

## Your Transplant Surgery

Many patients tell us that they are very excited and happy on the day of their transplant surgery. You, too, will probably be thrilled at the prospect of a healthier life. But you also may be a little worried about your surgery and hospital stay. It is surgery after all—even if the end result will most likely be a better quality of life. It's only natural to be a little nervous.

But please be assured: You are in expert hands. Our transplant surgeons and staff are highly skilled and experienced. They perform hundreds of transplant surgeries each year. You're also at one of the top hospitals in the country. Renowned doctors in almost every field of medicine are only a phone call away. So, you can feel confident that we are applying the best in medicine to help ensure the success of your transplant.

This chapter gives an overview of what to expect during your surgery and hospital stay. We also encourage you to ask lots of questions. Having a good idea of what you'll be going through can help relieve any worries and stress.

## Hours Before Your Surgery

### IN SHORT

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**We will tell you when to be at the hospital and where to go.**

**Pack a bag for your hospital stay. Don't forget your medicines.**

**If you get dialysis at home, bring your dialysis supplies.**

**You may have some tests done. Then, you will be taken to surgery.**

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If you are receiving a kidney from a living donor, you will know the exact date of your transplant surgery in advance. You will be asked to come to the University of Chicago Hospitals about 1 to 2 weeks before your surgery for a pre-admission visit. During this visit, you will fill out some paperwork that will speed up your admission on the day of your surgery.

Your experience will be different if you are waiting for an organ from a deceased donor. As discussed in Before Your Transplant chapter, your pre-transplant coordinator could call you at any time of the day or night to tell you that a compatible organ is available. It's very easy to get excited or nervous when you get the phone call. Try taking a deep breath so you can focus. You are going to need to get to the hospital quickly—within a few hours, if possible. So, there's a lot for you to do in a short time. The pre-transplant coordinator will give you instructions when she or he calls. Be sure to write these down. It's easy to forget things when you're excited or anxious.

Please tell the pre-transplant coordinator on the phone whether you have or recently had an illness or infection. Examples include pneumonia, a cold, or an infection in your dialysis catheter. If you have diabetes, mention any sores you have that are not healing properly. And be sure to tell the pre-transplant coordinator about any recent hospitalizations or blood transfusions.

**Before You Leave Your Home.** Here are some general guidelines to help you get ready for your surgery and hospital stay. Many of these plans can be done before you know the date of your surgery.

- Know how you will get to the hospital. It helps to make some transportation arrangements ahead of time. You might want to have a Plan A and a Plan B. For instance, you might ask your neighbor to be your back-up driver in case your sister can't drive you when the time arrives.
- Do not eat or drink anything after you get the call that an organ is available. If you are receiving a living organ, don't eat or drink anything for six to eight hours before you arrive at the hospital.
- Pack a suitcase or bag for your hospital stay. Here's what to pack:
  - Bring all of your medicines. Make sure your name is written on all the containers.
  - If you are on peritoneal dialysis, bring your capping-or disconnecting-supplies with you.

- o Bring insurance information, including the name of your insurance company(ies) and the policy number(s).
- o Carry a small amount of money with you to buy a magazine or phone card for long-distance calls. (Local calls are free.) We suggest that you do not bring large amounts of cash, credit cards, or valuable items such as jewelry. You will not need them while you are in the hospital.
- o Pack your personal toiletries, a bathrobe, slippers, and socks.
- o Don't forget your eye glasses, dentures, hearing aid, etc.

**Admission.** Your pre-transplant coordinator will tell you what time to arrive at the hospital. If you are getting a living donor transplant, you and your donor should go directly to the Surgery Waiting Room (P-211) when you arrive at the hospital.

The place you should go if you're getting a deceased donor transplant depends on the time of day:

- If it's between 6 a.m. and 10 p.m.: Enter the hospital through the Bernard Mitchell Hospital door at 5815 South Maryland Avenue (one block north of 59th Street and one block east of Cottage Grove Avenue). Then, go to Admission Services (Room TS-200E), located in the lobby on the second floor. You will be asked to provide some admissions information such as your insurance provider(s), etc.

- If it's after 10 p.m. and not yet 6 a.m.: Go to the Emergency Room entrance at 901 East 58th Street. The Bernard Mitchell entrance is closed late at night. Tell the clerk that you are here for an organ transplant. The pre-transplant coordinator will have already submitted your admissions information so you won't need to go through that step.

**Testing Deceased Donor Organs.** If you're receiving a deceased donor organ, a lot is going on behind the scenes while you are traveling to the hospital. Both Gift of Hope and the University of Chicago transplant team evaluate the medical status and history of the donor. We make sure that the organs are healthy and free of transmissible diseases. The donor organ is also carefully tested to ensure that it is healthy and will survive as long as possible after the transplant. In addition, Gift of Hope must transport the organ(s) to the University of Chicago Hospitals, either by car or airplane. The organ is stored in a preservative solution until transplantation. The solution prevents swelling and damage and keeps the organ cool.

There's a chance that you may arrive at the hospital only to find out that the donor organ is incompatible or, for some other reason, not able to be safely transplanted into you. If this happens, your surgery will be cancelled. You're bound to feel disappointed if this happens. But it is better to continue to wait for the next suitable organ. You don't want to go through surgery only to have the transplanted organ have problems or fail. You

will maintain your same position on the waiting list and receive a compatible organ as soon as one becomes available.

