SURGICAL PROCEDURES

Open Abdomino-perineal Excision of Rectum

Sussex Surgical Specialists

The main treatment for rectal cancer is surgery. Treatment is tailored to the individual patient and the nature of their cancer. Initial investigations may include examination by your surgeon, Colonoscopy, CT and MRI scanning. The results of these and other later investigations will determine whether or not radiation or chemotherapy is required before or after surgery. Some important information may not be available until after the surgery is performed. The operation includes removal of the back passage and the muscles that control continence (the anal canal). The result is the formation of a permanent colostomy. This is where part of the bowel is brought to the surface of the abdomen and it is through this, that bowel motion is passed into a bag. A separate leaflet is available describing the implications of having a colostomy. More information and support is available from the Stoma Care Nurses who will see you before the operation, during your hospital stay and when you return home.

The operation itself is a major operation that requires a general anaesthetic. There will be an incision down the abdomen, a colostomy and a wound where the anus was. The usual stay in hospital for this operation is between ten days and two weeks, dependent upon how quickly you recover.

What happens before the operation?

You will have specific tests to ensure your fitness for surgery, which are not directly related to the treatment of the tumour itself. These include blood tests, x-rays and an ECG or echocardiogram of the heart. These tests will be organised by your surgeon or by one of the junior members of the surgical team at your pre-admission clinic visit. The purpose of this visit is to spot any abnormalities well in advance of surgery and to make sure that there are no delays prior to timely completion of your operation.

You will be admitted to one of the surgical wards. A senior nurse will complete the admission process detailing your current condition, ongoing medical problems and medications as well as personal details such as next of kin. Usually one or two enemas are given rectally to assist with a good bowel movement just prior to the operation. Occasionally, for technical reasons your surgeon may wish you to have full oral bowel preparation as for a colonoscopy although this is unusual. Ward staff may administer a subcutaneous injection of a blood thinning agent to protect against developing clots in the legs or lungs as a result of the surgery you are about to undergo and from the expected decreased mobility that you may encounter during the early stages of your hospital stay. You will be permitted to eat up to six hours and drink up to two hours before surgery at the discretion of the ward staff.

The Stoma Care Nurse will visit you to mark an optimum site on your abdomen for your colostomy.
An Anaesthetist will visit you prior to your surgery to discuss the nature of your anaesthetic and methods of pain control both before and after the operation. Your surgeon will visit you and discuss the operation again and ask you to sign a consent form, once you are happy that all your questions have been answered and the risks and benefits have been explained.

Mr G J G Harris FRCS
Sussex Surgical
24 West Street
Chichester
PO19 1QP

T: 01243 789630
F: 01243 536591
secretary@sussexsurgical.co.uk

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What are the complications of the operation?

Although there are infrequent risks attached to this operation the nature of the surgery means that these may be significant and on occasion life threatening.

Infection – Chest, Urinary Tract, Wound and Pelvis

The nature of the surgery means that infective complications are the most common after such operations but are usually quite easily and successfully treated whilst you are in hospital. Chest infections are best avoided by early mobilisation and regular breathing exercises, which will be taught to you by the Physiotherapists on the ward.

Infections of the urinary tract occur as a result of catheter insertion during the time of surgery and this tube, which drains urine from the bladder, will be removed at the earliest possible time. Wound infections are an unfortunately common occurrence after major bowel surgery and particularly in emergency surgery sometimes inevitable. They are usually easily treated but best avoided by good wound care. A wound dressing should not usually be removed before the fifth postoperative day unless you are being discharged home, even if it appears “dirty”. Pelvic or abdominal infections are more complex, difficult to treat and may require insertion of drainage tubes using x-ray guidance or further surgery. They are fortunately the least common type of infection encountered with this surgery.

Bleeding

Major surgery such as an abdomino-perineal excision of the rectum involves division of many major and minor blood vessels. Although meticulous care is taken to prevent bleeding it is a recognised but small risk of such operations and may require a return to the operating theatre to correct.

Blood Clots – Legs, Lungs and Heart

Operations on the pelvis such as an abdomino-perineal excision of the rectum increase the chance of clots developing in the deep veins of the legs and pelvis (thrombosis or DVT). Should they become dislodged they may impact in the lungs, which is known as a pulmonary embolus. Similarly blood clots that may occur in the arterial system of the heart can result in heart attacks. All of these conditions are generally treated satisfactorily whilst in hospital but in extreme cases can be life threatening. The best way of avoiding such problems is with injectable medication to thin the blood during your hospital stay and early mobilisation shortly after surgery.

Wound Failure

The perineal (bottom) wound, of all surgical wounds created anywhere in the body, is the one most prone to failure (opening). The reasons for this relate to its position (in an area under pressure while patients are recovering in bed or in a chair), the amount of bacteria present in the vicinity (from the bowel or urinary tract), the amount of tissue that must be removed to complete the surgery and the common use of radiotherapy before surgery that may hamper healing. Delay in healing may take many weeks and delay discharge from hospital and return to normal activities.

