



References

If you require a full list of references for this leaflet please email patient.information@ulh.nhs.uk

The Trust endeavours to ensure that the information given here is accurate and impartial.



If you require this information in another language, large print, audio (CD or tape) or braille, please email the Patient Information team at patient.information@ulh.nhs.uk

Anterior Resection

Colorectal Departments

Pilgrim Hospital 01205 446466
Grantham Hospital 01476 464822
Lincoln County Hospital 01522 573776
www.ulh.nhs.uk

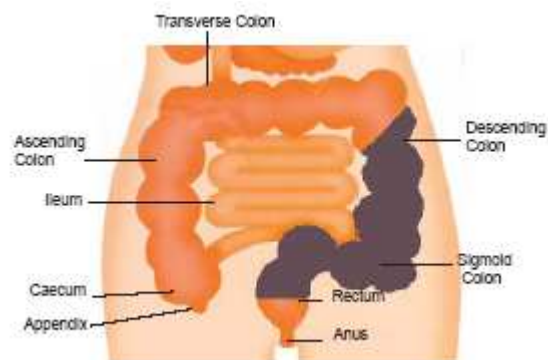
Aim of the leaflet

This leaflet is for patients undergoing anterior resection surgery. The aim of this leaflet is to provide further information and advice about the surgery.

What is it and why is it done?

The tests you have had show that there is disease in your back passage (rectum). If it is a growth or tumour, which has been diagnosed as cancerous (malignant), it requires surgery to remove it.

Surgery to remove part of the rectum (leaving the anus) is called an **anterior resection**.



Operative details

The rectum and part of the descending colon is removed. Continuity is restored by joining the two ends back together. The shaded area is the part of the bowel that will be removed. It is very possible that, in order to allow the join to heal, the bowel contents will be diverted through an opening in the bowel 'upstream' of the join. This is known as a STOMA (colostomy or ileostomy).

The colorectal nurse will discuss this with you and give you a practice pack in order to become more familiar with the stoma management.

Contact Information

If you require further advice/information regarding the content of this leaflet, please contact the Colorectal Nurse Specialists on:

Pilgrim Hospital

Colorectal Nursing Team 01205 446466

Ward..... 01205

Grantham Hospital

Colorectal Nursing Team 01476 464822

Ward..... 01476

Lincoln County Hospital

Colorectal Nursing Team 01522 573776

Ward..... 01522

What about after the surgery?

After discharge, you will be phoned frequently by the colorectal nurses in the first 14 days after surgery, as this is when patients can be most anxious about the progress of their recovery. You are then encouraged to phone the colorectal nurses if you have ongoing worries.

A routine outpatients appointment will be arranged for approximately 4 to 6 weeks after discharge.

All colorectal cancer patients are discussed at a multidisciplinary team meeting (MDT) which takes place once a week.

Here the best course of follow up care or treatment will be identified. This treatment could consist of chemotherapy.

With prior discussion and your agreement, we normally inform you of the outcome of this discussion with a telephone call.

Present at this meeting will include:

- Your Consultant
- The Oncologist - a cancer specialist doctor
- The Pathologist - who examines the piece of bowel that is removed
- The Colorectal Nurse Specialist

If you do not require further treatment such as chemotherapy you will be followed up in clinic for up to 5 years.

Are there any alternatives to surgery?

If you have cancer in the bowel then surgery is the main form of treatment and can be completely curative. If surgery is not performed then it is possible that the bowel will become blocked by the growth, which would make you very unwell and may require emergency surgery. This carries a much higher risk than planned surgery. Radiotherapy is sometimes used as a course of treatment, either combined with chemotherapy or on its own, before surgery but is rarely used as the sole treatment.

What are the benefits of surgery?

The benefit of surgery is that there is a good chance of curing a cancer or at least of preventing the bowel from becoming blocked at a later stage. Surgery will also allow the doctor to find the extent of any growth. If it is done for other problems such as a join between the bowel and another organ in the pelvis, (bladder or vagina) then this should resolve the unpleasant symptoms you have been experiencing.

What are the risks of surgery?

