East Kent NHS Hospitals Trust

QEQM-KCH
Pelvic Floor Service

Laparoscopic or open Resection - Rectopexy *Patient Leaflet*

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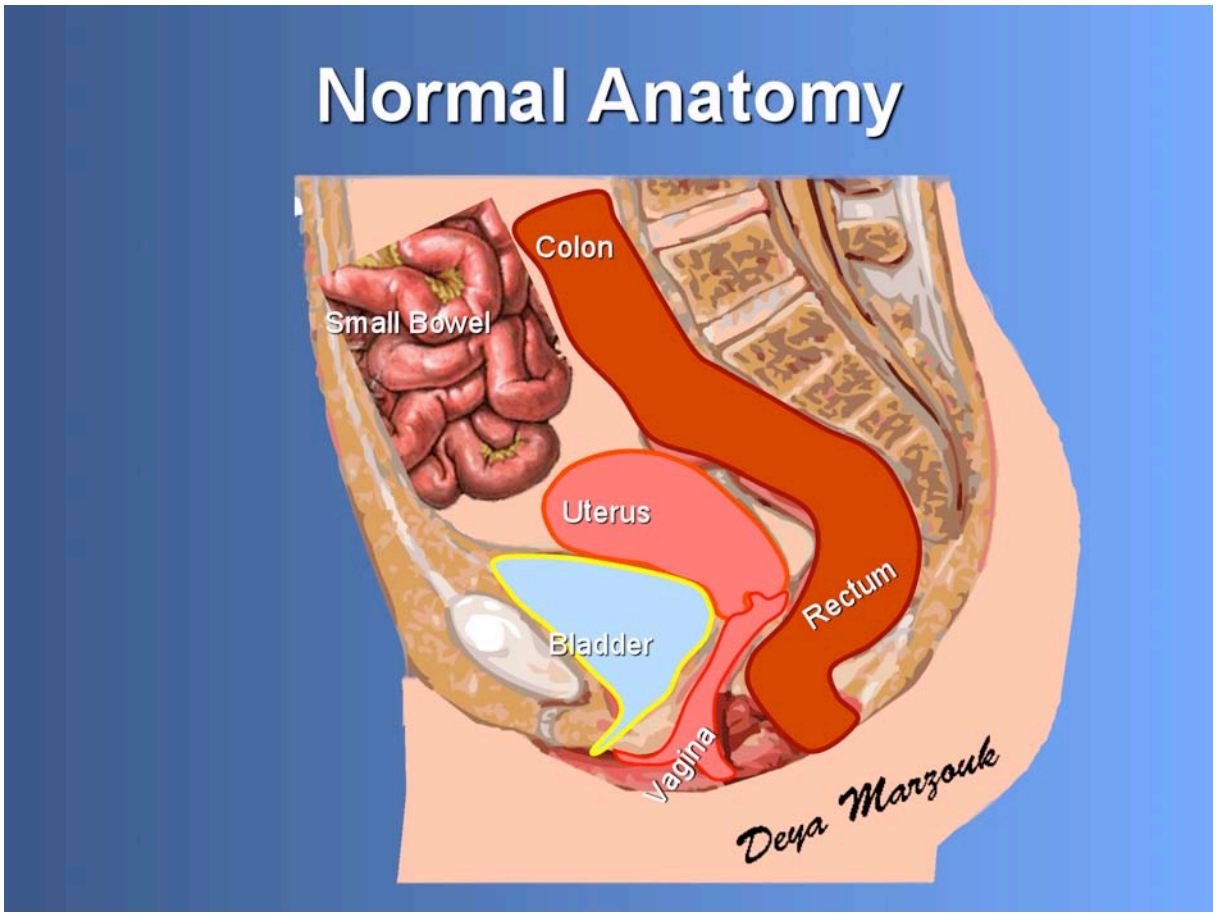
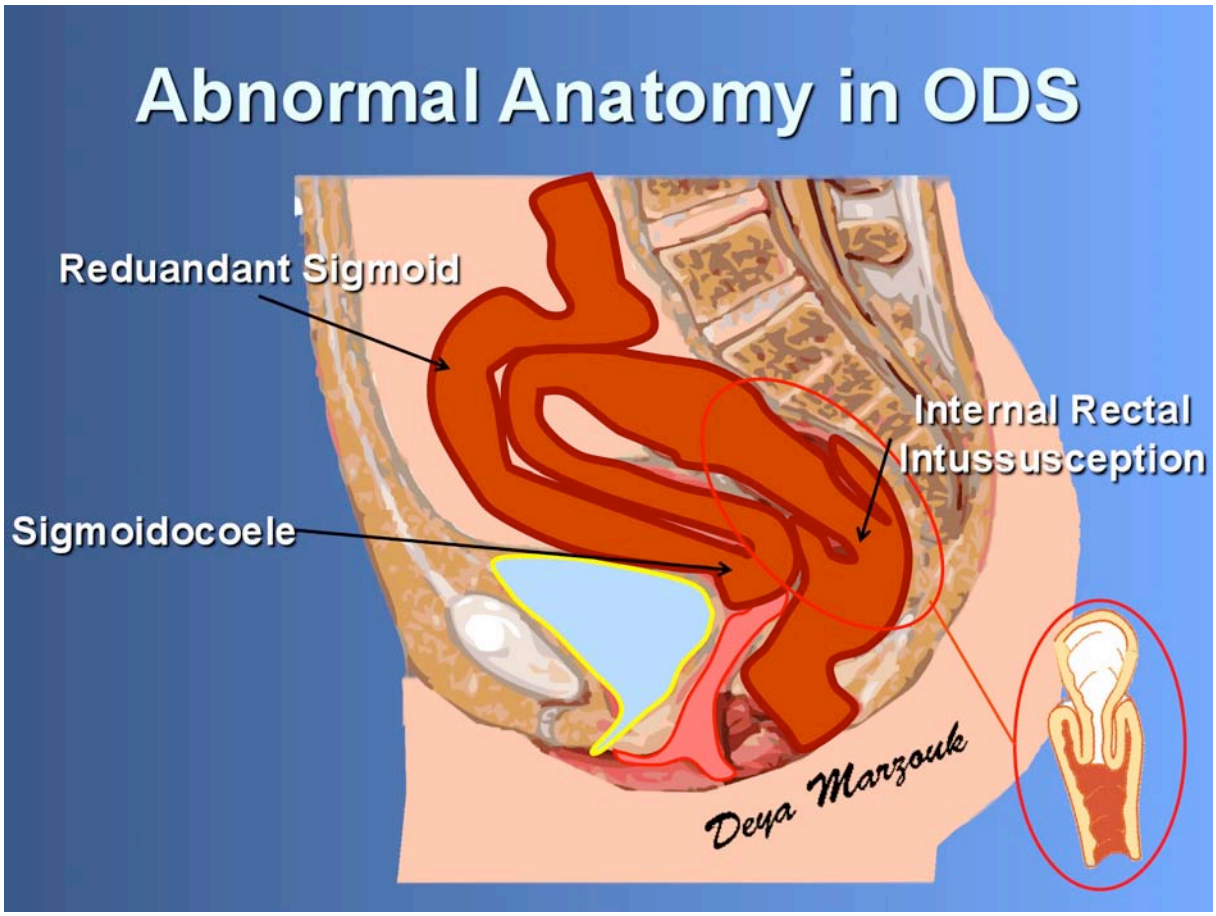
Introduction
This leaflet is about the procedure known as resection-rectopexy for internal & external prolapse of the rectum. It briefly explains what is involved in the surgery, and some of the more common complications that may be associated with this procedure that you need to be aware of. This leaflet is not meant to replace discussing this operation with your surgeon.

