



University Hospitals Birmingham
NHS Foundation Trust



Preparation for Oesophagectomy

Building healthier lives

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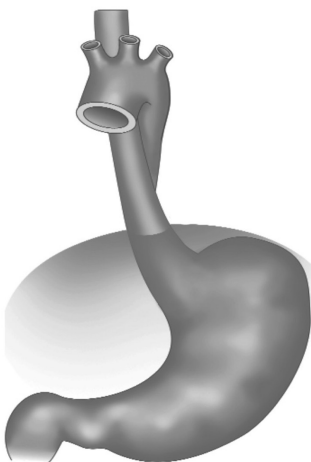
Introduction

This leaflet has been written to help you understand the operation you are about to have. It does not replace the discussion between you and your doctor but has been created to provide you with a greater understanding of what will be discussed.

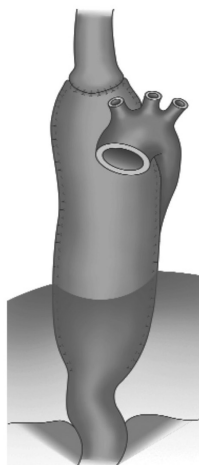
You have been advised that an operation to remove the cancer in your oesophagus (gullet) may be possible. The surgery can be performed using open surgery, laparoscopic (keyhole) surgery, or a combination of both types (hybrid). Your surgeon will decide on the most appropriate approach to remove your particular cancer.

Open operation

During the operation, a cut will be made in your abdomen, your chest and/or the left side of your neck. One of your lungs will be deflated to allow the surgeon to get access to the gullet during the surgery. Approximately two thirds of the gullet, the upper stomach and the surrounding tissue will be removed. The rest of the stomach is lengthened to form of a tube and moved upwards to the chest or neck to replace the gullet. It is joined to the remaining gullet, allowing food to pass from the mouth into the stomach and then into the rest of the intestine (see drawings below).



Before the operation



After the operation

Keyhole surgery

During the operation, small cuts will be made in your chest and abdomen, and sometimes your neck. One of your lungs may be deflated or both lungs may be gently inflated with oxygen, so that they are not fully collapsed during surgery.

Approximately two thirds of the gullet, the upper stomach and the surrounding tissue will be removed. The rest of the stomach is lengthened to form of a tube and moved upwards to the chest or neck to replace the gullet. It is joined to the remaining gullet to allow food to pass from the mouth into the stomach and then into the rest of the intestine (see drawings above).

What are the benefits?

Oesophagectomy is considered the best treatment for potentially curable oesophageal cancer. It gives good symptom relief and offers the best chance of a long-term cure.

What are the risks?

This operation is major surgery and there are risks attached to it. Make sure you discuss the possible complications with your surgeon and ask all the questions you need to. You will have a chance to ask more questions before the operation and will be asked to sign a consent form.

Possible risks are:

- Death. There is around a 5% risk of death from this procedure (around 1 in 20 patients die)
- Chest infection and pneumonia (these are common complications that occur after many operations). There are breathing exercises that you can do before and after surgery to reduce risk. If you currently smoke, stopping can significantly reduce these risks
- Heart problems, including heart attack or abnormal heart rhythms. This is due to the strain that the operation puts on the heart. You will receive heart tests before your surgery to assess your fitness for the operation

- A leak where the stomach and the gullet are stitched together
- Infection of your wounds or drain sites
- Blood clot in your legs (called deep vein thrombosis) and/or in your lung (called pulmonary embolus)
- As your stomach will be moved up into your chest, emptying can be delayed. This can lead to vomiting, a feeling of fullness and loss of appetite. The stomach usually recovers within days to weeks, but this problem can occasionally persist
- Reflux. As the valve between the gullet and stomach is removed during this operation and the stomach is moved up into the chest, stomach acid can reflux causing heartburn. This can be treated with antacid medications. Many patients need to sleep more upright after surgery

Complications can be serious and delay your recovery. Also, it may not be possible to remove the cancer, if it is more advanced than the staging investigations suggested.

Is there an alternative?

A combination of pre-operative chemotherapy followed by surgery (oesophagectomy), is presently considered the best treatment for potentially curable oesophageal cancer. A specialist multidisciplinary team (including your Surgeon) will have discussed your case in detail. Chemotherapy or endoscopic procedures are potential alternatives but are considered palliative (non-curative) only. Sometimes a combination of chemotherapy and radiotherapy may be recommended as a curative treatment, depending on the type of cancer you have.

What happens before the operation?

Before your operation you will be seen at the pre-operative assessment clinic or on the ward, where you will be asked routine health questions and about any medication you are taking. There will be an opportunity to carry out any further necessary routine tests, including blood tests, X-rays and a heart and lung assessment. You will have a chance to discuss any further concerns with the medical and nursing staff.

What can I do to get ready for my operation?

