for patients

NHS
East Suffolk and North Essex
NHS Foundation Trust

Bowel surgery
Right hemicolectomy

Laparoscopic Colorectal Surgery
Colchester Hospital
Tel: 01206 742356

(DPS: 01501-22)

Introduction

This booklet aims to give you information about laparoscopic treatment for your specific diagnosis with a section about major surgery for the treatment of bowel cancer. This information is important for you to be able to consent to your treatment. We must, by law, obtain your written consent before any operation and some other procedures. If you are unsure about any aspect of the proposed treatment, please do not hesitate to ask to speak to a senior member of staff.

If possible, we will perform your operation using laparoscopic surgery which is also known as keyhole surgery, minimal access surgery or minimally invasive surgery. Occasionally it is necessary to revert to conventional open surgery due to a complication as sometimes it is difficult to proceed safely with laparoscopic surgery. Whichever method is used to perform the operation it will always be with your best interests in mind.

Laparoscopy and laparoscopic surgery are usually performed while you are asleep under general anaesthetic.

Anaesthetics

There is a separate leaflet available called 'Anaesthetics' with information about the anaesthetic used during your procedure and the risks involved. If you have any concerns, talk these over with your anaesthetist. If you have not been given an information sheet about anaesthesia, please ask for one.

What is laparoscopy?

Laparoscopy is a procedure to look inside your abdomen using a laparoscope. A laparoscope is like a thin, flexible telescope with a light and magnifier inside which is connected to a

television monitor. This enables the surgeon to see clearly inside the abdomen. It is passed into the abdomen through a small incision (cut) often referred to as a port. Laparoscopy may be done to find the cause of symptoms or look at a specific area within the abdomen or pelvis.

What is laparoscopic surgery?

In addition to simply looking inside, the surgeon can use fine instruments to perform operations. These are also passed into the abdomen through three or four small incisions in the skin and are used to cut, trim, biopsy, grab etc inside the abdomen. Laparoscopic surgery is common practice in this hospital for bowel surgery.

Benefits of using a laparoscope

Laparoscopic surgery has many advantages which include decreased blood loss, reduced postoperative pain, fewer complications, earlier return to a normal quality of life and a reduced length of stay in hospital after your operation.

How is it done?

The abdominal skin surface is cleaned. The surgeon then makes a small incision (cut) about 1–2 centimetres long near the navel (belly button). Carbon dioxide gas is introduced through the incision to slightly distend the abdominal wall. This makes it easier to see the internal organs with the laparoscope which is gently pushed through the incision into the abdominal cavity.

The surgeon views the end of these instruments through the laparoscope and manipulates them to perform the required procedure. One larger wound is made, usually through the navel, through which the bowel is removed.

When the procedure is completed the laparoscope and instruments are removed. Dissolvable stitches are used to close the incisions and dressings applied.

After laparoscopic surgery

You may feel a little sore around the cuts in your tummy. You may have some pain in your shoulder tip. This is caused by the gas pumped inside irritating the diaphragm which has the same nerve supply as the shoulder tip. This pain gradually eases, particularly once you are up and moving about. The length of time to recover can vary from patient to patient but usually takes approximately 2–4 weeks.

The operation

Surgery is the main treatment for bowel cancer. Usually the cancer and a length of normal bowel on either side of the cancer (as well as nearby lymph nodes) are removed. The healthy parts of the bowel are then stitched or stapled together (anastomosis).

If the doctor is not able to join the bowel back together, an opening (stoma) will be made on the outside of the body for waste to pass. This is called a colostomy or stoma. A stoma is made to allow waste to pass through an opening in the abdominal wall.

A number of different surgical procedures are used depending on where the cancer is and whether it has spread. The operation planned for you is called 'right hemicolectomy'. This is an operation to remove a cancer in the caecum (which is part of the large intestine) or the

ascending colon by removing the last part of the small bowel, the caecum, ascending colon and a small part of the transverse colon. The appendix is also removed. The last part of the small bowel (terminal ileum) is joined to the large bowel, usually at the transverse colon. It is extremely unlikely that you would require a stoma in this instance.

General risks

They include:

- small areas of the lungs may collapse, increasing the risk of chest infection. This may need antibiotics and physiotherapy
- clots in the legs (deep vein thrombosis) with pain and swelling. Rarely, part of this clot may break off and go to the lungs which is more serious and can be fatal
- strain on the heart can in some cases lead to a heart attack or stroke
- people who are obese are at increased risk of wound and chest infections, or heart, lung and circulatory complications
- the procedure or subsequent complications can be fatal.

