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ABDOMINAL WALL RECONSTRUCTION AND MAJOR INCISIONAL HERNIA REPAIR

*THIS INFORMATION REFLECTS THE PERSONAL PRACTICE OF DR KELLE SLATER ONLY
AND DOES NOT SUBSTITUTE FOR DISCUSSION WITH YOUR SURGEON.*

YOUR ADMISSION DETAILS:

Your admission date is: _____

Date of your operation: _____

Fasting time from: _____

Greenslopes Private Hospital Admissions (Phone 1800 777 101) will contact you **the day before** you are due to enter the hospital to confirm the details.

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WHAT IS AN INCISIONAL HERNIA?

An incisional hernia occurs when there is a hole in the deep layers of an old surgical scar. As the muscle layers separate, a piece of bowel or fat from inside the abdominal cavity may protrude through this hole. A hernia will appear as a lump in the surgical scar and become more prominent when standing up. The lump may disappear or become smaller when lying down. Hernias come in all shapes and sizes.



Diagram 1. Illustrates how the bowel protrudes through a hole in the deep muscle layer beneath a surgical scar

WHAT IS A MASSIVE INCISIONAL HERNIA? WHAT PROBLEMS DO THEY CAUSE?

The abdominal wall has many functions. It protects the bowels and abdominal organs. During urination and bowel movements it helps to push the waste out. These muscles are also responsible for posture and movement.

A massive incisional hernia usually occurs after serious or repeated abdominal surgery. The muscles that have been stitched together after the operation will come apart and allow the bowels to protrude through. A typical massive incisional hernia patient will have spent a long time in the hospital and will have suffered many complications. There may be open wounds on the abdomen. There may be bowel or stomach coming to the surface of the skin leaking mucous or faeces. Normally muscle and skin cover the bowels entirely but when an incisional hernia occurs, there may be a wide gap between the muscles and the bowels may protrude, covered only by a thin layer of skin. In extreme cases, the bowels may sit completely outside the abdominal cavity. The bowels may even be exposed to the air and their only protection might be a special dressing.

When there is a massive incisional hernia, the abdominal wall does not perform its normal functions. The bowels may be very susceptible to injury. Bowel that has no coverage is at risk to develop holes called fistulas. Faeces will flow out of these holes and onto the skin. This is a very challenging problem to fix. The other feared complication of a large incisional

hernia is when a piece of bowel becomes trapped in scar tissue and causes a bowel obstruction or even worse, loses its blood supply and dies. This is a surgical emergency and can be life threatening. Symptoms of this include sudden, extreme pain in the hernia, inability to push the hernia back in, vomiting or redness over the hernia. This can be a catastrophe for a patient with massive incisional hernia as these operations need to be well planned.

In addition, living with a massive incisional hernia makes simple tasks like sitting up, walking and having a bowel movement very difficult. Finally, massive incisional hernia are cosmetically unappealing.

WHAT CAUSES A MASSIVE INCISIONAL HERNIA?

There are many factors that contribute to a hernia.

- Poor wound healing after surgery
- Many operations via the same incision
- Wound infections after surgery
- Obesity
- Diabetes
- Operations for severe pancreatitis
- Colostomy or stomas
- Long term prednisone or immunosuppression drugs

Patients with these types of hernias are very special. They have usually had life threatening surgical problems and may have been unwell for many months. They will have had multiple procedures and are very run down.

HOW ARE MASSIVE INCISIONAL HERNIAS TREATED?

Massive incisional hernias will not go away without surgical treatment. A great deal of planning must go into repairing a hernia like this. Each case is individual. Patients with massive incisional hernias must be fully rehabilitated before an attempt at surgery is made. This is sometimes several years after the event that caused the hernia.