Prolapse of the rectum & Obstructed Defaecation Syndrome
The residue of food [waste] that remains following digestion passes to the colon (large bowel), and becomes faeces. The colon absorbs most of the remaining water in the residue, making the faeces more solid. The faeces are stored in the left side of the colon as well as in the rectum.
When the rectum becomes full, patients will normally get the desire to defaecate.

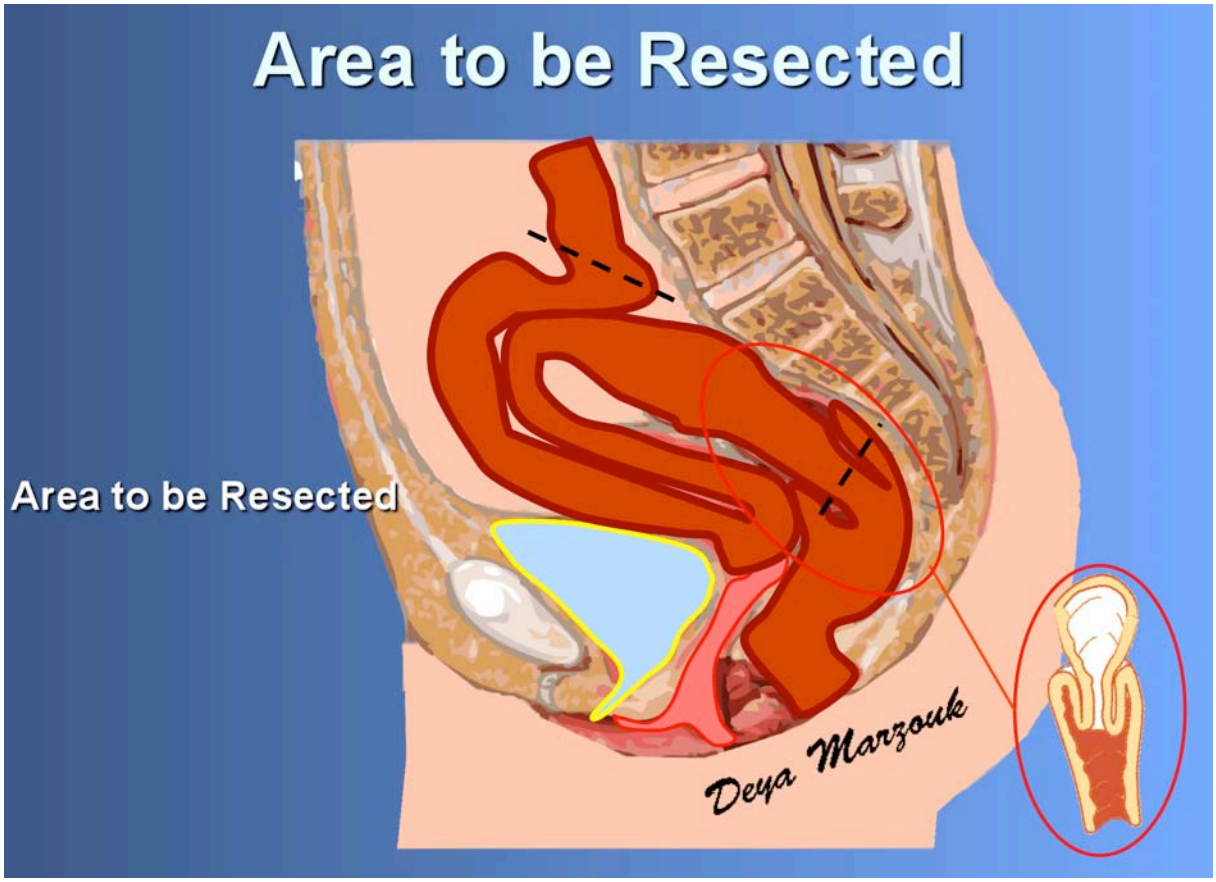


Defaecation is a complex process, which depends on many factors, but in general it follows widespread contractions of the colon [called mass colonic movements], which normally occurs once or twice per day in most patients. This normally initiates defaecation [if patient responds to the call to stools and does not suppress it]. Many patients also aid the process by straining, which increases the pressure inside the abdomen [tummy] and press on the upper rectum helping in pushing the faeces out through the anus (back passage) when going to the toilet.

