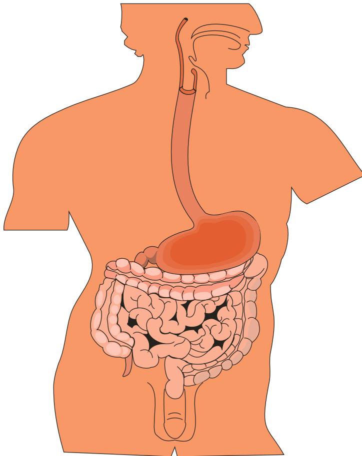
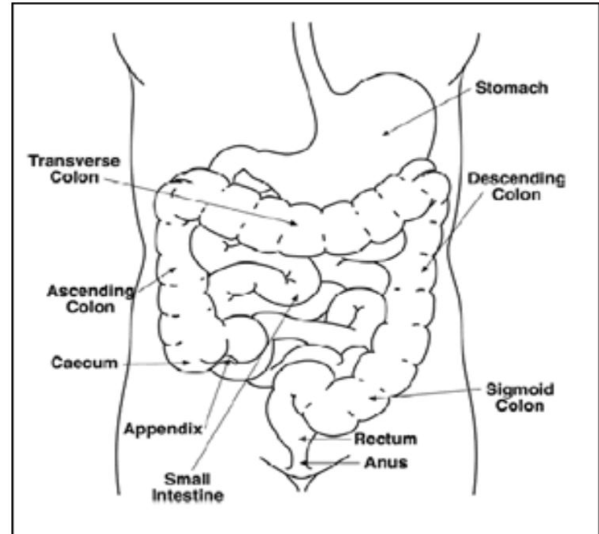
Anterior Resection with Colon J-Pouch

Patient Information – Department of General Surgery





Introduction

This leaflet provides information about your operation. Please do not hesitate to ask any questions that you or your family/whanau may have. This leaflet also provides information on support networks, services provided within the hospital and what to expect following treatment. There is a space at the end of this booklet to write down any questions that you may have.

What is the Large Bowel (Colon) and Rectum?

The large bowel (colon) and rectum is a muscular tube, approximately 1.5 meters long and is divided into 7 sections; the caecum, the ascending colon, the transverse colon, the descending colon, the sigmoid colon, the rectum and the anus.

After food has been swallowed, it passes down through the gullet and stomach into the small bowel. As food passes through the small bowel it is digested and the body absorbs essential vitamins and nutrients. From here the food passes into the large bowel (colon).

The main functions of the large bowel are:

- To absorb water and salt back into the body
- To store waste (faeces or stool)
- To secrete mucous which acts as a lubricant

Types of Surgery

Open Surgery

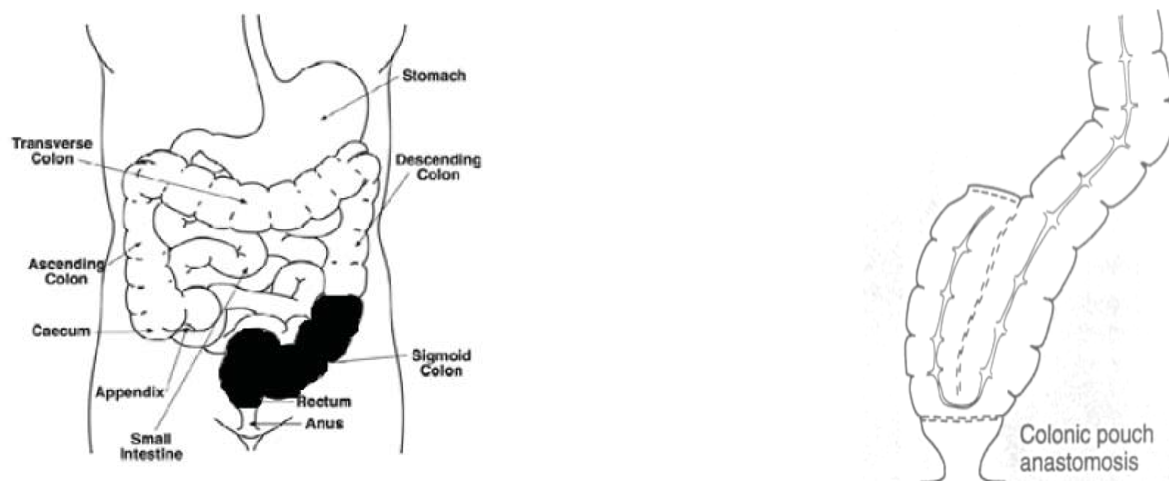
Some patients will have open surgery, which involves an incision (cut) in the abdomen called a laparotomy.

