Pan-Birmingham Cancer Network NHS

Anterior Resection

Your Operation Explained

Pan Birmingham Cancer Network

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 that you need to be aware of. It is not meant to replace discussion between you and your surgeon, but as a guide to be used in connection to what is discussed.

The Digestive System

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

When food is eaten it passes from the mouth down the oesophagus (food pipe) into the stomach. Here it is broken down and becomes semi-liquid. It then continues through the small intestine (small bowel), a coiled tube many feet long where food is digested and nutrients (things your body needs) are absorbed.

The semi-liquid food is then passed into the colon (large bowel), a wider, shorter tube, where it becomes faeces (waste). The main job of the colon is to absorb water into our bodies making the faeces more solid.

The faeces then enter the rectum (storage area). When the rectum is full, we get the desire to open our bowels. The waste is finally passed through the anus (back passage) when going to the toilet.

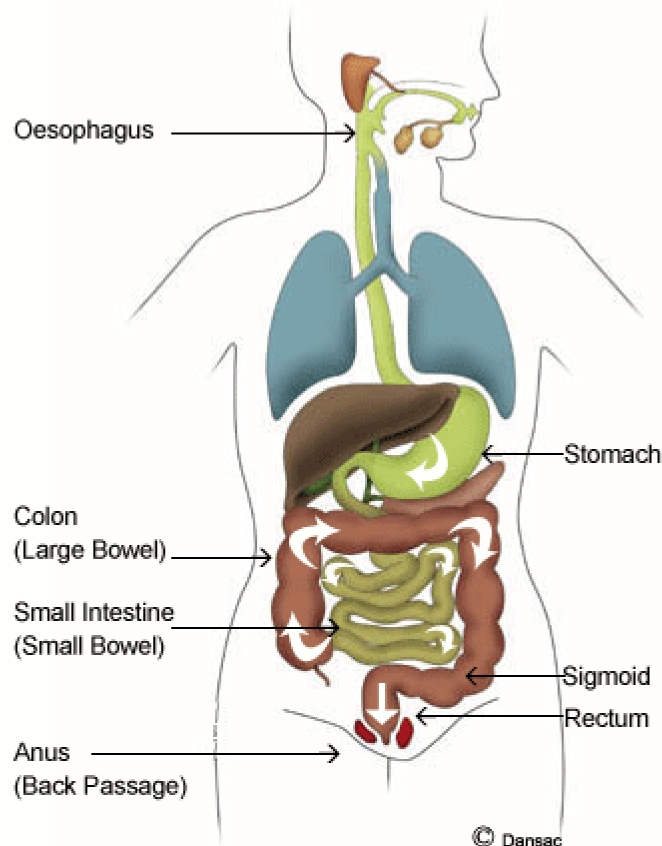
What is an Anterior Resection?

This operation is necessary to remove the area of bowel that is diseased.

The operation removes a piece of your bowel and rectum shown as the diagram on page 4.

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 the disease. The two ends of healthy bowel are then anastomosed (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.

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 and stitched to the skin through a small cut in

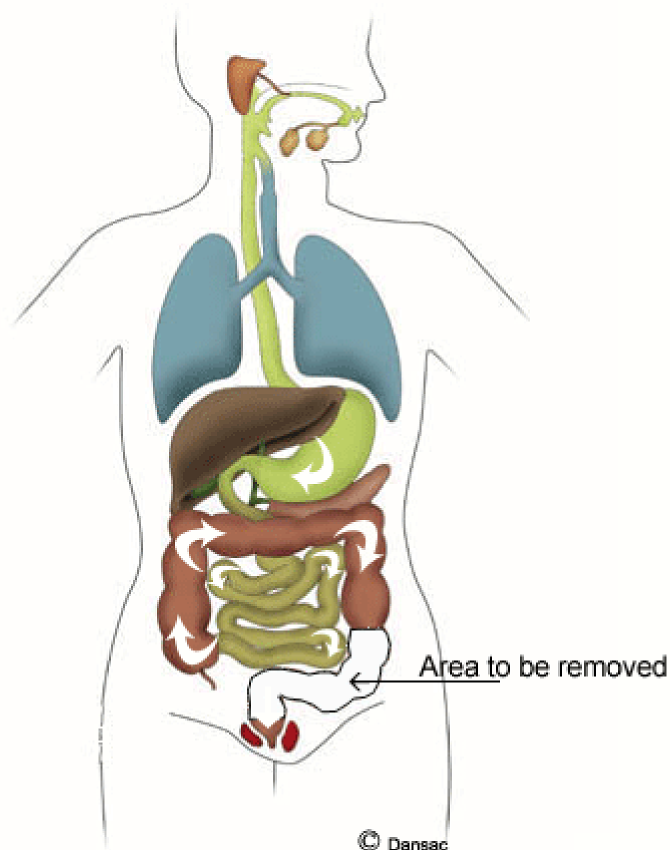


the abdomen. Bowel waste that comes out of the ileostomy is collected in a bag that covers it. A colorectal nurse will discuss this with you and also mark a suitable site on your tummy in case an ileostomy is necessary.

