

Hartmann's procedure

This is an operation to remove part of the sigmoid colon and/ or the rectum. It is most usually performed for patients with a bowel cancer or diverticular disease. It is often performed in an emergency situation where there is a blockage of the bowel, a perforation of the bowel or of if there is a lot of infection (abscess) around the bowel.

What does the operation involve?

Whilst this operation can be performed as a laparoscopic (keyhole) procedure because it is usually performed as an emergency an open technique is often preferred. During the operation the diseased part of the sigmoid colon and/or rectum is removed. This involves taking away the blood vessels and lymph nodes to this part of the bowel.

If the surgeon doesn't feel that it is safe to rejoin the bowel, because of infection, obstruction or perforation, the end of the colon is brought to the surface on the left side of the abdomen to create a colostomy. The rectum that is left behind is usually closed off with staples or sutures and left inside the abdomen. Forming a colostomy and leaving the other end of the bowel inside is known as Hartmann's operation or procedure.

The operation time may vary for this type of surgery but is usually around 3 hours. The piece of bowel that is removed is sent to the pathology department where the pathologist carefully examines it. The results are usually available within two weeks of the operation.

What are the risks?

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.

Sometimes the bowel may 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).

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.

There are important nerves in the pelvis and whilst the surgeon will make every effort to avoid damaging these it is recognised that they can sometimes be involved in this type of surgery. These nerves are important as they control erections and ejaculation in men and influence bladder emptying in men and women. The effects may improve with time but sometimes these can be permanent. Patients who have had radiotherapy are at higher risk of pelvic nerve dysfunction after surgery.

What happens after the operation?

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) is normally kept in place for 48-72 hours.

Occasionally an abdominal drain is used (small tube passing through the abdominal wall). This is normally removed after a few days.

An epidural is often used in keyhole and open surgery to provide pain relief after the operation and is usually continued at least until the next day. Your anaesthetist will be able to discuss this with you before the operation.

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.

Hospital stay is usually 5-7 days for keyhole surgery and 7-10 days for open surgery 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 4-6 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 many cases the colostomy can be reversed. This involves another operation when the surgeon takes away the colostomy and rejoins this to the end of the bowel that has been left inside. The surgeon will discuss this at follow up. Normally patients are advised to wait at least 3 months, so they are fully recovered, before undergoing a reversal.