**The Pre-Operative Period.** Once you're admitted to the hospital, you'll be assigned to a patient room to wait for your surgery. Family members or loved ones can stay with you during this period, if you like. For specific visiting policies, ask the unit nurses.

Soon after you arrive in your room, you'll be asked to take off your clothes and put on a hospital gown. Several members of the transplant team will probably stop by to talk with you and your loved ones. Your transplant surgeon will come by to explain the surgery to you again. This is your chance to ask the surgeon any other questions you may have. The surgeon or another doctor will examine you and ask about any recent health issues that you've had, including any illnesses. You may be asked to provide a list of all the medicines you currently take. If you have any sores or open cuts, be sure to show the doctor. In addition, the *anesthesiologist* will also talk with you about how you will be put to sleep for the operation.

Some of the doctors who stop by your room may be *residents* or *fellows*, or doctors who are receiving training in transplant care. The University of Chicago Hospitals is a teaching hospital. It is also a premier transplant training center in the United States. So, residents and fellows will be contributing a lot to your care, under the direction of your attending surgeon.

*anesthesiologist* –  
A doctor who puts you or parts of your body to sleep during surgery.

*residents* –  
Doctors with one to five years of advanced training beyond medical school.

*fellows* –  
Doctors who have completed a residency and are getting advanced training in an area of medicine, such as transplant care.

*electrocardiogram (EKG)* – A painless test that shows us the electrical activity inside your heart.

You will also be given various tests, procedures, and medicines during the pre-operative period. These vary from patient to patient, but commonly include:

- Blood samples.
- A chest x-ray.
- An *electrocardiogram* (EKG), which is a quick, painless test to measure the electrical current in your heart.
- A dialysis treatment, if needed.
- A bath with a special disinfectant soap.
- An intravenous line (IV) in your arm so you can receive anesthesia and medicine before surgery.

The pre-operative period usually goes as quickly as we can get all of your tests and consults completed—usually a matter of hours. If you're receiving a living donor organ, we may complete some of your tests and consultations prior to the day of your surgery.

You will then be wheeled into the operating room for surgery. Your loved ones may wait in the Surgical Waiting Room (Room P-211) during the operation. It is a comfortable room with televisions and public phones. Cell phones are allowed. A unit nurse or staff person may be able to recommend other places to wait—or get some sleep, if it's late at night. Once the surgery is over, the transplant surgeon or another staff member will let your loved ones know how everything went.

# The Transplant Operation

## IN SHORT

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**You will be given medicine to put you in a deep sleep. Then, a cut will be made in your stomach area.**

**Your new organ(s) will be put inside you. Then, some connections will be made so your new organ(s) can work.**

**Kidney-only surgery takes 2-3 hours. Pancreas-only surgery takes about 4 hours. Kidney-pancreas surgery takes 6-8 hours.**

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Transplant surgery involves the same steps whether you are receiving a living or deceased donor organ.

The initial steps for all of these surgeries are similar. First, you will receive a general anesthetic in the operating room through an IV in your arm. This will make you unconscious throughout the whole operation.

Once you are asleep, the transplant team will insert several additional IVs so we can monitor you and your fluids, medicine, and blood during and after surgery. You will begin getting anti-rejection medicines in the operating room—and sometimes beforehand. A *Foley catheter*, which is a thin, flexible tube, will be placed into your bladder after you are asleep to drain urine. You will be connected to a heart monitor machine so we can track your heart function. An *endotracheal tube* will be inserted through your mouth or nose and into your windpipe to control your breathing. In addition, a *nasogastric (NG) tube*, or stomach tube, will be

*Foley catheter* – A thin tube that is placed into your bladder during surgery to drain urine. The catheter will stay in place for two to five days after surgery.

*endotracheal tube* – A tube that is put through your mouth or nose

and into your lungs during surgery. The tube helps you control your breathing.

