The ROYAL MARSDEN
NHS Foundation Trust

Surgery for recurrent cancer of the rectum

GI Unit

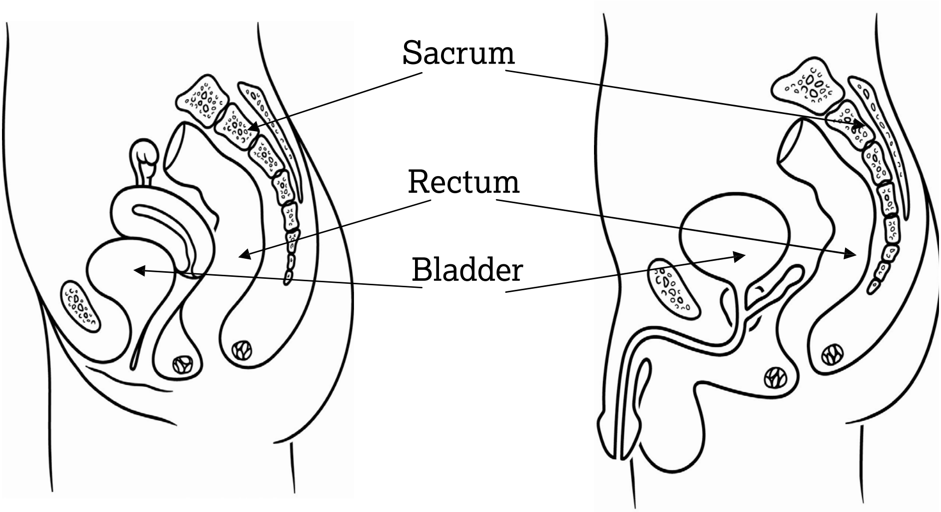
Patient Information

Introduction

Your doctor has recommended that you have an operation called an abdomino-sacral resection (sacrectomy) to remove the cancer in your rectum and lower spine (sacrum). This information explains your operation and answers some common questions that you may have.

What does the operation involve?

An abdomino-sacral resection is carried out for tumours of the rectum that are invading part of the sacrum and/or spine. In order for the surgeon to remove your tumour, your rectum and part of your lower spine will need to be removed. Your doctor will provide you with more details on this.



Female pelvis

Male pelvis

An abdomino-sacral resection results in a permanent stoma. A stoma is where part of the bowel is brought onto the abdominal wall. The waste matter from the bowel will pass through the stoma into a bag. We will introduce you to a stoma care nurse who will be able to support you with this.

Because your rectum has been removed, the opening to your anus will be closed permanently. Please speak to your key worker if you have concerns about this. You will have a wound on your perineum (the area between the genitals and the anal opening) and your abdomen.

This area will sometimes require a flap (a piece of muscle and skin usually taken from either your buttocks or abdomen) in order to close the area. The plastic surgery team will discuss this with you in more detail.

The operation takes approximately 10–12 hours. The length of stay in hospital varies between individuals depending on their recovery but it is usually 14–20 days.

All the tissue removed is looked at under a microscope to check that the cancer has been completely removed. The result of this test takes about three weeks.

What are the risks and complications of surgery?

Complications can happen which will slow down recovery and if they become serious, can carry a small risk of death.

As with any major surgery, there are also risks related to having a general anaesthetic. You will meet with an anaesthetist before your operation to discuss your general health. Your surgeon will discuss other possible risks with you. You may find The Royal Marsden booklet *Your operation and anaesthetic* helpful. It gives general information about what happens before and after an operation.

These are the most common complications:

- **Infection**
  There is an increased risk of developing an infection after the operation. This can affect your chest, urinary tract or your wound. If you do develop an infection, we will treat it quickly, often by giving you antibiotics.

- **Blood clot (thrombosis)**
  The risk of developing a deep vein thrombosis (DVT), a blood clot in the leg, or a pulmonary embolism, a blood clot in the lung, increases after any surgery. To prevent this happening, we will ask you to wear special stockings while you are in hospital. We will also give you a small daily injection of an anticoagulant, which reduces the body's ability to form a DVT.
- **Slow bowel (ileus)**
  Occasionally the bowel is slow to start working again because of the effects of the anaesthetic, and the bowel being handled and repositioned during the operation. This may just take some time to get back to normal.
- **Sexual function**
  During surgery, the surgeon may come into contact with important nerves responsible for sexual function. If you find you are experiencing problems, please tell your doctor or specialist nurse. You may require a referral to a urology or gynaecology specialist to manage this once you have recovered from your surgery.
- **Urinary function**
  During the surgery, the surgeon may come into contact with important nerves responsible for bladder function. Therefore you may require a catheter temporarily or permanently

What happens before my operation?