Incisional hernias can be extremely difficult to repair because the tissues we are working with are stretched thin and have very little strength. Each case is assessed on an individual basis. There may have been previous attempts made at repairing these hernias and this can make the surgery more complicated. A good way to think about fixing a hernia is to liken it to patching a hole in a plaster wall. The edges of the hole are difficult to pull together, so a patch or “mesh” is placed behind the defect. This reinforces the weakened tissue and muscle. The mesh can be made of several different types of material. (see below) The mesh becomes incorporated into the body and adds extra strength. The mesh can be used in a variety of ways but it is usually placed against the muscle inside the abdominal cavity. A combination of stitches and staples can be used to hold the mesh in place. The weakened muscle layer is then pulled closed over the top of the mesh. These tightened layers will eventually weaken again and the mesh is there to bridge the gap as they separate.

Massive incisional hernias are mainly repaired with an open operation i.e. a big cut usually through the previous scar. Sometimes keyhole techniques will also be used to help the muscles come together. These hernia repairs involve carefully separating the small bowel from the abdominal wall. Sections of bowel may need to be removed to repair fistulas and sometimes more than one operation is required. These operations can take hours.

Most often a variety of creative techniques are required to repair these hernias.

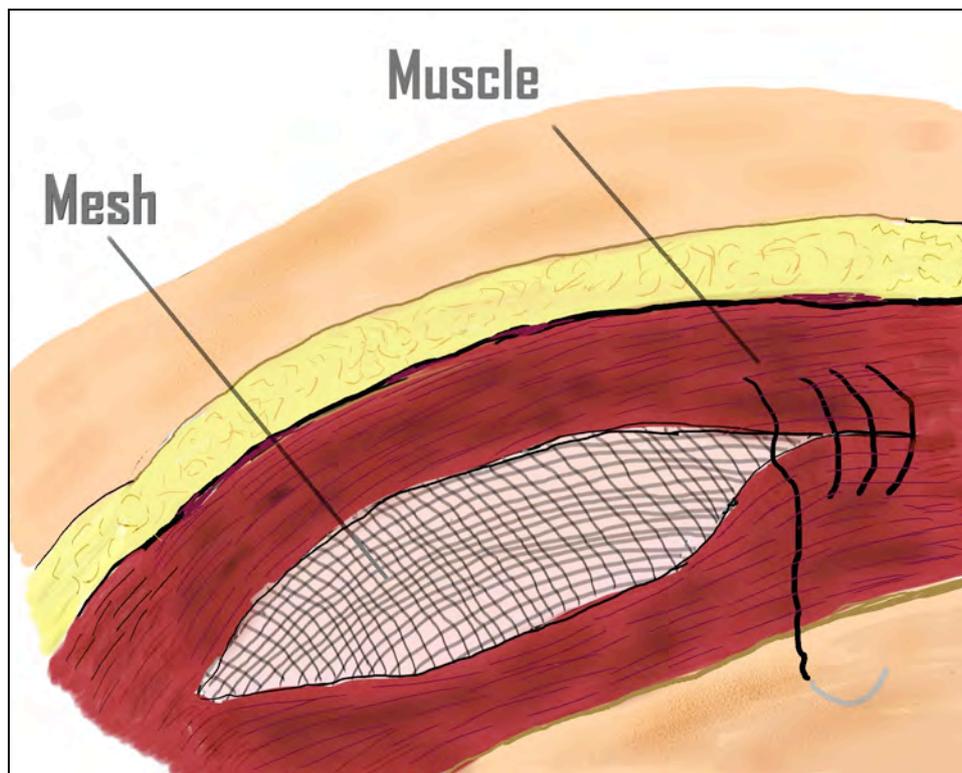


Diagram 2. This is how the mesh is inserted underneath the muscle layers.

Chronic Pneumoperitoneum

Sometimes the abdominal muscles are so far apart, that the bowels and other organs may protrude forward and sit permanently outside the abdominal cavity. For this problem, it may be possible to use a technique called “Chronic Pneumoperitoneum”. This is a labour intensive procedure that might require a lengthy hospital stay. You may require more than one operation to pull the abdominal wall closed.

