

Patient Information

Repair of Abdominal Aortic Aneurysm

We have developed this booklet to give you some information about repair of abdominal aortic aneurysm and what to expect when you decide to have this operation. We have outlined some of the benefits, risks and alternatives, if any, to the operation. We hope that this information will help you in making your decision. Please ask your surgeon about anything you do not fully understand or you wish to be explained in more detail.

Why do I need an operation?

Your consultant has discussed your condition with you and recommended surgery to repair your aneurysm. The decision to operate on an aneurysm depends on its size and risks involved. Once an aneurysm has reached 5.5cm surgery is recommended to reduce the risk of the aneurysm bursting (rupture). This is a life-threatening situation.

What are the benefits of having the operation?

Repairing an aneurysm reduces the risk of rupture potentially extending your life. Having an arranged date for your operation also reduces the risk of emergency surgery.

Once I undergo surgery what are the risks?

Aortic aneurysm repair is major surgery with risks attached. Your consultant will discuss these with you. The following is an outline of possible risks from this operation.

- Death - this may occur in 5-10% cases and most deaths are due to heart problems.
- Heart problems - these include heart attack, heart failure, and odd rhythms.
- Chest problems - pneumonia, chest infections, clots in the lungs. (pulmonary embolism).
- Stroke - fatal or severely disabling.
- Bleeding - either at the time of the operation or a few hours later. This would require going back to theatre.
- Blocked graft/infection - due to clot or infection.
- Kidney problems - such as kidney failure.

- Nerve injury to the spinal cord or paralysis of legs.
- Damage to bowel due to lack of blood supply/clot
- Possible risk of amputation of (leg/s) due to clots blocking leg arteries
- Damage to the nerves in the pelvis which may result in impotence in men
- Swelling around the graft (false aneurysm)

What are the alternatives?

If you leave things as they are, there is a high chance of the aneurysm rupturing (bursting). As the aneurysm gets bigger it may become more difficult to operate on, so increasing your risk of complications from surgery. An operation is usually the best way forward.

What happens before the operation?

About a week before surgery you will be asked to attend pre-admission clinic. There you will be seen by a junior doctor who will take a detailed history from you and perform an examination. Please remember to bring in your list of tablets. Blood tests heart tracings and a chest x-ray will be performed.

On the day of admission please contact the ward to check that a bed is available for you. Once the bed has been confirmed, please make your way to the hospital. Do not bring any valuables with you.

Prior to surgery you will meet your consultant and the medical team responsible for your care, where more details will be explained to you regarding anaesthetic etc. If beds in HDU/ITU are not available sometimes surgery is delayed.

When you are admitted, the ward nurse will prepare you for theatre.

What does the operation involve?

A cut will be made on your abdomen usually on the left below the ribs towards your groin. A new graft (plastic fabric) is stitched in place inside the aneurysm. The cut is then stitched up.

Sometimes the arteries, which run down your legs, are affected. If this is the case the graft will extend into your groins.

What happens after the operation?

Once the operation is completed you will be transferred to ITU/HDU where you will be very closely monitored. Once you are stable you will be transferred back to the ward. As the days go by we expect your recovery to continue and you become more independent. The physiotherapist will visit you and instruct you on deep breathing exercises and mobility.

The doctors will give you medication for pain through a pump called PCA/epidural pump. Your doctor will advise you on when you can eat and drink. The wound is closely observed to check for infection. Clips/stitches are usually removed 14 days after the operation.

When can I expect to go home?

You can expect to be in hospital for 1-2 weeks before you feel strong enough for discharge. It is normal to feel tired which may last for 4-6 weeks. You will be followed up in outpatients to check on your progress.

What can I do when I get home?

Do not overdo any activity. It should be gradually increased. It is important you do not lift heavy things or push heavy objects for 2-3 months. This is to prevent causing any damage to yourself.

Rest when you feel tired. You may drive when you are able to perform an emergency stop without discomfort and this is usually 4-8 weeks after the operation.

You can restart sexual relations at 4-6 weeks, however, should you experience impotence please contact your GP.

Regarding work, you should be able to resume light duties approximately 3 months after the operation.

Should I be worried about anything?

Complications can occur due to the nature of the operation. If you think that all is not well please speak to your doctor.

Bruising and swelling around the wound(s) may be troublesome but should take 4-6 weeks to settle.

Infection can happen and usually settles with antibiotic therapy.

Aches and twinges may be felt for up to 6 months following surgery. Occasionally there are numb patches in the skin which improve over the following months.

Sometimes there are problems with circulation to the legs/feet/toes and these will be discussed with you.

General Information

The operation may sound complicated but it is an everyday procedure for us. It is important that you understand your condition and treatment options, if you still have any queries do not hesitate to ask.

You may contact your consultant/GP or vascular nurse Tracey Hutchings on:-
01633 – 234373 or 01633 234234 bleep 0359.

References:-

Campbell B (1996) Complications of arterial surgery

Davies S, Beard J, Wyatt M. (1999)
Essential vascular Surgery p.155 -183