Subtotal Colectomy

This leaflet tells you about the procedure known as a subtotal colectomy. It explains what is involved and some of the common complications that are associated with bowel surgery. It is not intended to replace any discussion between you and the health care team, but is to be used as a guide in addition to what is discussed.

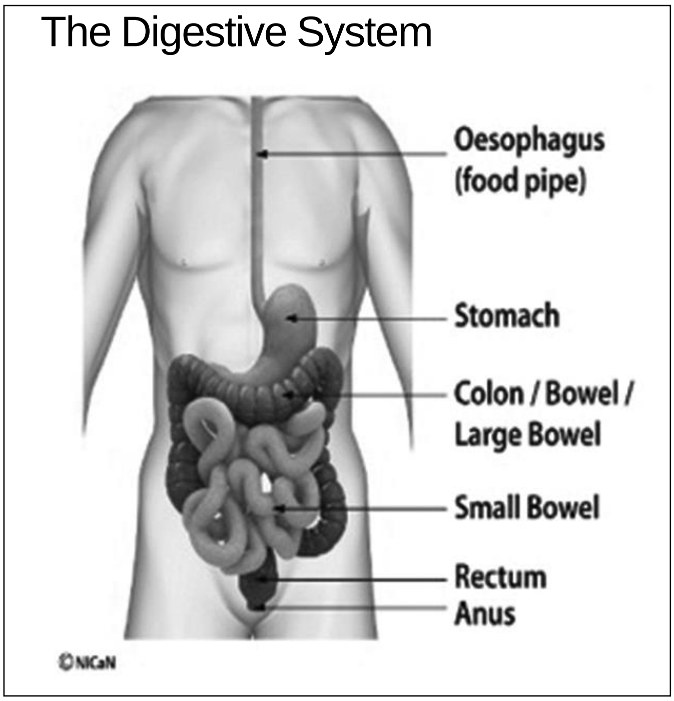
The digestive tract

To help you understand your operation you may find it helpful to have some understanding of how your digestive system works.

When you eat food it travels down your oesophagus (food pipe) and from here it passes in to your stomach. In the stomach food is turned in to a semi-liquid consistency. It then continues through the small intestine (small bowel), a coiled tube many feet long where food is digested and nutrients are absorbed. This is then passed into the colon (large bowel), a wider, shorter tube, where it becomes faeces (stools). The main function of the colon is to absorb water into our bodies making the stool more solid.

The stools then enter the storage area called the rectum. When the rectum is full, we get the urge to open our bowels. The stools are finally passed through the anus (back passage) when going to the toilet.

The diagram below helps to explain this process.



What is a subtotal colectomy?

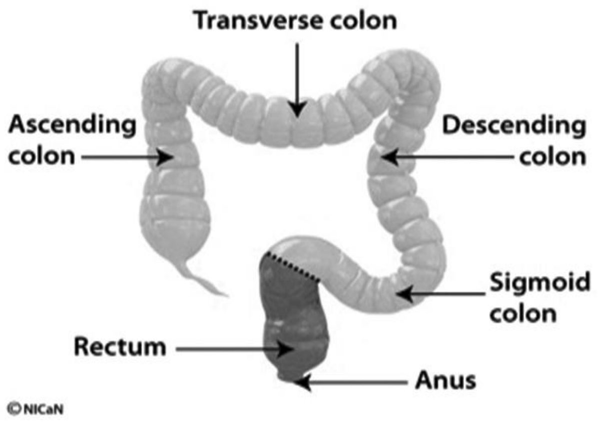
Your operation is called a subtotal colectomy and is necessary to remove the area of colon (large bowel) that is diseased. Your rectum and anus are left intact. This could be for a non-cancer (benign) bowel disease or for a cancer (malignant). Depending on the reason for your surgery, there are two possible outcomes. The first is when the surgeon removes your large bowel and the small bowel is then joined to the rectum. This is called an ileorectal anastomosis.

The second outcome is when an ileostomy (stoma or bag) is created which may be temporary or permanent. With this operation the surgeon will remove the large bowel, but instead of joining the small bowel to the rectum, the end of your small bowel (ileum) is brought to the surface as a stoma. Bowel waste passes out through this into a bag (or pouch) that you stick to your tummy. Your rectum will be oversewn inside as it will be not be used whilst you have a stoma. Your clinical nurse specialist will explain more about this.

When you are fit enough it may be possible to have further surgery to have the stoma reversed and the small bowel joined to the rectum. Your future options can be discussed with your surgeon and clinical nurse specialist.