Under full anaesthetic, a small tube is placed in the abdominal cavity. You are then woken up and admitted to the ward. Each day several litres of air will be injected into the tube, effectively inflating the abdomen like a balloon. This technique increases the size of the cavity where the bowels should be, making way for their eventual return. This will also stretch the muscles sufficiently to allow them to close over the top of the bowels. Typically air is injected daily for 2-3 weeks and then elective surgery is performed. You will be asked to wear a tight elastic garment to try and keep most of the air out of the hernia sac. This is major surgery with lots of risks. You will require intensive care after the operation, because

closing the abdomen like this can have an effect on your ability to take a deep breath for a while.

Laparoscopic or Open Component Separation

When the abdominal muscles are separated by more than about 17cm, it will be impossible to pull the muscles back together again. Something must be done to loosen the abdominal wall. The abdominal wall is made up of three layers. It is possible to release the tissue of one of the layers and this provides more “spring” in the abdominal wall. This is called component separation. This surgery can be done via the main surgical incision or with keyhole surgery via three cuts in both flanks.

WHAT TESTS MIGHT I HAVE BEFORE AN OPERATION IS CONSIDERED?

Planning for massive incisional hernia repair requires a number of tests. You must be medically and physically fit to undergo an operation of this caliber.

Some of the tests you can expect to have may include but are not limited to:

1. Blood Tests

Full blood count, Kidney and Liver function tests.

2. CT scan of the abdomen

Scan performed to inspect the state of the muscles of the abdominal wall and measure how far apart they are. It will also assess how much of the bowel is outside the abdominal cavity. This scan is also done to look for any undiagnosed problems in the abdomen like gallstones and tumours.

3. Colonoscopy

Bowel cancer is relatively common in our society and if you have not had a colonoscopy (a telescope passed around the large bowel) this will be done to ensure you do not have an undetected cancer.

4. Heart and lung tests

These will be performed to assess your fitness for major surgery. This will depend on your age and other health problems. The tests may be an ultrasound of the heart (Echocardiogram), lung function tests and exercise tests. You may be asked to see a heart or lung specialist.

WHAT IS MESH?

There are many types of mesh on the market and the choice will often boil down to surgeon preference and experience in using that type of mesh. Choice of mesh will also depend on whether active infection is present. Mesh falls into two main categories.

1. Synthetic mesh



Ethicon Physiomesher®

These meshes are made of a nylon often coated with a dissolving material that can make these types of mesh safer to place in contact with the bowel. There are many different brands of mesh and one is not generally more effective than another.

2. Biologic mesh



Cook Medical Surgisis® Biologic Mesh

This type of mesh is made from highly purified animal products – usually pig and offer some advantages in that they completely disappear over time. They are best used in wounds that are infected.

ARE THERE ANY ALTERNATIVES TO HAVING INCISIONAL HERNIA SURGERY?

There are no treatment alternatives for fixing incisional hernias other than surgical repair. Some people wear a support garment called a truss. This is an elastic band that can attempt to keep the hernia in place. This will not fix the hernia and can be quite uncomfortable. These garments are generally used when someone is unfit to undergo surgical treatment.

WHAT WILL MY ABDOMEN LOOK LIKE AFTER HAVING INCISIONAL HERNIA?

No surgeon can ever make your abdomen look the way it did when you were born. Your abdominal wall will always be scarred and lumpy. You will never have a so called “wash-board” appearance to your abdomen. The aim of incisional hernia surgery is to bring the muscles back together. This returns some function to the abdominal wall and gets rid of the unsightly hernia bulge.

