Royal Surrey
County Hospital
NHS Foundation Trust

A Guide to your Bowel Surgery

Colorectal Department

Patient information leaflet

Contents page

Introduction

This booklet has been given to you by your doctor or Colorectal Nurse Specialist to help explain your Colorectal Cancer diagnosis and treatment.

The Colorectal Nurse Specialist acts as your 'key worker' and works alongside the doctors and nurses on the wards and in the outpatient department. Their role is to coordinate care and promote continuity, mainly by being available as a point of contact for information and advice to you and those close to you throughout your treatment.

What is colorectal cancer?

Colorectal cancer is a general term applied to cancers occurring anywhere within the colon (large bowel or intestine) or the rectum (back passage). In order to decide the best treatment for your particular cancer you have various tests to find out the size and position of the cancer, and whether it has spread. This process is called 'staging'.

The final 'staging' of the cancer can only be known after your operation, when the section of the bowel has been removed and analysed by a consultant histopathologist.

What is the function of the large bowel?

The bowel, otherwise known as the colon, is part of our digestive system and is divided into the small and large bowel. The large bowel is made up of the colon and rectum. It is approximately about 1.5 metres long.

Food passes from the stomach to the small bowel. After the small bowel takes nutrients into the body, any undigested food passes through the large bowel, where water is removed from the waste matter. This waste matter is held in the rectum (back passage) until it leaves the body as bowel motions (also known as stools or faeces).

How is the diagnosis made?

A colorectal cancer is diagnosed following various tests and all these results are discussed by the Colorectal Multi-disciplinary team (MDT), which consists of Colorectal Surgeons, Oncologists, Radiologists, Pathologists and Gastroenterologists. These meetings allow the team to be able to advise you on which is the best course of action and plan of treatment. It is also important to take into consideration other factors, such as your age, general health, the type and size of the tumour, and whether it has begun to spread.

Treatment

A plan of treatment will be agreed at the colorectal MDT and will be discussed with you at your next appointment by your consultant.

What treatments are available?

Surgery – This main treatment for colorectal cancer is surgery, but sometimes patients may require other treatments, depending on the site and stage of their cancer. For some rectal cancers a combination of chemotherapy and radiotherapy is required to reduce the size of the tumour before surgery.

Occasionally it is not possible to do surgery, therefore chemotherapy or radiotherapy may be offered to try to stop the cancer advancing, and to control symptoms. This is known as palliative treatment.

After surgery the final stage of the cancer will be known and additional treatments may be recommended. This may be in the form of radiotherapy and/or chemotherapy.

Radiotherapy – treats cancer by using high-energy rays to destroy cancer cells, while doing as little harm as possible to normal cells. Radiotherapy is usually only used to treat cancer of the rectum. It is not normally used for colon cancer except occasionally to relieve symptoms.

Radiotherapy may be given before surgery to shrink a tumour and make it easier to remove. It also reduces the chance of the cancer coming back. Usually a course of radiotherapy lasts for up to six weeks and this is usually given with chemotherapy (chemo/radiotherapy) The chemotherapy makes the cancer more sensitive to radiation.

Chemotherapy – is a drug treatment which is used to try and kill cancer cells, reduce the risk of the cancer coming back or stop them spreading. There are various types of drugs; a separate leaflet will be given to you if you will require chemotherapy.

Colonic Stents – these devices are occasionally used to relieve obstruction and they can help keep the bowel working when the tumour is blocking the passage of stool. The colonic stent can sometimes be inserted to relieve symptoms prior to a planned operation, or where there is advanced disease and surgery is not appropriate.

What operation will I have?

The site of your disease will determine which operation your surgeon will perform. Outlined on the next page are the common types of surgery. Your surgeon will explain which one is best suited to you and the colorectal nurse specialist will be able to discuss it further with you and your family.

How will the operation be performed?

There are two approaches that the surgeon may take in order to perform the surgery; either laparoscopically (keyhole) or through an open incision. Whichever approach is used you will be taking part in an enhanced recovery programme, to help you recover quickly and safely. The surgeon will discuss with you the most suitable approach.