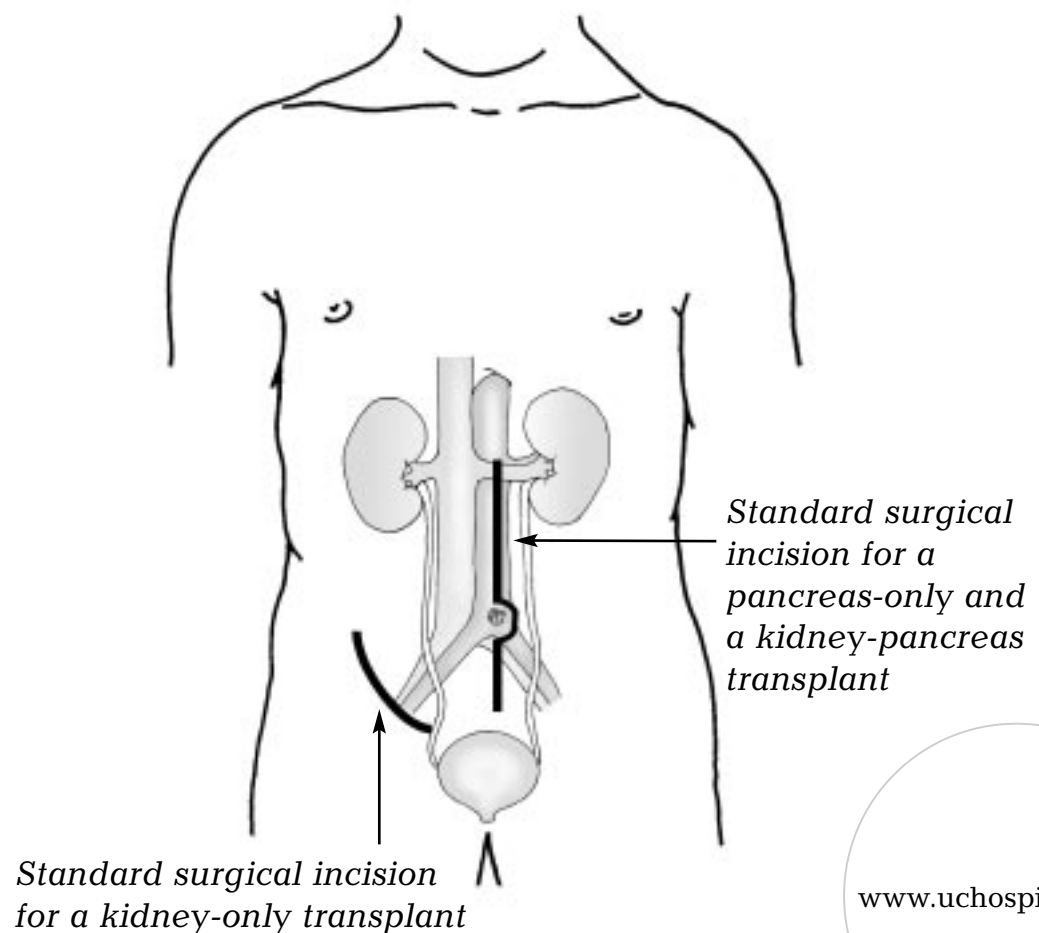
*nasogastric (NG) tube*– A tube that is passed through the nose and into your stomach. The NG tube helps keep your stomach empty during surgery or recovery.

inserted through your nose or mouth and down into your stomach to keep it empty throughout surgery.

All of these steps are routine during surgeries that require general anesthesia. Some of these tubes and monitors will be removed after surgery; others will remain for a few days.

**Kidney-Only Surgery.** The surgeon will make an incision that's about eight inches long in your lower abdomen. (See Figure 1) The donor kidney will then be placed in the small pocket under your pelvic bone, on either your left or right side.

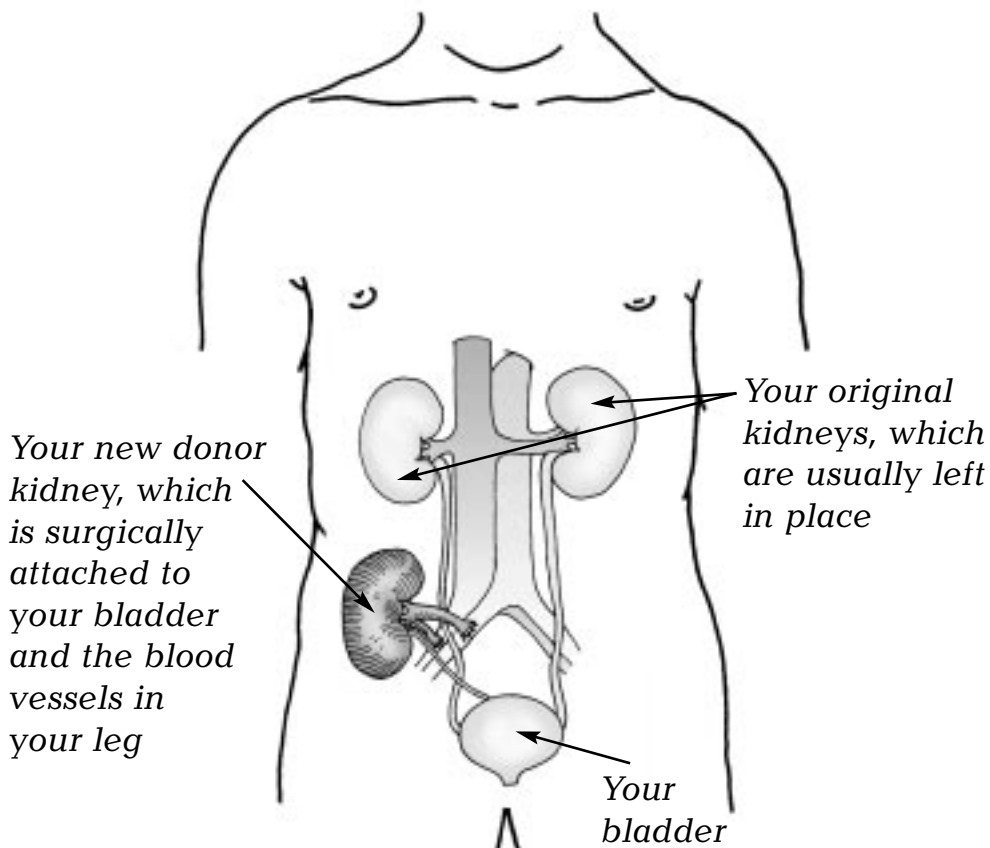
**Figure 1. Surgical Incisions for Transplant Surgeries**



The surgeon will then make a few connections to get your new kidney working. He or she will connect the main blood vessels going to your leg, which are called the iliac artery and vein, to the blood vessels on the donor kidney. This gets blood flowing through the new kidney. The surgeon will also connect your bladder to the donor kidney's ureter, a tube that drains urine. This connection makes it possible for your new kidney to make urine. Typically, donor kidneys start working right away; but some take a few hours, days, or even weeks to start making urine.