Seromas – fluid collections

Almost all incisional hernia operations will result in an accumulation of fluid under the surgical wound. This is expected and is not a complication. Frequently, a surgical drain will be left in the wound for a few days or even a few weeks to minimize this problem. Despite this, it is still common, for a leak of fluid to occur and this will often present as a lump under the wound several days and even weeks after surgery. Occasionally it is necessary to insert a fine needle into these fluid collections to drain them. This may need to be done several times. It is usually painless. Sometime the fluid may escape from the wound. This can be a dramatic gush, but the problem is usually minor. Call the office the following day if this occurs.

When biologic meshes are used, the inflammation that occurs as the mesh disappears can be significant. The wound may suddenly become red several weeks after the repair. The seroma will persist for weeks and even months. This is normal.

Good results take time

Incisional hernia repairs take many months to heal. Your abdominal wall will change shape over time. It will take at least six months for the inflammation, fluid collections and scarring to settle. Be patient during this time.

WHAT ARE THE RISKS THAT MAY OCCUR AFTER ABDOMINAL WALL RECONSTRUCTION?

- **Injury to the bowel** may occur in an open operation. This is because the bowel may be caught up in scar tissue (adhesions) and easily torn. This is usually repaired at the time of the operation, but it may prohibit the use of mesh. Rarely, bowel contents may leak out of the wound after surgery and require another operation and many weeks in the hospital. Bowel perforation can be fatal.
- **Mesh infection:** the mesh used to repair the hernia may become infected. This is rare. If infection occurs, the mesh needs to be removed at another operation. Synthetic mesh is rarely used where there has been leakage of bowel content or if the wound is already infected. The biologic mesh will be used in this case.
- **Wound infection:** occurs in 1 – 4% of patients having this surgery.
- **Recurrence of the hernia:** mesh pulling away from the edge of the repair is very common. It is likely that approximately 10-20% of incisional hernias come back. This risk can be minimized by not lifting heavy weights for at least six weeks after surgery. Lifting very heavy weights may be off limits forever in very big hernias. The risk is increased in patients who have a poor immune system, diabetes, obesity, smokers or those who have had multiple previous hernia repairs.
- **Loss of skin:** when you have had multiple incisions, there is a risk that the blood supply to the skin may be very poor. Another incision may result in the death of the skin over the wound. This is a big problem if it occurs and may require weeks of dressings and further plastic surgery including skin grafts. It is uncommon.
- **Abdominal compartment syndrome:** This can be a deadly condition. The bowels and kidneys do not get enough blood supply due to a corset like effect from the closed abdominal muscles. The kidneys may stop working and urgent operation to release the tight abdominal wall will be required.
- **Exposed Mesh:** occasionally the mesh may wear through the skin and become exposed. If this happens it will need to be removed. Mesh has been known to migrate from its original position and end up in the bowel, bladder or other organ. Further surgery is often required in this situation.
- **Numbness of the skin:** after any surgery, there will be numbness of the skin around the wound that is permanent. This is something that your body gets used to.
- **Bowel obstruction:** because the mesh is often placed fully in the abdominal cavity, there is the risk of a piece of bowel sticking to the mesh leading to a blockage of the bowel or leakage of bowel content. This is uncommon and the risk is life long.
- **Pain:** it is very common to have discomfort or pain for several days and weeks after the surgery. This is usually manageable with pain medicine. Rarely there can be

pain related to nerves being trapped in scar tissue. This can be permanent and required treatment by a pain specialist. Occasionally these trapped nerves can result in chronic pain that alters lifestyle.

If parts of the surgery are performed via a keyhole or laparoscopic technique to Laparoscopic Incisional Hernia Repair

Encompasses all the previously mentioned complications plus:

