Cheltenham
Colorectal

A Patient's guide to

Anterior Resection of the rectum

Mr Neil R Borley
Consultant Colorectal Surgeon

Imperial Medical Group
Cheltenham & Gloucester Nuffield Hospital
Hatherley Lane
Cheltenham, GL51 6SY
01242 246526

www.cheltenham-colorectal.org.uk

Introduction

You have been diagnosed with a tumour in your rectum (back passage) and advised to have an operation to remove your tumour.
This leaflet aims to answer some of the questions you may have about the surgery.

What is an Anterior Resection?

Anterior resection is the name given to the operation to remove part or all of the rectum (back passage) but where the anus ('tail end') is kept and the bowel is joined back up inside to make a new 'back passage'. The aim of the operation is to remove all the cancer together with a margin of healthy normal tissue around it to ensure that the risk of the cancer returning is as low as possible.

How is it done?

The operation is usually performed through an 'up and down' cut in the abdomen (belly) called a laparotomy. Once inside the surgeon will free up the rectum and remove all that is necessary to try to ensure complete removal of the cancer. This includes all the fatty tissue around the rectum as well as all the blood vessels and lymph glands which supply the rectum. Occasionally, it is necessary to remove all or part of other organs close to the rectum to ensure complete removal of the cancer. In women this rarely means removal of one or both ovaries or part or all of the uterus. In men, a small part of the bladder may need to be removed. If it is expected that this may be necessary, it will usually be discussed with you before the operation by the surgeon. Once the necessary parts of the rectum have been removed, the healthy bowel from above is brought down and joined up to the remaining rectum or the anus. This can be done in several different ways but it always results in a join between the two pieces of bowel. This join is called the 'anastomosis'. If there is concern that the cancer is so low down in the rectum that it may not be possible to join the ends back up again, this will be discussed in detail with you before the operation.

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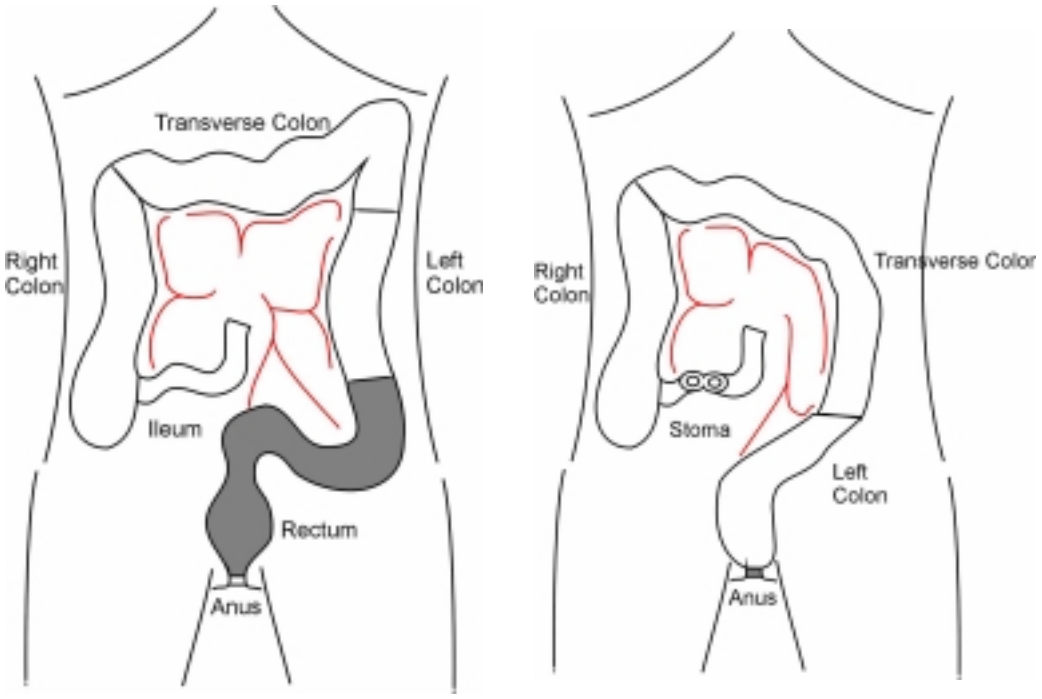

Will I need a 'bag'?

The join up (anastomosis) is extremely important. However well made it is, leakage can occur from the join in the days after the operation which can cause infection inside the abdomen. Depending how easily the join up goes, the surgeon may decide to bring the bowel upstream of the join out onto the abdominal wall as a stoma ('bag'). This stoma is designed to be a temporary safety valve to allow the join to heal up without the pressure caused by motions passing through it. If it is likely to be necessary, it should be discussed with you before the operation and you may well see the specialist stoma nurses to explain more about it. Very occasionally it is necessary to make a temporary stoma even though it was not expected. The stoma is usually kept until we are happy that the join has healed up without any problems. It is then usually possible to get rid of the stoma and start the bowel working in the normal way by a much smaller second operation.

