The Royal Wolverhampton
NHS Trust

Anterior Resection

Colorectal Nursing

The prevention of infection is a major priority in all healthcare and everyone has a part to play.

- **Wash your hands with soap and warm water and dry thoroughly. Use hand gel, if provided, in care facilities.**
- **If you have symptoms of diarrhoea and vomiting stay at home and do not visit relatives that are vulnerable in hospital or in residential care. You will spread the illness.**
- **Keep the environment clean and safe. Let's work together to keep it that way. Prevention is better than cure.**

Introduction

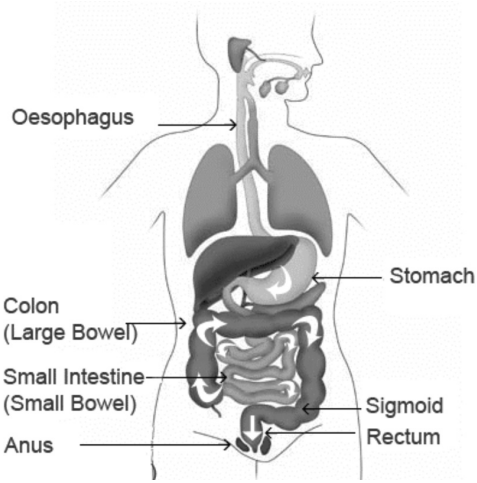
This leaflet tells you about the procedure known as an Anterior Resection. It explains what is involved, and some of the common complications associated with this procedure. It is not meant to replace discussion between you and your Consultant Surgeon, but is intended to be used as a guide in connection to what is discussed.

The Digestive System

To understand your operation it helps to have some knowledge of how your body works.

The bowel is part of our digestive system. It is divided into two parts: the small bowel and the large bowel.

The large bowel is made up of the colon and rectum.

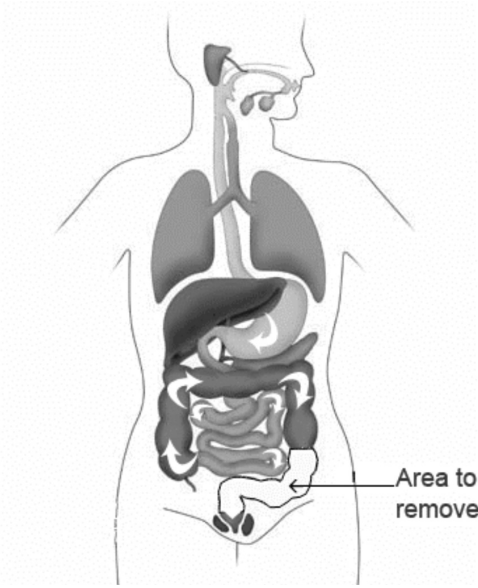


Once food is swallowed, it passes down the gullet (oesophagus) to the stomach, where digestion begins. It then passes through the small bowel, where essential nutrients are taken into the body. The digested food then moves into the colon where water is absorbed.

After the colon, the remaining waste matter – known as stools or faeces – is held in the rectum (back passage) until it is ready to be passed from the body through the anus as a bowel motion (stool).

What is an Anterior Resection?

This operation is necessary to remove the area of bowel that is diseased. The operation removes a piece of your bowel and rectum shown below.



A cut will be made in your abdomen (tummy). The Surgeon will remove the diseased area of bowel and a length of normal bowel either side of it (in an attempt to remove any potentially diseased areas). The two ends of healthy bowel are then joined together by stitching or stapling the ends together. The wound on the abdomen will be closed either with clips or stitches. Any visible stitches or clips will need to be removed in about 7 to 12 days after your operation.

It may also be necessary to have a temporary loop ileostomy (opening in the small intestine).

A loop ileostomy is a section of the small bowel brought to the surface of and stitched to the skin through a small cut in the abdomen. Bowel waste that comes out of the ileostomy is collected in to a bag that covers it. A Colorectal Nurse Specialist will discuss this with you and also mark a suitable site on your tummy in case an ileostomy is necessary.

If a temporary loop ileostomy is necessary, a second, smaller operation can be performed to put the bowel back inside your abdomen. The timing of this is variable and will be discussed with you by your Consultant Surgeon and Colorectal Nurse Specialist.

Anterior Resection may be offered as laparoscopic surgery (minimally invasive surgery). This is also known as keyhole surgery. The aim of this type of surgery is to:

- Reduce your hospital stay
- Reduce discomfort following surgery
- Minimise scarring

The risks remain the same as that of open surgery.

Consent

We must seek your consent for any procedure or treatment beforehand. Your doctor will explain the risks, benefits and alternatives where relevant before they ask for your consent. If you are unsure about any aspect of the procedure or treatment proposed please do not hesitate to ask for more information.