Risks of this procedure

There are some risks or complications which include:

- leakage where the bowel was stitched together. This is a very serious complication that can be fatal. It almost always requires further surgery, often as an emergency and usually requires a stoma even if one was not in the first operation
- bleeding in the abdomen. This may need fluid replacement or a blood transfusion and further surgery

- bowel is paralysed, causing abdominal bloating and vomiting. This is usually temporary and will resolve without treatment
- the wound may become infected. This is usually treated with antibiotics or the wound may need to be opened
- urinary tract infection. Antibiotics may be used to control the infection
- infection in the abdominal cavity. This may form an abscess that may need drainage and antibiotics. Drainage may be carried out in X-ray or you may have to return to theatre.
- the bowel may be unable to be joined and may be brought to the surface as a stoma, with the following problems:
    - the blood supply to the stoma may fail and cause damage. This may need further surgery
    - excess fluid loss from the stoma
    - stoma prolapse – the bowel protrudes past the skin
    - parastomal hernia – the bowel pushes through a weak point in the muscle wall, causing pain
    - local skin irritation – reddening of the skin and a rash in reaction to the stoma bag glue
- damage to the tube bringing the urine from the kidney to the bladder
- abnormal emptying of the bladder. It may empty without control or may not empty at all
- inability to have and/or maintain an erection in men. In women it can cause pain during or after intercourse
- there may be complications with would healing and the scar may be thickened, red and tender;

- the bowel actions may be much looser after the operation this may depend on how much bowel is removed
- adhesions (bands of scar tissue) may develop in the abdominal cavity and the bowel may block
- death within 30 days of surgery is estimated at 3.7%.

Major bowel surgery for cancer

The condition

The large bowel (intestine) is made up of the colon and rectum (back passage). This part of the digestive tract carries the remains of digested food from the small bowel and gets rid of it as waste through the opening to the back passage (anus). Cells that line the colon and rectum may begin to grow out of control, forming a cancer (a growth of cancer cells).

The bowel has four sections: the ascending colon, the transverse colon, the descending colon and the sigmoid colon. Cancers can start in any of these areas or in the back passage. They start in the innermost layer and can grow through some or all of the other layers.

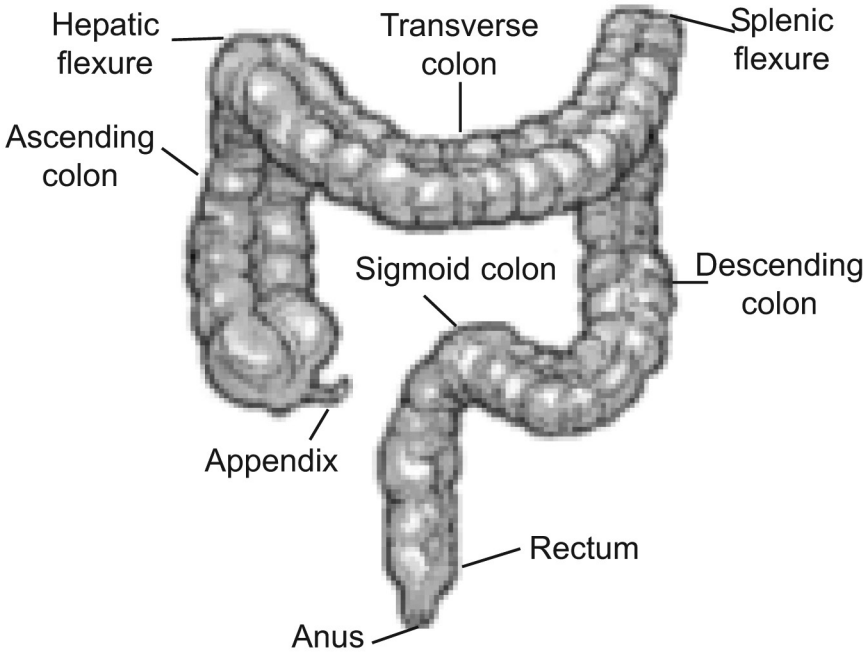

Diagram showing parts of the bowel

Preparation for surgery

You cannot eat for at least six hours before your surgery but you can drink water up until two hours before surgery. Please see the 'Enhanced Recovery' leaflet you have been given for the remainder of the information you require in preparation for your surgery.