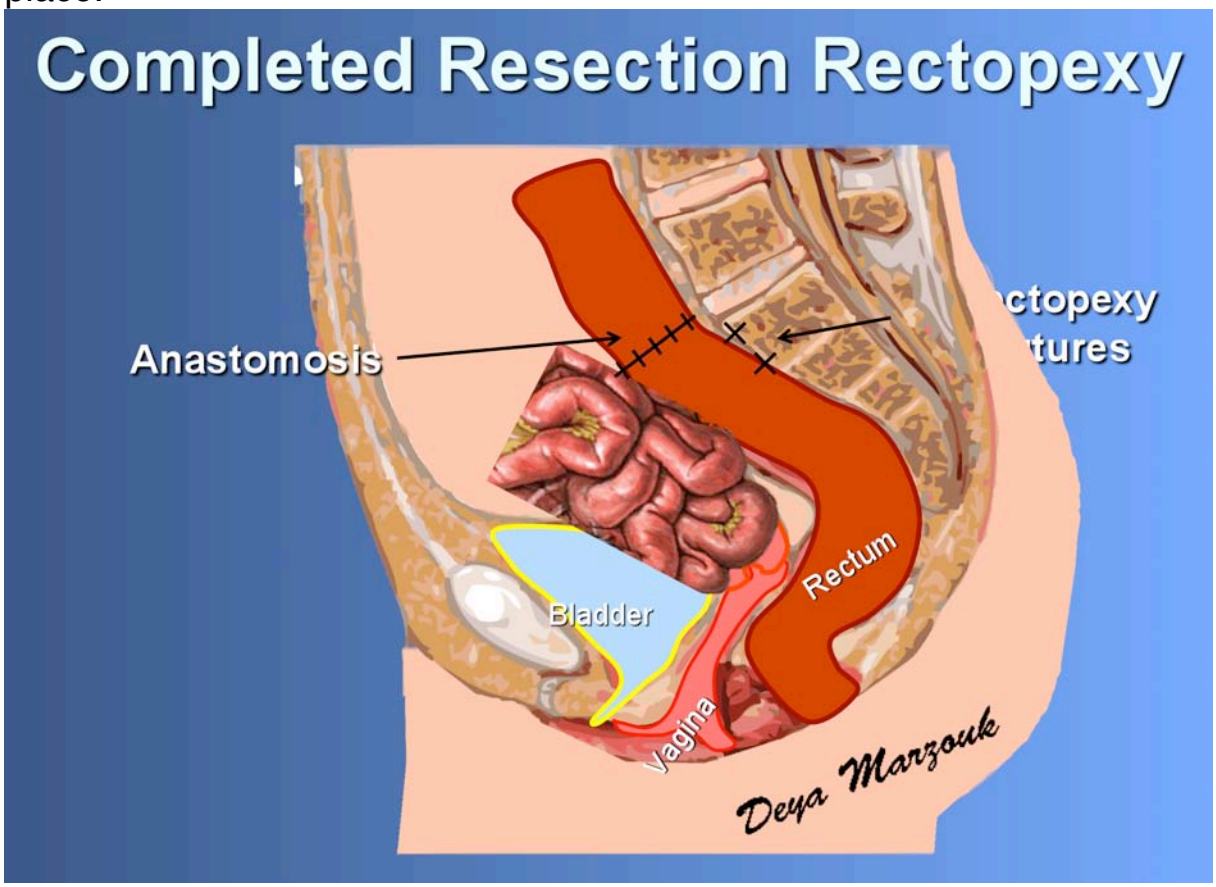
In patients with pelvic floor problems, including rectal prolapse, whether it is external [prolaping outside the anus] or internal [prolapsing into itself and causing defaecation difficulties], the defaecation process is disordered and many patients strain excessively worsening their prolapse eventually necessitating operation to correct the problem.
Difficulties in evacuation or emptying of the rectum is called obstructed defaecation (OD), as opposed to constipation which refers to infrequent opening of bowels less than once every 3 days or passing very hard faeces. Further information on the subject can be found in the net in www.obstructed-defaecation.com



What is an Anterior Resection-Rectopexy?
This operation is necessary to remove the redundant segment of the colon which is prolapsing inside or outside the back passage and prevent bowel angulation [which may cause further postoperative defaecation difficulties] following fixing the prolapsed rectum to its original place in the abdomen. The operation removes the segment of the colon known as the sigmoid. Some patients may require removal of more adjacent bowel including part of the upper rectum or the descending colon as well



The operation may be performed laparoscopically [key-hole] or by open surgery, removing redundant colon, joining the two ends of bowel together, by stitches or staples & fixing the rectum back in place.



