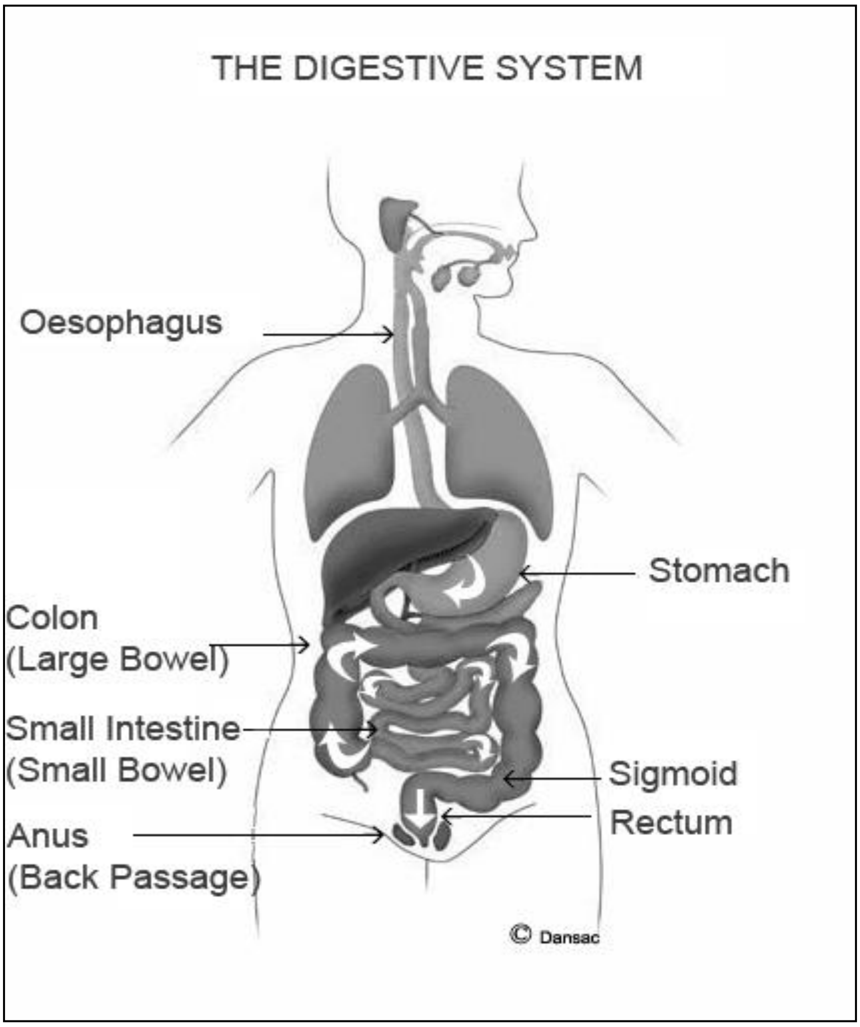
Hartmann's Procedure - Your operation explained

Introduction

This leaflet tells you about the operation known as Hartmann's procedure. It explains what is involved and some of the common complications associated with this procedure that you need to be aware of. It does not replace the discussion between you and your consultant surgeon but helps you to understand more about what is discussed.

The digestive system

To understand your operation it helps to have some knowledge of how your body works (see drawing below).



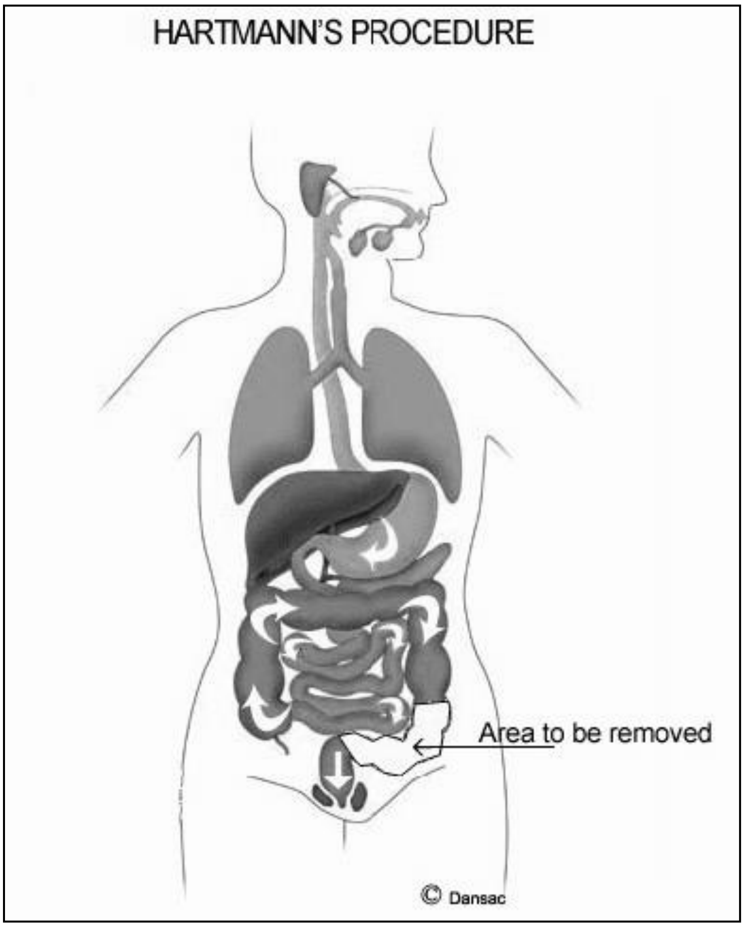
When food is eaten it passes from the mouth down the oesophagus (food pipe) into the stomach where it is broken down and becomes semi-liquid. It then continues through the small intestine (small bowel), a coiled tube many feet long where food is digested and nutrients (things your body needs) are absorbed.