- **Injury to the bowel** may occur more easily in laparoscopic surgery and is more difficult to detect. This will result in a leak of bowel fluid into the abdominal cavity and require an open operation to repair. This is a serious and possibly life threatening complication and can result in many months in hospital.
- **Conversion to open operation:** this is not really considered a complication. Sometimes it is just not possible to repair hernias with keyhole surgery. This is usually due to bowel stuck in the hernia that is not safely removable. If this is the case, then we will make a bigger cut and fix it with the open technique. This is considered sound judgment.
- **Injury to any other organ** in the abdomen may occur with laparoscopic surgery: aorta, liver and stomach. This is rare.
- **Gas embolism:** in keyhole surgery, gas is used to inflate your abdomen. A bubble of carbon dioxide may get into a blood vessel and causes life threatening heart problems. This is very, very rare.
- **Re-operation:** if we have to re-operate for any reason, this may be done with keyhole surgery or an open operation.
- **Complications of the metal or absorbable tacks used to hold the mesh in place:** it is possible that the tacks used to secure the mesh may erode through bowel, muscle, bladder and skin and cause further problems.

General Risks:

- **Death:** approximately 1/10,000 risk for all patients having this type of operation.
- **Bleeding:** usually occurs in the first 24 hours and may require further surgery. This bleeding may be from the abdominal wall or from inside the abdomen. You may require a blood transfusion if the bleeding is severe.
- **Other blood vessel problems:** heart attack, stroke. This is very rare.
- **Infections:** wound, pneumonia, urine, intra-abdominal, IV line related.
- **Permanent or temporary damage to nerves** in the arms, legs and neck due to prolonged immobilization on the operating table. This may result in loss of feeling or movement in arms or legs.
- **Clots in the legs** that may travel to the lungs and be fatal.
- **Wound pain, abnormal (keloid) scarring or hernia of the wound.**

WHAT IS THE PROBLEM WITH BEING OVERWEIGHT AND SMOKING?

- Obesity contributes to the formation of hernias because of the pressure created in the abdominal cavity by too much fat. As the pressure increases, it looks for a way to release and does this through the weakest point – a surgical scar.
- If your Body Mass Index is >35 i.e. you are morbidly obese, the surgery is far more difficult and the risks of complications including bowel perforation and recurrence of the hernia are far higher. There is no point repairing a hernia until the weight problem is brought under control. The hernia has a very high chance of coming back if the cause is not rectified. If it is medically suitable, I may recommend a period of weight loss before you have surgery. This can be a long and difficult process and we recommend you seek professional help for this.
- You will not receive incisional hernia surgery while you are still smoking. There is strong evidence that smoking leads to poor wound healing and failure of the repair.

WHAT TO EXPECT IMMEDIATELY AFTER SURGERY

Intensive Care

After the operation is finished, you will be transferred to intensive care. You may be kept asleep (induced coma) for a short time after the operation. Alternately you may be woken up straight away. There are many factors that go into making this decision and your family will be told whether you will be awake or left asleep. You will spend at least one night in intensive care. When you are stable you will come to the ward. Because your abdominal wall has been tightened, you will need the support of ICU.

Pain Relief

In the first few days after surgery there may be a moderate amount of discomfort. All efforts will be made to ensure you are not in terrible pain, but you will have a number of tubes you are attached to that will make things reasonably uncomfortable.

You will have some form of pain relief. There will usually be a choice of:

- Epidural (if medically suitable) – this is a fine tube placed in the back that delivers local anaesthetic to the nerves around the spinal cord. It is highly effective and you will still be able to walk with it in. There are small risks associated with its use and your anaesthetist will discuss this with you at length. The epidural will be in place for three to four days after surgery and you will be able to stand up and walk while it is in.
- Patient Controlled Analgesia (PCA) and a “Pain buster” - a button you will press that results in strong pain killers (like morphine) running straight into your IV line. This is combined with a tiny catheter placed in the wound that dispenses local

anaesthetic. These devices are very safe and have locking mechanisms to prevent overdose.

IT IS VERY IMPORTANT THAT YOUR RELATIVES DO NOT PUSH THE PAIN BUTTON FOR YOU. THIS WILL RESULT IN AN OVERDOSE OF MEDICATION THAT MAY STOP YOUR BREATHING.

Your anaesthetist will discuss the pros and cons of each with you prior to surgery and it is your choice in conjunction with what your anaesthetist feels is in your best interest. Either option may not be suitable for every person.