Laparoscopic (Keyhole) surgery

This is where small cuts are made in the abdomen and a harmless gas is pumped in to create a working space to allow insertion of a camera and instruments. The smaller incisions result in the operation being less traumatic and are associated with less pain and more rapid recovery.

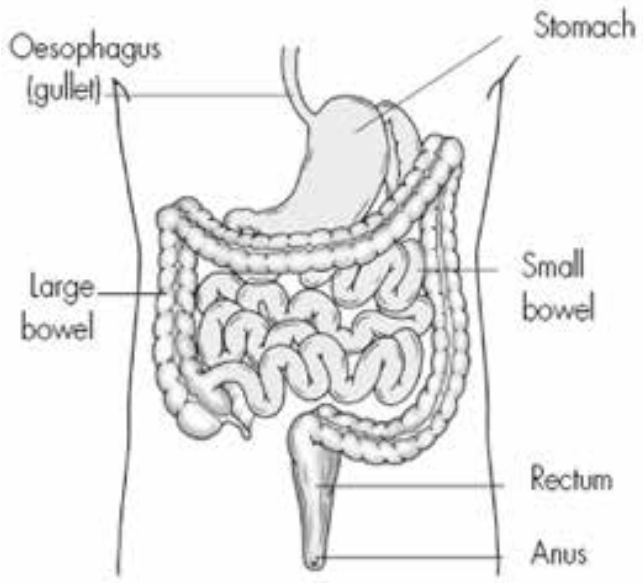
Open incision

This involves one continuous incision on the abdomen which is either horizontal or vertical depending on the operation you will be having.

Which operation will I need?

Name of operation …….....

This diagram can be used to help explain your operation to you.



- **Hemicolectomy** – The right or left side of the colon is removed and the remaining bowel rejoined.
- **Sigmoid Colectomy** – The sigmoid colon is removed and the remaining bowel rejoined.
- **Anterior Resection** – Part of the rectum is removed and the remaining bowel rejoined. With this procedure you may need to have a stoma for a few months in order for the join (anastomosis) to heal.
- **Hartmann's Procedure** – Part of the rectum is removed but the bowel cannot be rejoined at this operation. The surgeon will form a stoma (bag), which may be possible to reverse in the future.
- **Abdomino-Perineal Excision of the Rectum** – The rectum and anal canal are removed and a permanent stoma (bag) formed. Your back passage will be sewn up and will not be able to be used for passing motions any more. Your motions will be passed into the stoma bag.

Are there any alternatives to an operation?

Yes, but these vary from patient to patient depending on the location of the cancer. The team will discuss treatment options available to you. It may be necessary to have additional treatments including chemotherapy and radiotherapy before and after your operation.

What happens if I decide not to have bowel surgery?

If you decide not to have surgery, the cancer may continue to grow and your symptoms may get worse. The team will discuss with you what may happen if you do not have surgery and if appropriate, discuss other treatment that may be suitable for you.

Will I need a stoma?

With some operations it is necessary to form a stoma (bag). A stoma is when part of the bowel is brought out onto the surface of your abdomen. It is formed to divert the flow of motion. In some cases, it is temporary and others it is permanent. The name for the stoma is either a colostomy or ileostomy depending on where in the bowel it is created.

If it is necessary for you to have a stoma (colostomy or ileostomy), or if it is thought that you might need to have one, you will be referred to the Stoma Care Nurse before your operation.

The stoma nurse has undergone specialist training in stoma care, and will be able to answer any questions you may have. They also understand you may feel uneasy about having a stoma. They will teach you how to look after your stoma, and provide advice and support you so that you may return to a normal active life.

What are the benefits and risks of the operation?

Benefits - Depending on the reasons you require surgery, the aim of the operation is to cure your disease, or relieve your symptoms. This cannot be guaranteed and sometimes you may be offered additional treatment once the results of the operation are available.

Risks – This is a major operation and as with any form of surgery, problems can occur. The most common risks of surgery include are chest infection, wound infection, urinary infection, bleeding, blood clots and pressure sores. These risks are reduced by the use of blood-thinning drugs, physiotherapy and early mobilisation. Less common risks of surgery include, post-operative bleeding (haemorrhage), heart attack or blood clot in the chest (pulmonary embolism).