The semi-liquid food is then passed into the colon (large bowel), a wider, shorter tube, where it becomes faeces (waste). The main job of the colon is to absorb water into our bodies so making the faeces more solid.

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

What is Hartmann's Procedure?

This operation is necessary to remove the area of bowel that is diseased. The operation removes the piece of your bowel and rectum shown in the diagram below.



This operation is sometimes used as an emergency procedure when the bowel is either obstructed (blocked) or perforated (has a hole in it).

If this is a planned procedure then it may be carried out because the risk of forming a join in the bowel is considered to be too high. This is usually because other medical problems that you may have complicate the surgery.

A cut will be made in your abdomen (tummy). The consultant surgeon will remove the diseased area of bowel and make a colostomy. A colostomy is the end of the colon brought to the surface and stitched to the skin through a small cut in the abdomen. Faecal waste is then passed through the colostomy and collected in a bag that sticks to the skin (stoma). In some cases, it is possible to have this type of colostomy reversed – your consultant surgeon will discuss this with you. The wound on your abdomen will be closed either with clips or stitches. Any visible stitches or clips will need to be removed in about 7 to 12 days.

If this is a planned procedure, your consultant surgeon and colorectal nurse will carefully explain the procedure involved before your operation, 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.

What risks are there in having this procedure?

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

Nerve damage:
The operation is very close to the muscle in the back passage (anal sphincter). This may become bruised causing a loss of sensation which occasionally leads to slight incontinence of wind and/or faeces in the early days after your operation.

The operation is also very close to the bladder and nerves responsible for sexual function. Bladder and sexual function may be disturbed although the risk is small and often temporary. Some men may have problems with erection and ejaculation. Some may have problems passing urine.

Ileus (paralysis of the bowel) and small bowel obstruction:
Sometimes the bowel is slow to start working after surgery (ileus) or can be obstructed.

If this happens the bowel may need to be rested and a drip (a tube into a vein in your arm) is used to replace fluids (instead of drinking). In addition, you may need a nasogastric tube (tube in your nose which passes into your stomach) which in most cases will prevent vomiting. These will remain in place until the bowel recovers.

Sometimes if the bowel is obstructed an operation may be required.

Possible stoma problems:

- Necrotic stoma (reduced blood supply to the stoma). This may need further surgery.
- Stomas prolapse (when the stoma comes out too far past the skin). In serious cases further surgery may be needed.
- Parastomal hernia (when the bowel pushes through a weak point in the abdominal muscle wall). Small hernias can be treated with a support garment or belt. Surgery may be needed for larger hernias.

What are the risks after the operation?

Risks are possible after any major operation. These include:

Chest infection:
You can help by practising deep breathing exercises and following the instructions of the physiotherapist. If you smoke, we strongly advise you to stop.

Wound infection:
This is increased with bowel surgery. Antibiotics will usually be given through a drip to help reduce the risk of this happening.

Thrombosis (blood clot in the leg):
Major surgery carries a risk of clot formation in the leg. 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. If you smoke, we strongly advise you to stop.

Pulmonary embolism (blood clot in the lungs):
Rarely a blood clot from the leg can break off and become lodged in the lungs. This is treated with anticoagulant (blood thinning or clot dissolving) medication. Your doctor will explain more if this rare event occurs.

Bleeding:
A blood transfusion may be needed. Very rarely, further surgery may be required.

Risk to life:
Bowel surgery is classified as major surgery. It can carry a risk to your life. Your consultant surgeon will discuss this risk with you.

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. Your consultant surgeon will discuss these risks with you.

What are the benefits of this procedure?