The diagram below helps to explain the procedure.

Total Colectomy



Surgery is performed under a general anaesthetic. It is likely that your operation will be performed using keyhole surgery. In this instance, you will avoid having a large open wound. The benefits of keyhole surgery are:

- A shorter hospital stay
- No large open wound, only 3–4 small ones
- Less visible scarring
- Less pain from incisions

These options will be discussed with you by your medical team. Occasionally it may be necessary to ‘open’ the abdomen with a larger cut.

What risks are involved with this procedure?

Surgery to remove part of your bowel is a major operation, and there are risks associated with it that you need to be aware of. Some of these risks are discussed below:

Chest infection: it is important to be able to deep breathe and cough after your operation to avoid developing breathing problems. The physiotherapist and nursing staff will help you to do this.

Wound infection: if you develop a wound infection, you may require antibiotics via a drip in your arm or tablets. Your wound will be reviewed regularly during your stay and will be dressed as needed.

Ileus (paralysis of the bowel): this is a particular risk of bowel surgery. Sometimes, the bowel is slow to start working after your operation, or can become obstructed. If this occurs, the bowel may need to be rested and a drip (fluid given via a vein in your arm) is used to replace fluids instead of drinking. You may also need to have a tube in your nose that will prevent you from vomiting. This will stay in until your bowel starts to work again.

Thrombosis (blood clot in the leg): major surgery carries a risk of clot formation in your leg. You can help yourself by mobilizing as quickly as possible following your surgery and doing leg exercises in bed. The physiotherapist and ward staff can help you with this. It is advisable to wear the support stockings that you are given for the duration of your stay. In addition you will have daily injections that will help to thin your blood.
These will continue when you go home and the ward will discharge you with your own supply. The nursing staff will teach you how to do the injection, so that you can inject yourself at home.

Pulmonary embolism (PE): occasionally, a blood clot can break off from your leg and travel to your lung. This does not happen very often but if it does, we would be able to treat you.

Bleeding: bleeding is rare, but if it does occur a blood transfusion may be required.

Risk to life: abdominal surgery is major surgery, and this can carry a risk to your life. This risk increases for those who already have medical conditions such as diabetes, breathing problems or a heart condition. Your risk also increases if you smoke or are overweight. However, it is important to note that most people will not experience any serious complications, but it is something you need to be aware of.

Your surgeon will discuss the risks with you pre operatively so that you can make an informed decision about the surgery and the risks to you personally.

What are the benefits of this procedure?

This operation will remove the diseased part of your bowel and will give you a significant improvement in your quality of life. You should feel well again so that you can begin to lead a normal life and resume activities that you have previously not been able to do.

What are the alternatives?

If this operation has been offered to you by your surgeon as the recommended treatment, then not having the surgery is very likely to lead to further worsening of your health. Depending on what is wrong with you, you may develop a blockage of the bowel, leakage of the bowel content into your abdomen, or an abscess, all of which can be life threatening. If you have cancer the longer it remains the more likely it will spread and become incurable.

Before the operation

Unless your operation is done as an emergency, it is important beforehand that you try and prepare yourself physically. If you are able, try and maintain a balanced, healthy diet. Take some gentle exercise, and if you smoke it is strongly advised that you attempt to stop.

Before your operation you will meet with one of the colorectal nurse specialists, who will be able to discuss with you any questions that you may have about the surgery and the stoma. If appropriate the nurse specialist will also provide you with a teaching pack that prepares you for how to care for your stoma.

Pre-screening clinic

About a week before your operation you will have an appointment to attend the pre-screening clinic in the Outpatients Department. At this appointment a nurse will discuss your admission and tell you what to expect. They will complete a health questionnaire with you. They will also carry out a number of tests which may include a blood test, a chest x-ray and a tracing of your heart (ECG). These are to check that you are fit for the anaesthetic; you will also be given some pre operative bowel clearing medicine and some carbohydrate drinks and instructions about taking them. We wish to understand what help and support, if any, you will need on your discharge from hospital so it is very important that you attend this appointment.

Your admission to hospital

If you are not already an inpatient, it is most likely that you will be admitted to the admissions lounge on the day of your surgery. You will receive a letter in the post to confirm this. In the admissions lounge you will meet with a member of the nursing staff who will get you ready for theatre. You will also meet with an anaesthetist where you will have the opportunity to discuss any concerns. A member of the medical team will also meet with you so that you can sign a consent form if you have not already done so.

