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Brisbane Liver and Gallbladder Surgery
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INSERTION OF A PORTACATH

THIS INFORMATION REFLECTS THE PERSONAL PRACTICE OF DR KELLEE 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: _____

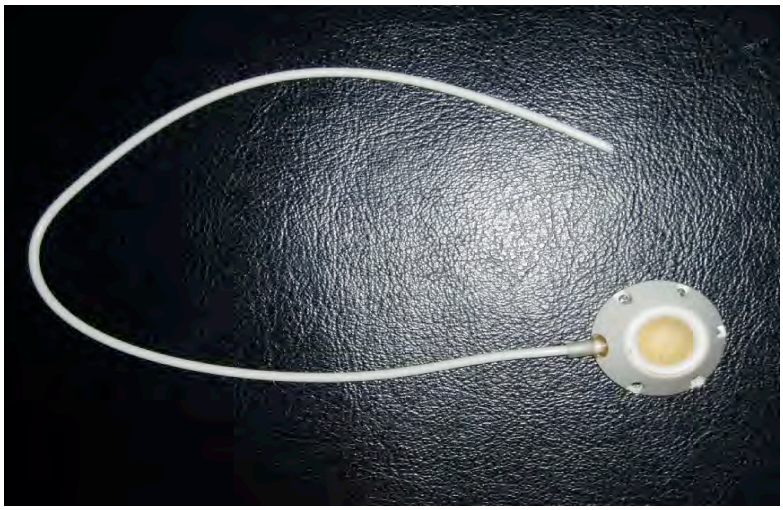
Day Surgery Patient Stay ☐

Overnight Patient Stay ☐

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.

WHAT IS A PORTACATH?

A portacath is a plastic catheter attached to a small port or reservoir. It is placed in a large vein in the neck. It is implanted beneath the skin and aside from a visible lump, there is no tubing to be seen and the device is completely covered by healed skin.



WHY IS A PORTACATH INSERTED?

A portacath is used when people need to have frequent intravenous injections of drugs e.g. chemotherapy, immune treatments. These drugs must be given into a large vein because they can be toxic and damage the small veins in the arms.

Having the port enables the needles to be inserted relatively painlessly and leaves the arms free for other activities. It also saves the veins in the arm from being damaged from long term use.

HOW IS THE PORT USED?

The port is completely under the skin. It has a small chamber that is filled with fluid. When it needs to be 'accessed' a needle is inserted into the port. This needle may stay in for many hours and you will not feel it. Nurses must be specially trained to put the needle in the port. The skin under the port will become numb very quickly and there should be very little discomfort involved

WHAT LIQUID IS IN THE PORT?

The port will contain a liquid medication called heparin. This thins the blood and helps to stop clots forming in the tube. This heparin will be removed from the port before each use.

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HOW IS A PORTACATH INSERTED?

It is normally done as a day procedure under a general anaesthetic (completely asleep).

A tube is placed in one of the four large veins in the neck (either the subclavian or jugular veins of either side.) The tube is about 15cm long and its tip sits at the point where these blood vessels enter the heart. Its position is checked with an X-ray before you leave the operating theatre.

These veins are accessed via an incision about 4cm long just under the collar bone on the right OR left sides. The position of these large veins may vary in each person. Sometimes it is necessary to try on both sides to insert the catheter.

The tube is attached to a port about the size of a 50 cent piece. This is anchored to the muscle of the chest wall and covered with skin.

HOW LONG CAN A PORTACATH STAY IN?

A port can safely stay in for many months and even years. It is left in until you have finished your treatment. Your oncologist will usually advise me when it is ready to come out.

If it becomes infected it will need to be removed urgently. (see below)

HOW IS THE PORT REMOVED?

Taking the port out is usually easier than putting it in. It can be done under a local or general anaesthetic and takes about 10 minutes. The old incision is reopened and the port pulled out.

WHAT ARE THE COMPLICATIONS OF PORTACATH INSERTION?

There are a great many complications of portacaths' outlined below. I must stress that most of these are uncommon and the benefits of having a portacath outweigh the risks.

General Risks:

Anaesthetic risks; like any surgery, there is a small risks of severe allergy, inhalation of vomitus, drug reaction and even death during an anaesthetic. (1/50,000)

Risks specific to portacaths:

Pneumothorax: The large blood vessels of the neck are very close to the lung. When placing the port, the lung may be punctured. An X-ray will be taken of your chest in the recovery unit to determine if this has occurred. If it has, then you may require a small

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tube to be placed in your chest to evacuate the air. You will then need to stay in the hospital for observation. The tube will usually be removed within 2 – 3 days. Rarely does this problem require surgery to fix the puncture.

The punctured lung is usually obvious immediately, but in some cases, it may not present itself for several days. If you experience shortness of breath, you should return to the hospital.

Abnormal heart beats: This may occur during the surgery and is usually quickly correctable. Rarely, in patients that are very unwell it is fatal.

Infection: There are two types of infections that occur.

> ***Infection of the skin wound*** occurs in the first 5 days of the surgery. This can sometimes go on to infect the port itself. Aggressive treatment with intravenous antibiotics is usually required.
>
> ***Infection of the port*** may occur at anytime. Bacteria love to live on plastic and you must notify your oncologist if you have fever, new pain over the port or redness over the port.

