Mr Sanjeev Sarin MS FRCS

Consultant General & Vascular Surgeon

www.sarin.uk.com

Patient Information Sheet - Cholecystectomy (laparoscopic)

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 gallstones and have been advised to have your gallbladder removed. 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 risks of not removing your gallbladder include continuing discomfort, inflammation of the gallbladder, jaundice, inflammation of the pancreas, cholangitis and empyema. The latter three complications are serious and can result in peritonitis and death. Very occasionally, I advise patients that they should not have their gallbladder removed. This is usually because of extreme frailty associated with minimal symptoms.

Most gallbladder problems have to be dealt with surgically under general anaesthetic. These days the operation is usually undertaken using the keyhole method and will require one or two nights in hospital. In some cases (less than 5%), the operation is started using the keyhole method but then for technical reasons requires to be converted to the traditional 'open' method. This is usually the case if the surgeon considers it unsafe to proceed with the keyhole method. The open technique involves a larger scar and a 4 or 5 night hospital stay. In addition the recovery period is longer.

Most operations are undertaken without complications. Less than one in 20 of patients suffer any complications from this operation. The common complications associated with this operation are wound infection and blood or fluid collecting at the gallbladder site. These are relatively minor complications which are usually dealt with by a course of antibiotics or drainage through the skin. Sometimes it may be necessary to undertake an additional procedure to help the drainage of bile. On rare occasions more serious complications (e.g. bleeding) may occur.

On balance, the risks of not treating you outweigh the risks of surgery and I have recommended you to have your gallbladder removed. 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

Mr Sanjeev Sarin MS FRCS

Consultant General & Vascular Surgeon

www.sarin.uk.com

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. 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.

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.

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.

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.

Operative

The anaesthetic is given through a needle in the back of your hand and you will fall asleep within seconds. A small dose of heparin is given to reduce the risk of deep vein thrombosis, the abdominal area is cleaned with an antiseptic and the site draped with sterile towels.

The abdominal cavity is filled with a gas (carbon dioxide) and the camera and instruments inserted. The gallbladder is identified and removed. 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. The gallstones will be given to you and the gallbladder itself sent, as a matter of course, to be looked at under the microscope (histology).

Mr Sanjeev Sarin MS FRCS

Consultant General & Vascular Surgeon

www.sarin.uk.com

Post-operative

Although you will be conscious a minute or two after the operation ends, you are unlikely to remember anything until you are back in your bed on the ward. Some patients feel a bit sick for up to 24 hours after operation, but this passes off. You will be given some treatment for sickness if necessary. You may be given oxygen from a face mask for a few hours if you have had chest problems in the past.

The drugs we give for a general anaesthetic will make you clumsy, slow and forgetful for about 24 hours. This happens even if you feel quite alright.

For 24 hours after your general anaesthetic:

- Do not make any important decisions.
- Do not drive.
- Do not use machinery at work or at home. (e.g. do not mow the lawn).

There is some discomfort on moving rather than severe pain. You will be given injections or tablets to control this as required. Ask for more if the pain is still unpleasant. You will be expected to get out of bed the day of the operation despite the discomfort. You will not do the wound any harm, and the exercise is very helpful for you. The day after the operation you should be able to walk slowly. By the end of the second week the wound should be virtually pain-free.

You will be able to drink within an hour or two of the operation provided you are not feeling sick. The next day you should be able to manage a light diet. It is quite normal for the bowels not to open for a day or so after operation. If you have not opened your bowels after 2 days and you feel uncomfortable, you can take a laxative.

It is important that you pass urine and empty your bladder within 6-12 hours of the operation. If you find using a bed pan or a bottle difficult, the nurses will assist you to a commode or the toilet. If you still cannot pass urine let the nurses know and steps will be taken to correct the problem.

The wounds have a dressing which may show some staining with old blood in the first 24 hours. You can take the dressings off after 48 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.

Mr Sanjeev Sarin MS FRCS

Consultant General & Vascular Surgeon

www.sarin.uk.com

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, i.e. after about 5 to 7 days. 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 14 days, and any heavy job within 4 weeks.

Complications are unusual. Infection is a rare problem and settles down with antibiotics in a week or two. Aches and twinges may be felt in the wound for up to 6 months.

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