

## Colostomy formation

This is an operation to create a stoma or an opening in the colon, which is stitched to the skin.

Colostomies can be made with just one end of the bowel stitched to the skin, or with two ends of the bowel stitched to the skin.

A bag is fitted to the skin around the colostomy and the patient passes their stools into the bag, which they then empty, and change as required. This operation may be performed on its own, or as part of another operation such as abdomino perineal excision of the rectum or Hartmann's procedure. Colostomies are sometimes recommended prior to chemoradiotherapy for anal cancer or rectal cancer.

### What does the operation involve?

This operation can be performed as a laparoscopic (keyhole) procedure or an open procedure.

To make the colostomy, the surgeon makes a hole through the abdominal wall. If the surgeon is making an 'end' colostomy then just the upper end of the colon is stitched to the skin. The other end may have been removed or is simply closed off using staples or stitches and left inside the abdomen. Sometimes the surgeon will form a 'loop' colostomy. In this case both the upstream and downstream ends of the colon are stitched to the skin surface.

### What are the risks?

If the colostomy is formed as part of another operation such as abdominoperineal resection of the rectum or a Hartmann's procedure please see refer to the relevant sections on the Birmingham Bowel Clinic website covering those procedures for more specific information.

There are risks associated with any abdominal operation. Pre-operative assessment of heart and lung conditions are made, as well as any coexisting medical conditions. During the hospital admission patients wear stockings and are given a regular tiny injections to prevent thrombosis (blood clots).

Bleeding is very rare in this type of surgery, blood is always available if a transfusion is required. Wound infections can occur in any form of intestinal surgery, open or laparoscopic. Wound infections rarely cause serious problems but may require treatment with antibiotics.

As with any form of abdominal surgery the bowel may sometimes take longer than normal to start working, this is known as ileus. Patients may develop abdominal distension and vomiting. If this happens the surgeon will normally recommend a period of bowel rest with continued intravenous fluids and sometimes a tube passed via the nose to the stomach (nasogastric tube).

Occasionally when the bowel doesn't start working properly, there may be a kink, twist or an adhesion causing a blockage. This is known as obstruction. Patients may develop colicky abdominal pains, abdominal distension and vomiting. If this happens the surgeon will normally recommend a period of bowel rest with continued intravenous fluids and sometimes a tube passed via the nose to the stomach (nasogastric tube). In most cases

the obstruction settles spontaneously, occasionally an operation is required to relieve the blockage.

Short-term risks include retraction of the colostomy. This is where the stitches between the colon and skin come apart and the colon starts to fall back into the abdomen. In some cases, if the colon falls back too far, an operation to refix the colostomy may be required.

Longer-term problems can include narrowing of the colostomy (stenosis), prolapse (when the bowel telescopes out) of the colostomy. Both these complications are uncommon but may require a further operation to correct.

Hernias around the colostomy site are quite common. If they become large patients can have problems with fitting their bags. Very rarely a hernia can be a cause of bowel obstruction. Most hernias are quite small and are best not treated but some patients may benefit from a support belt. Larger hernias which are causing problems can be repaired.

### **What happens after the operation?**

If the colostomy is formed as part of another operation such as abdominoperineal resection of the rectum or a Hartmanns' procedure.

Please see refer to the Birmingham Bowel Clinic website for more information covering those procedures.

After the operation patients will have an intravenous drip, which is normally in place for 24 hours, or until, a normal fluid intake is resumed.

A catheter (tube inserted to drain the bladder) may be passed at the time of the procedure and is normally kept in place for 24-48 hours.

Patients are allowed to eat and drink as soon as they feel able after the operation (usually the same day).

Patients are encouraged to mobilise as soon as possible after the operation.

The colorectal nurse specialist will see patients on the ward after the operation. The nurse specialist will show patients how to empty and change their bags so that they can do this independently before they leave hospital.

The consultant and colorectal nurse specialist will continue to provide backup care after discharge from the hospital. For more information see patient information section on the Birmingham Bowel Clinic website about Stoma care on discharge from hospital. Hospital stay is usually 3-5 days although this may vary.

Following discharge from hospital, patients are encouraged to keep mobile. They should avoid heavy lifting or increased physical activities for about 6 weeks. Patients can normally resume driving after about 2-4 weeks but this may vary.

A follow up consultation is usually arranged after about two weeks. Patients can always be seen sooner if there are problems.

In some cases the colostomy can be reversed. This would involve another operation, where the surgeon takes away the colostomy and rejoins the bowel. The surgeon will usually discuss this possibility before a colostomy is created. Normally patients are advised to wait at least 3 months, so they are fully recovered, before undergoing a reversal.