GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Abertawe Bro Morgannwg University Health Board

Morriston Hospital

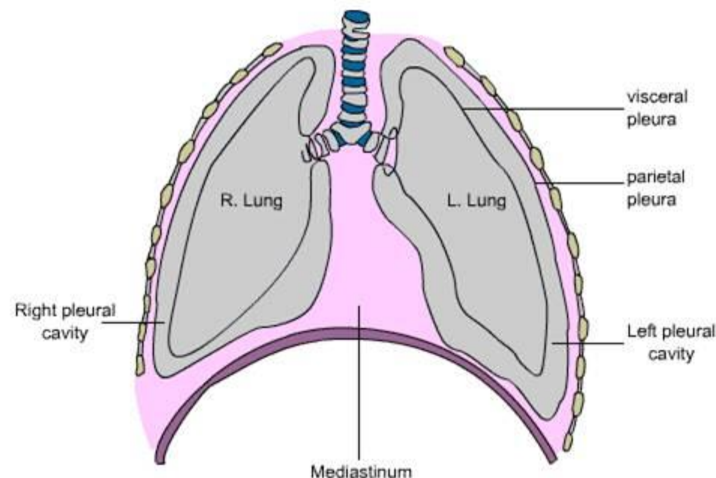
Surgery for Blebectomy,

Bullectomy, Pleurectomy and Pleurodesis

Information for Patients

Introduction

This leaflet describes the surgical treatment required if you have a recurring lung collapse (pneumothorax) or a build-up of fluid within your chest cavity (pleural effusion).



Types of surgery

Video assisted thoracoscopic surgery (VATS)

The operation is keyhole surgery via several small holes in the side of your chest. These holes allow the surgeon to pass a small camera and instruments required for the operation. An enlarged view of your chest and lung will appear on the screen.

Thoracotomy

A thoracotomy is an incision made in the side of your chest through the intercostal muscles between your ribs. Your ribs will be held apart so that the surgeon can see into your chest without breaking any of your ribs.

Blebectomy and Bullectomy

A bleb is a small air sac on the surface of the lung. A bulla is very similar but contains a large volume of air. When these air sacs burst, the air they contain squeezes between the lung and the chest wall. The seal

between the lung and the chest wall is then compromised causing the lung to collapse.

These air sacs are removed during a blebectomy or bullectomy using VATS. This procedure removes the cause of your collapsed lung and reduces the risks of any further incidences on the side that has been operated on.

Pleurodesis

A pleurodesis is a procedure to help the lung stick to the chest wall. There are different types of pleurodesis your surgeon could offer depending on your need.

Pleurectomy

In pleurectomy the thin lining of the chest wall is removed making the surface sticky which allows the lung to stick to the chest wall.

Abrasion pleurodesis

In abrasion pleurodesis the membranes of the lung are scratched using a sterile brush. This allows an inflammatory reaction that causes the lung and the chest wall to stick together.

Talc pleurodesis

In talc pleurodesis a fine sterile powder is puffed onto the surface of the lung causing an inflammatory reaction that causes the lung to stick to the chest wall.

Preparation for surgery

Continue taking your medications as normal unless advised otherwise by your surgeon.

Keep active. Being as physically fit as possible will enhance your recovery.

You will be admitted to the Cyril Evans Ward the day before your surgery where you will be seen by the medical team. You will have blood tests and often a chest X-ray. You will be told when to stop drinking fluids and eating food. The evening before, and the morning of, your surgery you will be required to use a pink chlorhexidine wash provided to help reduce the levels of bacteria on your skin. You will need to wash your hair with this the night before but not in the morning.

Anti-embolic stockings are usually given to all of our patients. These stockings help to prevent blood clots or deep vein thrombosis (DVT). You will be given a blood thinner injection in your abdomen the night before surgery.

After your operation

You will spend a minimum of two hours in the recovery unit where we ensure you are fully awake after your anesthetic and control any pain you may have. You will be connected to several drips and tubes which will remain in place for a few days. You will return to the Cardiac High Dependency Unit (CHDU) once the recovery nurse is happy you are fully awake and pain is controlled. Most patients are discharged to the Cyril Evans Ward on day 2 or 3 and home within one week. However, due to individual patient needs, some patients will require a longer stay.