Before your admission

PreAdmission Clinic

You may be asked to attend a PAC (Pre-admission Clinic) to see members of the medical or nursing team who will ask you some questions in order to make your hospital admission as smooth as possible. You will also have blood taken. An ECG and chest X-ray may also be done. There may also be an opportunity to see a physiotherapist or Nurse Specialist.
If you have any questions please ask any of the above and they will endeavour to ensure that you know as much as you want to know.

What will happen when I go into hospital ?

Bowel preparation

You will usually be admitted a day before your operation. You may be asked to take some bowel preparation. This acts to clean your bowel and allow it to be as clear as possible of stool. The bowel prep is in the form of liquid laxatives which you drink.
The laxative will work within a few hours and will give you time to get to the toilet. If you generally have any impaired mobility, then extra help will be given by nurses who are used to the embarrassment that laxatives may cause you. Some people prefer to flavour the taste of the laxative with their own squash. You will not be able to take any diet once you start your bowel preparation and you will have nothing to eat or drink 6 hours before your operation.

Medication

You should continue to take your own medication up until admission unless advised to stop by the doctor in the pre-admission clinic. You should bring your medication with you into hospital but the nursing staff will administer the medication in order to keep a check on what is being taken overall.

Before your operation

You will have surgical stockings fitted and have a blood thinning injection; these help to prevent blood clots developing in your legs and this will be continued after the operation.
The anaesthetist will see you before your operation. They will discuss your general anaesthetic with you where you will be asleep during your operation. The anaesthetist is responsible for the medication and equipment used for looking after your heart and breathing throughout your anaesthetic. They will also discuss the type of pain relief you will wake up with. For most people this is an epidural where a very fine “drip” administers a continuous amount of a strong pain killer to an area of your spine where your operation nerves go. Occasionally an alternative to an epidural called a PCA (patient controlled analgesia) will be used. Here, instead of having a continuous amount of pain killer, you press a button when you feel pain killers are needed and a small amount of strong analgesia is given via a “drip”.
Just before you go to theatre you will be asked to put a gown on. Several checks are made by the nurses in order to ensure that everything is correct. You will be taken to theatre on a trolley with a ward team member and a porter. The trained theatre nurses make further checks. They will make sure that you are safely cared for during your time in theatre. During your operation all the tubes and drains that you require will be put in place. After your operation you will be taken to the recovery room until you have fully woken up, when you will be escorted back to the ward.

Recovering after your operation

The initial recovery period

Qualified nurses will observe you carefully immediately after surgery and whilst you are waking up.

On waking you may have a mask over your mouth or a tube on your nose to give you oxygen. This is normal and may stay on for a few days.
The nurses will check your blood pressure, pulse, respiratory rate, temperature and oxygen levels regularly on a monitor.

- *Intravenous drip*

You will have an intravenous infusion (drip) going into your arm or neck so that fluids and certain medicines can be given. This will stay until you are able to eat and drink normally again a few days later.

- *Catheter*

You will have a catheter (tube) placed in your bladder at the operation to drain your urine away into a collection bag. This may be placed internally or via the abdominal wall. The catheter is necessary while you are less mobile. It will be removed as soon as possible a few days after your surgery.

- *Drains*

Other tubes or drains may be present to allow any excess fluid which might collect around the site of the operation, to drain through the tubes instead of forming a bruise on the inside.

- *Pain relief*

The epidural or PCA will need to stay for a few days. At this point it should be sufficient to just take tablets for analgesia. You should not feel too sore but if you do then please ask the nurses for some more pain killers.

- *Sickness*

If you are feeling sick you can have some anti-sickness medication to relieve this. Fluid from your stomach may be drained via a tube through your nose into a drainage bag. This will stop you feeling sick until your bowels become more active again.

- *Eating and drinking*

The doctors will also decide on how much you can have to drink and when you can start to eat again. This is based on when your bowel starts to work. In some people this can take about a week but most patients can drink a limited amount the next day after their surgery and gradually build up to take free fluids before taking diet. You will usually be eating within 5-7 days. It is advisable not to drink fizzy drinks for at least the first 2 weeks after your operation as these can cause excessive wind and discomfort.

- *Doctors*

You will see a senior doctor every day along with a team of doctors and nurses. They check on your progress and decide when it is appropriate for all the tubes, drips and catheters to be removed.

- *Wound*

The nurses and doctors will also assess your wound regularly for signs of infection. Most stitches in the wound are dissolvable. If you have non-dissolvable stitches, they will be removed 7-10 days after your operation.

- *Blood samples*

Your blood will be checked regularly for signs of anaemia, infection and imbalanced blood chemistry. This allows the doctors to identify and treat any problems.

- *Physiotherapy*

A physiotherapist will see you regularly and encourage you to breath deeply to help prevent a chest infection. They will assist you with any appropriate breathing or mobility exercises.