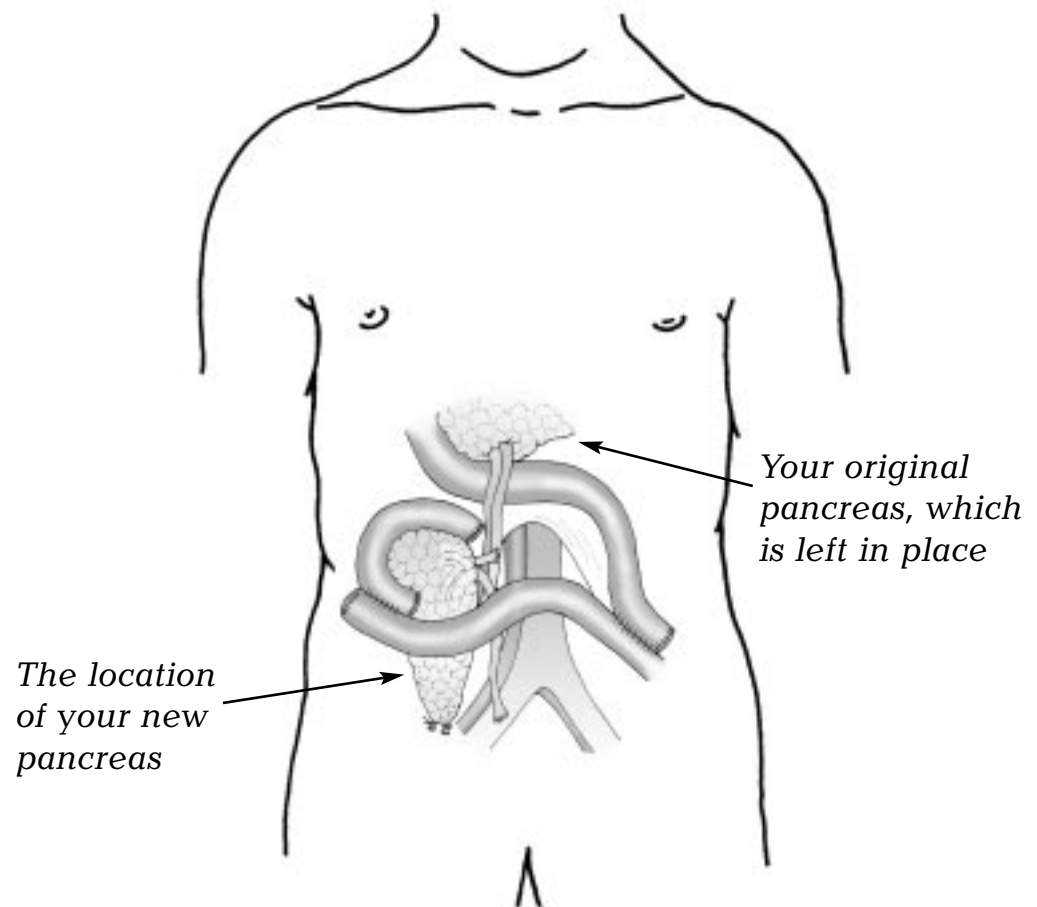
After all the connections are made, the surgeon closes up the incision. Your own defective kidneys will probably not be removed, unless they are causing problems. Figure 2, page 10, shows where your new kidney will be placed.

**Figure 2. Placement of a Donor Kidney**



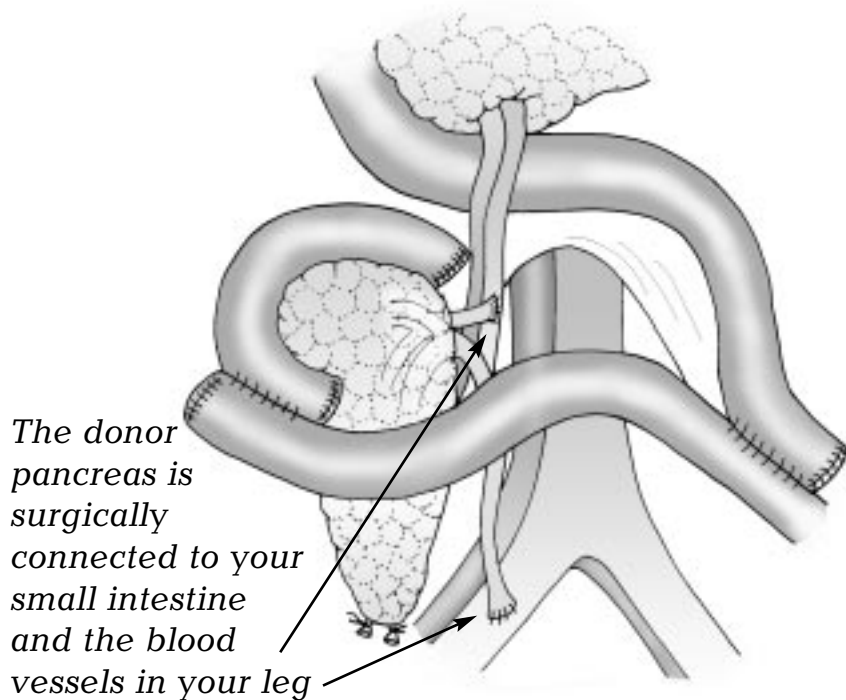
**Pancreas-Only Surgery.** For a pancreas-only transplant, the surgeon will make a 10- to 12-inch incision in your abdomen. (See Figure 1, page 9.) The donor pancreas is placed in the middle of your abdomen (See Figure 3, page 11).

