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Aortic Aneurysms – Patient Information Sheet

The aim of this information sheet is to ensure that you understand the nature of the treatment you wish to undertake. Please read it carefully and discuss any queries with us.. You have an abdominal aortic aneurysm and have been advised to have it repaired. This is an information sheet which advises you of the pros and cons of having this operation and answers to common worries that patients have. It is not intended to replace a consultation nor is it intended to be a textbook of surgery.

The main risk of not repairing your aneurysm is that of rupture. This is a very serious event and usually results in death.

Very occasionally, I advise patients that they should not have their abdominal aneurysm repaired. This is usually because of extreme frailty associated with a small aneurysm.

Most operations are undertaken without major complications. However, one in 20 patients (approximately 5%) will suffer with a complication resulting in death. This is usually as a result of failure of one or more of the organ systems. In particular the heart, kidneys and lungs are put under great strain and may not be able to withstand the surgery. Other major, albeit, infrequent complications are loss of limb and sometimes, stroke. It is also likely that you will require some blood over the course of the operation - any objection to transfusion should be discussed. As aortic aneurysms are common in men in their 60's and 70's, it should be noted that there is also a risk of erectile dysfunction (impotence) after this procedure.

On balance, the risks of not treating you outweigh the risks of surgery and you have been recommended to have your abdominal aneurysm repaired. Closer to the date of your operation, you will receive an appointment for a pre-operative visit to the hospital. You will receive further details of the operation and pre-operative preparations then, and will have the opportunity to ask any questions. However, if you have any worries that cannot wait until then, please make an appointment for my Out-patient Clinic at the hospital.

Pre-operative

You may be required to come into hospital a few days before admission, for any special tests (such as X-rays, blood tests etc.) that I or a member of my team have requested. These tests

may include scans of the abdomen or x-rays of the arteries (angiogram) if these have not already been done. Special scans of your heart to check that it is working properly may also be needed. Because the operation is undertaken with a General Anaesthetic (i.e. you are asleep during the procedure) you will need to have starved (no fluids or solids) for at least 6 hours before the operation. All patients who undergo this procedure are transferred to the intensive care unit (ITU) post-operatively for 24 hours or so. If possible, you will be shown the ITU and introduced to a member of that unit.

On admission to the ward you will have your details checked and have some basic tests 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. You may be required to shave the operative site before surgery. It is best if this is done a few hours before the operation. In addition you will be asked to shower using an antiseptic soap in an effort to reduce the number of skin organisms. A saline intra-venous drip will be started overnight to make sure you are well hydrated

I, or a member of my team, will check that all the necessary preparations have been made. You will be asked to sign a consent form. The form signifies that you know and understand why the operation is required and what it involves. The anaesthetist who will be giving your anaesthetic will also interview and examine you. He/she will be especially interested in chest troubles, dental treatment and any previous anaesthetics you have had, plus any anaesthetic problems in the family.

The timing of your operation is usually arranged the day before. 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. The order of the list is usually on the basis of medical priority. Just because you are not 'first' on the list does not mean that you are unimportant. At the current time, particularly within the NHS, there is a dire shortage of intensive care beds and the ITU bed allocated to you may be used for another more pressing problem. Cancellation of the operation at such short notice can result in extreme frustration for you and all members of staff and all will be done to make sure that such an eventuality does not happen.

You will be taken on a trolley to the operating suite by a ward nurse and a theatre porter. There will be several checks on your details on the way to the anaesthetic room.

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Operative

The anaesthetic is given through a needle in the back of your hand and you will fall asleep within seconds. As well as being put to sleep you may have a small tube placed in your back (epidural) to help with pain relief following surgery. Whilst you are asleep tubes will also be inserted into your bladder to drain your urine, into your stomach (via your nose) to stop you feeling sick, and into a vein in your neck for blood pressure measurements and administration of fluid following surgery.

The abdominal area is cleaned with an antiseptic and the site draped with sterile towels. You will have a cut down or across your abdomen and occasionally it is necessary to make a smaller cut in one or both groins. The aorta and particularly the swollen area will be replaced by an artificial blood vessel made of plastic (Dacron). The cuts in the skin are then closed up. My preference is to use 'dissolvable' sutures which are absorbed by the body over a period of a few weeks and therefore do not have to be removed. The entire area is treated with a long acting local anaesthetic which provides excellent pain relief for the first few hours. Sometimes, it is necessary to leave a tube (drain) in the abdominal cavity to help drain any blood or fluids that may collect. The drain is usually removed in 24 to 48 hours.

Post-operative

You will usually be taken to an intensive care or high dependency unit following your operation in order to be able to monitor your progress closely. It is sometimes necessary for you to remain on a breathing machine for a period after the operation but you will be taken off this as soon as possible.

Following this sort of surgery the bowel stops working for a while and you will be given all the fluids you require in a drip until your bowel will cope with fluids by mouth. A blood transfusion may also be required. The nurses and doctors will try and keep you free of pain by giving pain killers by injection, via a tube in your back, or by a machine that you are able to control yourself by pressing a button. As the days pass and you improve the various tubes will be removed and you will be returned to the normal ward until you are fit enough to go home. You will be visited by the physiotherapist before and after your operation who will help you with your breathing to prevent you developing a chest infection and with your walking.

The wounds have a dressing which may show some staining with old blood in the first 24 hours. Most patients prefer to keep a dressing on the wound to protect it from rubbing from clothing. There may be some purple bruising around the wound which spreads downward 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 over 2 to 3 weeks After 7 to 10 days, slight crusts on the wound will fall off. Occasionally minor match head sized blebs form on the wound line. These settle down after discharging a blob of yellow fluid for a day or so. You can wash the wound area 48 hours after the operation. Soap and warm tap water are entirely adequate. Salted water is not necessary. You can shower or take a bath as often as you want.

You will be given an appointment to visit the Outpatient Department about two weeks after you leave hospital. If your sutures have not still dissolved they will be removed at this time. Please ask the nurses for sick notes, certificates etc, the day before discharge.

Back at home

You are likely to feel very tired and need rests 2 to 3 times a day for a week or more. You will gradually improve so that by the time 2 weeks has passed you will be able to return completely to your usual level of activity. There is no value in attempting to speed the recovery of the wound by special exercises before the month is out. You can drive as soon as you can make an emergency stop without discomfort in the wound. You can restart sexual relations within a week or two, when the wounds are comfortable enough and you should be able to return to a light job after about 6 weeks, and any heavy job within 12 weeks. You should avoid heavy lifting or straining for 6 weeks after the operation.

You will usually be sent home on a small dose of aspirin if you were not already taking it. This is to make the blood less sticky. If you are unable to tolerate aspirin an alternative drug may be prescribed

Complications at this stage are unusual. Chest infections can occur following this type of surgery, particularly in smokers, and may require treatment with antibiotics and physiotherapy. Slight discomfort and twinges of pain in your wound is normal for several months following surgery, but wounds sometimes become infected and these can usually be successfully be treated with antibiotics. Also the wound in your groin can fill with a fluid called lymph that may discharge between the stitches but this usually settles down with time. Sexual activity may be affected due to the operation.

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Practically all patients are back to their normal duties within six weeks. If you have any problems or queries after discharge, please ring the ward who will advise and contact me if necessary.