Every effort will be made to minimize the discomfort and make it bearable. Your nurses will be monitoring your level of pain frequently. When you are eating, you will be converted to oral pain relief.

Tubes and IV's

You will have a number of plastic tubes in your body following the operation. They will vary a little depending on your particular medical need. They will be removed at variable times following your surgery under my direction. All tubes except for an IV in your hand will be put in under anaesthesia, so you will not be aware of this.

1. IV line: central venous line placed in your neck (done under anaesthesia) to give you fluids and pain relief after surgery.
2. Urinary catheter: tube placed in your bladder so you don't have to get up to pass urine.
3. Arterial line: a fine catheter inserted into the artery of the wrist to monitor the blood pressure.
4. Nasogastric tube: all patients require a tube that goes from their nose into their stomach for a variable time after the operation.

Drain tubes

It is likely that you will wake up after surgery with one or more soft plastic drain tubes coming out of your abdomen. We will advise when these need to be removed. When using the biologic or mesh made from animal products, the manufacturer recommends that the drains be left in for many days after the operation. These types of mesh tend to make the body produce a great deal of fluid as they incorporate into the tissues. You may need to go home with the drains in place and they will be removed as an outpatient.

Eating

You will not have anything to eat or drink for a variable time after surgery. This depends on how much dissection of the bowel has taken place. Your bowels may be slow to wake up. An intravenous infusion will provide you with the necessary fluids. You will have a nasogastric tube (NG) in your nose that will remove the stomach contents until your stomach and intestines recover. I will let you know when you will be able to eat. You will start on liquids first and gradually take solids. If you are unable to eat adequate amounts of food after a short period of time, you will be fed via an IV or a tube in your nose.

People who drink more than two cups of coffee a day may notice a caffeine withdrawal headache and irritability for a few days after surgery.

You may lose your taste for food. It will return within a few months. It is normal to have a sore throat for a few days after the surgery because of the anaesthetic tube and the nasogastric tube.

Urinating/Bowel Movements

In the first few days after the surgery, a tube placed in your bladder will drain your urine. As your bowels start to wake up, you will pass excessive amount of urine. This is a good sign.

After any surgery, a patient may have trouble passing urine once the catheter is removed. This is uncommon and if it occurs, is usually temporary. Occasionally, a catheter needs to be reinserted to help you pass urine. If this is the case, a urology doctor (kidney specialist) will be asked to see you. It is normal to have the sensation of passing wind via the urine. This will go away.

You will probably not have a bowel movement until 5-7 days after the surgery. Many patients worry about this, but it is normal. You will pass wind a few days before your bowels work.

There may be some disturbance to your bowels for many weeks after surgery. Moving your bowels relies heavily on the muscles of the abdominal wall. The best strategy to move your bowels after surgery is to drink plenty of water (about 8 glasses a day), do not lie in bed all day long. Try natural laxatives like prunes and fibre. If this does not work, you will be started on a mild laxative like Movicol. When you sit on the toilet to have a bowel movement, lean slightly forward and relax. Sometimes, sitting with your feet resting on a small footstool will help.

Activity

You can expect your nurse and physiotherapist to help you get out of bed on the first day after surgery. You will be able to walk short distances even with all of the tubes and intravenous lines. As each day passes, your tolerance for walking and sitting in a chair will increase. This is extremely important to prevent pneumonia, clots in the legs and loss of general condition.

Other Medications and Preventative Measures

You will be given a blood thinner once or twice a day as a small injection under the skin. This helps to prevent clots in the legs (DVT) that may travel to the lungs and be life-threatening. If you are in a high risk group for DVT, you may be sent home with this injection for several weeks after surgery. You or a family member will be taught how to give the injections. You will be asked to wear TED stockings throughout your hospital stay. These prevent clots in the legs. You may stop wearing these when you are able to get up and walk easily by yourself.