**Figure 3. Placement of a Donor Pancreas**



The surgeon will then make the necessary connections to get the new pancreas working. He or she will connect the main blood vessels going to your leg, which are called the iliac artery and vein, to the blood vessels on the donor pancreas. This gets blood flowing through the new

### Figure 4. Surgical Connections for a Pancreas Transplant



*The donor pancreas is surgically connected to your small intestine and the blood vessels in your leg*

pancreas. Figure 4, page 12, shows you where these connections will be made. The surgeon will also connect your small intestine to the donor duodenum. The duodenum is a small piece of the donor's small intestine that is kept with the donor pancreas. This linkage allows you to excrete the extra digestive enzymes and fluids that are produced by your new donor pancreas. Once the connection is made, all the juices that are made by the donor pancreas are drained out of your body through your gastrointestinal tract.

After all the connections are made, the surgeon closes up the incision. Your own pancreas will stay in place. Remember, only a small part of your own pancreas is defective—the beta cells in the islets. The rest of your pancreas is still functioning and capable of producing digestive enzymes.

Typically, the donor pancreas starts working right away. But some take a few hours or days to start making insulin. It is normal to receive IV insulin for the first day or two after the transplant to carefully control your glucose level.

**Combined Kidney-Pancreas Operation.** The transplant surgeon will make a 10- to 12-inch incision in your abdomen. (See Figure 1, page 9.) The donor kidney is usually placed on the right side of your lower abdomen. The donor pancreas is placed in the middle of the abdomen. (See Figures 2 and 3, page 10 and page 11).

The surgeon then makes the necessary connections to get your new organs working. He or she will connect the main blood vessels going to your leg (ie, the iliac artery and vein), to the blood vessels on the donor kidney and pancreas. This gets blood flowing through the donor organs.

The surgeon will then connect your bladder to the donor kidney's ureter, a tube that drains urine. This makes it possible for your new kidney to make urine. The surgeon will also connect the donor pancreas to your small intestine. This linkage allows you to excrete the extra digestive enzymes and hormones that are produced by your new donor pancreas.

After all the connections are made, the surgeon closes up the incision. Your own kidneys and pancreas will stay in place unless there are problems that make it necessary for them to be removed.

## What to Expect After Surgery

### IN SHORT

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**You will need to stay in the hospital 4 to 10 days. When you wake up, you will have tubes and monitors attached to you. A nurse will show you how to control your pain. We will help you get up and walk within 24 hours. Ask the nurse if you have any questions.**

**Before you leave the hospital, we will teach you about all your medicines.**

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Most kidney-only recipients stay in the hospital for about four days. Combined kidney-pancreas recipients and pancreas-only recipients typically remain in the hospital for about seven to 10 days.

The recovery period is somewhat different for every patient. It also varies depending on the type of transplant you received. For instance, younger patients may recover faster than older patients. And patients who get a combined kidney-pancreas transplant usually take a little longer to recover than patients who only receive one organ. Plus, some patients develop complications that may affect their recovery.

So, it's impossible to predict exactly what your hospital stay will be like. The scenario presented below is an attempt to show the "typical" patient experience. Your doctors and nurses will also be explaining everything to you as it happens. If you have any questions or concerns, please ask.

*spirometer*—  
A device that helps you keep your lungs clear after surgery. You breathe air in and blow it out through a tube.

**The First Few Hours After Surgery.** After your operation, you will be brought into the surgical recovery room.

This unit is specially staffed and equipped to take care of post-surgical patients. You will likely stay in the recovery room until the anesthesia wears off, which typically takes an hour or two.

Many patients only have a vague memory of the recovery room. But you may recall waking up. You'll be very groggy at first and may notice that you have various IVs, tubes, and monitors attached to you. As you wake up, a nurse or doctor may ask you to breath deeply into *spirometer* or tri-flow, which is a device that tests and improves lung function. Let a nurse or doctor know if you are in any pain or experiencing any nausea.

**One to Two Days After Surgery.** Soon after the anesthesia wears off, patients are usually taken to a step-down unit for one or two days. Step-down units are designed to provide care for patients who are stable but need continuous monitoring. The nurses and doctors will be watching you closely to make sure the transplanted organ is working properly.

The longer you're out of surgery, the more aware you will become. You may wonder why you have so many tubes, lines, and monitors attached to you. They are all there for important reasons:

- You will have a few IVs in your neck, hand, or arm that we use to provide you with medicines, fluids, and nutrients. The IV's will stay in place for several days.