Should a temporary loop ileostomy be 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 surgeon and colorectal nurse.

Before your operation, your consultant surgeon and colorectal nurse will carefully explain the procedure involved, although details will vary according to each individual case. You will need to sign a consent form to confirm that you agree to have surgery.

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.

What risks are there in having this procedure?
Removing part of the bowel is a major operation. As with any surgery there are risks with the 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.

This can be a serious complication and sometimes surgery to form a

stoma (see below) may be required.

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.

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.

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 (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 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 surgeon will discuss this with you in more detail.

What are the alternatives?
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 transanal 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, cauterisation (electrical burning) is appropriate.

Your 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 for advice.

Before the 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.

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 social worker may come and discuss these arrangements with you.

When you come into hospital

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 be given fluids only during this time. It is important that you drink plenty to reduce the risk of dehydration.

You will not be allowed **anything** to eat for 6 hours before surgery. You will be advised when to stop drinking water (2 to 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.

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, or require information in another language, please ask the ward staff to contact one of the pain management nurses.

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

After your 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 tummy.

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 5 to 12 days, however, you may need to stay in longer. This will be discussed with you by your surgeon or colorectal nurse.

About 2 to 3 weeks after your surgery a report on the piece of bowel removed at operation will be sent to your 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 surgeon will advise you which will be appropriate for you.

If you have any questions about your diet, please ask your colorectal nurse who can advise you.

Discharge 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.

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 surgeon for advice.

You may resume sexual activity when it is comfortable for you. If you are unsure, please speak to your GP, surgeon or colorectal nurse.

Within a few weeks you will normally be sent an appointment to see your 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 surgeon or colorectal nurse.

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

Birmingham Women's Healthcare NHS Trust
Health Information Centre
Birmingham Women's Healthcare NHS Trust
Metchley Park Road
Edgbaston
Birmingham
B15 2TG
Telephone: 0121 627 2608

Good Hope Hospital NHS Trust
Cancer Information and Support Centre
Good Hope Hospital NHS Trust
Rectory Road
Sutton Coldfield
B75 7RR
Telephone: 0121 378 6641

Heart of England NHS Foundation Trust
Patient Information Centre
Birmingham Heartlands Hospital
Bordesley Green East
Birmingham
B9 5SS
Telephone: 0121 424 2280
Email: healthinfo.centre@heartofengland.nhs.uk

Sandwell and West Birmingham Hospitals NHS Trust
Cancer Information Centre
Sandwell and West Birmingham Hospitals NHS Trust
Sandwell General Hospital (Main Reception)
Lyndon
West Bromwich
B71 4HJ
Telephone: 0121 607 7971
Fax: 0121 607 7972

University Hospital Birmingham NHS Foundation Trust
The Patrick Room
Cancer Centre
University Hospital Birmingham NHS Foundation Trust
Queen Elizabeth Hospital
Edgbaston
Birmingham
B15 2TH
Telephone: 0121 697 8417

Walsall Primary Care Trust
Cancer Information & Support Services
Challenge Building
Hatherton Street
Walsall
Freephone: 0800 783 9050

For details of local cancer support groups and organisations, please ask your colorectal nurse.

Cancerbackup - Information in your language
Cancerbackup's freephone helpline can now give information and support to people affected by cancer in more than 100 languages. People whose first language is not English can contact the specialist cancer information nurses on freephone **0808 800 1234**, who will then link in a relevant interpreter. There are also 12 additional freephone lines specifically for speakers of the most common community languages. Lines are open Monday to Friday 9am-8pm.

Freephone numbers:
Arabic: 0808 800 0130
Bengali: 0808 800 0131
Cantonese: 0808 800 0132
English: 0808 800 1234
French: 0808 800 0133
Greek: 0808 800 0134
Gujarati: 0808 800 0135
Hindi: 0808 800 0136
Polish: 0808 800 0137
Punjabi: 0808 800 0138
Turkish: 0808 800 0139
Urdu: 0808 800 0140
Vietnamese: 0808 800 0141 (Source: Cancerbackup)

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 are constantly striving to improve the quality of our information. If you have a suggestion about how this information can be improved, please contact us via our website:
http://www.birminghamcancer.nhs.uk

This information was produced by Pan Birmingham Cancer Network and was written by Consultant Surgeons, Clinical Nurse Specialists, Allied Health Professionals, and Patients and Carers from the following Trusts:

Good Hope Hospital Trust
Heart of England NHS Foundation Trust
Sandwell and West Birmingham NHS Trust
University Hospital Birmingham Foundation Trust
Walsall Hospitals NHS Trust

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