The operation is to remove the diseased part of your bowel. In most cases this will give you the best chance of a cure or significant improvement in your bowel problems. Your consultant surgeon will discuss this with you in more detail.

What are the alternatives?

This operation is often performed as an emergency, when there are few other options available. Not having this operation will lead to bleeding, discharge, pain and possibly a complete blockage of the bowel.

If there is a perforation, then this part of the bowel will need to be removed, otherwise, there is a high risk of life threatening infection.

Another option is a stent (an internal splint in the bowel). A stent is a hollow tube made of a flexible alloy mesh. Stents can be rolled up tightly to the size of a bic pen to allow them to be inserted through the blockage or tumour in the bowel. Once in place, stents are allowed to expand and therefore keep open the passage through the tumour.

This may help your symptoms but will not cure the disease. Your consultant surgeon can talk to you about these options.

What are the consequences of treatment?

The diseased area of your bowel will have been removed and any symptoms you may have been experiencing before surgery will have gone.

You will then have a colostomy. You will receive a separate leaflet on the management of your colostomy. In some cases, it is possible to have this type of colostomy reversed – your consultant surgeon will discuss this with you.

The rectum (back passage) will still be present and will produce a discharge. This discharge can be slimy, blood stained or in the form of waxy or faecal pellets that you pass from time to time. If the discharge increases or smells abnormal, contact your colorectal nurse for advice.

You may have a sensation of wanting to go to the toilet through your back passage. You may also pass wind and this is quite normal.

Please do not hesitate to contact your colorectal nurse for advice.

Before the operation

While you are waiting for your operation, it is important you try to prepare yourself physically. If you are able, try and eat a well- balanced diet including: meat, fruit and vegetables. Take gentle exercise such as walking and get plenty of fresh air. If you smoke, we strongly advise you to stop.

Pre-admission clinic

To plan your operation and stay in hospital you may be asked to attend the hospital for a health check a week or two before your admission.

This can take about 2 hours. If you are taking any medications please bring them with you.
A doctor or nurse will listen to your chest, check your blood pressure and may send you for other tests, for example, a chest X-ray and an ECG (electrocardiograph – a tracing of your heart). This information will help the anaesthetist plan the best general anaesthetic for you.

Blood will also be taken to check for any abnormalities so that these can be corrected before your operation.

A nurse may also ask questions relating to your health and to your home circumstances. If you live alone and have no friends or family to help you, please let us know and we will try and organise some help or care for you. A social worker may come and discuss these arrangements with you after you are admitted.

When you come into hospital

In preparation for the operation you may be given a strong laxative to clear the bowel. You may have already experienced this during some of the investigations. Details of the laxative will be discussed with you. 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.

A nurse will take you to theatre. Your operation will usually take between 2 to 4 hours.

Whenever possible, prior to your operation, a stoma nurse will explain what is involved in caring for your colostomy bag.

After your operation

Immediately after surgery you may have a number of tubes attached to your body. You may have:

- 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.
- A tube, either in your arm (PCA) or in your back (epidural), slowly releasing medication to ease any pain.
- Drainage tubes at the site of the operation to clear away any oozing fluids around the operation site inside.
- A nasogastric tube which passes into your stomach, to keep your stomach empty and to stop you from feeling sick.
- Continuous oxygen by a face mask or small tube placed to your nose.
- A stoma appliance (bag) on your tummy.

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.

People recover from surgery at different rates. The average stay in hospital is 5 to 12 days, however, you may need to stay in longer.

This will be discussed with you by your consultant surgeon or colorectal nurse.

About 2 to 3 weeks after your surgery a report on the piece of bowel removed at operation will be sent to your consultant surgeon.

Dependent upon the results, further treatment may be offered, the details of which will be discussed with you. If there is an option for further treatment such as chemotherapy, an appointment will sometimes be made directly with an oncologist. This will allow treatment to start sooner after surgery.

The colorectal nurse will see you on a regular basis to provide support, discuss your progress and teach you how to manage your colostomy. You will need to be able to care for your colostomy yourself before you go home. Support from a colorectal nurse will continue after discharge.

When can I start to eat and drink?

Your bowel function may rapidly return to normal. If this is the case, you will be able to eat and drink soon after your surgery.

In some cases, bowel function may be slow to start and diet and fluids may have to be restricted for a few days.
After your operation, your consultant surgeon will advise you which will be appropriate for you.
If you have any questions about your diet, please ask your colorectal nurse who can advise you.

Discharge home

Following your operation you will feel tired and weak, but as full recovery may take several weeks, there is no need to stay in hospital. In fact many people report that they feel better sooner in their home. However, it will be necessary to make sure that there is someone to help with getting meals, cleaning your home and shopping.