- You will have a *central line* in your neck, which may stay for a few days. A central line is thin tube that is inserted into a vein and threaded toward the heart. It is used for measuring the pressure in your vein and collecting fluids.
- You may have a line in the artery of your wrist, which helps us measure your blood pressure and take blood. This line is usually removed after 24 hours.
- You may have electrodes (patches) taped to your chest, which are attached to a heart monitor. These usually stay in place for a day or two until we're sure that your heart is recovering from surgery.
- You may have a blood pressure monitor around one of your arms, which takes your blood pressure from time to time.
- You will have a catheter that drains urine from your bladder into a container at the foot or side of the bed. It is normal to feel pressure in your bladder from the catheter. The catheter makes it easier for us to measure urine production, which we will need to do several times a day to check your kidney function. Right after surgery, it will be difficult for you to get out of bed and give frequent urine samples. If you have a kidney transplant, you also need a catheter so as to give your bladder time to heal. Remember, the surgeon had to "sew" the donor kidney to your bladder. You will need the catheter for two to five days.
- If you received a donor pancreas, you may have a nasogastric (NG) tube in your nose that reaches down to your stomach. The NG tube gives your intestines time to

*central line*—  
A central line is thin tube that is inserted into a major vein and threaded into the heart. It is useful for measuring and collecting fluids.

heal and recover. As described earlier, the surgeon had to connect the donor pancreas to your small intestine. The NG tube will remain until you can pass gas or demonstrate other signs of normal bowel function—usually within a few days.

- You will likely have a surgical drain in your lower abdomen. This flexible, plastic tube helps remove any excess fluid or blood into a container.
- You may have special socks or compression sleeves on your legs to prevent blood clots.

Many patients report feeling little to no pain after surgery. Others say they feel quite a bit of pain. The key is to control any pain that you do feel. Most likely, you will be given a patient-controlled pump that allows you to give yourself pain medicine as needed through one of your IVs. A nurse will teach you how to use this. You'll also probably be asked many times to rate your pain on a scale from 1 to 10 (with 10 being the worst possible pain). If necessary, we may increase the dose of your pain medicine or switch to another type of pain medicine. However, we also want to avoid the side effects that you can get from pain medicines, such as confusion and mood swings.

Please tell a nurse or doctor whenever you are in a lot of discomfort. Also, let us know if you feel sick to your stomach. Some patients feel nauseous after having anesthesia or as a side effect of pain medicine.

Within 24 hours of surgery, a nurse will help you sit up and take a short walk. Every day you're in the hospital, the walks will get longer. The sooner you move around after surgery, the quicker you will recover. It may be hard to get out of bed the first time after surgery. Your body has been through a lot. But the nurse and other staff will be there to prevent you from falling. (Don't try this without help.) Getting up will get easier every time you do it.

Kidney-only transplant patients can begin drinking fluids within 24 hours of surgery. But, if you had a pancreas transplant, you won't be allowed to eat or drink anything for a few days. Most likely, this won't bother you because you won't have much of an appetite. You'll be getting all the fluid and nutrients you need through your IVs. If your mouth is dry, ask if you can suck on some ice cubes. The doctor will be listening to your bowels with a stethoscope. Once your bowels start functioning, your NG tube will be removed. You will then be given clear liquids to drink. Once you're able to digest liquids with no problems, you'll be given some solid foods.

In between resting and recovering, you'll have many visits from members of the transplant team. A transplant surgeon and transplant nephrologist will stop by daily to monitor your condition. In addition, fellows and residents will check on you several times a day. The nurses will also come to your room for various reasons throughout the day and night.

We will perform various tests to see how well the new organ is functioning. These tests may include blood and urine

analyses, ultrasounds of the donor organ(s), and biopsies. We will also weigh you everyday once you are up and walking.

We began giving you anti-rejection medicines in the operating room—and in some cases before surgery—to prevent organ rejection. For a short while after surgery, you'll get your anti-rejection drugs through your IVs. But, soon after surgery, a nurse will bring you the pills to take at the right times.

Your family and loved ones are welcome to visit with you while you're in the step-down unit. If you have a question about visiting policies, ask a unit nurse.

**The Rest of Your Hospital Stay.** As soon as you are ready, you will be given a private room on the Transplant Unit (Unit 4 NW). The nursing staff on the transplant floor has lots of experience working with patients who have had an organ transplant. The transplant team will continue to monitor you very closely. But you will probably notice that you will not be as closely monitored as you were on the step-down unit. You're much stronger now and don't require constant watching. But we will still need to take frequent vital signs and collect daily blood and urine samples.

Every day, you'll start getting stronger and have more energy. Your daily walks will become more frequent and longer. You'll start eating solid foods and having normal bowel movements. Eventually, the catheter and most of your IVs will be removed.

Before you leave the hospital, you will learn how to take care of yourself and your new organ when you go home. An in-hospital transplant nurse and dietician will talk with you and your family about wound care, healthy eating habits, physical activities, and other important information.

The transplant pharmacist and a transplant nurse will also give you detailed information about your anti-rejection medicines. You will be told about the specific purpose of each medicine, how to take each medicine, potential side effects, and precautions. (Life After Your Transplant chapter goes into great detail about anti-rejection medicines and other aspects of post-transplant care. Your Transplant Medicines chapter provides more information on your medicines.)

You will be discharged from the hospital once you have recovered enough to eat, walk without assistance, and move your bowels. We also need to make sure that your transplanted organs are working as expected. Plus, we need to know that you can handle taking your anti-rejection medicines as prescribed. You will need to take these medicines for the rest of your life.

You may need an IV for medicine at home for a few days after you are discharged. This may be prescribed as an extra precaution against rejection or to prevent certain virus infections. A special IV may be placed in your neck or arm for this purpose. We will arrange for a home care nurse to visit your home to help you with this medicine.

