West Midlands Referrals

Post-operative care for patients after surgery to remove the gall bladder (cholecystectomy)

The gall bladder is a reservoir of bile, a thick, dark, tarry liquid which is in part excretory (getting wastes out of the body via the intestinal system) and in part digestive (containing chemicals which help digest fats). The gall bladder should periodically empty its contents into the upper small intestine. If it doesn't and bile "backs up" in the bile drainage system, then the patient often has signs of liver disease and may well be jaundiced. Reasons for removing the gall bladder include enlargement/impaction of the gall bladder and less commonly neoplasia (tumour) of the gall bladder. If the gall bladder is diseased and the wall loses its integrity then bile can access the peritoneal cavity, which is the cavity in which the major abdominal organs like the guts, liver, spleen and bladder are found. Bile is a noxious, irritant substance if it escapes from the biliary system. If it escapes it can cause local or generalised septic peritonitis and these can be life threatening. Removal of the gall bladder can vary between straight-forwards to very challenging, largely dependant on whether the wall is thin and friable and likely to tear during removal. The gall bladder needs to be separated from adjacent liver and a snug ligature needs to be placed to seal of the duct linking the neck of the gallbladder to the bile duct drainage system.

Pre-operative assessment usual involves an ultrasound scan, possibly a CT scan, and biochemistry/haematology blood work.

This is not risk free surgery, and principal concerns include being confident that the bile ducts can still drain; ensuring that there is no bile leakage; ensuring that we don't encounter bleeding from the liver, and achieving a safe anaesthetic (as the liver is the major organ that clears many drugs and anaesthetic agents from the patient's system). Access can sometimes be a challenge as the liver and the gall bladder sit under the rib cage close to the diaphragm.

Medication:

Antibiotics: Antibiotics like claviseptin are usually given for a few days (usually tablets given twice daily).

Anti-inflammatories: Non-steroidal anti-inflammatory drugs may well not be given if the liver biochemical parameters are raised on screening blood tests. If they are given, they usually start/resume the morning after surgery. These are tablets (eg carprofen) or liquid (meloxicam). They should be given with food. If vomiting or diarrhoea is noted, stop these and seek prompt advice.

Analgesics: We are likely to have dispensed tramadol, (tablets given twice daily) for 5-7 days.

The wound must not be interfered with or bathed. An Elizabethan collar can help prevent interference with wounds. Any ooze may be gently blotted with kitchen towel, but if ooze is seen, advice should be sought promptly.

Rechecks a few days after surgery may be with your own vet to save un-necessary travelling. We could do this check-up if travelling is not an issue, and all post-op check-ups are free of charge with us under our "fixed price" schemes. Please contact us to book an appointment for us to see the case back 2-3 weeks post-operatively when we can remove sutures/staples and check that all is going to plan.

Dressings may be used post-operatively, typically a thin white Primapore, to give the wound some on-going protection. These should be kept dry at all times. If they do become significantly wet then they can be removed.

Strict restriction and supervision of activity is required. Dogs should be on a lead anywhere outside of the house including the garden. Allow just 5 minutes of lead restricted exercise, three times a day, until you are advised to the contrary. Consider confining cats to a cage. Cages which will fold flat when not in use are readily available from pet superstores, Argos, many DIY stores or from on-line retailers. Cats can be given several short periods of supervised walking around the kitchen each day. For both species, running / jumping / climbing (into cars, upstairs, onto furniture, onto kitchen work tops etc) should be prevented. Consider using stair gates and ramps, and keep doors and windows shut to avoid escapes!

It is unlikely that your pet will have been discharged until it is eating, drinking and until we are confident that this is occurring without vomiting or diarrhoea. However if vomiting and diarrhoea are seen, seek prompt advice.

The real "danger period" of internal wound breakdown with the serious and potentially fatal consequence of peritonitis, is the first few days after surgery. If bile leaks it can be really serious and potentially fatal. A patient that is still recovering well by a week post-operatively is not "out of the woods" but its likelihood of making a full recovery is greatly increased. Strict exercise restriction and vigilance is still required for at least two weeks post-operatively.

Several small meals should be offered each day rather than just one or two larger ones. The total volume of food that should be consumed per day can be limited to about two thirds of your pet's normal food volume for the first few days post-operatively. A nutritious, readily digestible and balanced food is ideal. Your vet can provide you with a commercial diet or we can advise on this for your particular pet.

Our fixed prices include any follow up consults with us, but don't include further medication or revision surgery.
For further details please see www.wm-referrals.com, "about us", "FAQs".
For further advice please contact us by phone on 07944 105501 or at enquiries@wm-referrals.com. Consider texting/emailing pictures.

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