You will attend a pre-assessment clinic to check that you are fit enough to have a general anaesthetic and an operation. This check may include further tests such as heart and lung tests, and you are likely to be at the hospital for most of the day. If you have a history of heart problems you may need to see a cardiologist (heart specialist) for assessment.

You will meet members of the team looking after you including an anaesthetist, a clinical nurse specialist (CNS) and possibly a dietitian. You will see a physiotherapist either here or when you are admitted to the ward. The physiotherapist will talk to you about your general health and level of activity, and will assess your breathing and mobility. You will also be offered a visit to the Critical Care Unit (CCU) and the ward.

- **Bowel preparation**
  You may need bowel preparation before surgery. You will be asked to take a laxative the day before your surgery. This will cause diarrhoea and empty the bowel. Your nurse will provide you with the information and advise you on what to eat and drink.
- **Stoma counselling**
  You will meet with your specialist nurse/stoma care nurse to discuss what it means to have a stoma. This will give you an opportunity to look at some stoma bags and ask questions. The nurse will also mark a place on your abdomen where the stoma will be formed.

What happens immediately after the operation?

We will take you to the CCU where nursing staff will watch you closely for several days and try to make you as comfortable as possible. During your stay on CCU, only two visitors are allowed at any one time. This is to allow both you and other patients time to recover from surgery. Visiting times for CCU are restricted – visitors are permitted between 11am and 8pm. Unfortunately, flowers are not allowed on the unit (for infection control purposes). However, they can be kept on the ward for you to enjoy when you return there.

Good pain relief after surgery is important. It prevents discomfort and helps you recover more quickly. Normally before the operation, an anaesthetist will discuss with you the different ways your pain can be controlled. More information on pain relief after surgery is available in The Royal Marsden booklet *Your operation and anaesthetic.*

When you wake up after the operation, you may be aware of several tubes coming out of your body. Some of them may provide fluid or nutrition and medication. Some of these tubes may be attached to monitors. These help the staff check your progress and provide you with fluids and medication. Some of the monitors and pumps may alarm at regular intervals – this does not necessarily mean something is wrong. Other tubes will drain away fluids.

You may notice the following tubes/drainage bags:

- **Intravenous cannulae/central venous catheters** – We can give fluids, pain relief and antibiotics directly into a vein through these tubes. One is usually inserted into a vein in the side of your neck and another into a vein in your arm.
- **Nasogastric tube** – This tube is passed through your nose and down the back of your throat into your stomach. This is inserted during the operation and drains away secretions from your stomach. It can also help relieve nausea and vomiting.
- **Urinary catheter** – Immediately after the operation, it can be difficult for you to pass urine while lying in bed. This tube is put into your bladder during the operation and drains your urine into a bag and allows the nurses to monitor your urine output. This saves you from having to get up to pass urine.
- **Epidural catheter** – An epidural catheter is a small plastic tube placed into the spinal column. Pain relief (analgesia) is slowly and continuously pumped through it. The epidural will be stopped when members of the specialist pain control team feel you no longer need it. Once the epidural has been stopped, you will be given pain medicines by mouth.
- **Wound drains** – These are put in to drain away any blood or fluid that collects around the operation site.

- **Stoma** – We will keep an eye on your new stoma during your hospital stay to make sure that it is healing and working. You will have a clear drainable bag over it so that the stoma can be easily seen. You will have stitches which are normally soluble. If not, your nurse will remove them before you leave hospital. The stoma tends to be quite swollen initially after surgery but it will reduce in size over the first six weeks.

Recovering from your operation

Most patients stay in hospital for around two weeks after surgery.

Physiotherapy – After your operation you will be encouraged to start moving about as soon as possible. This is an important part of your recovery and helps to reduce the risk of complications. The physiotherapist will encourage regular leg exercises and deep breathing.

Eating and drinking – Your surgeon will advise you on when you can start eating and drinking. You will usually be allowed to start sipping water within one to two days and then build up slowly to a light diet. Due to your bowel being handled and repositioned during the operation, it may be slow to start working again, so you should not start eating and drinking straight away.

Bowels – Your bowels will usually start to make sounds after two to three days and you may have a bowel movement after four to five days. This varies between individuals. Usually the first sign that your bowel is beginning to work is when you notice air in the bag over your stoma. The stool may be liquid to begin with. This will thicken as you start eating and drinking normally.

Going home

Although you are well enough to go home, it will be a few months before you recover fully. We will provide you with contact numbers and names of your specialist nurse and doctors so that you can continue to receive information and support.

