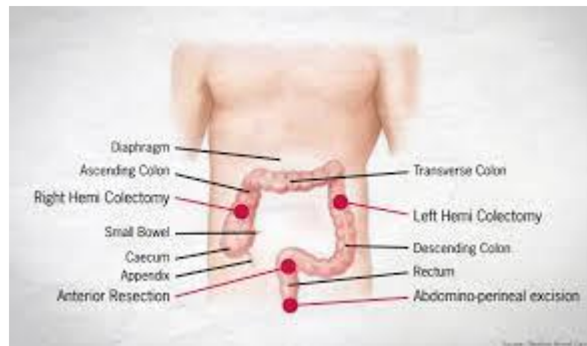
ANTERIOR RESECTION FOR RECTAL CANCER



This guide is designed to provide background information to the operation that you will shortly undergo. It aims to supplement verbal discussion, to answer common questions and to be readily available as an *aide memoir.* It cannot cover in detail every aspect of your individual operation and may not deal with some areas that are of particular concern to you. These can be dealt with individually.

You should feel free to ask about any aspect of your care. All you questions will be answered fully, honestly and in as much detail as you wish. In the heat of the moment it is easy for questions that you intend to ask to slip from your mind. You should take not on paper any questions you may have.

What is involved?
The aim of the operation is to remove the segment of bowel that contains the cancer. The incision will either be a low transverse incision or an 'up and down' incision in the middle of the abdomen. A general examination will then be performed to determine the exact extent of the cancer and to ensure there are no abnormalities in the abdomen. The involved bowel will then be resected and the two ends joined together. The wound is then closed. There may or may not skin sutures that have to be removed some 8-10 days later.

Will a colostomy be required?
A stoma (colostomy or ileostomy) is when part of the bowel is brought up onto the abdominal wall and a bag has to be worn. A stoma may be required as part of this operation. Sometimes it is clear prior to surgery that a stoma may be required and you will be so advised. On other occasions it may be deemed prudent during the operation to raise a temporary stoma. This does not necessarily mean that there is a problem and is undertaken as a precaution. Such stomas are normally closed six to ten weeks later with a second, smaller operation.

Before the operation.
You will have a number of routine blood tests. You may also have a scan. The exact type will be determined on the basis of your individual requirements. You will be assessed by the anaesthetist who will advise you on the various ways of controlling post-operative pain.

It is important we know every medical issue that might affect you. What may appear unimportant to you may be essential for us to know. In particular we need to know all the drugs you are taking and you should bring them to hospital in their original

packet. Unless advised specifically to the contrary you should take all your drugs up to and including the morning of surgery. The exception to this are blood thinning agents, such as warfarin, and diabetic drugs. These require special arrangements. Stop any aspirin containing drugs 10 days prior to surgery.

Prior to the operation you will be given a laxative to empty and clean the bowel. Once you are asleep various tubes and lines will be inserted into your veins, the bladder and through your nose into your stomach. These will be removed during the first 2-4 days followings surgery.

Pain relief.
There are many ways of reliving pain and the anaesthetist will discuss these with you. No matter which method you choose you should remember that pain relieving drugs work best if you anticipate the pain. A small quantity of the drug taken regularly (even if pain free at the time) will work better than waiting for the pain to occur and then taking a larger dose of the drug. Even when you are largely pain free during the day you may wish to continue with pain tablets at night as nothing is more wearing then a poor nights sleep.

The first 24 hours.
You may be nursed in a High Dependency Unit (HDU) where you are kept under constant observation. You will be attached to various monitors and numerous observations will be performed. The physiotherapist will visit you and will ensure your lungs are clear and free of secretions and exercise your legs.

The second 24 hours.
Much as day one but you will be sat in a chair during pard of the day.

Days three to five.
Some of the tubes may be removed. You may be permitted some fluid by mouth and you may pass some flatus (wind) through your anus.

Days five to ten.
You will start eating, moving around the ward, have a bath and generally return to normal, but limited, activities. Your bowel will start to work but maybe a little erratic and you may have some diarrhoea. You may have an episode of incontinence. Patients recover at different speeds and you should not be concerned if your progress appears slower than anticipated.

Going home.
You will normally return home 10-16 days after your surgery but this will vary with your progress and your home progress. You will obviously be tired and you should plan to rest during each day. You should avoid domestic activities for at least the first three weeks. Sitting in a high backed chair can reduce the strain on your abdominal wound, as it is easier to get up out of.