In some instances you will be given a medication to decrease the acid secretions in the stomach. This prevents stomach ulcers that may occur after major surgery. You must not smoke at all.

Your Incision

Your dressing will be waterproof and left in place for 5 days after the surgery. The dressing is like a second skin and some fluid will collect underneath. This is normal and not an infection. Remove the dressing after 5 days, wash the wound off in the shower and leave it open to the air. You may wear loose clothing over the top of it.

Your incision may be slightly red along the cut. This is normal. If there is spreading redness or a new painful or uneven bulge appears, this is not normal and you should call the rooms or if it is after hours, the Emergency Department.

You may see a small amount of clear or light red fluid staining your dressing or clothes. If it is minor cover that part of the incision with a pad. If leaking is severe, or if it is pus you should call the rooms or if it is after hours, the Emergency Department.

You may gently wash dried material off from around your incision. Use a towel to pat your wound dry. Do not rub soap, talc or moisturizer into your incision until at least 4 weeks or until it is fully healed.

You may rub vitamin E cream onto the incision after it is fully healed.

It is normal to feel a ridge along the incision. This will go away.

It is normal to have patches of numbness around the surgical wound. This will not go away, but you will stop noticing it.

Over the next few months your incision will fade and become less prominent.

Your deep muscle layers are sewn together with nylon stitches that do not dissolve. If you are thin, you may feel the knotted end of one of these stitches under your wound. This is harmless. If it annoys you, it can be easily removed at some time after your surgery. Occasionally, a stitch may poke out of your wound. This is quite safe. Please come and see me on a non-urgent basis if this occurs.

Length of Stay in Hospital

Length of stay is variable depending on the size of the hernia. Patients with massive incisional hernia repairs may need many days and even weeks in hospital. You may even need some time in the rehabilitation ward.

Other Important Information

You can expect to see me surgeon every week day. On weekends or in times when I am operating urgently, you will see one of the practice partners. All are very experienced in this type of surgery and commonly assist each other in the operating theatre.

We will make every effort to keep you informed of your progress. We are always honest and open with you and your family. Feel free to ask questions.

AFTER DISCHARGE

What should I eat after I go home?

It is best to eat a low fat, healthy diet after any surgery. Once you are eating well however, there is no special diet.

How you may feel

It is quite common to feel very tired and to want to have daytime naps for the first month after surgery. Listen to your body and rest when you need to.

Activity

Do not drive until you have stopped taking narcotic pain medication (Endone, Oxycontin) and feel you could respond in an emergency. This is different for everyone.

You may climb stairs and lift your arms above your head. Try to avoid straining when moving your bowels and take a laxative if this is a problem.

Do not lift more than 10kg at least 6 weeks after hernia surgery. (This is about the weight of a briefcase or a bag of groceries) This also applies to lifting children, but they may sit on your lap. Your hernia repair will never be as strong as your abdominal wall used to be and repeated heavy lifting will lead to a recurrence of the hernia. You should never lift weights >20kg as this will weaken your abdominal wall and jeopardize the repair.

Resume all exercise in a sensible manner and if your wound hurts or pulls stop doing the activity immediately.

You may start some light walking when you feel comfortable.

You may swim after 4 weeks or when your wound is fully healed.

You may resume sedate sexual activity when you feel ready unless I have told you otherwise.

WHAT PREPARATIONS DO I NEED TO MAKE BEFORE MY SURGERY?

Hospital

The hospital will call you the day before your operation to confirm your admission time. They will also let you know about any hospital excess you may have to pay.

Fasting

You must have nothing to eat or drink for six hours prior to surgery. (You may take sips of water up until 2 hours before the operation and you may take your medications with a sip of water). You must not chew gum or smoke on the day of the operation.

