The ENDOSCOPY CLINIC

Information sheet for patients undergoing Anterior Resection of the Rectum

Your specialist has advised you to undergo the above operation

What is an Anterior Resection of the Rectum

An operation to surgically remove the rectum via the abdomen and to restore continuity of the bowel.

Indications

The operation is being performed to remove a cancer (malignant tumour) within the rectum.

Pre-operative preparation

Your specialist will arrange blood tests, x-rays, scans and consultations with other specialists (such as cardiologists) as appropriate. You will need to take a bowel preparation to thoroughly cleanse the bowel – similar to that required for colonoscopy.

Anaesthesia and antibiotics

The operation will be performed under a general anaesthetic, administered by an anaesthetist. Antibiotics will be given in the operating room.

Operative procedure

The rectum will be operated on through an incision made in the abdomen.

The rectum is the last part of the gut, just before it becomes the anus. It passes down through the pelvis and in so doing is attached to the side walls of the pelvis and the other organs within the pelvis, namely bladder and ureters (tubes that carry urine from the kidneys to the bladder), pelvic nerves, uterus and vagina in females, and prostate gland and seminal vesicles in males. The operation involves separating the rectum, and the surrounding lymph nodes, from these structures, whilst taking great care to protect and preserve the latter. It also involves cutting across the rectum below the tumour (to include a safe margin of healthy tissue), and through the part of the colon upstream of the rectum.

The final part of the operation is to join (an anastamosis) the cut ends to restore continuity of the bowel. This is done with a single-use (disposable) device which places a double row of titanium (inert) staples around the circumference of the bowel.

Expected post-operative course

Pain relief (analgesia) – pain is an inevitable feature of surgery but it will be adequately controlled. There is achieved by either an **epidural**: a small tube inserted around the nerves in the back where they exit from the spinal cord, which continuously delivers morphine; or **Patient Controlled Analgesia** (PCA) whereby morphine is delivered into the blood stream at the push of a button by you. Both methods will be discussed with you by your anaesthetist prior to surgery. Whichever method is used, your pain should diminish so that by day 3 or 4 it will be adequately controlled by painkillers taken by mouth.

When you wake from operation you will be attached to various tubes:

An **epidural,** if used (see above).

The Endoscopy Clinic
Level 1, 9 Caledonian Road, Christchurch 8013
P: (03) 961 6666
E: info@endoscopyclinic.co.nz

Southern Cross Health Society Affiliated Provider

FRACS Fellow of the Royal Australasian College of Surgeons

A **urinary catheter** to drain the bladder. This is usually removed on day 3 or 4, or earlier.

An **intravenous drip** to supplement oral fluids and to deliver morphine if a **PCA** is used (see above). After an operation on the bowel it temporarily ceases to push things through, so care must be exercised as to how much is taken in by mouth. The nurses will advise you how much you can take, but during this period, the fluid in the drip makes up for any deficit. When the bowel starts to work properly the first thing you will experience is the passage of flatus (wind) which usually happens on day 2 or 3. At this point it is safe to take in unrestricted fluids and the drip is taken down. The first bowel motion usually happens on day 4 or 5 (but can sometimes take an extra few days), at which point a light diet is started.

A **drain** (thin tube) coming from the abdomen to drain any fluid (a natural reaction of the body) formed at the operation site.

Prevention of Deep Vein Thrombosis (DVT): As in long-haul plane trips there is an increased risk of this occuring due to your relative immobility. You will be fitted with graduated compression stockings and mechanical compression devices to promote blood flow in the legs. These will not stop you from mobilising which you will be encouraged to do, with the close assistance of ward staff. A blood thinning agent will also be administered on a daily basis until you are fully mobile. With these measures, less than 1% of patients will suffer from a DVT.

Prevention of chest infections: The physiotherapist will help you with breathing exercises to ensure proper lung inflation which will help prevent a chest infection. Less than 1% of patients will suffer from a chest infection.

Bowel function: The main function of the rectum is to act as a storage organ for the faeces so removing it will partially remove some of this ability. You will therefore notice an increase in the frequency of defaecation. Initially the motions will be quite loose but will firm up over time. If the tumour is low down necessitating removal of of the whole rectum (but preserving the anus and therefore continence), then your surgeon will construct a new reservoir from the portion of colon that is being joined, partially restoring rectal function.

Potential complications

Wound infection – approximately 1% of patients will suffer a wound infection. This is kept to a minimum with antibiotics used at surgery. It may require a further course to help clear it.

DVT and **chest infection** as described above

Internal bleeding – this is most unusual, and nearly always stops without further surgery.

Anastamotic dehiscence (leakage from the join in the bowel, within the pelvis or abdomen) will occur in a small percentage of patients at about a week after surgery. The effects are very much dependant on the size of the defect and hence the amount of leakage (of faecal material): small leaks are often not even noticed. Larger leaks may produce a localised abscess requiring drainage, usually under with a local anaesthetic. Substantial leaks will require a second operation and it may be necessary to give you a temporary colostomy (bag), which can be reversed at a later date.

Urinary function – you may experience difficulty voiding the bladder and increased frequency initially. If this does happen it usually improves with time and physiotherapy.

Sexual function – unusually, men may experience failure of erection and women vaginal dryness. It is rarely permanent.

Discharge from hospital

This will happen only when you, your specialist and the nursing staff are all happy that you have recovered sufficiently such that you manage independently at home with day-to-day activities such as feeding, dressing and washing. For most people this will be at 7-10 days after surgery.

Follow up

Arrangements will be made upon discharge for removal of stitches or clips (if appropriate) and a follow-up with either the district nurse or the Practice Nurse, and your specialist.

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