Laparoscopic Surgery

The operation is done through small incisions using specialised equipment. Some advantages of this can be early recovery and return to work, reduced scarring of the abdomen and fewer respiratory problems. Your surgeon will offer laparoscopic surgery if it is suitable for you.

Anterior Resection with Colon J Pouch

An anterior resection with colon J pouch is performed for cancer of the rectum. The area of disease is removed and the J-pouch becomes a reservoir for waste and replaces the function of the rectum that was removed. The surgeon constructs the pouch from about 5-10 centimetres of colon (large intestine) and attaches it to the remaining rectum or to the anus if the entire rectum has been removed. A temporary bag (ileostomy) will be required until the join in the bowel has healed. The ileostomy is made to divert the bowel motion away from where your bowel has been joined. This allows healing to take place and reduces complications.



What is an Ileostomy?

An ileostomy is an opening on your abdomen where the small bowel is brought up through the muscle layers to the abdominal wall and stitched to the skin. A bag is placed over this opening to allow your bowel motion to be collected. You will be seen by a stomal therapist prior to your surgery. They will provide you with information and support. A mark will be placed on your abdomen which will identify a suitable site for the stoma. Whilst in hospital you will be seen regularly by the stomal therapist to teach you how to care for your stoma. Initially on discharge from the hospital the stomal therapist will visit you at home to provide ongoing support, education and bags. You will then be followed up at their clinic. If you live outside of the Canterbury region you will be followed up by your local stomal therapy service.

Following this operation, you may still pass mucus or brown stained fluid similar to a bowel motion from your anus. The frequency may vary from once to several times per day, but this is not uncommon. If you have concerns about this, please discuss them with your GP or surgeon.

You will have an x-ray to check how well the join has healed approximately three to six months after you have left hospital. This is done at an outpatient appointment in the x-ray department.

The ileostomy closure is done as a second operation usually within six to twelve months after your first operation (please refer to Closure of Ileostomy pamphlet).

Preparing for Surgery

Prior to your surgery you will be asked to attend a preadmission clinic. You will be assessed at this time for surgery. This will usually occur one week prior to your surgery and may take several hours.

At the preadmission clinic you will be seen by an anaesthetist and a nurse. This appointment will allow you and your family the opportunity to ask any questions you may have.

Planning for your discharge begins at the preadmission clinic. If you have any concerns about how you will cope when you are discharged please discuss these with the nurse at this time.

Please be aware that occasionally your care may be handed over to another surgeon due to the number of urgent patients on the waiting list for surgery, or the specific skills required for your surgery. As we feel it is in your best interests to have met the surgeon and discussed surgical management with him/her, a further appointment will be made for you to meet the new surgeon who will be caring for you.

Complications of Surgery

About one in three people having bowel surgery will have a complication related to their operation. Most of these are very minor but some are more significant and may be life threatening.

Complications can be divided into those related to the anaesthetic and those related to the surgery.

Your anaesthetist will discuss the anaesthetic with you. If you have any further concerns please discuss them with your surgeon or his/her team. Some of the significant complications are discussed below.

Bleeding

Bleeding can occur during surgery or even up to a few days later. If this happens, you may need a blood transfusion but this is only given with your consent. Occasionally we use radiological techniques (x-ray) to stop the bleeding and occasionally surgery is required.