There are specific risks related to the operation itself. They include a leak from the join inside (anastamosis), adhesions which are fibrous bands that can form inside. Occasionally the bowel can be slow to start working again (ileus), this requires patience but usually resolves in time. Damage or bruising to the nerves which control the bladder can happen or damage to the tubes which drain urine from the

kidneys (ureters). If your surgery involves removing part or your entire rectum, there is a potential risk of nerve damage to your sexual organs which may result in impotence, ejaculatory disturbance or bladder dysfunction.

Please do not be alarmed at these risks as they happen only in the minority of cases and methods of prevention are implemented prior to your operation. Most people will not experience any serious complications from their surgery. However, risks do increase with age and for those who already have heart, chest or other medical conditions such as diabetes or for those who are overweight or smoke. If your surgeon is concerned about any aspect of your health prior to surgery it will be investigated thoroughly beforehand.

What is Enhanced Recovery Programme?

The Enhanced Recovery Programme has been introduced to improve outcomes and speed up your recovery after surgery. The programme relies on you becoming an active participant in your own recovery process. It also aims to ensure that you receive evidence based care at the right time.

The programme particularly focuses on:

- Reducing the physical stress of the operation
- A structured approach to immediate post-operative management, including pain relief
- Early mobilisation

Some patients will be able to benefit from all aspects of this programme, whilst others will be able to benefit from just some aspects of it. This will depend on several factors, particularly your state of health and fitness at the outset. However, we will endeavour to use as much of the programme as is practicable in each individual patients' case. The main points of the programme are explained later on in this booklet.

What should I expect before the operation?

If time allows, you will be seen in the pre-assessment clinic before your admission to hospital. This assessment will establish we have all the necessary information to determine your fitness for surgery and to ensure the best possible recovery for you. It is also an opportunity for you to tell us all about your individual needs and circumstances.

At the Pre-Assessment clinic you will be seen by a nurse to complete the necessary paperwork required for your admission. You will also be examined and routine tests will be requested, which may include blood tests, chest x-ray and a heart tracing (ECG). The nurses running this clinic will answer any questions you may have, and will contact the Colorectal Specialist Nurse if you wish to talk to them.

Also, during pre-assessment clinic you will be asked questions about your weight, appetite and dietary intake. If you have lost weight without trying to do so or your appetite has been poor, they will have given you some advice and written information. They may also have suggested they refer you to a dietitian and/or advise you to commence supplement drinks three days before your surgery.

On the day before your surgery you should eat and drink as normal, unless you have been told you need to take full bowel preparation (picolax). In order to maximise your nutritional status, we recommend you include a few extra snacks in your diet. If not diabetic, a key aspect of your recovery is that you will be given a carbohydrate (sugary) drink to drink the night before your surgery and a further drink up to 2 hours before your surgery. This drink is called **preload**.

These drinks are an important part of your treatment, and will help with wound healing, reduce infection, and assist your recovery. In addition to these drinks you should also drink plenty of fluids.

While waiting to come in to hospital for your operation it is important to prepare yourself as much as you can. Try to eat as well as you can, and take gentle exercise such as walking, getting as much fresh air as you can. If you smoke, please try to stop before your operation.

If you live on your own it is advisable to have someone to stay with you, (or for you to stay with someone) for a week on discharge. If you have any concerns about whether you will be able to manage your daily activities when you are discharged you should let us know. This gives us an opportunity organise whatever social support you might need.

When will you be admitted for your operation?

It is usual to be admitted the day of your surgery to the Elective Surgery Unit (ESU). You will be contacted by the ESU staff on the evening prior to your admission, or on Friday evening if your operation is scheduled for a Monday, informing you what time to come in.

When you arrive at ESU, the necessary documentation will be completed and any nursing procedures will be carried out. You will go to theatre from ESU and after your surgery you will be allocated a bed on one of the main wards or units. Please note that your property will remain in ESU until you have returned from theatre and placed onto a ward or unit. Therefore it is advisable not to bring any valuables.

Preparing your bowel for surgery

Sometimes it is necessary for the bowel to be prepared for surgery and this will depend on what operation you are due to have. You may have to take some medicine the day before surgery, or you will be given an enema on the day of surgery. Some patients may not require any bowel preparation at all. This will be discussed with you when you are admitted.