What is shared decision making?

The choice about which treatment is best for you will be made together with your Consultant Surgeon. This will be based on the risks and benefits of the treatment and your individual circumstances.

Are there any risks involved in having this treatment?

There are nearly always side effects to any treatment. Here are some of the side – effects that may occur when having this operation. Risks with this operation include:

Anastomotic leak:
Sometimes the anastomosis (join in the bowel) leaks. Treatment with antibiotics and resting the bowel is generally successful. At times an Endo-SPONGE (B.Braun) is used if a leak occurs. The aim of this is to improve healing of the join (anastomotic leak) without the need for surgery. Endo-SPONGE is a vacuum therapy using a polyurethane foam sponge inserted into the leakage cavity using a flexible tube called an endoscope. A drainage tube is connected to the sponge and leaves the body through the anus and is connected to a wound drainage system. The sponge is changed every 24 to 73 hours. Sedation and pain relief may be needed for the procedure and this will be done in theatre.

An anastomotic leak can be a serious complication and sometimes surgery to form a stoma (see below) may be required.

Colostomy or Stoma formation:
A stoma is a false opening made into the bowel via the skin. Sometimes this is planned before surgery. At other times it may be necessary to do this because of a complication or an unforeseen circumstance. Your Colorectal Clinical Nurse Specialist will discuss this further with you.

Nerve damage:
The operation is very close to the muscle in the back passage (anal sphincter). This may become bruised causing a loss of sensation which occasionally leads to slight incontinence of wind and/or faeces in the early days after your operation.

The operation is also very close to the bladder and nerves responsible for sexual function. Bladder and sexual function may be disturbed although the risk is small and often temporary.

Some men may have problems with erection and ejaculation. Some may have problems passing urine.

Ileus (paralysis of the bowel) and small bowel obstruction:
Sometimes the bowel is slow to start working after surgery (ileus) or can be obstructed. If this happens the bowel may need to be rested and a drip (a tube into a vein in your arm) is used to replace fluids (instead of drinking).

In addition, you may need a nasogastric tube (a tube in your nose which passes into your stomach) which in most cases will prevent vomiting. These will remain in place until the bowel recovers. Sometimes if the bowel is obstructed an operation may be required.

After any major operation there is a risk of:

Chest infection:
You can help by practising deep breathing exercises and following the instructions of the physiotherapist. If you smoke, we strongly advise you to stop.

Wound infection:
The risk of this is increased with bowel surgery. Antibiotics will usually be given through a drip to help reduce the risk of this happening.

Thrombosis (blood clot in the leg):
Major surgery carries a risk of clot formation in the leg. A small dose of heparin (blood thinning medication) will be injected once or twice daily until you go home. You can help by moving around as much as you are able and in particular regularly exercising your legs. You may also be fitted with some support stockings for the duration of your stay in hospital. If you smoke, we strongly advise you to stop.

Pulmonary Embolism (blood clot in the lungs):
Rarely a blood clot from the leg can break off, and become lodged in the lungs.

Bleeding:
A blood transfusion may be needed. Very rarely, further surgery may be required.

Risk to life:
Surgery for bowel cancer is classified as major surgery. It can carry a risk to your life. Your Consultant Surgeon will discuss this risk with you.

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 if you are overweight or smoke.

What are the benefits of this procedure?

The operation is to remove the diseased bowel. In most cases this will give you the best chance of a cure or significant improvement in your bowel problems. Your Consultant Surgeon will discuss this with you in more detail.

Are there any alternatives to having an Anterior Resection and what would happen if I decided not to have this treatment?

Your Consultant Surgeon will have explained the different treatment options available to you and what would happen if you decided not to have any treatment at all. These are the treatment options open to you:

- No treatment. Doing nothing will lead to bleeding, discharge, pain and possibly a complete blockage of the bowel.

If you choose not to have surgery, radiotherapy and chemotherapy may be offered. This may control your symptoms but will not cure the disease.

- Occasionally it is possible to remove a rectal cancer directly from within the back passage by an operation called a trans anal resection. This type of surgery is only suitable for a small number of patients.

- Another option is a stent (an internal splint in the bowel). This is inserted through the back passage into the rectum to keep the bowel open. This may help your symptoms but will not cure the disease.
- Very rarely, and only with small cancers of the rectum, cauterization (electrical burning) is appropriate.

Your Consultant Surgeon can talk to you about these options.

What are the consequences of treatment?

After any major bowel operation the function of the bowel can change. You may experience:

- Urgency
- Diarrhoea
- Loose stools.