Benefits of treatment

Removal of the diseased bowel by an operation is the best treatment for a cancer of the bowel. The aim of the operation is to give you the best chance of cure through total removal of the cancer.

Treatment alternatives

Bowel cancer can be treated in a number of ways, with people often having a combination of treatments. Your treatment will be designed to suit you as an individual:

- radiation therapy is used for some people as the initial treatment for rectal cancers. This is to shrink the cancer and make it easier to remove at the time of the operation;
- chemotherapy (use of drugs to treat the cancer) is usually used either before or after surgical removal of the bowel;
- argon beam therapy is a special gas used to try to slow the progress of the cancer;
- placement of a colorectal stent, where a metal tube is placed inside the bowel and cancerous growth to try and keep the passage open. This is only suitable for cancers in the upper rectum and large intestine.

Risks of not having the surgery

Symptoms including pain and bleeding may become worse and your bowel may completely block or burst. Without surgery, the disease may spread to other areas of your body.

Risks of having the surgery

An estimated 3.7% of patients who have this procedure die within 30 days, depending on how low the join of the bowel is.

Recovering from your operation

After the operation the nursing staff will closely watch you until you have recovered from the anaesthetic. You may even be cared for in the Intensive Care Unit immediately following your surgery.

The recovery period after bowel surgery varies. In uncomplicated cases it usually involves a 3–10 day stay in the hospital. Immediately after your operation the following are usually in place for your care and wellbeing:

- intravenous fluids via a cannula (fine plastic tube) in your neck or arm to keep you hydrated until you are able to drink enough. You may also be given medication via this tube;
- an epidural or patient controlled analgesia (PCA) machine in order to provide pain relief and enable you to feel able to move around more comfortably;
- a catheter (plastic tube) draining urine from your bladder into a collection bag so we can accurately measure the amount.

These are removed as soon as possible after your operation depending on your condition and rate of recovery. You will be discouraged from spending long periods of time in bed and given the help you require to carry out your daily hygiene, dietary and exercise routines until you gradually become stronger and more independent.

Major bowel surgery for cancer

The risk	What happens	What can be done about it
Leakage of bowel fluid inside the abdomen.	Leakage of bowel fluid at the site where the bowel was stitched or stapled back together.	Further surgery may be required.
Ileus.	The bowel is paralysed leading to abdominal bloating and vomiting.	Treatment is to deflate the bowel with suction, using a tube (naso-gastric tube) put up the nose, down the throat and into the stomach or bowel.
Wound infection	The wound may become infected.	This may be treated with antibiotics. These may be given by a drip into a vein or by mouth. The wound may need to be opened to drain.
Urinary tract infection	Germs enter the tube leading to the bladder and cause inflammation and infection.	Mild cases may clear up without treatment. Usually antibiotics are used to treat the infection.

The risk	What happens	What can be done about it
Loss of blood supply to the stoma.	The blood supply to the stoma may fail and cause damage to the bowel.	This may need further surgery.
Stoma prolapse.	Some of the bowel sticks out too far past the skin.	For minor prolapses no treatment is needed. For more serious cases, more surgery may be needed.
Parastomal hernia.	The bowel pushes through a weak point in the muscle wall and causes pain and bulging of the skin near the stoma.	Minor hernias may need no treatment. Larger hernias may need more surgery.
Local skin irritation.	Reddening of the skin and a rash in reaction to the glue used to stick the stoma bag.	Changing the type of stomal bag usually treats this.
Post-operative bleeding.	Bleeding inside the abdomen. The wound drain may measure this.	A blood transfusion may be needed to replace lost blood. Sometimes more surgery is needed to stop the bleeding.
Damage to the ureter (tube from kidney to bladder).	Rarely, during surgery, the ureter, which brings urine from the kidney to the bladder, may be damaged	This may require further surgery.

The risk	What happens	What can be done about it
Bladder may not empty properly or may empty without warning.	A urinary bladder problem where there is abnormal emptying of the bladder. It may empty without warning or may not empty at all.	A tube (catheter) into the bladder may be used to drain the urine away.
Bowel blockage.	Adhesions (bands of scar tissue) may develop inside the abdomen and the bowel may block. This is a short-term and long-term complication.	This may require further surgery.
Change in bowel habits.	Bowel habits will change. Stools maybecome looser, smaller and more frequent. There may be some leakage of stools particularly at night depending on the type of surgery.	In most people this improves in time without further treatment.
Increased risk in obese patients.	An increased risk of wound infection, chest infection, heart and lung complications and thrombosis.	The risk can be reduced by weight loss, however small, prior to surgery.