What to expect after the operation

Immediately after surgery you will be cared for in the Recovery area of the Operating Theatre, until you are awake and comfortable. Afterwards you will either return to your ward, or to the High Dependency Unit, according to your condition.

The nurses will make you comfortable and monitor your condition closely, including blood pressure and pulse rate, etc. The medical team will assess you daily and supervise your process.

Pain control – The anaesthetist will discuss your pain management with you before your operation. The main pain relief options are spinal or patient controlled analgesia (PCA), which gives a continuous supply of pain relieving medicine, very occasionally we will use an Epidural. Recovery is enhanced by you being up and about, eating, drinking and sleeping so it is essential your pain is well controlled. If your pain is not under control, please inform the doctors or nurses.

By the time you are ready to leave hospital, simple painkilling tablets are effective, and they will be provided for you on discharge.

If you had a laparoscopic procedure it is not unusual to experience shoulder tip discomfort, which is due to trapped gas from the operation. This will settle quickly but pain relief and gentle mobilisation will be helpful.

Sickness – It is not unusual to feel sick, or even be sick after your operation. This is often due to the anaesthetic or to other drugs you have been given. It is important you tell the ward staff if you feel sick, so they can help, as being able to eat and drink normally is an essential part of your recovery.

Drip – You will have a drip (IV fluids) usually in your arm, but sometimes in your neck to keep you hydrated until you are drinking normally.

Catheter – A tube (called a catheter) is placed in your bladder to drain off your urine and to monitor your kidney function. This is removed as soon as possible by the ward nurses.

Drain – When you have had an operation it is normal for blood and fluid to be produced, therefore, you may have a drain or tube in your abdomen to remove this fluid. The amount will be monitored and the tube will be removed when the drainage decreases. The ward nurse will remove the drain.

Wound – Your abdominal wound(s) will have been joined with either stitches (which are often dissolvable and do not need to be removed), glue or staples (metal clips) that are normally removed after 10-14 days. If you have a perineal (back passage) wound the stitches are either dissolvable or will need removing normally removed after 10-14 days. The district or practice nurse will remove these.

What can I do to help my recovery?

You can start assisting your recovery as soon as you return to the ward. You will be encouraged to sip or drink fluids and maybe some protein drinks. The nurses will help you to get out of bed, if your condition allows, once you have been on the ward for 6 hours. You will also be encouraged to move your legs and take deep breaths to prevent a DVT (clot) and chest infection. As you begin to feel better you will be able to sit out for longer and also go for walks.

The following day after your operation we will aim to remove the IVI (Drip), catheter and the continuous pain relief (PCA or Epidural) providing you are comfortable. We will also expect you to be spending at least six hours out of bed each subsequent day, and will be encouraged to take short walks around the ward (60 metres 3-4 times daily).

You will be asked to drink high energy drinks and other drinks as well as eating 'little and often'.

These goals are part of the Enhanced Recovery Programme and **YOU** have control – we can assist you and help you towards a full and speedy recovery, but it is important that you help yourself too!

How long will I be in hospital?

This will depend whether your operation was performed laparoscopically (keyhole) or was an open operation. Usually you will be discharged 2–7 days after the operation. This can vary with individuals and the doctors will be able to tell you more as you progress.

What should I expect when I return home?

Everyone's recovery occurs at different rates and is dependent on their illness and surgery. When you first go home you will feel tired and will need periods of rest both in the morning and the afternoon. However, it is important that you try and keep active and you should be up and dressed. You should aim to do a little walking each day and increase the amount daily so you are back to your normal activities, within 4–6 weeks of your surgery.

The main restriction is not to undertake any heavy lifting, or to do any strenuous work such as lawn mowing or digging, for six weeks.

In order to reduce the risk of clots forming, the majority of patients will require to have daily injections of Fragmin, which is an anti-coagulant, for up to 28 days. The expectation is that you will be taught how to inject the Fragmin yourself; if you feel you will be unable to do this, please try and identify someone who can do this for you i.e. a relative or a friend.

What can I eat?

