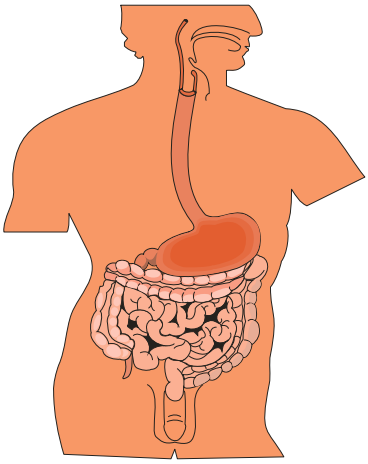
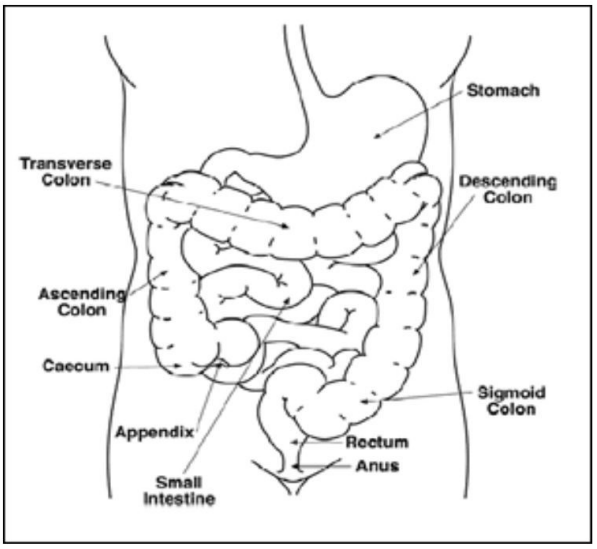
Canterbury District Health Board
Te Poari Hauora o Waitaha

Total Colectomy
Department of General Surgery

Total Colectomy

Patient information - Department of General Surgery





Introduction

This booklet provides information about your operation. Please do not hesitate to ask any questions that you or your family/whanau may have. This booklet 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 metres 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

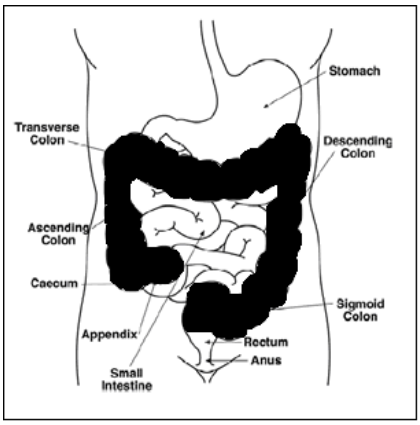
Types of Surgery

Open Surgery

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

Laparoscopic Surgery
This is a relatively new approach to bowel surgery in which 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.

Total Colectomy



A total colectomy is performed for diseases anywhere in the colon including

- Cancer
- Crohn's
- Diverticular Disease
- Ulcerative Colitis
- Familial Adenomatous Polyposis (FAP) and Hereditary Non Polyposis Colorectal Cancer (HNPCC)

The entire colon is removed apart from the rectum. The small bowel may be joined to the rectum, if the small bowel is not joined to the rectum an ileostomy (bag) will be required.

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 if you have a temporary stoma you may still pass mucus or brown stained fluid similar to a bowel motion through 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. If you have a temporary ileostomy as a result of this operation 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 a doctor, an anaesthetist and a nurse. This appointment will also 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 rarely 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 and other complications mentioned.

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 often 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 rejoined 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). It is quite common after closure of ileostomy where it occurs briefly in up to twenty percent of patients. 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) 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.
- Convalescence care should be discussed prior to your admission. There are limited convalescence beds available in the Canterbury area, which you may be eligible to access. A referral to a social worker will be made if this is an option. You will be responsible for travelling to and from these facilities.
- Convalescence into a rest home can incur a payment for service. This is based on certain criteria, which may apply. A referral to a social worker will be made if this is an option.

The earlier we are aware of the need for convalescence care, the more likely you are to secure a bed in the facility of your choice.

If you live alone, it may be helpful to place extra meals in the freezer for your return home, or place easy to cook meals in the cupboard e.g. soup and tinned meals. 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.

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
- Diarrhoea / Constipation
- 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 your 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 whether you have an ileostomy or not. 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. If you don't have an ileostomy, it is still necessary to alter your diet slightly to assist in reducing complications.

Bowel Function

It is not uncommon following this type of bowel surgery (regardless of whether you have an ileostomy or not) 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
- Increased wind
- Abdominal bloating

If you have not got an ileostomy as part of this surgery you may experience

- An urgent need to go to the toilet as the bowel motion is moving through the bowel more quickly as a result of surgery

Regardless of whether you have an ileostomy or not please discuss these issues with your healthcare provider as a combination of the following may help to improve your bowel function

- Diet
- Fibre and fibre supplements
- Medications

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.

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.

Contacts

Colorectal Nurse Specialist Department of Surgery Christchurch Hospital Phone: 364 1687 Cell phone: 0211957717 Pager: 8095	Nurse Maude Stoma Advisory Service 24 McDougall Avenue Merivale Christchurch Phone: 375 4289

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**
Crohn's and Colitis Foundation of America **www.ccfa.org**
Macmillan Cancer Support **www.macmillan.org.uk**
The Mayo Clinic **www.mayoclinic.com/health/diverticulitis**

Acknowledgements

Thank you to all those who were involved in the development of this booklet, 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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For more information about:

- your health and medication, go to www.healthinfo.org.nz
- hospital and specialist services, go to www.cdhb.health.nz