This type of operation is classed as major surgery and as with any form of surgery, carries risk (including risk to life). The general risks are as follows:

- Post operative bleeding (haemorrhage)
- Wound infection (high risk in colorectal surgery and also increases significantly in patients who smoke, are obese or have diabetes)
- Blood clot in legs or lungs (potentially life threatening)
- Chest infection, urinary infection

Specific risks for this surgery are as follows:

- Risk of the internal join (anastomosis) in the bowel leaking (5 to 10%)
- Risk of damage to the nerve supply in the pelvis, which may

cause sexual difficulties such as impotence and/or difficulties with passing water. This may only be temporary but could be permanent

- Risk that the cancer may not be completely removed if it has already started to spread outside the bowel
- There is a possibility that, if the tumour has spread, it would be better not to try to join the bowel. In this case a permanent colostomy would be performed at the time of the operation
- Small risk of damage to the spleen which may result in its removal; or damage to the ureter (tube which joins the kidney to the bladder)
- Risk of complications with the stoma itself such as loss of blood supply (necrosis), retraction, prolapse, mucocutaneous separation (where the bowel edge becomes slightly detached from the skin edge) and hernia formation in the longer term

Longer term risks:

- Adhesions - this is scar tissue which forms into tough fibrous bands inside the abdomen. In some people this can lead to further problems such as intermittent temporary blockages. This is less likely with laparoscopic surgery, it can take days or years to develop, if ever, but in a small number of cases may need further surgery
- Incisional hernia formation - where the weakened abdominal muscles allow the bowel to form a bulge under the skin; these sometimes require surgical repair

What does the surgery involve?

Preparation

We want you to be in the fittest possible condition prior to your operation so we may need to ask your own doctor to help us achieve this. If you have high blood pressure or are anaemic for example, together we will try to improve these conditions before your operation.

Bowel function (non stoma patients)

When part of the back passage (rectum) is removed it means that you have lost some or all of the storage capacity, so people often find that they need to open their bowels more frequently or may suffer moderate to severe disruption in function. This may improve over a period of a few months, but may never return to 'normal'. Please feel free to discuss any ongoing difficulties with the colorectal nurses.

For some it can result in poor control of their bowels, possibly even incontinence. If this is the case then there are things that can be done to help the situation such as medication and specific exercises i.e. pelvic floor exercises.

Recovery at home (See your 'Going Home' leaflet for further advice)

It can take roughly 3 months before you feel fully fit again, during which time you will need to balance rest with regular gentle activity such as walking. Trying to push yourself to do a little more each day can have beneficial effects and can improve the tiredness, however, exercise involving excessive strain on the abdominal muscles must be avoided for at least 6 weeks. A leaflet for exercises to strengthen the tummy muscles may be provided to use in the early post operative stages.

Your risk of Deep Vein Thrombosis is raised for around 3 months after surgery and you may be given a supply of the anti-coagulant (blood thinning) injections to continue at home for 4 weeks. Long haul air travel is not advised for 3 months after the operation due to the increased risk of deep vein thrombosis.

For the first 4 to 6 weeks you will be unable to drive.

If you find you have sexual difficulties caused by the surgery then this can be discussed and possibly treated at a later stage.

You will be encouraged to walk about 60 metres three times a day and sit out of bed for at least 8 hours each day in total if you are well enough. Being out of bed in a more upright position and walking regularly improves lung function and the circulation of oxygen through your body and reduces the chance of a chest infection.

You will have a catheter (a tube which passes up into your bladder) to drain urine. This is to measure your fluid balance accurately. This is normally removed after 1 to 2 days.

You may also have a wound drain (sometimes two). This is a tube which passes into your abdomen and drains fluid from under the wound. This fluid will be bloodstained to begin with which is entirely normal and nothing to worry about. The drains will be removed after 1 to 2 days.

In some cases a tube into the stomach through the nose may be required if vomiting develops and persists.

Stoma education

If you have a stoma you will be supervised to change the pouch yourself until able to do so independently. Most people are competent 4 to 5 days after their surgery. You will be given supplies to take home with you and arrangements will be made for the colorectal nurses to see you following your discharge.

