you to sleep.

Physiotherapy.

The physiotherapist will check that you are clearing your lungs of phlegm by coughing and that you are helping your circulation by continuous movement of body and limbs.

The wound and stitches.

The wound has a dressing which may show some staining with old blood in the first 24 hours. The dressing will be removed and the wound checked as necessary. Once the stitches are taken out there is no need for a dressing unless the wound is painful when rubbed by clothing. The wound is held together underneath the skin and does not need further attention. There may be some purple bruising around the wound which spreads downwards by gravity and fades to a yellow colour after 2 to 3 days. It is not important. There may be some swelling of the surrounding skin which also improves in 2 to 3 days. After 10 to 20 days, slight crusts on the wound will fall off. Occasionally minor matchhead sized blebs form on the wound line, but these settle down after discharging a blob of yellow fluid for a day or so.