Gradually increase the exercise you take. However, you should avoid strenuous exercise for four weeks. ‘Little but often’ should be your aim and a short walk two or three times a day is better than one long work. Gradually increase the distance you

walk over the next few weeks. It is almost impossible to 'over exercise' yourself to the extent that you damage the surgical area. If you feel comfortable doing a particular activity then it is very unlikely you will do your self any harm. In general it is sudden, unplanned movements that cause problems.

As you start to feel better the likelihood is that you will overdo it and at this stage is a couple of days of feeling well (and overdoing it) will be followed by a bad day as your body compensates. Be warned! In general you should stop if you feel tired or if you feel pain.
For medico-legal reasons you must not drive for four weeks.

Bathing and showering.
It is quite safe to get your wound wet in the shower or quick bath two or three days after your operation. However, long soaking baths with a Jeffery Archer novel should be avoided for at least three weeks as the wound will become soft and the scab may become infected. Adding salt to the bath will not help the wound and may make your skin dry and tight. After washing, pat the wound dry with a dry and clean towel. A bath mat helps prevent slipping and a towel hooked around the bath taps can be a helpful lever when you try to get out. It can also be reassuring to have someone else in the house the first time you have a bath, even if you don't need help.

Sleep.
Changes in your routine, restricted movement, lack of exercise and wound discomfort will interrupt your normal sleep pattern or wake you during the night. Uninterrupted sleep is better than 'cat-napping' so you may find it helpful to take a pain killer before you go to bed. You may resume sexual activity when this feels comfortable.

Eating.
Your appetite will not be good for some weeks after surgery and you may feel aches, bloating and indigestion after meals. These symptoms usually disappear as you become more active. You should take small, frequent meals with good intake in protein (lean meat, dairy produce, fish etc). A small amount of alcohol can improve your appetite and is not usually harmful.

The wound.
Wounds progress through several stagers of healing. You may experience: -

- Unusual tingling, numbness or itching sensations.
- A slightly hard or 'lumpy' feeling as new tissues form.
- Pulling around the stiches or staples as the wound heals.

This is Normal. Do not pull at any scabs as they act as a natural dressing and protect the new skin underneath. They will fall off when no longer required. You should seek help if any of the following occur: -

- The wound pain increases
- The wound becomes more reddened or swollen
- There is any discharge from the wound.

Work.
Your return to work depends on many factors, including your occupation, age, and general health. You will defiantly require one month off work, but many will require up to two months and some may require a third month. It is better to feel completely

well before you return to work rather than have more time off a few weeks or days later because you have returned to work too early.
At six weeks you will be about 75-80% back to you pre-operative state. It will take three to six months to be 100%.

Your post-operative bowel habit.
This operation removes the rectum and replaces it with a segment of colon. The colon does not have some of the important characteristics of the rectum, such as the ability to store faeces. It is inevitable that your bowel habit will be disrupted in the post-operative period and this may include increased frequency (up to six times per day and again at night), urgency and occasional episodes of incontinence of either flatus (wind) or faeces. Understandably patients find these problems distressing but they do improve enormously over the first three and even further over the next six months. Some patients notice an ongoing improvement for up to two years. Depending on your circumstances it may be necessary to prescribe some tablets to help you.

In the past many patients with low cancer 9 less than 8cm from the anus would have a permanent colostomy. Modern surgical techniques do the permit the bowel to be rejoined in many patients and therefore avoid a permanent colostomy. In patients with a very low cancer the best way of managing these problems may be to create a small pouch from the colon. If this is likely it will be discussed with you. This technique normally requires a temporary ileostomy. However, the functional results following resection of a very low cancer are not always perfect. Patients may experience urgency and leaking. In some patients there can be troublesome incontinence. Some patients prefer minor, intermitted functional problems to a permanent colostomy. Others would prefer to have a stoma created.

Surgical trainees.
Some patients may have their anterior resection undertaken by a surgical trainee. A trainee performing an anterior resection is normally, but not always, under the direct supervision of the consult. It is important that, as part of their training, trainees gain independent experience whilst consult cover is still immediately available. There is a substantial amount of surgical literature that shows the outcome of operations undertaken by properly supervised trainees is no worse than those performed by the consultant. This literature specifically includes anterior resections.

What can go wrong?
You will be undergoing a major operation. Major operations are sometimes complicated by adverse events. That said, the surgeons, anaesthetists and nurses caring for you have an extensive experience in what is, to them, a routinely performed operation.