Infection

Infection can occur in a number of sites including inside the abdomen, the lungs, the bladder and in the wound. A number of techniques are used to prevent infection. These include antibiotics, sterile wound dressings and isolation of patients with bad infections. It is an expectation of the surgical team that you begin mobilising either the day of your operation or the day after to reduce the risk of this complication.

Anastomotic (the join in your bowel) Leak

In any operation where a piece of bowel is removed and a join is made it is possible for a leak to occur. It is one of the most important complications that your surgeon will worry about. A leak occurs in about three to four percent of patients and almost always requires another operation.

Frequently it is necessary to take the join apart and to bring out the ends as a stoma (bag). If it is going to occur an anastomotic leak will usually happen in the first week after surgery. The bowel may be re-joined at a later operation.

Bowel Obstruction

This is usually caused by internal scarring, also referred to as “adhesions”. It can occur after any abdominal operation, sometimes years later. Mostly it is treated with intravenous fluids (a drip), pain relief and sometimes a drainage tube, which is inserted through your nose and passed down into the stomach (nasogastric tube). Mostly it does not require another operation and will settle with the above treatment.

The symptoms of a bowel obstruction are a combination of:

- Not passing wind or a bowel motion
- Abdominal pain or cramps
- Vomiting
- Abdominal swelling

Death

The chance of dying as a result of your surgery is very low (less than one percent), but this risk increases as you get older (>80 years), or if you are very unwell at the time of your surgery (for example people having emergency surgery for a bowel obstruction or bowel perforation).

Wound Hernia

Like some bowel obstructions this is a late complication and may take some years to present. Hernias are a weakness in the abdominal wall and are more common in obese patients, smokers and after wound infections. Sometimes they require surgical repair.

Deep Vein Thrombosis (DVT/Leg Clots)

This is the same as “travellers’ clots” seen in long flight airline passengers and is due to reduced mobility for long periods of time (such as when you are anaesthetised during your operation). Being overweight, having cancer surgery, smoking, and not moving after surgery all increase the risk of clotting. The chance of this happening can be reduced by the use of anti-clotting agents (small injection under the abdominal skin), specialised stockings and getting you up and mobile as soon as possible.

Planning for Your Discharge from Hospital

It is very important to consider how you will manage your care once you are discharged from hospital and discuss this with your family. You need to consider this before you come in for your surgery.

The following options may be discussed with you and should be considered:

- Organising to stay with family and friends or arranging someone to stay with you for at least 48 hours after your discharge from hospital.
- Going home with extra supports, for example, assistance with personal cares and domestic assistance.

Please note: Domestic assistance is free only if you fit the criteria which are:

A) You have a community services card.

B) You live alone.

- A short period of rehabilitation may be required at Burwood Hospital. This will be assessed during your recovery.

If you have any concerns about how you will manage at home after your surgery, please discuss these with your family and the nurse caring for you and a referral will be made to a Social worker.

Leaving Hospital

You will be able to return home once your doctor feels you are safe from any complications.

Please see your GP for medical advice if you become unwell after your discharge from hospital or you develop any of the following:

- Chest pain
- Shortness of breath
- Fever or chills
- Calf pain
- Nausea or vomiting
- Excessive Bleeding
- Increasing Abdominal Pain

IN THE EVENT OF AN EMERGENCY CALL AN AMBULANCE IMMEDIATELY

Helping Yourself

Getting back to normal can take some time. It can sometimes take up to a year following bowel surgery to return back to your normal level of function, so don't get discouraged.

Rest and Activity

It is important to gradually increase your activity after your surgery so that you return to your normal ability / mobility levels. Building up the distance you walk will improve your fitness and strength and may help to prevent chest infections. Over 4-5 weeks aim to build up to 30-40 minutes walking at a pace that just starts to make you breathe a little harder than at rest. Please avoid lifting any heavy objects for at least six weeks following your surgery as your abdominal muscles will be weak and this will reduce the risk of developing a hernia.