Once you leave the hospital, we will expect you to come back frequently to visit the Post-Transplant Clinic. (See Life After Your Transplant chapter for details on your post-transplant care.)

## Possible Short-Term Complications

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**Sometimes problems occur after surgery. We will watch you very closely. If a problem occurs, we will treat it.**

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Transplant surgeries are becoming more and more routine. The majority of transplants are successful. But complications do sometimes occur during or right after surgery.

**Delayed Graft Function.** Some donor organs may take days or weeks to start working. This is called *delayed graft function*. It is more common with deceased donor organs because they spend more time out of the body than living donor organs do.

Usually, the transplanted organ(s) recovers slowly on its own. In the meantime, you may need to continue on dialysis or insulin injections until your new organ(s) begins to function on its own.

If a kidney is slow to start working, you may retain fluids. This can cause your body to swell. Your weight may also increase. If this occurs, don't worry about being over your dry weight. We want your kidney to be well hydrated. This excess fluid will go away once your new kidney is working well.

*delayed graft function* – When a transplanted kidney takes some time to start working. When this occurs, kidney recipients need to continue on dialysis until their transplanted kidney starts working.

**Infections.** About one in four transplant patients develop some type of infection, such as a bladder infection, while they're in the hospital. Your risk of infection is highest right after surgery. You may develop a fever, chills, and other symptoms. We will be watching you carefully and doing everything we can to prevent infection. For instance, one of the reasons you'll be asked to breathe into a spirometer a lot during your hospital stay is to prevent lung infections. If an infection develops you may need to stay in or return to the hospital until it is safe for you to go home.

**Blood Vessel Problems.** After a kidney transplant, the artery within the kidney sometimes clots, blocking the supply of blood to the organ. This is known as *renal artery thrombosis*. It occurs in less than 1% of surgeries. Urgent surgery is often needed to fix this problem.

Sometimes your own blood vessels or the blood vessels of the donor organ(s) leak, causing bleeding and other problems. We may treat this with surgery to stop the bleeding.

**Urine Leak.** If the connection between your bladder and the donor kidney heals poorly, you may develop a *urine leak*. This occurs in less than 1% of kidney transplant surgeries. You may have pain in your abdomen, low urine output, or high creatinine levels. Your incision may also leak clear fluid. Surgery may be necessary to repair the leak if a catheter alone does not allow the leak to heal.

**Rejection.** Rejection occurs when your body attacks the donor organ. There are three types of rejection: hyper-acute,

*renal artery thrombosis* –

Occurs when a clot forms, blocking the supply of blood to the oxygen.

*urine leak* –

When the connection between the recipient's bladder and a donor kidney heals poorly. Surgery may be needed to repair the leak.

acute, and chronic. Hyper-acute rejection occurs when the donor organ fails in the operating room or within a few hours of surgery. Hyper-acute rejection rarely if ever occurs because we are extremely careful about making sure that you and the donor are compatible.

Acute rejection can happen while your body is still adjusting to your new organ. One of the reasons we keep such close watch on you at first is to prevent acute rejection. It tends to occur within three to six months of transplant surgery. However, acute rejection can occur at anytime if you stop taking your anti-rejection medicines. Usually rejection is picked up by your blood chemistries (for example, a rise in the serum creatinine level). You may also experience symptoms such as a fever or pain over the kidney transplant. If we see signs of acute rejection, we can usually alter your medicines to control it. Thanks to medical advances, only a small number of patients lose transplanted organs to acute rejection in the first year after surgery.

Chronic rejection develops slowly and is more difficult to treat. One cause of chronic rejection is not taking your anti-rejection medicines as prescribed. But no transplanted organ will function forever. It is important to work with the transplant team to keep your transplanted organ working as well and as long as possible. (See Life After Your Transplant chapter for more information on rejection.)

## Common Questions About Transplant Surgery

**Q. I'm from out-of-town and am waiting for a deceased donor organ. I will have to fly to Chicago after a suitable organ has been found. Will there be enough time for me to get to the hospital in time for surgery?**

**A.** When an organ that seems to be compatible for you becomes available, we may call you and put you on alert so you can begin to make travel plans to get here. But, we may stop you while you're in route to tell you that the organ is not suitable for you.

You should talk to your insurer about your arrangements. Insurers often have special travel arrangements with the airlines for transplant patients.

While you're making travel plans, remember that Chicago has two airports. Midway is closer to the University of Chicago Hospitals. But O'Hare tends to offer more flight options.

**Q. Will I need a blood transfusion during surgery?**

**A.** As with any surgery, some bleeding can occur. So, you may need a blood transfusion, especially if you are already anemic. If you cannot receive blood products for religious or other reasons, please tell the transplant surgeon at your first meeting. The surgeon may be able to conduct your surgery in such a way as to avoid the need for a blood transfusion.

Blood that is infused is always tested. But there is a small risk of getting hepatitis or another disease from a blood transfusion. So, we only give transfusions when they are clearly needed.

**Q. Can my family members or I donate blood to be used in my operation?**

**A.** Living donor transplants are scheduled in advance. So it may be possible in these cases to store a supply of blood for your own surgery. You may be too anemic to donate your own blood. But your living donor or your family members might donate. Appointments at the hospital's blood bank can be made by calling 773-702-6247.

With a deceased donor transplant, we don't know when the transplant will happen, making it difficult to plan ahead in time to store blood for the surgery.