The operation will usually take between 2 and 4 hours.
A cut or cuts will be made in your abdomen (tummy). The wound(s) will be closed with clips or stiches. These will need removal in about 7 to10 days [sometimes absorbale sutures may be used, these will dissolve on their own].

Possibility of a temporary "bag"
It may also be necessary to have a temporary loop ileostomy (opening in the small intestine to divert faeces from the healing new joint in the bowel). This is commonly known to the public as a "bag" A loop ileostomy is done by bringing a loop of small bowel to the surface, making a hole in it and stitching to the skin in the abdomen. Bowel waste that comes out of the ileostomy is collected in a bag that covers it.
A specialist nurse [called stoma nurse] will discuss this with you and also mark a suitable site on your tummy in case an ileostomy is necessary.

Should a temporary loop ileostomy be necessary, a second, smaller operation can be performed to put the bowel back inside your abdomen. The timing of this is variable and is dependent on healing of the new joint in the bowel [as tested by special x-rays]

Informed consent & risks of surgery
Before your operation, your consultant surgeon or his registrar will explain the procedure involved, although details will vary according to each individual case. You will need to sign a consent form to confirm that you agree to have surgery.

Removing part of the bowel is a major operation. As with any surgery there are risks with the operation.

What risks are there in having this procedure?

<u>I. Specific Complications:</u>

Anastomotic leak:
Sometimes the anastomosis (joint in the bowel) leaks. Treatment with antibiotics and resting the bowel is generally successful. However, this can be a very serious complication and sometimes surgery to clean the effects of the leakage and form a stoma "bag" may be required.

Ileus (paralysis of the bowel) and small bowel obstruction:

Sometimes normal bowel function is delayed following surgery and patients may require intravenous fluids for a few days. They may also need a nasogastric tube to empty the stoch & prevent vomiting. Rarely bowel may become obstructed and an operation may be required.

Nerve damage (Bladder & sexual dysfunction):
The operation is carried out in close proximity to nerves that control bladder function as well as ejaculation and erection. These nerves may become damaged, especially in patients who had previous surgery or radiotherapy, causing bladder & sexual dysfunction. Some may have problems passing urine, often temporary, but sometimes requiring prolonged catheter drainage of bladder or even operations on the prostate [in men]. Some men may have problems with erection and ejaculation. Rarely women may have decreased sexual libido.
The deep pelvic dissection in this operation [which is necessary to prevent recurrence] can cause a loss of the sensation of rectal filling for a year or more.

II. General Complications (After any major operation):

Chest infection:
The risk of chest infection increases in patients who smoke. You should stop smoking at least 10 days before your surgery & not resume until you have gone home. Patients with emphysema, chronic bronchitis or recent chest infections are also at increased risk. You can also help by practicing deep breathing exercises and following the instructions of the chest physiotherapist.

Wound infection & MRSA Infection:
The risk of this is increased with bowel surgery. Antibiotics will usually be given to help reduce the risk. MRSA is not common.

Deep venous thrombosis (blood clot in the leg) & Pulmonary Embolism (blood clot in the lungs)
Major surgery carries a risk of clot formation in the leg. Rarely a blood clot from the leg can break off, and become lodged in the lungs. This can be serious & rarely fatal.
A small dose of heparin (blood thinning medication) will be injected once or twice daily until you go home. You can help by moving around as much as you are able and in particular regularly exercising your legs. You may also be fitted with some support

stockings for the duration of your stay in hospital.

Bleeding
Bleeding sometimes occur during the surgery. The risk increases in patients who had previous surgery or radiotherapy. A blood transfusion may be needed. Rarely, further surgery may be required.

Risk to life
Surgery on large bowel is classified as major surgery. It carries a risk to your life [1-3% death rate]. Patients with major heart, lung disorders or diabetes may have higher risk. Your anaesthetist or surgeon can discuss this risk with you.