Pain Relief

Continue taking regular pain relief as discussed prior to your discharge.

Wound Care

If you’re abdominal wound becomes red, painful or has a discharge, please see your GP for advice. If you have clips or sutures in your wound you will need to make an appointment with your GP to have these removed. You will be given a clip remover prior to your discharge from hospital.

Dietary Advice

You will be provided with advice about diet from a dietitian while in hospital. It is important to make some changes to your diet to avoid complications with an ileostomy and this will be reinforced by both stomal therapists and nursing staff.

Bowel Function

Your bowel habits may also take up to a year to settle down because your bowel has been shortened, however some people never have the same consistency of bowel motion after this type of operation. It is not uncommon following this type of bowel surgery to experience:

- Loose bowel motions as the bowel length has been shortened by the surgery and therefore less fluid is absorbed from the bowel motion.
- More frequent bowel motions.
- Not being able to completely empty your bowel the first time you pass a motion during the day and need to return several times to the toilet to feel completely empty.
- An urgent need to go to the toilet—the bowel motion is moving through the bowel more quickly as a result of surgery or other treatment you may have had like radiation.
- Increased wind.
- Abdominal bloating.

Please discuss this with your healthcare provider as a combination of the following may help to improve your bowel function:

- Diet
- Fibre and fibre supplements
- Medications
- You may also want to try sitting on the toilet for a longer period of time to allow the bowel to completely empty.

Returning to Work

This depends on your occupation and how you feel physically and emotionally. You can be issued with a medical certificate if required. Please discuss with the medical staff prior to discharge.

Driving

You may commence driving when you can put your foot on the brake in an emergency situation without discomfort. This is usually about 6 weeks after, if you had open surgery but is generally a shorter timeframe if you had laparoscopic surgery. Some pain relief can cause drowsiness and may alter your normal driving responses. Some insurance agencies may not cover you in an accident

for up to 6 weeks following surgery. It is your responsibility to check this with your insurance company.

Sexual Activity

It is usually safe to engage in sexual intercourse approximately six weeks after surgery unless you have been advised otherwise. It is not uncommon for sexual desire to be reduced following surgery but this should only be temporary. After this surgery however, the nerves that assist with sexual arousal may become damaged as a result of the surgery itself or radiation. For men this may mean a loss in the ability to gain or maintain an erection. Men may also find that if they are able to climax that their semen is not expelled at this time but may be released from the body next time they pass urine. This is called retrograde ejaculation.

For women this may mean an inability to climax or pain on intercourse. If you have concerns regarding this please discuss them with your GP or surgeon as there are ways in which these problems can be addressed and we are happy to discuss these issues as they are common to our practice.

What are the Results from my Surgery (histology)?

Histology reports are available for your surgeon seven to ten days after surgery and include information about the type of disease you have and how complex it may be. If you do not receive the results of your surgery while you are in hospital these will be given to you at an outpatient appointment. Please try to bring a support person with you to your outpatient appointment.

Follow Up

Initial follow up after your surgery will be with your surgeon or a member of their team approximately two to six weeks after discharge from hospital. Further follow up will be determined depending on the results from this operation.

Colorectal Nurse Specialist Department of Surgery Christchurch Hospital Cell phone: 0211957717	Nurse Maude Stoma Advisory Service 24 McDougall Avenue Merivale Christchurch Phone: 375 4289

Contacts

Useful Websites

The value of the internet is widely recognised, however, not all the information available may be accurate and up to date. For this reason, we have selected some key sites that people might find useful.

Beat Bowel Cancer Aotearoa **www.beatbowelcancer.org.nz**

Cancer Society of New Zealand **www.cancernz.org.nz**

Colorectal Surgical Society of Australia and NZ **www.cssanz.org**

Macmillan Cancer Support **www.macmillan.org.uk**

Acknowledgements

Thank you to all those who were involved in the development of this leaflet, including patients, their families, hospital staff and Nurse Maude Stomal Therapists.

Questions/Notes

Please make a note of any questions you would like to ask:

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