John Gregory: I have a newfound appreciation for the rehabilitation required after surgery.

A Patient's Recovery from Emergency Surgery

John Gregory discusses his surgery and the physical and psychological ramifications of a protracted recovery

John has 20 years of healthcare industry experience in the UK, the US and Canada, half of which have been spent in wound care. He completed the International Interprofessional Wound Care Course in 2008. He has served as an industry representative to the CAWC and was chair of the MEDEC Wound Care Committee from 2007 to 2011. He presented an oral poster at the 2009 CAWC conference regarding the use of a blog as an enabler for lower limb assessment. He is currently relocating from Milton, Ontario, to the UK with his wife, Sarah Quart.

Patient history

In October 2010, I presented at a walk-in clinic in Jasper, Alberta, with excruciating abdominal pain. I was referred to the emergency department and airlifted to Edmonton 40 minutes later, where I presented with a sigmoid volvulus. I underwent a sigmoid resection 4 days after my arrival at Misericordia Community Hospital in Edmonton. From the time of the initial emergency airlift, 2 weeks of my life disappeared.

My wife, Sarah, flew immediately from Toronto to join me in Edmonton. We were impressed that the hospital organized homecare follow-up in Milton, and we received a call from the Mississauga and Halton Community Care Access Centre (CCAC) even before we left Edmonton. Despite a physician order stating I was fit to fly, the airline would not allow me to do so and it was challenging to return home.

Prior to discharge, some of the staples were removed on postoperative day 4, creating a dehisced surgical wound that later became infected with a 9 cm tunnel. Although I was cared for daily by homecare, I was fortunate to be referred as a patient to Dr. Gary Sibbald, a dermatologist and wound-healing expert in Mississauga, Ontario. His intervention was analytical, decisive and aggressive. At his clinic, I became both the patient and the student. He excised the wound on 2 occasions to open it up and create a new acute wound. The wound finally closed in the middle of January. I can't imagine how much longer it would have taken without his intervention.

Sarah took time off work and drove me around for weeks after we returned home. I can appreciate how hard this is for any spouse or caregiver. I now also recognize the challenges of integrating back into the workforce, both physically and – more importantly – psychologically.

Physical ramifications

The first 6–8 weeks after my surgery were very tough. I shuffled around for the first couple of weeks, and getting in and out of the car was difficult and painful. I lost 15 pounds as a result of the surgery as I had no appetite; by Christmas, my ribs were visible. Moreover, eating caused distention and bloating, which increased the wound pain and made me even less inclined to eat anything. I wanted nothing other than soup. In addition, sleep was painful and a challenge back in the comfort of my own home. I was uncomfortable at night, no doubt a result of the polypharmacy and the dressing itself.

During the day, I would return exhausted from a round of CCAC, doctor's office and pharmacy visits, collapse and fall asleep. For many weeks I felt sick each morning, often getting up and then lying down again 30 minutes later. It felt so insignificant that I had a wound only a few inches long given the profound effect it was having on how I felt. Prior to the surgery, I was doing about 10 hours of exercise per week, a combination of kayaking, biking, yoga and gym. In the first months of 2011, I experienced dizziness at times. The dizziness eventually disappeared, and 10 months

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later a cardiologist investigated my unusually low pulse rate with electrocardiography and a Holter monitor. In addition, the surgery and medications resulted in changes to the skin of my trunk and face, making me self-conscious about my appearance. A plastic surgeon recommended that I massage the scar with moisturizer and then use scar treatments.

Five months post-op, I again started yoga, kayaking and spinning, albeit at a gentler intensity. Various healthcare professionals have made me rather anxious about returning to a high level of exercise too quickly, thereby risking a hernia. My goal was to be fit to play at the 2011 Canadian Canoe Polo National Championships in Sudbury, Ontario.

Psychological ramifications

I recognize the strong psychological component to trauma and recovery. I had all this time on my hands, but the fatigue demotivated me to start or do anything. I desperately wanted to use my newfound time productively, but felt weak, drained and lethargic until Christmas. This was depressing. I had moments where I wished to just get back to normal and saw flashes of all the things I could have been doing with the time at my disposal; however, I felt too lethargic to do anything significant. After 8 weeks, I finally felt motivated to get back into a normal morning routine. Only after the wound closed was I again able to shower easily and as often as I wanted.

Reflections

I have a newfound appreciation for the rehabilitation required after surgery. As a manager, I now have a deeper empathy and understand that someone cannot be expected to return to work a week after surgery. I was very fit and healthy going into the surgery, and it took me at least 8 weeks to gain any sense of normality. My own employer was excellent in ensuring that I did not return too quickly. I feel fortunate that at the age of 40, my recovery was relatively short and I was soon able to return to my previous levels of mobility and activity. For elderly patients, I can appreciate that it may take 6–12 months to recover from the surgery itself.

I also have a new respect for talking to patients, and understanding their history and changes in wound appearance. We often discuss addressing patient-centred concerns as part of our wound-healing paradigm to complement treating the cause and local wound care. Being the patient has given me a new perspective on these patient-centred concerns. I was impressed to find a couple of graduates from the International Interprofessional Wound Care Course among the hospital and homecare nurses.

Over the last decade, much has been made of pain at dressing changes. I experienced pain from the use of stainless-steel forceps to pack the wound. Wound care practitioners must do everything possible at the dressing change to avoid damage to the newly vascularized granulation tissue in the wound bed and pain to the patient from the process of removing the wound contact layer, irrigation, assessment and repacking. I identified some potential room for improvement in patient education – particularly at discharge – in terms of expectations for healing, knowing when to seek further medical help and the implications on everyday life, including driving and showering.

Finally, I learned the value of sleep in a hospital environment. As a patient, all I wanted to do was sleep – more than anything else. Product-selection committees should pay attention to patient factors, particularly the noise generated by a piece of equipment. We are lucky to live in a healthcare system with such medical technology; however, at 2:00 am I just wanted to sleep and wished all the equipment was silent and not lit up like a Christmas tree!