The risk	What happens	What can be done about it
Increased risk for smokers.	An increased risk of wound infection, chest infection, heart and lung complications and thrombosis.	Giving up smoking before the operation will help reduce the risk.
Sexual problems.	Men may be unable to get an erection or keep an erection. It may also mean that they cannot ejaculate. In women it may cause pain during or after intercourse.	For both men and women, time may improve the condition. Treatment for men may include counselling and medication. For women, counselling and use of water soluble lubricants during intercourse may help.

Diet

During the first few days of recovery, you will be able to eat but will probably have a reduced appetite. It is important to choose small amounts at more frequent intervals at first. Meals can be supplemented with nourishing soups and snacks and with high energy drinks. The body will use a lot of calories during the healing process.

Bowel actions

The bowel may take a little while to recover and work normally. This time will vary with individuals but you will

know the bowel is beginning to work when you pass wind and/or have a bowel movement. It is perfectly normal for the bowels to be more erratic and less predictable after this type of operation.

Sometimes it is necessary to use medicines prescribed from the hospital or by your GP to slow down the gut or to use a gentle laxative to encourage bowel actions.

If you have a stoma

The stoma drains waste from the bowel into the collection bag. Most stoma waste is softer and more liquid than normally passed bowel waste.

The thickness of the bowel waste depends on where the stoma is. If you have an ileostomy, your stoma will have been formed using the small bowel and the waste will be more liquid. If you have a colostomy, your stoma will have been formed using the large bowel and the waste will be more solid. There is a wide variety of appliances (bags) available to suit your particular requirements. These stick to the skin around the stoma, are very discreet and most people easily adapt to taking care of their stoma themselves. You will be given full information and support to enable you to manage your stoma both in the hospital and following your discharge.

Your lungs and blood supply

It is likely that on your return from surgery you will be wearing elastic (anti-embolism) stockings. These are tight-fitting stockings that are used to reduce the risk of blood clots forming in your legs.

It is very important after surgery that you start moving as soon as possible. This helps to prevent blood clots forming in your legs and possibly going to your lungs. This can be fatal. Also you need to do your deep breathing exercises. Take 10 deep breaths every hour to prevent secretions collecting in the lungs. If this happens, you may develop a chest infection. At all costs, avoid smoking after surgery as this increases your risk of chest infection. Coughing is painful after abdominal surgery.

Exercise

Expect to feel tired for some time after surgery. You need to take things easy and gradually return to normal activities and work, as you feel able. The time taken to recover from your operation is very variable and dependent on you as a person and the type of operation you have had. In most cases this should take no longer than 2–6 months.

Driving

Check with your insurance company about whether there are any exclusions to you driving. This includes being under the influence of some pain medication. Ensure you can do an emergency stop and wear a safety belt.

Lifting after surgery

The best advice is 'if it hurts do not do it'. Lifting heavy weights is not advisable until about four weeks after your surgery.

Further information

Please phone the hospital switchboard and ask for the Colorectal team on bleep 944 or the nurse practitioner on bleep 471.

Verifying your identity

When you attend hospital you will be asked to confirm your first and last names, date of birth, postcode and NHS number, if you know it, and to let us know if you have any allergies.

Identification wristbands

Wristbands are used to identify hospital inpatients. When you are in hospital it is essential that you are given and wear your wristband, which carries your name, date of birth, NHS number and hospital number. This ensures that staff can identify you correctly and give you the right care.

Your photographic records

As part of your treatment, a photographic record may be made, such as X-ray(s), clinical photographs or digital images, which will be kept confidentially in your health records and seen only by people involved in your care or quality checking. They are also extremely important for teaching or medical research so we may ask for your written consent to use your images, in which case your personal details will be removed so you cannot be identified.

Your experience matters

We value your feedback. Please help us improve our services by answering a simple question, in our online survey – "Overall, how was your experience of our services?"

This survey is known as "The Friends and Family Test".

You can either scan this QR code with a smart phone camera:

Or type the following web address into your browser: www.esneft.nhs.uk/get-involved/your-views-matter/friends-and-family-test/

Thank you very much.

Please ask if you need this leaflet in an alternative format.

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