**Q. What will happen to my own kidneys and pancreas?**

**A.** Most likely, the surgeon will not remove your own kidneys and/or pancreas unless they are infected or causing health problems, such as high blood pressure.

**Q. Will I be in a lot of pain after surgery?**

**A.** Many patients report feeling little to no pain. Others say they feel quite a bit of pain. Most likely, you will be given a patient-controlled pump that allows you to give yourself pain medicine as needed through one of your IVs. If the pain medicine is not working, be sure to tell the doctors or nurses. We will work with you until your pain is controlled.

**Q. What are the hospital's visiting policies?**

**A.** Visiting hours and policies vary from unit to unit. But generally family and friends older than age 16 are welcome to visit at most times of the day and night. Usually, only

two visitors are allowed in a patient room at one time. If you have any questions, ask the unit nurses or staff.

**Q. I am getting a living donor transplant. How soon after surgery will I get to see my living donor?**

**A.** Typically, living donors recover on a different unit than the donor recipients. The main goal of your hospital stay is to recover. You need to focus on your own health after surgery—just like your donor needs to focus on his or her recovery. As soon as you or your donor is able to walk around, you can go visit each other. This is usually possible a day or two after surgery.

Hospital staff can let you know soon after your surgery how your living donor is doing.

**Q. How long will it be after surgery before I can drive, eat a regular meal, and do other normal activities?**

**A.** You will need to have someone drive you home from the hospital. We don't advise you to drive until your incision has healed and you are off pain medicines—usually about three to four weeks. Also, don't lift anything heavy (more than 10 pounds) for a month to six weeks.

You should be able to eat normally by the time you leave the hospital. Often one of the joys of having a transplant is that you'll be free of many of the dietary restrictions you had before surgery.

We encourage you to walk everyday. But wait until we give you the OK to try more intense exercises. Patients can resume sexual relations as soon as they are comfortable.

See Life After Your Transplant chapter for more post-surgical instructions.

## A Transplant Patient's Surgical Experience

*Sam, a 49-year-old kidney-pancreas recipient, shares his hospital experience.*

I was diagnosed with type 1 diabetes in the summer of 1973. Over the years, I thought I was managing fine and everything was going OK. Then, in 1998, I started to notice that my ankles looked fat. I just didn't have any energy. I got it checked out, and the doctor told me that my diabetes was starting to impact my kidney function. Eventually, I had to go on dialysis.

Around the same time, I looked into getting a kidney-pancreas transplant at the University of Chicago Hospitals. I went through all the evaluations and was put on the waiting list.

I was only on dialysis for a little over a year when they found a suitable kidney and pancreas for me. It was a Friday evening, and I had just left dialysis when I found out. My wife and kids came to pick me up. We all stopped at Pizza Hut for some food when my sister bursts in and yells, "Get to the hospital, get to the hospital." I stood up and said, "Who's hurt?" Then, my sister said, "No, they have organs for you." I remember feeling really scared when I got the news. Suddenly everything I wanted was right in my face. All kinds of thoughts were going through my head.

After the initial shock wore off, we started driving to the hospital. But something told me to stop and call. So I called, and the pre-transplant coordinator told me that they needed

to check the organs again. She told me to go home and wait for her to call me. So, we went home. Then, around midnight, they called back and said the organs were a good match, and I should come in.

So, my wife and I went to the hospital. Once we got there, we had to check in. Then, they took me almost immediately to prep for the operation. They gave me a shot to start making me sleepy. Then the surgeon came in and explained exactly what was going to happen. I finally dozed off, and they took me up to surgery.

My wife said it was a five-hour operation. Right after the transplant, the surgical team noticed I was bleeding internally. So, they took me back into surgery to fix the bleeding. But everything turned out fine. I woke up the morning after my surgery. My wife and kids were standing around and looking at me, asking if I was OK. It felt like I was dreaming throughout the whole thing.

After I woke up, the surgeon came in and said everything had gone well other than the little episode of bleeding. Both my new kidney and my new pancreas started working right away. I no longer needed dialysis or insulin shots.

The surgeon encouraged me to get up and start walking. But I was like, "Whoa, is it even OK to move?" But he said I should be able to get up and start walking the next day. He said the sooner I can walk, the sooner I can get out. So, I was kind of bent on getting out as soon as I could. Slowly but

surely, I started moving around the room and then down the hall a little bit. By the third day, I was walking all the way down the hall and back to the room with no difficulty. I would stop at the nursing station and say "Hi" throughout the day.

I wasn't in very much pain. I found this odd given everything that my body had been through. I also don't remember being bothered by a lot of tubes or monitors. I did have a tube through my nose and down my throat for a couple of days that was annoying. It didn't hurt. It was just annoying.

It was really amazing to me that so many doctors, nurses, and other staff came in to talk to me. They weren't just people doing a job. They seemed to be really concerned and caring folk. You hear that all the time. But I think I was privileged to really experience it. They really took care of you as a person—as one human being to another human being.

I was in the hospital for 10 days. And when it was time to get out, I honestly started crying. The nurses and other staff were crying, too. There was a real connection there. Everyone at the hospital truly demonstrated to me what compassion is all about. They were really wonderful to me.

*Sam has now been an organ recipient for three years. He feels great and no longer needs dialysis or insulin shots. He has this advice for other transplant patients: "Gear yourself up for getting through this. You've got to make it up in your mind that this is what you've been waiting for and looking for. So, do everything the doctors and nurses tell you to do."*