

Information for patients having a low anterior resection

This leaflet will explain what will happen when you come to the hospital for your operation. It is important that you understand what to expect and feel able to take an active role in your treatment. Your surgeon will have already discussed your treatment with you and will give advice about what to do when you get home.

What is a low anterior resection?

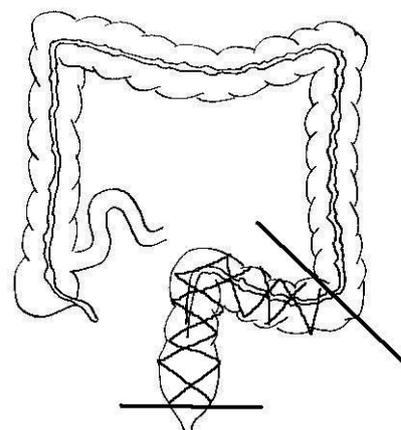
This operation involves removing some or all of your sigmoid colon, which lies on the left side of your abdominal cavity (tummy), and all, or nearly all, of the rectum (the “storage” organ of the bowel). We would then normally join the remaining left colon to the remaining rectum. The lines on the attached diagram show the piece of bowel being removed.

The diagram opposite shows the part of the bowel being removed (hatched area between the lines).

This operation is done with you asleep (general anaesthetic). The operation not only removes the bowel containing the tumour but also removes the draining lymph glands from this part of the bowel. This is sent to the pathologists who will then analyse each bit of the bowel and the lymph glands in detail under the microscope.

This operation is usually carried out in a “keyhole” manner, which means less trauma to the abdominal muscles as the biggest wound is the one to remove the bowel from the abdomen. Sometimes this is not possible, in which case I do the same operation but through a bigger incision in the abdominal wall – this is called an ‘open’ operation. It does take longer to recover with an open operation but, if it is necessary, it is the safest thing to do.

Following surgery you will usually have some form of stoma – this is a piece of bowel on the outside of your abdomen where stool will drain into a bag. This is most likely to be a temporary stoma (called an ileostomy) which acts as a diversion to protect the join that we have made. The stool would then come out of the ileostomy rather than travelling further on round the colon past the newly-made join. This is something we would then reverse at a later date so that you would eventually open your bowels in the normal way.



However, there is a smaller chance that it will be a permanent colostomy if the surgeon feels unable to make a join at all.

What are the possible risks of this operation?

1. Anastomotic leak: this is where the join leaks – it can do this whether you have a temporary ileostomy or not but the consequences are usually more dangerous when there is no ileostomy in place. This is the most dangerous of complications as it can potentially lead to peritonitis (inflammation of the peritoneum, the thin layer of tissue that lines the inside of the abdomen) and very occasionally this is fatal. It will sometimes lead to us needing to remove the join in your bowel and leave you with a permanent colostomy.
2. Infection: this happens in the wounds most commonly but can also occur deep in the tummy cavity in some circumstances, requiring either antibiotics or sometimes even drains to be inserted by the radiology doctors. Infection occurs after bowel surgery in up to 20% of people (2 out of 10 cases). Chest infections can also occur and so we encourage people to do breathing exercises afterwards to help avoid this.
3. Bleeding: significant bleeding is uncommon after bowel surgery but occasionally some patients can bleed enough to require a blood transfusion.
4. Blood clots in the legs and lungs: deep vein thrombosis and pulmonary embolus can occur as a result of being immobile during your operation and then being less mobile afterwards. We reduce this risk by giving you compression stockings to wear, injecting you with blood-thinning medication every evening while you are in hospital and getting you mobile as quickly as possible.
5. Damage to other structures: there is a 1% chance of damaging something we didn't mean to – especially in keyhole surgery. Although not usually a problem if we notice it, the danger occurs if we damage something but don't recognise this. Common things to get damaged are: the bowel, the ureter (the tubes that run from your kidney to your bladder), and the bladder.
6. Sexual and bladder dysfunction: the nerves that run from your spine to your penis, prostate, clitoris, vagina and bladder run very close to the back/sides of the rectum. As such they can get bruised during this operation and not work so well afterwards for some months. However, occasionally they are damaged permanently. In men, this can lead to some trouble with erection and /or ejaculation. In women this nerve damage can lead to vaginal dryness, a less intense orgasm and it can take much longer to achieve orgasm. In both men and women it can also very occasionally cause a problem with bladder function.
7. Ileus: this is where the bowel stops working and effectively “goes on strike”. It is a common problem in any bowel operation but is particularly a problem in this operation. Occasionally it lasts only 24hrs but can be considerably longer. This can require a tube placed through your nose to drain the stomach contents whilst we wait for the bowel to start working again

This isn't a comprehensive list of all the risks of surgery but explains those most common to bowel surgery.

What are the alternatives to surgery?

Surgery is not the only option for the treatment of bowel cancer but for the majority of cancers it is the only chance of a potential cure. If there is a potential for being cured without surgery this will be discussed with you along with the risks of a non-operative approach. However if we believe surgery is the only possibility of curing your cancer we will recommend this operation.

When will I be admitted?

You will be admitted on the day of surgery. You will be given an enema before surgery to clear the lower part of the bowel. Following surgery you will be taken to the recovery area or to the Intensive Care Unit – this is quite routine after this sort of major surgery.

What happens after the operation?

Providing all has gone well we try to get your gut back to normal as soon as possible. This means starting you drinking and occasionally eating on the day of your operation. Diet in the first few weeks needs to be slightly different, avoiding foods which are too rich, fatty or fibrous. "Bland" food is usually ideal in the first week – e.g. mashed potato, fish, minced meat, rice, pasta etc. These are foods which are easy to digest but have some nutritional value.

We will try to get you mobile the following day, even though it is sore, as we know that mobility helps get your bowel working and reduces the risk of complications.

You'll get plenty of advice and help from the colorectal nurses, stoma nurses, nurses on the ward and physiotherapists as well as from your surgeon and the medical staff.

If all goes well and you don't have any complications after your operation, we expect you to be in hospital for three days if it is done keyhole, and five days if it is done 'open'.

However, it may be a shorter or longer stay depending on your recovery. If you do have a stoma it sometimes means a slightly longer stay to ensure you are confident with the stoma before discharge.

Aftercare advice at home

Before discharge the staff looking after you will tell you any important specific information. Your recovery is often gradual and generally you will feel better week by week. However, you are unlikely to be back to full fitness for some months after surgery.

Useful telephone numbers

Hunter Ward	0118 322 7535
Lister Ward	0118 322 7539
Intensive Care Unit	0118 322 7257
Colorectal nurses	0118 322 7182 office; 07659 129415 pager
Stoma Nurses	0118 322 7640

This document can be made available in other languages and formats upon request.

Philip Conaghan DM FRCS, Consultant Colorectal Surgeon, December 2018
Review due: December 2020