You may be connected to one or more of the following

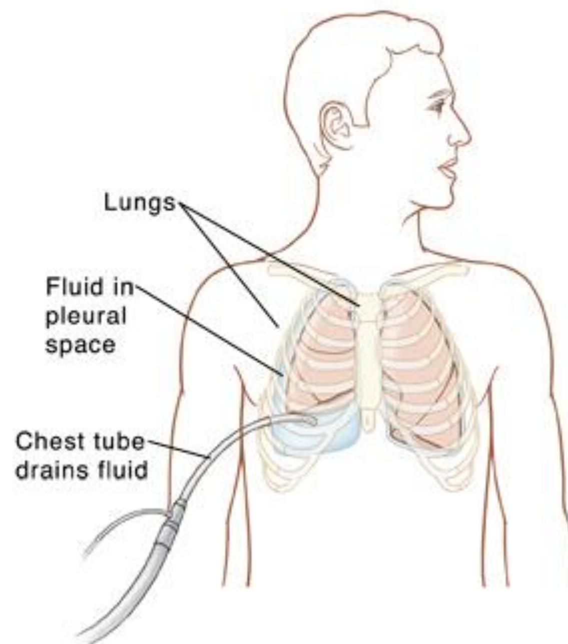
Intravenous infusion lines (drips):

These are small plastic tubes allowing for the administration of fluids or medications straight into your vein.

Chest drain:

Allows air, fluid or blood that may have collected in your chest, due to your operation, to be removed. This drain will be connected to a drainage bottle and often on low suction. Your surgeon will advise

whether this drain should stay continuously. The chest drain is situated in the pleural cavity between your lung and your chest wall. You should breathe deeply and cough regularly to promote full lung expansion and drainage of any fluid. If you cannot breathe deeply or cough, you should ask your nurse for pain relief. The drain will be removed as soon as it is no longer needed. This is usually 3-5 days after your surgery, although some people require the drain for longer and sometimes patients go home with a drain. If you go home with your drain, you will be closely monitored with regular clinic appointments until your drain is ready to be safely removed.



Urinary catheter:

This is a tube passed through the urethra into the bladder allowing urine to drain freely into a drainage bag. The catheter will be removed once you are mobile and passing good volumes of urine.

Patient controlled analgesia (PCA):

This is a pump containing pain relief controlled by the press of a button. The button must only be pressed by you, although your nurse may remind you that it is there. Once the button is pressed, the pump will give you a dose of intravenous pain relief. The pump will lock out for 2-5

minutes giving the medication time to work before allowing you to press it again.

Epidural:

Occasionally the anesthetist will insert a thoracic epidural catheter to assist with pain management. This will not numb your arms or legs and you will be able to mobilise fully with assistance. The button must only be pressed by you, although your nurse may remind you that it is there. The pump will lock-out for 2-5 minutes giving the medication time to work before allowing you to press it again.

Enhanced recovery

You will be sitting out of bed on the day of your surgery or the morning after. This is essential to help you recover.

The physiotherapists will assist you with coughing, breathing and mobilsation every day during your stay on the CHDU.

Eating a high-protein diet together with plenty of fluids after the operation is very important to help wound healing and recovery. Your friends and family are welcome to bring you snacks or food that can be kept in the fridge, although we cannot reheat meals.

We recognise that the pain relief we give you can cause constipation and therefore we give all of our patients' laxatives. These laxatives are mild and often take two or three days to work.

When you go home

The nursing staff will teach you to administer the blood thinning injection yourself, however if you are unhappy or unable to do so we can arrange your district nurse or practice nurse in the community to do this for you. You will also be provided with a sharps box to dispose of your injections. This box then needs to be returned to either you GP or the hospital for proper disposal. Please do not dispose of this box in your normal household waste.

As well as your regular medications, you will be provided with pain relief. The pharmacist will explain how and when you should take them. We strongly advise you to continue to take your pain relief as advised to prevent pain becoming problematic. You may also be discharged with the blood-thinning injection that is given into your abdomen. The nurse will tell you how and when you should take this.

You will have a follow-up appointment approximately four weeks after you go home. Should you have any concerns you are advised to contact your GP or thoracic nurse specialist.

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