With a stoma you may still experience the sensation and urge to pass wind/motion from your bottom. This is because mucous (slime) is still produced by the unused bowel and collects up. It is ok to sit on the toilet and pass this. In some people it can leak without you being aware and can be quite troublesome. If this is the case you may need to wear a pad to protect your clothing.

You can help yourself by trying to be as physically active as you can prior to admission, reducing cigarette and alcohol intake and maintaining a healthy nourishing diet.

If you are having difficulty with eating and have significant weight loss or need further advice regarding a low fibre diet (for management of bowel function) please speak to the colorectal nurses.

You will be required to attend for a pre-assessment appointment which involves checking you are fit and well enough to undergo the surgery, information giving and carrying out relevant tests such as an ECG (heart reading) and blood tests.

At this appointment you will be given a carbohydrate drink called Pre-Load to take home with you. It needs to be taken the day before your operation and also on the day of your operation. This drink helps to reduce some of the acute physical responses your body goes through due to surgery (similar to the effects of running a marathon).

In some cases you may also be prescribed bowel preparation or enema(s).

Enhanced Recovery Programme

Most patients will follow an enhanced recovery programme, the aim of which is to get you back to full health as quickly as possible after your operation. The programme is research based and has been shown that the earlier you get out of bed, start moving, eating and drinking, the quicker your recovery and less likely complications will develop.

During your hospital stay you will have daily goals which you will be encouraged to achieve. A team of doctors, nurses and other health care professionals will be monitoring your progress and will support you in reaching your goals.

It will mean a stay of approximately 5 days in hospital.

Patients can be admitted on the day of surgery but in a small number of cases admission the day before the operation may be necessary.

On admission, the colorectal nurse will mark a spot on your tummy in case a stoma is required.

Many patients are suitable to have laparoscopic (keyhole) surgery, but not all. It is generally dependant on what previous surgery you may have had, your body mass index and complexity of the operation.

There may be other reasons why the operation cannot be completed laparoscopically but the surgeon will discuss this with you.

The surgery is done under general anaesthetic and from leaving the ward to returning can take several hours. Laparoscopic surgery takes longer in general than open.

Open Surgery

The cut in the tummy is around 8 to 10 inches long. This will potentially mean a slower recovery, increased discomfort and a longer hospital stay but the enhanced recovery programme helps to reduce this.

Laparoscopic (keyhole) surgery

If the surgery can be performed by the 'keyhole' method then you will have 3 to 4 very small cuts and a slightly larger one across the lower abdomen. You generally have less discomfort, are able to move more freely and go home a little sooner on average.

Recovery

Once you have returned to the ward or ICU we monitor your recovery closely.

The things we monitor include:

- Fluid intake
- Food eaten
- Fluid out

- When you have opened your bowels
- Pain assessment
- Number of walks
- Time out of bed

Pain control, sickness and diet

You will be given regular pain relief and also medication to combat any feelings of sickness or nausea.

Effective pain control is an essential part of the programme. We use a number of different pain killers to reduce your pain levels. If your pain is controlled this will allow you to breathe deeply, make you feel more relaxed, enable you to start walking early and also help you sleep well.

You will have an intravenous infusion to give you fluids for the first 24 to 48 hours but this will come down as soon as you are able to drink enough fluids without being sick.

In most cases you will be encouraged to start eating as soon as you feel able after the operation. Appetite can be variable in the beginning as the bowel can take time to begin functioning properly. During this time you may feel bloated and feel or be sick.

Small amounts of nourishing and easily digestible foods are advised when you begin eating. These might consist of lean meat, mashed potato, gravy, milk puddings. Things to avoid initially are fibrous food such as salad, raw vegetables/stalks, fruit skins and bran fibre.

For some, the bowel will have a delayed period of inactivity so you may find all is well for the first 2 to 3 days then you develop the nausea and vomiting for a few days. This generally settles by itself by resting the bowel with a period of no food or drink.

Staying out of bed and walking

We will help you out of bed and sit you in a chair the day after your operation. Early mobilisation after surgery has been shown to be of benefit so your hard work will pay off!