

## **MEditorial September 2009**

### **COMPLICATIONS**

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Atul Gawande, a General/Endocrine Surgeon @ Brigham and Womens' Hospital/Harvard Medical School in Boston, has a knack for compelling writing-- and has penned several noteworthy books about what it is like to be a surgeon. One could say his works are the "modern" day version of William Nolen's famous "The Making of a Surgeon".

"Better", the (audio)-book of Gawande's I myself have "listened to", and his 2002 "Complications" (I have read synopsis and reviews only) were both best-sellers-- and are great reads for the physician as well as the layperson.

At UCLA, where I was a Urology resident, I myself wrote a book chapter on ureteral problems in "Complications of Urologic Surgery". More than 20 years later, the chapter is outdated and the book has fortunately been revised several times. The types of surgeries now done involving the ureter have changed significantly, as have the resultant complications and management of those problems. As an aside, one of the doctor/editors of the book holding my claim to literary fame once said [and I paraphrase]: "Dr. Freedman... if you do not like complications, do not do surgery". Other aphorisms, albeit trite, include "surgery is not for the weak-hearted".

We who do surgery know there is always a chance of complications. We want to communicate this possibility in advance to our patient, but in a discrete and reassuring way so as not to dissuade surgery which is necessary and wanted. Surgery, when it goes well, is a powerful remedy for many health problems. In my

specialty of urology, surgical treatment of such diverse problems as prostate enlargement, prostate cancer, stones, incontinence, and impotence really do have a major beneficial impact on quality of life and, sometimes, longevity. If one “sees an opening” in terms of the advantage of surgery over, let’s say, medications or observation, one should take advantage of that probability for an excellent outcome. If the advantage is less clear, we need to have more detailed discussion to help the patient wade through the multitude of therapeutic options- if these do exist.

Surgery should be done when the benefits clearly exceed the risks. We as physicians must also judge (as would a financial adviser concerning our retirement assets), the risk aversion of the patient in question, especially when surgery is elective. Some, frankly, do not want to take the chance on a complication and would prefer to bear their symptoms/medical condition, hoping for a “better” procedure in the future. An example is a man suffering severe symptoms from prostate enlargement needing a TURP (transurethral resection) but not accepting the >50% permanent “problem” of retrograde (backwards) ejaculation. Some patients are misled into thinking a newer procedure, e.g., with lasers, microwave, or laparoscopy, are not only devoid of complications but are “guaranteed” to yield an excellent outcome.

The patient’s underlying condition will help guide us in stating the benefit versus risk of surgery. Poor overall medical condition, failed surgeries in the past, radiation damage to tissues, chronic use of blood thinners, interference with normal immune mechanisms by diseases such as diabetes or extensive cancer, or use of certain drugs, may all tilt the balance against the recommendation for surgery. Both the doctor and the patient need to have a specific goal for the surgery. Is it to cure cancer?; what is the likelihood in this case it will really happen? Is curing the cancer “worth” the risks of permanent disability? Is the surgery in question to eradicate one urinary stone causing symptoms--or all of a patient’s kidney stones? Is it to cure a myriad of urinary symptoms, or focused on

just one of a woman's symptoms, e.g., involuntary loss of urine? Will the patient be satisfied with a "narrow" good outcome--or only if he/she is totally better on all fronts?

We as surgeons must be careful in excluding patients who, for physical or psychological reasons, cannot withstand certain complications. We must always strive, as Dr. Gawande would say to be "better" and learn from past surgical misadventures or complications. We surgeons are, by nature and training, quite more perfectionistic than you could know. The patient, too, has a responsibility in self-screening for surgery, doing his homework on both the procedure and the surgeon, and having the maturity to accept that--despite the best actions and judgment of his surgeon-- things may not all go well. It is my personal observation that, over the past twenty years, such "maturity" has tended to take a back seat to unrealistic expectations and petulance over unintended outcomes.

A reasonable and informed patient is aware that such things as bleeding, infections, poor healing, acute and chronic pain, bodily dysfunction and need for reparative surgery for these complications can and do occur, in the best of hands. Exemplative of these principles, a patient of mine, treated elsewhere for a bad prostate cancer with surgery and then radiation (and still requiring hormonal therapy now for persistent cancer) had severe urinary leakage. After informed consent, including discussion of my concerns about post-radiation tissue alterations, he underwent placement of an artificial urinary sphincter, concurrent with insertion of a penile prosthesis for impotence (complication also variably seen after all treatments for prostate cancer). My surgery was not only technically "perfect" and unremarkable, but there was absolutely no concern after completing this procedure (on my part or his) about postoperative complications. After the sphincter was "activated", it worked so well that the man could not thank me enough. However, within 3 months of using the device, probably from the poor vascularity of the urethral tissues and their intolerance of a "foreign body" around them, the cuff of the device started to erode into the urethra,

necessitating prompt removal of the anti-incontinence prosthesis. He knows we will “try again” in the future--but the task will not be easy.

Whenever a patient of mine has a surgical complication, as a caring and concerned physician, I try never to pass this off as unavoidable or as “someone else’s fault”. There are always the “could have/should have” and “what if” self-questionings--in silence. However, when all is said and done, despite whatever unhappiness a complication brings to the patient, his loved ones and the doctor, we all need to accept that, let alone surgery, life does not always transpire as predicted, and a dose of philosophical “fate” is needed to help us move on and be “better”.

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