Approximately 2.5% of patients undergoing an anterior resection will die as a result of their operation. However, this is usually, but not always, a consequence of pre-

existing medical problems rather than a new event that occurs as a result of the surgery itself. Rarely, previously fit patients may develop heart problems or blood clots in the legs as a direct consequence of the operation. A wound infection is always possible.

There are two potential major problems specific to anterior resection. The first is a leak where the bowel was joined (the anastomosis). This is a serious complication (5-10% chance) and usually requires a second operation as an emergency. Normally this second operation will require a stoma. It may be possible to close this stoma at a second operation some months later. Up to one third of those developing an anastomotic leak will die as a result of the leak.
The second potential problem is damage to the nerves in the pelvis that supply the bladder and genitals. The whereabouts of these nerves is known and every effort is made to avoid damaging them. However, sometimes they are intimately involved with the cancer and may have to be sacrificed in order to obtain a complete cancer clearance in order to obtain a complete cancer clearance (the prime objective of the operation). On other occasions their post-operative function appears compromised even through there was no evidence that they were damaged during the operation.

If the nerves are damaged there may be problems with micturition and, in men, importance. In men under 50 years the risk of partial or compete impotence is probably less than 10%. For those aged 50-60years the risk of partial importance is 40% and total importance is 10%. For men over 60 years the risk of partial importance is 10% and total importance is 40%. The equivalent in women is vaginal dryness. Less commonly, damage to these nerves can lead to problems emptying the bladder.

Other complications are possible, as after any surgical procedure. These include drug reactions, post-operative bleeding, deep vein thrombosis, heart and lung complications and wound infections. This list is not exhaustive and if you have any concerns about the possible side effects or complications following an anterior resection you should ask about them before you sign the consent form.

Any further treatment?
The aim of the operation is to remove the cancer. Naturally you will wish to know how successful the operation has been and what the future hold for you. Immediately after the operation it will be possible to tell you how the surgery went and whether all the obvious cancer was removed. The bowel that is removed will be sent to the pathologists for detailed examination. This analysis takes time and a full report may not be available for seven days. You will be advised of the results as soon as they are available. However, these cannot be anticipated and patients often find waiting for the results a stressful period.

Experience has shown that even if there is no obvious cancer left at the end of the operation some patients will later develop further disease (a recurrence). This recurrence may either be local (at the site of the original cancer and the operation) or elsewhere (distal), usually the liver or lungs. Local recurrence is best prevented by adequate local surgery at the fist operation. The only additional treatment possible is radiotherapy. This is best given before any surgery, but may be delivered after the operation. There are advantages and disadvantages to both options and patients have

to be considered individually. The radiotherapy may or may not be given with chemotherapy. Radiotherapy has complications of its own. If it is likely that radiotherapy may be of benefit to you arrangements will be made for you to discuss this with the Radiation Oncologists.

Distal recurrence is believed to occur because some cancer cells, too few to be detected by either tests or the surgeon, have already spread beyond the operation area and with time these grow just like the original cancer. To reduce the chances of this occurring it is sometimes appropriate to offer further treatment to kill cells while they are very few in number. This is called chemotherapy. Pre-operative chemotherapy is normally only given with pre-operative radiotherapy. A decision about post-operative chemotherapy can only be made after the cancer has undergone histopathological examination. Exactly who will benefit from what chemotherapy is a complex decision and has to be individualized for each patient. If it is likely that chemotherapy may be of benefit to you arrangements will be made for you to discuss this with the medical oncologists (cancer specialists). This discussion does not commit you to undergo chemotherapy but does allow you to make an informed decision.

Follow-up.

You will be reviewed about six weeks after you undergo surgery. You will then be followed-up every 3-6 mouths for the next two years and then yearly for the next three years. At each visit you will be examined and blood tests may be performed. During the second year and sixth years a full colonoscopy may be performed. The aim of these visits is to ensure that you remain well and to detect, at the earliest possible moment, any recurrent disease should the cancer recur.

If you should have any concerns you should contact the surgical secretary who will arrange for a surgeon to ring you or for your next outpatient appointment to be brought forward.

How long have I got, doc?

This is likely to be the most important question you will have answered. It is also the hardest to answer accurately. It is impossible to ever begin to answer this question until the operation has been completed and the pathology reported. You will then wish to know what the future holds for you, as an individual. We cannot answer this precisely for you as an individual but we can tell you about the average outcome for a group of patients presenting the same type of cancer. These average outcome statistics are taken from many previous studies that have been reported from hospitals and countries around the world.