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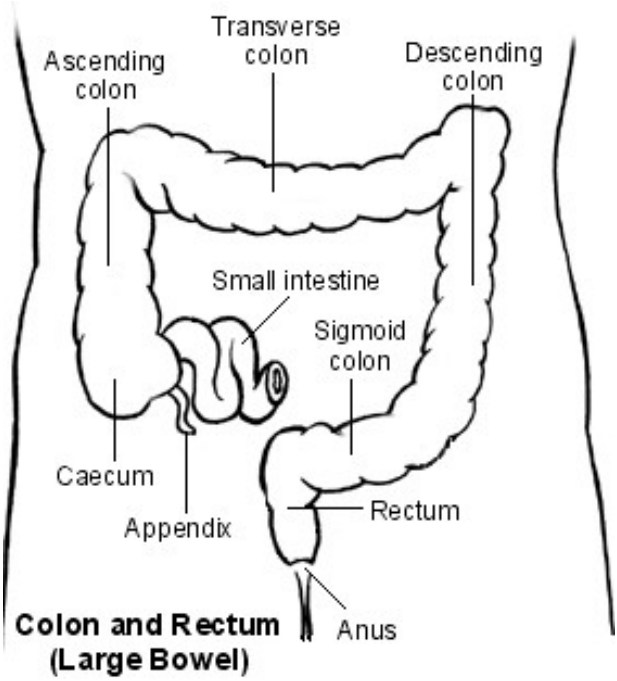
Subtotal Colectomy

Subtotal Colectomy is an operation which removes most of your large bowel and leaves the rectum behind, and in certain situations, part of your sigmoid colon too.



(The above image is courtesy of: University Hospitals Sussex NHS Foundation Trust.)

What is the colon?

The colon is also know as the large intestine or bowel. It forms the lowest part of the digestive system after the small intestine and it ends with the rectum and the anus (back passage).

What happens during the operation?

Your operation will be done either by laparoscopic (keyhole) surgery using a few small incisions (cuts) and one slightly larger incision (to

remove the piece of bowel) or by an ‘open’ operation where one long incision will be made in your abdomen (tummy). This surgery is most commonly performed laparoscopically but occasionally it is necessary to perform an open procedure. Each person's situation has to be considered on an individual basis so your surgeon will discuss with you which way of operating is most appropriate or possible for you.

After removing the portion of the colon (including any blood vessels and lymph nodes that supply this piece of bowel), where possible, the two ends of remaining healthy bowel (small bowel to rectum / sigmoid colon) are re-joined by stitching or, more commonly using a special stapling device, this is called an anastomosis. However, in some cases the consultant will discuss the benefits of you having a permanent stoma. If this is the case the small bowel is brought out on to the front of the abdomen as an ileostomy and the remaining bowel (rectum) is closed off and left inside.

If your operation is being done because you have cancer, the section of bowel that contains the cancer, along with the blood vessels and lymph nodes will be sent to the lab for further investigation.

If you have a laparoscopic (keyhole) operation

Your surgeon will make three or four small (one centimetre) cuts in your abdomen. They will put a telescope camera into one of these small cuts to show an enlarged image of the organs in your abdomen (on a television screen). The other cuts allow the surgeon to use special operating instruments. Your surgeon will make one of the cuts longer (8 to 10 cms) so they can remove the portion of the bowel they have operated on. Sometimes it is not possible or safe to finish the

operation using laparoscopic surgery. If so, your surgeon will change to an ‘open’ operation and make a larger incision to deal with this.

Preparation for Surgery

It is likely, although not always the case that you will need to take some medications in the 24 hours before your surgery. Oral bowel preparation and Antibiotics will be provided to you with instructions if you require them. You may also be given some high energy drinks to have the day before your surgery.

Will I need to have a stoma (ileostomy/colostomy)?