For the first week or so you may find that you tire easily. Try to alternate short bursts of light activity with periods of rest. A short sleep in the day is often helpful during the first 2 or 3 weeks after discharge home. It is unwise to stay in bed for too long though as this slows down the circulation of the blood and increases the risk of developing a thrombosis. Try to take some gentle exercise, like walking around the home or garden.

For the first 6 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.

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. Your doctor (GP or hospital consultant) will tell you when it is safe for you to start driving again. You are advised to contact your insurance company and seek advice first.

You may feel some pain and ‘twinges’ around your wound for several months. This is normal as it takes a while for full healing to take place. Taking a mild painkiller regularly will help you feel better and aid your recovery. If the pain does not seem to improve or you are worried, contact your GP or colorectal nurse.

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 consultant surgeon for advice. You may resume sexual intercourse when it is comfortable for you. If you are unsure, please speak to your GP, consultant surgeon or colorectal nurse.

Within a few weeks you will normally be sent an appointment to see your consultant surgeon. If the results on the piece of bowel removed during the operation are not available to give to you before you go home, an earlier outpatient appointment may be arranged to see your consultant surgeon or colorectal nurse.

Glossary of medical terms:

Anaesthetist: a person specially trained to administer anaesthetics.

Analgesia: painkiller.

Colostomy / stoma: a colostomy is the end of the colon brought to the surface and stitched to the skin through a small cut in the abdomen. Faecal waste is then passed through the colostomy and collected in a bag that sticks to the skin.

Intravenous infusion: fluids given into a vein.

Nasogastric tube: a tube in your nose which passes into your stomach.

Obstruction: a blockage in the bowel.

Patient Controlled Analgesia (PCA): a means for patients to self- administer pain medications by using a computerized pump, which introduces specific doses into an intravenous line (into a vein).

Perforation: a hole in the bowel.

Rectum: the outermost portion of the large intestine. Faeces are stored in the rectum until they are passed out of the body through the anus.

Stent: a hollow tube made of a flexible alloy mesh used to keep open the passage through the tumour.

University Hospital Birmingham NHS Foundation Trust:

Colorectal Nurse Specialist Teams (24 hour answerphone)
Heartlands/Solihull Hospitals Telephone: 0121 424 2730
Good Hope Hospital Telephone: 0121 424 7429
Queen Elizabeth Hospital Telephone: 0121 371 4501   Email: colorectalnursingcns@uhb.nhs.uk

The Patrick Room Cancer Centre
Queen Elizabeth Hospital Edgbaston
Birmingham B15 2TH Telephone: 0121 697 8417

Cancer Information and Support Centre Good Hope Hospital
Rectory Road
Sutton Coldfield B75 7RR Telephone: 0121 424 9486

Health Information Centre Birmingham Heartlands Hospital Bordesley Green
Birmingham B9 5SS Telephone: 0121 424 2280

Further Support:

Local:
Birmingham Cancer Support Centre (Help Harry Help Others): 0121 783 5407; www.hhho.org.uk
Sutton Cancer Support Centre: 0300 012 0245; www.suttoncancersupport.org
The Holly Trust (Bowel cancer support group): www.hollytrust.org.uk

National:
Bowel cancer UK
Call us on 020 7940 1760. We're open Monday to Friday 9am-5pm
Email us at admin@bowelcanceruk.org.uk

Colostomy UK
Helpline open 24 hours a day: 0800 328 4257
hello@colostomyuk.org
www.colostomyuk.org

Beating Bowel Cancer
Beating Bowel cancer provide medical advice to patients through a specialist nurse advisor line on 08450 719301 or
Email nurse@beatingbowelcancer.org
Website: http://www.beatingbowelcancer.org/

Patient Voices

The Patient Voices Group is part of Beating Bowel Cancer and is the only UK national patient-to-patient network for people with bowel cancer.

The group has also expanded to include close relatives of bowel cancer patients. Members of the group are willing to help in a number of ways including patient to patient support, raising awareness, and fundraising.
General enquiries: 08450 719301

Macmillan Benefits

Advisor present

Alternate Tuesdays at Good Hope Hospital Sheldon Unit

Alternate Thursdays at Heartlands Hospital

Macmillan Cancer Line 0808 808 0000
www.macmillan.org.uk

About this information

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.

We are constantly striving to improve the quality of our information. If you have a suggestion about how this information can be improved, please contact us via our website: http://www.birminghamcancer.nhs.uk.

This information was produced by Pan Birmingham Cancer Network and was written by Consultant Surgeons, Clinical Nurse Specialists, Allied Health Professionals, Patients and Carers from the following Trusts:

Heart of England NHS Foundation Trust Sandwell and West Birmingham NHS Trust University Hospital Birmingham Foundation Trust Walsall Hospital NHS Trust

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