If a stoma is planned as part of your operation the colorectal nurse specialist will visit to put a mark on your tummy where the stoma will be. You will have the opportunity to discuss this if you haven’t already done so in clinic.

If your admission letter does not ask you to come to the admissions lounge, it means that you will be admitted to a ward, usually the day before your surgery. The letter will tell you to phone the ward before you come into hospital to check that a bed is available.

After your operation

When you return from theatre you will have several drips and tubes attached to you. These are all necessary for your recovery, but will be removed after a couple of days as your condition improves. You will have:

- **A catheter:** this is a tube that is put in to your bladder to allow your urine to flow freely without having to go to the toilet. This is used so that your kidney function can be monitored
- **Naso-gastric tube:** this tube is put in to your nose and sits in your tummy to prevent you from being sick

- **Drip:** you will have a drip connected to a tube in your hand/arm or neck that will give you fluids to keep you hydrated. This will be stopped once you are eating and drinking sufficiently
- **Epidural or PCA:** to manage your pain you may have an epidural. This is a small tube that sits in your back which delivers continuous pain medication. If the anaesthetist decides not to give you an epidural you will have a PCA (patient controlled analgesia). The PCA is connected via a tube in to your vein and pain killers are delivered each time you press the button. This means that you will be in control of the amount of pain relief you receive. For the first few days the specialist pain nurses will review your pain on a daily basis and discuss any concerns with you. Whilst you have your PCA or epidural you will be attached to a monitor that will record your pulse, respiration rate and blood pressure. These readings will be recorded very frequently when you first come back from theatre. Around 1-2 days following your surgery, the epidural/PCA will be stopped and you will be given oral analgesia to take for your pain.
- **Drains**: initially, you may have a drain in your abdomen but this will be removed after a few days.
- **Stoma:** when you return from theatre you will have a clear bag on your stoma, and it will be checked by the nursing staff to check it is healthy.
- **Abdominal wound:** If you have had an open procedure, you will have a cut on your abdomen. If your operation was keyhole, you will have 3–4 small wounds
- **Diet and fluids:** you will be allowed to eat and drink straight away following your surgery. We advise that to begin with you have a low fibre diet (food that is easy for you to digest). If you are not sure what options to choose from your menu sheet, please ask the nursing staff for advice. Initially you may only be able to take small amounts, but this is normal. Your appetite will gradually return as you improve

Stoma care and what to expect from your ileostomy

Initially, you may only have wind (flatus) passing in to your stoma bag, and the stoma will be swollen with stitches around it. This swelling will reduce over time and the stitches will dissolve. It should be pink in colour, similar to the inside of your mouth. The waste that comes in to the bag is normally a porridge consistency, although it may be liquid initially. The stoma will work throughout the day and you will need to wear the bag all the time. The bag will need to be emptied 4-6 times a day on average. Most patients change the bag approximately every other day, depending on personal preference.

As you recover from the operation the colorectal nurse specialists will begin to teach you how to look after your stoma. You will be encouraged to participate until you are able to manage it independently.

Once you are confident that you will manage at home we will start to plan for your discharge from hospital. Information will be provided to you regarding your stoma bag supplies and prescription details. Once at home you will receive an appointment to attend stoma clinic for follow up so that the colorectal nurse specialists can check that you are managing your stoma care at home. You will also be followed up by your surgeon who will see you in clinic.

It may take 2–3 months before you feel fully back to normal and regained your usual strength. Any effort such as climbing the stairs will leave you feeling very weak but this is normal and you will gradually improve. Again, your appetite will improve as time passes. Most people are able to eat regular meals and know when to empty the bag before it gets too full.

Information for Patients

The information in this booklet is not intended to be exhaustive, and we understand that you may still have many questions. We are available to discuss your surgery and concerns before and after your operation. If we are unavailable we will return your call if you leave a message.

Contact us

Colorectal Nurse Specialists	**(24hr answer phone)**
Heartlands/Solihull Hospital	**0121 424 2730**
Good Hope Hospital	**0121 424 7429**
Queen Elizabeth Hospital	**0121 371 4501** colorectalnursingcns@uhb.nhs.uk

Follow us on Twitter @uhbcolorectal

Other useful addresses

Ileostomy Association
Birmingham branch: 0121 3552745/07842 555070
Email: Mike Jameson mike.jameson@iasupport.org
www.birmingham.iasupport.org

National Key Scheme
From RADAR
Tel: 0121 616 2942
Website: www.radar.org.uk

If you require this information in another format, such as a different language, large print, braille or audio version please ask a member of staff or email patientexperience@uhb.nhs.uk.