A stoma is an artificial opening of your bowel on the front of your abdomen, created during an operation, to collect faeces. Some patients will have a planned permanent stoma. Others may need to have a temporary stoma. Patients often need to have a stoma. The stoma protect or ‘rest’ the anastomosis (the join where the bowel is connected back together) allowing it to heal. Despite the presence of a stoma you may still pass a little old blood or mucus from your back passage.

It is possible but unlikely that if your operation is being done because you have inflammatory bowel disease, that a second stoma will be formed usually low down on your tummy. This second stoma is called a mucous fistula, and is the top end of the piece of bowel which continues down to your back passage. Initially you may need to wear a stoma bag over this, but as the bowel settles it will pass only a small amount of mucous and a small dressing can be worn over this.

If you need a stoma or it is possible that you may need a stoma, you will be seen by a stoma nurse. These specialist nurses are skilled in

caring for patients who have a stoma and will be able to answer any questions you may have.

Are there complications with this operation?

The risks of this operation are relatively small and much less likely to affect you negatively than the risk of doing nothing. However, this is a major operation and some people (less than 5%, or fewer than 1 in 20) do not survive the surgery.

There are sometimes complications. These may include:

- Bleeding;
- Infection (such as chest, urine and wound infections);
- A leak from the anastomosis (the join where the bowel is connected back together);
- A temporary hold up of bowel function (ileus) which leads to bloating, nausea and sometimes vomiting;
- Injury to other organs within the abdomen (for example, the small intestine, ureter or bladder);
- Problems with your hearts, lungs or kidneys;
- Problems passing urine (though this is usually only temporary);
- A lack of sexual desire and, in men, a difficulty in achieving an orgasm and maintaining an erection (though this is usually only temporary);
- Deep vein thrombosis (blood clots in the veins in the legs);

- Pulmonary embolism (blood clots in the lungs).

You may also experience the following:

- Anxiety due to the whole situation, although we will do our best to help you through this;
- A sore bottom due to the way they staple your bowel back together, this should settle with time;
- Your bowel habit after the surgery is likely to be different (usually looser) from what it was previously. It may also take many months for it to settle into its 'new normal'. Furthermore, if you did not need a stoma, you may have difficulty in controlling your bowels in the first few weeks after surgery, which may mark your underwear. It may be helpful for you to do some pelvic-floor exercises. These will help the muscles in your bottom cope with having a part of your back passage removed. You may have to adjust your diet or you may be given medication to help control your bowels.

Recovering after surgery on your bowel

You will be able to eat and drink soon after your operation, and you will be encouraged to sit out of bed and walk around the ward as much as possible from the day after your operation. This will help you to get better more quickly and avoid complications.

There are certain criteria you have to meet before you are able to be discharged:

- Do you feel confident about discharge?
- Is your pain well controlled?

- Are you eating and drinking?
- Have you passed wind or had your bowels open?
- Are you passing urine normally?
- Are you able to wash, dress, make drinks etc?
- Is there any sign of wound infection?
- If you have a stoma - you are self-caring regarding the care of your stoma and feeling confident.

You will be discharged home when we are all happy that all the discharge criteria are met.

It may be possible, if the discharge criteria is met, that you may go home the day after your surgery, however, this varies from person to person.

A lot of your recovery will take place at home and you should gradually increase the amount of activity and exercise you do each day, resting if you need to.

Results and follow up after surgery

If your operation was the result of having cancer the laboratory results are usually available approximately two weeks after your operation.

These results are reviewed at the Multi-Disciplinary Team meeting and then discussed with you as soon as possible after this. These results will indicate if any further treatment is required, such as chemotherapy.

If your operation was done for another reason, your consultant will discuss with you your follow up plan.

If you have a stoma you will be seen regularly by the stoma care nurses and you can contact them if you have any concerns about your stoma.

Further information

For any further information, please speak to your Colorectal Clinical Nurse Specialist on 01722 425 194 (direct line).

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www.salisbury.nhs.uk/wards-departments/departments/cancer-services