In most people, these improve with time but can take several months to settle down. You may sometimes need medication to help control your bowel.

Please do not hesitate to contact your Colorectal Nurse Specialist for advice.

What should I do before my operation?

While you are waiting for your operation, it is important you try to prepare yourself physically. If you are able, try and eat a well-balanced diet including meat, fruit and vegetables. Take gentle exercise such as walking and get plenty of fresh air. If you smoke, we strongly advise you to stop.

Will I need to attend pre-admission clinic?

To plan your operation and stay in hospital you may be asked to attend the hospital for a health check a week or two before your admission. This can take about two hours. If you are taking any medications please bring them with you.

A Doctor or Nurse will listen to your chest; check your blood pressure and may send you for other tests, for example, a chest X-ray and an ECG (electrocardiograph - a tracing of your heart). This information will help the Anaesthetist plan the best general anaesthetic for you. Blood will also be taken to check for any abnormalities so that these can be corrected before your operation.

A Nurse may also ask questions relating to your health and to your home circumstances. If you live alone and have no friends or family to help you, please let us know and we will try and organise some help or care for you. A discharge coordinator may come and discuss these arrangements with you.

In preparation for the operation you may be given a strong laxative to clear the bowel. You may have already experienced this during some of the investigations. Details of the laxative will be discussed with you. You will need to drink fluids only during this time. It is important that you drink plenty to reduce the risk of dehydration.

You will be advised of when to stop eating or drinking before you come into hospital. You will not be allowed anything to eat for 6 hours before surgery. This is to allow the stomach to empty to prevent vomiting during the operation. However, any important medication will be given with a small amount of water. You may be given a carbohydrate (sugar) drink to have before your surgery. This is to help you recover faster.

In most cases you will be admitted into hospital on the morning of your operation. Pain relief will be discussed with you by your Anaesthetist. You may be given analgesia (painkillers) through an epidural (tube in your back) or through a drip in your arm in the form of a PCA (patient controlled analgesia) hand held pump. This means you control the amount of painkiller you require. If you would like to talk about this further, please ask the ward staff.

A nurse will take you to theatre. Your operation will usually take between 2 and 4 hours.

What can I expect after my operation?

Immediately after surgery you may have a number of tubes attached to your body. You may have:

An intravenous infusion (drip tube), usually in your arm to feed you with fluids and often used to give drugs as well.

A catheter (tube) in your bladder to drain urine.

A tube, either in your arm (PCA) or in your back (epidural), slowly releasing medication to ease any pain.

Drainage tubes at the site of the operation to clear away any oozing fluids around the operation site inside.

A tube in your nose, which passes into your stomach, to keep your stomach empty and to stop you from feeling sick.

Continuous oxygen by a face mask or small tube placed to your nose.

A stoma appliance (bag) on your abdomen.

Most of the tubes are put in place while you are under anaesthetic.

Over a period of 1 to 5 days many or all of these tubes will be removed.

People recover from surgery at different rates. The average stay in hospital is 4 to 10 days, however, you may need to stay in longer. This will be discussed with you by your Consultant Surgeon or Colorectal Nurse Specialist.

About 2 to 3 weeks after your surgery a report on the piece of bowel removed at operation will be sent to your Consultant Surgeon. Dependent upon the results, further treatment may be offered, the details of which will be discussed with you. If there is an option for further treatment such as chemotherapy, an appointment will sometimes be made directly with an Oncologist. This will allow treatment to start sooner after surgery.

When can I start to eat and drink?

Your bowel function may rapidly return to normal. If this is the case, you will be able to eat and drink soon after your surgery. In some cases, bowel function may be slow to start and diet and fluids may have to be restricted for a few days. After your operation, your Consultant Surgeon will advise you which will be appropriate for you. If you have any questions about your diet, please ask your Colorectal Nurse Specialist who can advise you.

What can I do when I go home?

Following your operation you will feel tired and weak, but as full recovery may take several weeks, there is no need to stay in hospital. In fact many people report that they feel better sooner in their home. However, it will be necessary to make sure that there is someone to help with getting meals, cleaning your home and shopping.

For the first week or so you may find that you tire easily. Try to alternate short bursts of light activity with periods of rest. A short sleep in the day is often helpful during the first 2 to 3 weeks after discharge home.

It is unwise to stay in bed for too long though as this slows down the circulation of the blood and increases the risk of developing a thrombosis. Try to take some gentle exercise, like walking around the home or garden.

For the first 6 weeks you are advised not to lift anything heavy such as shopping or wet washing, and not to do anything strenuous like digging the garden or mowing the lawn.