- *Visitors*

You will be told the ward's visiting times. All the staff adhere to a strict confidentiality code. Your treatment/condition will not be discussed with anyone in detail without your express permission. Equally, we are unable to discuss your condition in detail over the phone with anyone, even if they are very close to you.

- *Results*

During your operation any bowel that is removed, or biopsies that are taken will be sent to the histology department for analysis. This process is very detailed and takes approximately a week for the results to return. Your surgeon will talk to you (and, if you wish, your relatives) about the results of your operation and discuss any further treatment that may be beneficial to you. This *may* be in the form of chemotherapy or radiotherapy. If this is considered appropriate, arrangements will

be made for you to see an Oncologist (medical cancer specialist) in the near future to discuss your additional treatment in detail.

Complications

Complications of surgery are not common but are important and may be serious. If you think that all is not well, please tell the nurses.

Complications might include :-

- *Problems with the heart and lungs.* Any anaesthetic carries risks to the heart and lungs. Part of your pre-operative assessment is to try and identify and reduce these risks but nevertheless, some people develop complications with their heart and/or lungs during or after the operation. Normally these can be corrected with close medical attention. In extreme cases these complications can be very serious. The overall risk to your life because of having the operation varies between each patient but is usually about 1 in 50.
- *Leakage*. Occasionally there are problems with your join in the bowel. The join has to be 100% water-tight to be successful. Depending on exactly how the join is made the surgeon may decide to make a temporary ileostomy (bag) to reduce the pressure on the join. In 5-10% of patients there can still be unforseen problems with the join's healing. This can result in a leak. This is an uncommon condition but it may require a return to the operating theatre to correct the problem or the insertion of extra drainage tubes.
- *Chest infection* – especially in smokers. If you get a chest infection it will be treated with antibiotics. Co-operation with the physiotherapist to clear the air passages will help to prevent a chest infection.
- *Wound infection* - Approximately 10-15% of patients will get a wound infection. This is generally not a serious condition but nevertheless will require treatment. You may be given antibiotics or if there is a collection of fluid this may need to be released to allow your wound to continue to heal. If your wound feels unusually tender, warm and looks red,
or discharges fluid then please inform the nurses or doctors. If this happens when you go home your G.P will need to assess your wound.
- With all operations to remove tumours of the rectum, there is a slight chance that there may be some degree of damage to the nerves in the pelvis. Their function is to help control the bladder and in men they control erection of the penis. Very occasionally some men might notice a change in their sexual function and experience problems with erection or ejaculation. The risk of this depends on several things. It is extremely uncommon in younger patients but older patients occasionally suffer problems. Nerve damage problems are also a bit more common if the cancer is large or needs radiotherapy before the operation. If you have any concerns about this, please ask for more information before your operation. If you experience any problems after your operation please tell your doctor, there may well be treatments available to help with or reverse these problems.
- Occasionally there are numb patches, aches and twinges around your scars for up to 6 months after your operation.
- Bowel actions are often different after surgery. You may notice that your bowels are looser than before your operation. This is normal, a regular pattern will re-establish itself in time with most patients. It is uncommon but a small number of patients find that they have difficulties opening their bowels which needs specific treatment.

Discharge advice

- **Rest and activity**

You will need to take things easy for a while. You will feel emotionally and physically exhausted. It can take up to 3 months to recover from major bowel surgery, often longer.
Have a rest period each day.
Plan to do a little more each week.
Remember it is normal to feel tired. Make the most of help offered.
Let friends know when your rest period is so that you are not disturbed.
Limit household jobs for the first 3-4 weeks. Avoid lifting heavy objects, pushing and pulling (vacuuming and mowing the lawn), excessive bending and stretching.

- **Getting about**

Increase your daily activity gradually. Start with a short walk 2-3 times a week. Be guided by how you feel.

- **Returning to work**

This depends on your occupation and how you feel physically and emotionally.
You can be issued with a medical certificate (sick note) on request and your G.P will continue to issue one until he feels you are fit to return to work.

- **Dietary advice**

If your bowels are still loose or you have diarrhoea, avoid becoming dehydrated by drinking plenty of sugary fluids. Your appetite may not fully return for a while so it is important to eat little and often and eat what you enjoy. If you wish to see a dietician, this can be arranged.

- **Driving**

Generally it is advised that you do not drive for several weeks after surgery. Your insurance company will not cover you until you can do an emergency stop comfortably and safely.

- **Sexual activity**

Everybody is different about when they feel ready for sexual activity. If there is any reason to delay due to the surgery this will be explained to you. A guide may be when you are ready to go back to work but you may feel ready before. Ask for advice if you are unsure.

- **Helping yourself**

Getting back to normal will take some time. Don’t rush things – you will get there.
Bowel surgery is part of our life, sometimes talking about it helps you and your relative come to terms with it. We are here to help support you and your relatives through this experience. Please contact us with any concerns.