Bleeding: It is common to have mild bruising around the port for a week or so. This can be improved by sleeping in a 45 degree position for the first 24 hours and not lying flat. Rarely a large bleed may occur around the port that will require a return to the operating theatre.

Breakage of the catheter: like all man-made devices, these plastic tubes can break while they are inside your body. It is unlikely that you will have any symptoms. This may be discovered in many ways: the port may suddenly stop working, it may be seen to be broken on an X-ray, it may be seen when the catheter is removed. Complete breakage of the catheter will result in a piece of plastic lodged in the heart or lungs. This is usually retrieved in the X-ray department with special tools. This complication is rare.

Flipping of the port: Occasionally the stitches anchoring the port to the chest wall do not hold and the port can flip over causing it not to work. This requires surgery to fix it.

Clot in the arm that may travel to the lung: any plastic tube placed in a blood vessel can cause a clot to form. This is fairly common and probably occurs in a minor way with all ports. Extensive clot may sometimes form, resulting in arm swelling (usually temporary). Rarely this clot may travel to the lungs and cause pain, shortness of breath and even death. If a major clot forms, the port is often removed and occasionally you will be put on blood thinning products like Warfarin for a short time.

Port too deep to access: in women (because of breast tissue) and in obese people, the tissue over the port can be very thick. This makes the port difficult to access. Every effort is made to remove excess fat over the top of the port at the first surgery. Further surgery may be required to improve things if the port is still too deep. Removing this excess fat can lead to a visual ‘divot’ in the skin over the port.

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Damage to the large arteries of the neck: the arteries of the neck lie directly behind the veins. Rarely, a port may be placed inadvertently into the artery. If this occurs, a bigger incision will be required and a vascular surgeon will need to repair the artery.

Damage to the lymphatic duct of the neck: in the left of the neck there is a large pipe that carries clear fluid called lymph. Very rarely this can be damaged when the port is inserted. This may result in a large collection of lymph in the chest and may require a drain in the chest or surgery.

Long term narrowing of the vein to the arm: this is rare, but scarring may lead to difficulty of the blood draining from the arm. The arm may swell. The main consequence of this is that it may affect you if you ever require dialysis for kidney failure.

Other General Problems:

- Complications related to having a general anaesthetic: heart attack, stroke, allergic reaction. This is uncommon.
- Other Infections: wound, pneumonia, urine, IV line related.
- Clots in the legs that may travel to the lungs and be fatal. (DVT)
- Wound pain and abnormal (keloid) scarring.

WHAT TO EXPECT IMMEDIATELY AFTER SURGERY

Pain Relief

Every effort will be made to minimize the discomfort. Your nurses will be monitoring your level of pain control frequently.

Local anaesthetic will be used in the wound and lasts for about 12 hours.

Sitting at 45 degrees will be very helpful in controlling pain and, therefore, swelling.

The best type of pain reliever is:

Panadol, Paracetamol, Panamax

You will be amazed the power of regular paracetamol. It will cut down the need for the very strong pain pills.

It does not cause constipation.

Do not take more than 8 tablets a day.

If you need something stronger, Panadeine and Panadeine Forte can be helpful. They will cause constipation.

Needle in the port

In the first two weeks after the portacath insertion, it will be quite uncomfortable to access with a needle. If you need chemotherapy straight after the port insertion, I will leave the needle in the port and it can be used as soon as you wake up from the anaesthetic.

Eating

It is usual to return to a normal diet within a day of surgery. There are no restrictions. It is common to feel nauseated and vomit on the first day because of the anaesthetic drugs.

Activity

It is usual for a portacath to be inserted and to go home the same day. It is very important to begin light activity shortly after surgery. This is to prevent pneumonia, clots in the legs and loss of general condition. You should avoid strenuous activity until your wound is healed.

AFTER DISCHARGE

You will normally be discharged the same day, after having something to eat. If there are any serious problems after going home, either call the rooms or attend the emergency department at Greenslopes Hospital. If it is an emergency, dial 000.

Sleeping with your head slightly elevated on pillows is recommended for at least 24 hours to decrease the swelling associated with the port.

Your Wound

You will have a waterproof dressing over your wound. You may shower with this on. Remove this dressing after 5 days and leave the wound open. You may get it wet after this time. There will be no stitches to remove. It is normal for an ‘end’ of stitch to poke out of the corner of the wound. If this bothers you, you may trim it off, otherwise it will fall off in about 6 weeks.

Activity

Do not drive until you feel you could respond in an emergency. Do not drive or sign legal documents within 24 hours of an anaesthetic.

You may start some light exercise when you feel comfortable. Strenuous sport should be avoided for about 4 weeks. I recommend that you do not ever perform very heavy activities with the arm the portacath is in. (Manual labour, physical sports).

You may gently swim when the wound is healed.

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

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How you may feel

It is quite common to feel quite tired for a few days after surgery.

CALL YOUR ONCOLOGIST / SURGEON IF:

- You have a fever, chills, shakes, feel generally unwell
- Have a red wound
- Have a swollen arm on the side of the port
- Have new pain over a previously normal port

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.

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 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 (131848) 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.

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- Do not bring large amounts of cash or valuables.

WHAT WILL THIS SURGERY COST ME?

We largely work as ‘no-gap’ doctors. This means that the surgeon fee for you 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.

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. Patient’s have a choice when it comes to paying for their health care and you are fully within your rights to shop around.

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

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