References

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

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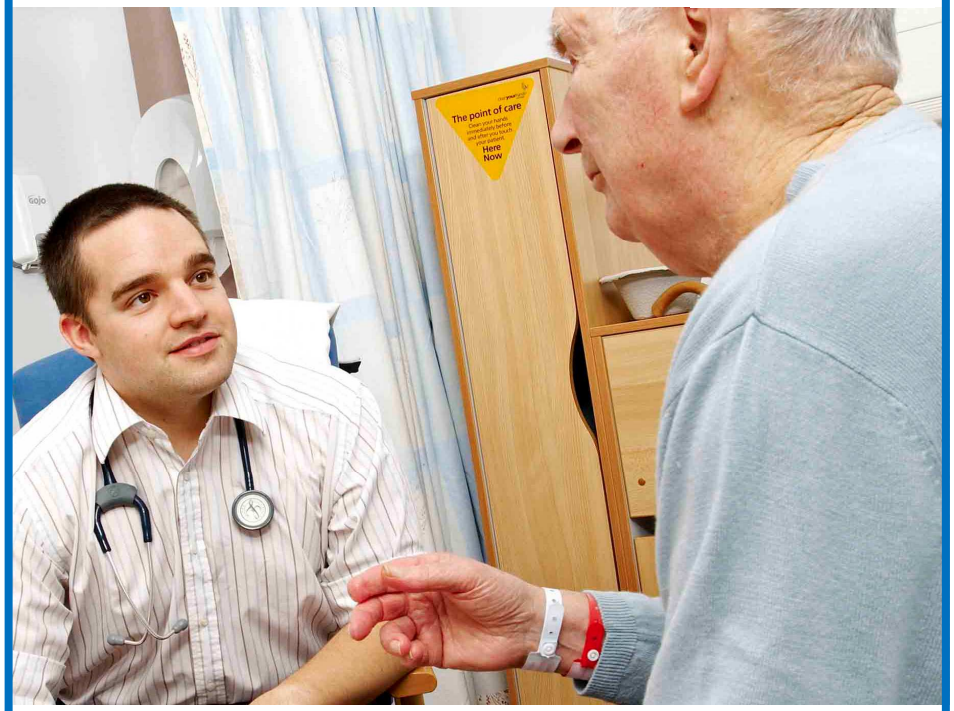


Left Hemicolectomy

Colorectal Departments

Pilgrim Hospital	01205 446466
Grantham Hospital	01476 464822
Lincoln County Hospital	01522 573776

www.ulh.nhs.uk

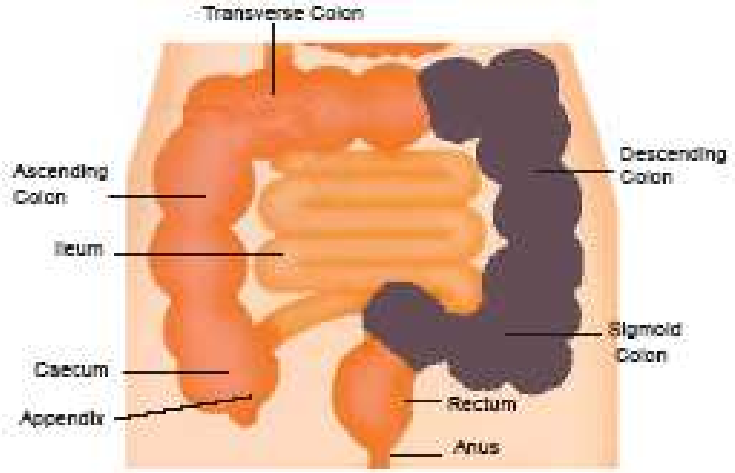
Aim of the leaflet

This leaflet is for patients undergoing left hemicolectomy 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 a problem in the left side of the large bowel. If it is a growth or tumour, which has been diagnosed as cancerous (malignant), it will require surgery to remove it. If it is a non cancerous condition such as diverticular disease and surgery has been suggested as the best option, then it is unlikely to improve without surgery.

Surgery to remove the left half of the large bowel is called a **Left Hemicolectomy.**



Operative details

The end of the transverse colon and descending colon is removed. Continuity is restored by joining the two ends of the bowel back together. The shaded area is the part of the bowel that will be removed.

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 roughly 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 first line 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. This would make you very unwell and may require emergency surgery which carries a much higher risk than planned surgery. Radiotherapy is not useful for cancer in this section of the large bowel. Chemotherapy is not used as the main treatment but is sometimes used after surgery.

What are the benefits of surgery?

The benefit of surgery is to remove the diseased section and so prevent future problems such as a blockage of the bowel. It should also resolve unpleasant symptoms you may have been experiencing. If the reason for surgery is a cancerous/pre-cancerous growth then it is the only chance of a cure.

What are the risks of surgery?

This type of operation is classed as major surgery and as with any form of surgery, carries risks (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. This is only a very small risk but is potentially dangerous and may require an emergency operation (5 to 10%).

- If the surgery is more complicated than anticipated there is also a very small risk of you waking up from the operation with a stoma 'bag' (colostomy or ileostomy). This may be temporary or permanent and means that the bowel contents are diverted through an opening on the surface of the abdomen into a 'bag' which sticks over the opening. The colorectal nurse will discuss this more fully with you if it is required.
- Risk that a cancer may not be completely removed if it has already started to spread outside the bowel.
- 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 (if required) such as loss of blood supply (necrosis), retraction, prolapse, muco-cutaneous 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.

There should be very few, if any, long term effects from having this section of the bowel removed. You may notice to start with that your motions are looser than before or you go a little more often, but this generally settles over the first few months.

Bowel function

Initially the bowels may start to work suddenly, with not much warning with loose, watery stools. In the very early stages you may find that your control is poor and accidents are not unexpected. The ward staff are vey accustomed to this and will provide support to you if it occurs. It will improve over time.

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 high risk of deep vein thrombosis.

You may get frustrated at not being strong enough to do what you want to begin with.

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

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 and 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.

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

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!

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. Drains are normally removed after 1 to 2 days.

Some people find that they produce more wind (flatus) or their bowel function can be more erratic.

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.

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 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) to take home and use yourself the evening before or morning of surgery. If you feel you would be unable to manage this, please speak to the pre-assessment or colorectal nurses.

If stoma formation is a possibility you will be offered a training pack to use prior to admission.

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. Most 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 had your bowels opened
- 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.