What are the benefits / pitfalls of this procedure?

The operation aims to correct the prolapse and defaecation mechanics.

IT DOES NOT AFFECT PAIN ASSOCIATED WITH PROLAPSE
Patients must not assume that it will make any difference to any pre-existing pain or failure of sensation of rectal filling

The operation DOES NOT CURE symptoms of obstructed defaecation or bowel incontinence. It merely improves symptoms to make situation more manageable for patients after the operation, often with continued medical help. Your surgeon will discuss this with you in more detail.

Most people will not experience any serious complications from their surgery. However, risks do increase with age and for those who already have heart, chest or other medical conditions such as diabetes or if you are overweight or smoke.

When you come into hospital
In preparation for the operation you will be given a strong laxative to clear the bowel. You may have already experienced in preparation for the colonoscopy. You will be given fluids only during this time. It is important that you drink plenty to reduce the risk of dehydration.
You will not be allowed **anything** to eat for 6 hours before surgery. You will be advised when to stop drinking water (2 to 6 hours before surgery). This is to allow the stomach to empty to prevent vomiting during the operation. However, any important medication will be given with a small amount of water.

Pain relief will be discussed with you by your anaesthetist. You may be given analgesia (painkillers) through an epidural (tube in your back) or through a drip in your arm in the form of a PCA (patient controlled analgesia) hand held pump. This means you control the amount of painkiller you require. Epidural is less likely if your operation will be key hole.

After your operation

You may have:

- Continuous oxygen by a face mask or small tube placed to your nose
- A tube in your nose, which passes into your stomach, to keep your stomach empty and to stop you from feeling sick
- An intravenous infusion (drip tube), usually in your arm to feed you with fluids and often used to give drugs as well
- A catheter (tube) in your bladder to drain urine
- Abdominal drain to clear away any oozing fluids around the operation site inside
- A stoma appliance bag on your tummy
- An epidural tube in the back for pain relief or in the arm (PCA) for pain relief

Most of the tubes are put in place while you are under anaesthetic. Over a period of 1 to 5 days many or all of these tubes will be removed.

When can I start to eat and drink?

People recover from surgery at different rates. Most patient can start drinking on the day following the surgery & may start eating one or 2 days later. In some cases, bowel function may be slow to start and diet and fluids may have to be restricted for a few days.

Discharge home

The average stay in hospital is 2-3 days after a laparoscopic operation & 5 to 12 days after an open procedure. However, you may need to stay in longer.

Activity

Following your operation you will feel tired and weak. This is normal, as full recovery may take several weeks. It is necessary to make sure that there is someone to help with getting meals, cleaning your home and do the shopping. For the first one or two weeks you may find that you tire easily. Alternate short periods of light activity with periods of rest. A short

sleep in the day is often helpful during the first 2 to 3 weeks after discharge home. It is however important to mobilize as much as you can, as inactivity & staying in bed for too long increases the risk of developing a thrombosis. Try to take some gentle exercise, like walking around the home or garden.

Lifting
For the first 12 weeks you are advised not to lift anything heavy such as shopping or wet washing, and not to do anything strenuous like digging the garden or mowing the lawn.

Driving
You should not drive until you can do an emergency stop, and you must be able to do this without hesitation caused by fear that your wound will hurt. You may wish to consult your GP before driving again. It is also advisable to check your car insurance policy, as there may be a clause in it about driving after operations.

Aches
You may feel some pain and 'twinges' around your abdominal wounds for several months. This is normal as it takes a while for full healing to take place. Taking a mild painkiller once in a while may help. If the pain does not seem to improve, contact your GP or the hospital.

Sex
You may resume sexual activity when it is comfortable for you.

Return to work
The length of time between your return to work following this type of surgery will depend upon the type of work you do. Ask your GP or surgeon for advice.

About this information
East Kent NHS Hospitals Trust
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This guide is provided for general information only and is not a substitute for professional medical advice. Every effort is taken to ensure that this information is accurate and consistent with current knowledge and practice at the time of publication.

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