What will happen after the operation?

A wound on your abdomen and perineum (bottom) will be closed with either stitches or clips and covered with a dressing.

You will have a colostomy covered by a stoma appliance (bag) on your abdomen.

You will have one or more intravenous drips providing you with fluids since it may be a day or so before you can resume full and normal diet.
You may have a tube in your nose, which passes down to the stomach. The aim of this tube is to prevent fluid accumulating there and making you feel sick before normal stomach emptying resumes a few days after your operation.

You may have a drain (a small tube), which drains any unwanted fluid from the abdominal cavity and exits through the abdominal wall.
You may have an epidural pump into the back or a patient controlled push button (PCA), both of which will provide you with pain relief.

It may take up to five days to get rid of all these tubes and drips during which time nurses on the ward will help you to wash and move in and out of bed. You will be given fluids and food to take by mouth starting immediately after surgery usually beginning with small amounts but building up quickly to full diet as tolerated.

After several days you will pass wind via the colostomy and bowel motion will begin. It is at this time that the Stoma Care Nurses will start demonstrating the practical care of the colostomy.

Some discomfort after surgery is normal but pain and nausea can be treated and even avoided altogether if you inform doctors and nurses on the ward as symptoms begin rather than letting any of them become intolerable.

The take home message is not to suffer in silence with any of these conditions. Avoidance of nausea and pain leads to earlier return to bowel function, improved mobility and decreased post-operative complications. No ward staff will be put out or offended by any request for assistance or for pain relief at any time. Should the prescribed measures not have the desired effect within a short period of time then do not hesitate to ask anyone at hand again for stronger or different medication.

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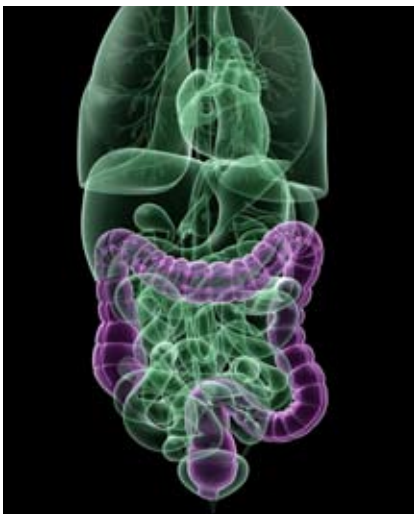

What happens next?

After your operation the affected segment of bowel will be very closely examined by Pathologists under a microscope. The time to process such large tissue samples and examine them on a microscopic level takes between seven and ten days. Your surgeon will be able to tell you the results of this microscopic examination as soon as the results are made available to him or her.

Around the half of the patients undergoing this kind of surgery do not require any further treatment. For the other half chemotherapy or more rarely radiotherapy may be recommended to reduce the risk of your cancer returning at a later date. Your surgeon will discuss your case on an individual basis with colleagues in the Department of Pathology, Radiology and Oncology (radiotherapy and chemotherapy) at weekly meetings, where a subsequent treatment program may be constructed to suit your individual case. You may be aware of this treatment plan whilst in hospital or informed of it at your first clinic appointment after discharge.

What happens after hospital?

How soon you go home after the operation depends on how quickly you recover from surgery, who is at home to help you and your independence with the care of your colostomy. Most people are largely back to normal at six weeks after such surgery but it may take up to three months before you can say that you are fully recovered from the operation. As you leave hospital your General Practitioner will be informed of your treatment and the plans for your follow up. The Stoma Nurses will keep in regular contact with you at home to ensure that there are no ongoing difficulties. You will be given or sent an appointment to be seen in the outpatient department by your surgeon between two and six weeks after discharge.

How will I feel when I go home?

Initially it is not unusual to feel very tired following your operation. Some people feel more exhausted than they felt in the hospital. It is also common to feel depressed. This is normal and often a reaction to the operation, your diagnosis and being in hospital. As time goes on, this will get better, but let somebody know how you feel, help is available.

It is important to rest initially when getting home, but it is equally important to gradually increase your activity. Listen to your body and stop when you begin to tire. Overall you should be making gradual but sustained progress. If you are not, your surgeon will want to know.
You are advised not to do any heavy lifting for six weeks after the operation. Driving should be avoided for at least 2 weeks and thereafter with caution. The main area of concern is your ability to perform an emergency stop. Check with your car insurance company regarding the cover you have following a major operation.

Who can I talk to?

The surgery that you are about to undergo is major and clearly there are significant fears and anxieties experienced by every patient. These are best allayed by asking someone involved in your care whatever you would like to know or are unsure about. Similarly close family members may be as or more anxious than you are but there should be many opportunities for them to discuss your treatment at any stage.

Members of the team involved in your care are Consultant Surgeon, Surgical Registrar, Surgical Senior House Officer, House Officer, Oncologist, Anaesthetist, Colorectal Nurse Specialist, Stoma Nurses, Surgical Ward Nurses.

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