You should not drive until you can do an emergency stop, and you must be able to do this without hesitation caused by fear that your wound will hurt. You may wish to consult your GP before driving again. It is also advisable to check your car insurance policy, as there may be a clause in it about driving after operations.

You may feel some pain and 'twinges' around your wound for several months. This is normal as it takes a while for full healing to take place. Taking a mild painkiller regularly will help you feel better and aid your recovery. If the pain does not seem to improve or you are worried, contact your GP or Colorectal Nurse Specialist.

The length of time between your return to work following this type of surgery will depend upon the type of work you do. Ask your GP or Consultant Surgeon for advice.

You may resume sexual activity when it is comfortable for you. If you are unsure, please speak to your GP, Consultant Surgeon or Colorectal Nurse Specialist.

When will I have my next appointment?

Within a few weeks you will normally be sent an appointment to see your Consultant Surgeon. If the results on the piece of bowel removed during the operation are not available to give to you before you go home, an earlier outpatient appointment may be arranged to see your Consultant Surgeon or Colorectal Nurse Specialist.

Where can I get more information?

If there are any further questions you would like to ask about an Anterior Resection please speak to your doctor or clinical nurse specialist.

Macmillan Cancer Support
Macmillan Cancer Support improves the lives of people affected by cancer. They are a source of support: providing practical, medical, emotional and financial help.
Tel 0808 808 00 00
Website: http://www.macmillan.org.uk

Beating Bowel Cancer
A charity for people with bowel cancer, working to raise awareness of symptoms, promote early diagnosis and encourage open access to treatment. You can get information on bowel cancer through its website or nurse advisory helpline.

Website: http://www.bowelcancer.org/ Email: nurse@beatingbowelcancer.org Tel 08450 719301

Local sources of further information

You can visit any of the health/cancer information centres listed below:

Macmillan Support and Information Centre
Hospital Street
New Cross Hospital
WV10 0QP
Tel 01902 695234
Email; cancercarewolverhampton.nhs.net
www.cancercarewolverhampton.nhs.uk

Wolverhampton Bowel Cancer Support Group
The support group meets on the third Monday of each month. For more information please telephone: 01902 694084 (answer machine service) or bleep the Colorectal Nurse specialists via the switchboard on 01902 307999

Colorectal Nurse Specialists
Colorectal Nursing Department
New Cross Hospital
01902 694084

This is a 24 hour answer phone please leave a brief message and contact number and your call will be returned within office hours.
www.royalwolverhampton.nhs.uk/colorectalnursing

About this information

This guide is provided for general information only and is not a substitute for professional medical advice. Every effort is taken to ensure that this information is accurate and consistent with current knowledge and practice at the time of publication.

We acknowledge the support of Cancerbackup and Pan Birmingham cancer network in producing this information.

English

If you need information in another way like easy read or a different language please let us know.

If you need an interpreter or assistance please let us know.

Lithuanian

Jeigu norėtumėte, kad informacija jums būtų pateikta kitu būdu, pavyzdžiui, supaprastinta forma ar kita kalba, prašome mums apie tai pranešti.

Jeigu jums reikia vertėjo ar kitos pagalbos, prašome mums apie tai pranešti.

Polish

Jeżeli chcieliby Państwo otrzymać te informacje w innej postaci, na przykład w wersji łatwej do czytania lub w innym języku, prosimy powiedzieć nam o tym.

Prosimy poinformować nas również, jeżeli potrzebowaliby Państwo usługi tłumaczenia ustnego lub innej pomocy.

Punjabi

ਜੇ ਤੁਹਾਨੂੰ ਇਹ ਜਾਣਕਾਰੀ ਕਿਸੇ ਹੋਰ ਰੂਪ ਵਿਚ, ਜਿਵੇਂ ਪੜ੍ਹਨ ਵਿਚ ਆਸਾਨ ਰੂਪ ਜਾਂ ਕਿਸੇ ਦੂਜੀ ਭਾਸ਼ਾ ਵਿਚ, ਚਾਹੀਦੀ ਹੈ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਸਾਨੂੰ ਦੱਸੋ।

ਜੇ ਤੁਹਾਨੂੰ ਦੁਭਾਸ਼ੀਏ ਦੀ ਜਾਂ ਸਹਾਇਤਾ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਸਾਨੂੰ ਦੱਸੋ।

Romanian

Dacă aveți nevoie de informații în alt format, ca de exemplu caractere ușor de citit sau altă limbă, vă rugăm să ne informați.

Dacă aveți nevoie de un interpret sau de asistență, vă rugăm să ne informați.

Traditional Chinese

如果您需要以其他方式了解信息，如易读或其他语种，请告诉我们。

如果您需要口译人员或帮助，请告诉我们。

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