Medications

- If you are on blood thinners such as Aspirin, Warfarin, Plavix, Iscover, Clopidogrel, Pradaxa, Dabigatran, Xarelto or anti-inflammatory drugs (Brufen, Mobic, Voltaren, etc), they can cause bleeding during surgery. We will advise you about what to do with these drugs prior to surgery. You must let us know about these drugs and the decision to stop them is based on each individual patient's needs.
- Diabetic medications: we will give you advice on whether to take your diabetic medications on the morning of surgery or not. Some diabetics will be admitted the night before the operation.
- If you are taking any alternative medications e.g. St John's Wort, fish oil or garlic, you should stop these tablets one week before surgery as they may lead to bleeding.
- You may continue to take a multivitamin.
- Continue to take all other medications, even on the morning of surgery with a small sip of water.

Other things to know

- You must bring all relevant x-rays to the hospital with you.
- If you smoke, it is in your best interests to stop completely as soon as you can. See your GP for alternatives or call Quitline (13 18 48) if you wish to seek advice.
- You should also abstain from drinking alcohol 24 hours prior to any surgery.

- Bring all your current medications with you to the hospital.
- Bring comfortable pyjamas, personal toiletries, small change for newspapers etc.
- Do not bring large amounts of cash or valuables.

WHAT WILL THIS SURGERY COST ME?

I largely work as a 'no-gap' doctor. This means that the surgeon fee for your operation will be sent to your health fund and there will be no 'gap' or extra amount of money to pay. There are always exceptions and decisions regarding this are made on a case-by-case basis.

If you do not have private health insurance or if you have overseas insurance, you will be given a quotation for surgery, anaesthetic and hospital fees and must pay in full **prior** to the operation.

Outpatient consultations are not covered by the health funds and there will be a charge for these meetings. You will get a proportion of this money back from Medicare. There is no fee to be paid for normal care after the operation.

If your Body Mass Index is >35, the surgery is far more difficult and the risks of complications including pancreatic leak is higher. If it is medically suitable, we may recommend a period of weight loss before contemplation of this operation, so it can be done more safely. This may involve a supervised weight loss program called INTENSIV to get the best results in the shortest time. This will occur an extra out of pocket expense.

There may be other out-of-pocket fees from your anaesthetist and any other specialists who are asked to look after you. You should ask them ahead of time any out-of-pocket costs. Ask us who will be performing your anaesthetic and you can make enquiries with them about any out-of-pocket expenses.

There may be extra costs for x-ray, pharmacy and pathology. You have a right to gain 'informed financial consent'. Fees from other practitioners are beyond our control and you should ask for the costs from each person who is asked to look after you. Patients have a choice when it comes to paying for their health care and you are fully within your rights to shop around.

If you do not live in Brisbane, you will be responsible for all accommodation, hotel, meal and transport costs for you and your family. There is some monetary assistance available for private patients through the Patient Travel Subsidy Scheme (PTSS) providing assistance to patients and in some cases their carers, to enable them to access specialist medical services that are not available locally. Please see Queensland Health's Patient Travel Subsidy Scheme site for details <http://www.health.qld.gov.au/iptu/html/ptss.asp>. Greenslopes Hospital web site has an extensive list of hotels available in the local area <http://www.greenslopesprivate.com.au/For-Visitors/off-site-accommodation.aspx>

ABOUT YOUR SURGEON

Dr Kellee Slater MBBS (Hons) FRACS

- 2006 – Present Staff Surgeon
Hepatopancreatic-Biliary-Liver Transplant
Princess Alexandra Hospital and
Greenslopes Private Hospital
Brisbane, Queensland
- 2004 – 2006 Hepatobiliary and Liver Transplant Fellowship
Princess Alexandra Hospital
Brisbane, Queensland
- 2002 – 2004 Liver and Kidney Transplant Fellowship
University of Colorado Hospital
Denver, Colorado, United States of America
- 2002 Fellow of the Royal Australian College of Surgeons (FRACS)
General Surgery
- 1989 – 1994 MBBS (Honours)
University of Queensland