A balanced and varied diet is recommended. You may find it may be a while before you get your appetite back and instead of eating 3 meals a day, it may be easier to have small and more frequent meals. It is important to drink plenty of water, as this helps to avoid constipation and straining, and helps to replace fluids in patients with loose or liquid stools.

Will the operation affect my bowels?

Your bowels may be unsettled for some weeks following surgery, and it will depend on which operation you have as to whether or not the consistency of the stools and the frequency of bowel movements will return to normal. It can take several months or up to a year for your bowels to completely settle, but this will be monitored at your outpatient follow-up clinic, and if required you may need to start medication to help control your bowels.

When can I go back to work?

The nature of your occupation will determine how soon you can return, but many people are able to return to work within 4 weeks following their surgery. Your GP or surgeon will advise. If you require a sickness certificate for work, your GP will provide this for you.

When can I drive?

Do not drive until you are confident that you can do safely. It will all depend on your ability to perform an emergency stop without it causing pain, how comfortable it is to wear a seat belt and how tired you feel. Usually this is between 2–4 weeks, if your unsure please check with your insurance company before you start driving again.

When can I resume a sexual relationship?

Sexual relations can be resumed as soon as you feel comfortable, generally about 4 weeks. Feeling tired and weak after any operation or illness naturally affects you. After surgery, you may need to try alternative positions, as some can be uncomfortable.

Occasionally, following surgery or radiotherapy to the rectum or lower colon, nerve damage can occur. In men, this may result in difficulty obtaining or maintaining an erection and, in women, discomfort or vaginal dryness may occur. If you do experience problems of this nature, please discuss it with your doctors or the Specialist Nurses, as specialist help is available.

When will the results be available?

The part of the bowel which was removed at the operation will be examined by a Histopathologist under the microscope. They will inform your surgeon the final 'stage' of your cancer. This result will be discussed at the MDT meeting, and will help to determine whether any further treatment is necessary. This procedure can take 2–3 weeks and you will be seen in the Outpatients department to discuss the results with you. Arrangement for further treatment or follow-up will be explained to you, and arrangements made accordingly.

Who can help?

During your hospital stay you will have met the Colorectal Nurse Specialist who is available to provide information and give support to you and your family. Please remember that following your discharge home from hospital the Colorectal Nurse Specialist is still available to support you and if at any point you have any questions or concerns please telephone them on **01483 406729** during office hours. Outside of these hours, or in an emergency, either contact the staff on Compton ward at the Royal Surrey County Hospital **01483 571122** ext. **4941** or your GP.

Reference source

http://www.acpgbi.org.uk/content/uploads/2007-CC-Management-Guidelines.pdf

Additional support available

Macmillan Cancer Support
Telephone: 0808 808 0000
www.macmillan.org.uk

Beating Bowel Cancer
Telephone: 0208 8973 0011
www.beatingbowelcancer.org.uk

The Fountain Centre
Telephone: 01483 406618 or 406619
www.fountaincentre.org

Colostomy Association
Telephone: 0800 328 4257
www.colostomyassociation.org.uk

The Ileostomy & Internal Pouch Support Group
Telephone: 0800 018 4724 or 028 9334 4043
www.iasupport.org

Notes and questions

You may think of further questions to ask about your treatment and it is a good idea to jot these down as you think of them – you could use the blank space below. This will help you when you next visit the hospital or your GP.

Notes

Contact details

For further information or advice contact
The Colorectal Nurse Specialists

Telephone: 01483 406729
Monday–Friday, 8.30am–4.30pm

Email: rsc-tr.ColorectalCNS@nhs.net

PALS and Advocacy contact details

Contact details of independent advocacy services can be provided by our Patient Advice and Liaison Service (PALS) who are located on the right hand side as you enter the main reception area. PALS are also your first point of contact for health related issues, questions or concerns surrounding RSCH patient services.

Telephone: 01483 402757

Email: rsc-tr.pals@nhs.net

Opening hours: 9.00am–3.00pm, Monday to Friday

If you would like information documents in large print, on tape or in another language or form please contact PALS.

Past review date: January 2017
Future review date: January 2020
Author: Angela Bates – Colorectal Nurse Specialist
PIN170126–1202