

Recovering from an Operation



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Depending on what data source and definition of an “operation” are used, there are 40 to 60 million such procedures performed annually in the US. Increasingly, these operations or procedures are performed in ambulatory care settings. When inpatient operations are performed, the length of stay is compressed, with same day admissions and a major emphasis on the earliest possible discharge consistent with safety. Minimally invasive procedures have altered the post-surgical course in many operations, and anesthesia techniques have greatly improved, but there remain issues of recovery in most patients. Given the emergence of this accelerated process, it has been my observation, based on more than 40 years of surgical practice, that patients often have relatively little practical information about the process of recovering from an operation. In addition to performing surgical procedures, I have had extensive experience as a patient, having had 40 operations subsequent to a variety of post-surgical misadventures. Although various complications that could occur were listed in detail, and appropriate consent forms for the procedures were signed, I have been fascinated through the years at the sparsity of information provided about the recovery process. As a surgeon, some of the best service I offered patients has been centered on such practical discussions.

One of the most important tenets of recovery, in my view, is that recovery is not a progressive linear process. I am astounded at how often patients are told something akin to “you will feel better every day” after a procedure. It is rare to “feel better every day” without an operation, so it would be unusual to do so after a procedure, particularly if it is a major one. It has been my observation that postoperative patients have what I call a “stuttering progression to wellness.” Patients who are informed that the process may involve 3 steps forward and 2 steps back are less apprehensive and less discouraged when they have a “bad day.” “Bad days” are not uncommon, even in the

absence of complications, and may cause significant angst when there is an expectation of daily continuous improvement. To counter these apprehensions, I advise that one examine their progress from Friday to Friday and not daily. Such a weeklong perspective may blunt inappropriate apprehension caused by a “down” day.

A second observation of poor advice about recovery might come under the oft-heard statement, “you can do what you feel like doing.” Although this seems reasonable, it may fail to be sage advice under some circumstances. Those in postoperative recovery may feel “wonderful” on awakening, but experience tremendous fatigue or other adverse reactions as the day progresses. Marathon runners or cyclists use the phrase “hitting the wall” during a race after initially feeling great. Recovering patients experience the same phenomena, albeit via a different physiologic mechanism. If such an experience occurs at home or in a controlled circumstance, there may be little, if any, consequence. However, many patients have related instances of such events while driving, shopping, or teaching school. Similarly, I advise caution in performing mental tasks after a significant operation. Not only does the body need a recovery phase, the brain may as well. I have had numerous hard charging patients (usually men) who have experienced major mental lapses by attempting to work in the early phase of their recovery. One attorney friend and patient describes, “trying to work in a fog,” despite the absence of pain medications. I caution against planning to make important decisions in the early postoperative state.

A third practical aspect of recovery involves dietary intake. Nutritional support of inpatients with prolonged admissions is a major industry, but advice to ambulatory patients often is a refrain similar to “eat what you feel like eating.” Depending on the procedure, this may be excellent advice, but starvation is not a major problem for many, and a slower progression to a full normal diet may be optimal. The number of instances of nausea, vomiting, bloating, constipation, and other gastrointestinal issues encountered through my years of practice is considerable and may be ameliorated by advice on dietary caution in the early recovery phase. The addition of pain medications may certainly exacerbate these problems.

The final area of recovery from operation in which I have observed inadequate counseling involves the management of pain. The opioid crisis has focused attention on the dangers of overprescribing of pain relieving drugs. Pain is a remarkably individual response, with 1 patient

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requiring no medication and another requiring significant treatment after what might appear to be identical procedures. The management of pain often appears to be done using a “play book,” where 1 size fits all. Although it is more time consuming at the outset, a more nuanced, individualized approach to pain management would be more appropriate. Queries regarding previous pain medication usage, psychotropic medication use, previous experience with operative recovery, and the like may permit more personalized approaches to pain management.

One of the most useful pieces of advice I received as a surgeon was given by the late Dr Frank Spencer. During a visiting professorship to Louisville in the late 1970s, Dr Spencer related that he made a practice of calling patients directly in the first week or 2 after an operation and checking on them. He related that he asked routine questions, such as “How are you feeling?,” “Do you have any questions?,” or “Are you taking your medication

appropriately?” I incorporated this into my practice and found it remarkably helpful for patients. Not only did it often appear to be comforting, but it also built amazing patient loyalty.

Finally, the value of concerned, conscientious nonphysician caregivers cannot be overstated in the recovery process of some patients. As a patient, the positive reinforcement of physical therapist was vital to my recovery after a prolonged hospitalization.

As a patient, I was advised (often in a cursory fashion) about potential complications of an operation; generally, bleeding, infection, need for reoperation, and possibly death. Rarely have I experienced a discussion of how “normal,” uncomplicated recovery might proceed. As a surgeon, it was my duty to be very informative about complications. However, my experience is that preparation for the vagaries of normal recovery is equally important.