mvsu
melbourne vascular surgery unit

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AORTIC ANEURYSM REPAIR WITH INTRALUMINAL STENT

(MINIMALLY INVASIVE REPAIR OF AORTIC ANEURYSM)

The aim of this procedure is to repair the main artery within the abdomen of your body. The materials used are already approved but the mechanism of use is new (15 years). Many of the prostheses (implants) used are still subject to trial conditions and require follow up and mandatory reporting.

Aortic aneurysm surgery (replacement of the main artery) has been practiced reliably since the early 1960's with decreasing risks and improved outcome for patients. Conventional surgery however still imposes significant strain and risk on patients undergoing surgery. "Minimally Invasive" surgery has developed from a desire to decrease these risks and stresses. The newer technology repair involves less blood loss than the older repair and a shorter hospital stay, on average 2.5 days instead of 7-10 days. There is still a period of feeling unwell after surgery, which lasts approximately 7 to 6 weeks days, but this is not as dramatic as the post-operative course of conventional repair of aneurysms. Mortality is now < 1% versus 5% for conventional repair.

DURABILITY:
At present the follow up of repairs by this method shows it to be effective for a period of 10 years but there are no patients with a follow up longer than 15 years. Patients accepting the newer technique must accept more frequent follow up. Computer scanning is required at six, twelve and twenty four months after surgery. Further scans may be required even after this period. Normally, after conventional aneurysm repair, follow up can be at every 2-5 years but the new technology requires annual visits. Further endovascular procedures are sometimes required to affect a complete cure. Late conversion to open surgery can be occasionally required for failure of the endovascular procedure

BEFORE THE OPERATION:
Mr. Milne and the Anaesthetist will see you before surgery to discuss the operative procedure and the anaesthesia involved. An assistant surgeon will be introduced to you prior to the start of your operation on the day of surgery. Pathology tests will be performed. You should inform your surgeon before surgery of any regular medication you take and bring all your medications with you to hospital.

OPERATION:
An incision is made in both groins. They are approximately 3cm long and do not give to much discomfort after the operation. A bladder catheter is sometimes required but you stand out of bed to void within 2 hours. You can normally shower after two days and resume normal eating and drinking within a few hours of surgery.

AFTER THE OPERATION:

Fever is almost universal after surgery, as it is after a conventional repair. It is however more florid and thus in the evenings your temperature may reach 38.5 degrees and require some anti-inflammatory tablets to make you more comfortable. You can resume normal activity, such as driving a car, with relative comfort within 5 days of surgery compared with 2 weeks with conventional aneurysm repair. On your discharge from hospital you will be able to walk. When you get home you can shower normally leaving the two groin incisions exposed. The suture in this area is absorbable and does not need removal. During the postoperative recovery period you will feel quite tired and note a substantial reduction in appetite for some weeks. You may experience a fever at night but this is expected. Walking, lifting and driving may be resumed after 2-7 days.

CONVERSION:

If deployment of your new technology device fails (the chance of this is approximately 1%) then conventional aneurysm repair is necessary. The conventional repair advice sheet then applies. Rarely conversion to open surgery is immediately required and by accepting this smaller procedure you may still end up with a large operation (< 1:200 cases).

SPECIAL RISKS:

There is an incidence of failure of the new repair, which might result in progression to a conventional aneurysm repair at a later date. Fortunately this is not common, occurring in 2 % of patients. So far most additional procedures have not required surgery on the abdomen. Therefore in spite of the risk of failure of the new technology there is as yet no evidence of significant problems associated with this. It simply means conversion to a conventional aneurysm repair as a subsequence of this difficulty. In accepting endoluminal repair you must also accept the possibility that a conventional open repair may need to be done if deployment of the new device fails.

You have a 98% expectation of an uncomplicated recovery as described. During the post operative phase however the following complications may occur:

- Heart Attack (Coronary Thrombosis, Myocardial Infarction)
- Pneumonia or other respiratory difficulties
- Infection - either of the lungs, device or wound - rarely occurs but constitutes a risk of surgery.

The risk of death, stroke, paralysis, infection, loss of life or legs associated with this surgery is 1%.

Failure of the device, in the years after deployment, has occurred and repair of the failed device may be required. Most additional repairs are usually done without surgery. Gross failure of the device, or dislodgment at a later stage, would require the use of the conventional repair technique to replace the main artery. This has occurred in this surgeons experience in 1% of patients.

After your operative procedure any complications or difficulties regarding the operation should be referred immediately to Mr. Milne's office or his call service. Telephone numbers as below. Any other unrelated medical condition should of course be referred back to your local doctor.

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