Please call them if you have any problems once you are at home. The ward nurses will arrange for district nurses/stoma care nurses and other support you may require, before you go home.

When will I be able to start doing normal daily activities?

You will likely feel tired up to several weeks or months after your operation. Gradually increase your activity every couple of days. Try to alternate periods of gentle activity, such as walking and climbing stairs. Listen to your body and increase any activity gradually.

It is important to rest regularly. The general rule is to go gently for the first six weeks after your operation while your wound and muscles have time to heal. Do not do anything that includes pushing, pulling, stretching or twisting. You should not lift anything heavier than 1kg (equivalent to a bag of sugar.) Do not carry out activities such as carrying shopping, lifting children, lifting wet washing, ironing, vacuuming or moving furniture for the first six weeks. After this time, introduce these activities gradually and slowly build up the amount you do.

Returning to work – This will depend on your job and how quickly you recover from your operation. Your doctor and specialist nurse will be able to advise you further.

Driving – You may resume driving from about six weeks, once you are able to move freely and quickly, concentrate sufficiently and tolerate the pressure of the seat belt on your wound. You should be able to react and move fast enough should you need to make an emergency stop. Also check that your insurance is valid after major surgery.

Diet – After having an operation on your bowel, there are no particular changes that you should make to what you eat and drink. You should eat a healthy balanced diet. If you have any concerns, please talk to your doctor or specialist nurse.

Bowels/stoma – Some people continue to experience unpredictable bowel habits whilst their body gets used to having a stoma. These may be improved by altering your diet and medication or they may just take time to settle down. You should always inform your doctor and specialist stoma care nurse so that they can advise you appropriately.

Rectal pain – Some patients suffer from rectal pain following this surgery. This can be a result of the perineal wound which can be painful until it heals completely. Some patients continue to experience an unpleasant sensation of wanting to have their bowels opened which is referred to as phantom rectum syndrome. This is thought to be caused by damage to the pelvic nerves during surgery. If you experience this, please inform your doctor or specialist nurse as this needs to be investigated before we can suggest what might help.

Urinary function – Some patients develop problems with urinating following this type of surgery. Many complain of urgency, frequency and loss of control. You may go home with a temporary catheter in place. This will allow your perineal wound time to heal and for your bladder to regain control. The nursing staff will discuss catheter care with you and arrange the necessary community support for you. This will then be removed at your outpatient's appointment.

Surgical wounds – You will have an abdominal and perineal incision from your surgery. These will take time to heal and will require close monitoring. You may need a district nurse to care for the wounds once you have gone home. The plastic surgery team will follow you up closely.

Sexual activities – Once you have recovered from your operation, there is no medical reason why you should not resume your sex life when you feel ready. Operations on the anus and rectum often cause damage to nerves connected to the sexual organs. Men may find it difficult to gain or maintain an erection and women may suffer with problems such as pain and dryness. If you do develop problems, please inform your doctor or specialist nurse.

Psychological issues – Having an operation can be very stressful and some days you may feel tearful, sluggish and low in mood. This is perfectly normal and you should start to feel better as your fitness returns to normal. If you are finding it difficult to cope or would just like someone to talk to, please inform your specialist nurse and a referral to the Psychological Support Team can be made.

Outpatients follow up – We expect your recovery to continue when you go home. We will arrange your first outpatients appointment for two to three weeks' time. Here, we will monitor your progress and discuss the pathology results with you. If you have any problems, please contact your team.

Contact details

Often you may have questions you wish to ask. Writing these down beforehand may help you to remember them. You are also welcome to bring someone with you to your appointments.

If you have any queries or concerns, please contact us on the numbers below.

Colorectal PA	020 7808 2195
Clinical Nurse Specialist (CNS)	020 7811 8108
Stoma Nurse Call the switchboard and ask for extension	1616
Critical Care Unit (CCU)	020 7808 2040

Alternatively, please call:

The Royal Marsden Macmillan Hotline: (available 24 hours a day, 7 days a week)	020 8915 6899

Call us straight away if you are feeling unwell or are worried about the side effects of cancer treatments.

This service provides specialist advice and support to all Royal Marsden patients, as well as to their carers, and both hospital and community-based doctors and nurses caring for Royal Marsden patients.

Notes and questions

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References

This booklet is evidence based wherever the appropriate evidence is available, and represents an accumulation of expert opinion and professional interpretation.

Details of the references used in writing this booklet are available on request from:

The Royal Marsden Help Centre
Telephone: Chelsea 020 7811 8438 / 020 7808 2083
Sutton 020 8661 3759 / 3951
Email: patientcentre@rmh.nhs.uk

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Should you require information in an alternative format, please contact The Royal Marsden Help Centre.

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