- **Stop smoking** – to help reduce the risks of breathing problems during and after your operation
- **Try to eat a well balanced diet** – to aid healing after your operation. The dietitian will advise you on this
- Try to limit your alcohol intake
- **Take some gentle exercise** – to improve your general fitness

It is also important to telephone the nurse specialist or ward if you develop an infection such as a cold, in the week before the operation.

How long will I be in hospital?

You will generally come into hospital the day before your operation or on the morning of your operation. You will remain in hospital for approximately 10 days. For some of this time you will be less mobile than usual. You may find it helpful to bring in several books, magazines or a personal stereo to avoid boredom.

Can I eat and drink?

If you are in the hospital, the nurses on the ward will advise you what you can eat and drink the evening before surgery. An intravenous infusion (drip) may be started after your evening meal. You will be kept fasting from midnight to ensure that your stomach is empty at the time of surgery. If you are coming in on the day of your surgery, you will be told when to start fasting when you come to your pre-operative assessment.

Will I go back to the ward after the operation?

After the operation you will be taken to the intensive care/high dependency unit, where your initial recovery time be closely monitored. If the intensive care/high dependency unit bed is not available, then the operation will not go ahead that day. Most patients will be awake and able to breathe for themselves within hours of the surgery. You will have an oxygen mask over your nose and mouth to support your breathing.

Who will be looking after me?

There will be a large team looking after you. The doctors and nurses will be supervising your progress. The physiotherapist will help with your breathing and mobility. You will be expected to sit out in a chair within six to 12 hours of your surgery, walk around your bed on day one after surgery, and gradually increase your mobility, so that you can walk assisted along the ward corridor, within two to three days. The dietitian will advise you on what to drink and eat.

Will it hurt?

The anaesthetist will see you before your operation. Together you can discuss an epidural or patient controlled pain relief. As you recover, you will be given tablet painkillers once you are eating and drinking. If at any time you experience any pain or discomfort, let the nurses looking after you know.

Will I be attached to any tubes?

We will use tubes and machines to monitor you closely and promote a safe, quick recovery. These are routine, so try not to be alarmed by their appearance. The following tubes may be used:

- A (central line) tube, to prevent dehydration and to allow us to monitor your fluid needs
- A (nasogastric) tube, that is placed up your nose and goes down into your stomach, to drain it and to stop you feeling sick
- A (jejunostomy) tube that goes into your abdomen to give you liquid food
- Two drains (chest drains), to remove any excess fluid from your chest
- One or more tubes (wound drains) in the abdomen. These drains stop blood, bile and tissue fluids collecting around the site of the surgery
- A tube (catheter) into your bladder to monitor the amount of urine you are passing

Once the doctors are happy with your progress these tubes will be removed.

When can I eat and drink again?

Initially after your operation you will not be able to take anything by mouth for up to five days, not even water. This allows the join (anastomosis) to heal with fewer risks of complications. You may receive liquid food via a feeding tube inserted into your small intestine at the time of surgery.

You may have a contrast swallow (X-ray) to make sure that the join has healed. You will be asked to swallow liquid barium and the radiologist will take a series of X-ray pictures to find out whether the join is intact. If the X-ray shows the join is intact, the nasogastric tube will be taken out and you will be allowed to start drinking (small amounts at first). You will be given advice on when and what to start eating. It is not unusual to experience diarrhoea. If the join has not healed completely, you will be kept fasting and we will continue to feed you through the feeding jejunostomy.

What about my family?

This is a stressful time for both you and your family and we will keep you informed on what is happening. Your family will be able to visit you, although it is worth remembering that you will need lots of rest after the operation.

Here are some important tips for you to pass on to your family and friends:

- Only two visitors are allowed per bed space whilst you are in the Intensive Care/High Dependency Unit and on the ward
- Keep visiting time short – this enables you to get rest
- Whilst the team are happy to keep family and friends informed about the patients progress, their main responsibility is the care and safety of the patient. To assist them as much as possible, please nominate one family member to ask questions and then relay progress reports back to the family
- Do not bring flowers as a gift whilst the patient is in Intensive Care/ High Dependency Unit, as they are not allowed, due to the infection risk

- Visitors should use the alcohol hand wash rub before entering the ward areas to reduce infection risks, and should not visit the hospital if they have a cough, a cold or any recent diarrhoea or vomiting

The Specialist Nursing team is always available for questions. During your inpatient stay you can ask the ward staff to contact them.

Upper GI/Hepatobiliary Nurses

Birmingham Heartlands Hospital, Good Hope Hospital and Solihull Hospital Tel: **0121 424 0570**
HGSuppergicns@nhs.net

Queen Elizabeth Hospital UGI Clinical Nurses
Tel: **0121 371 6650**
Macmillan.ugi@uhb.nhs.uk

Patients can use these email addresses to contact the Clinical Nurse Specialists.

This leaflet was originally developed by a range of health care professionals and the copyright was through the former Pan Birmingham Cancer Network. The leaflet has now been adopted by University Hospitals Birmingham. The leaflet has now been reviewed and revised in line with trust policy.

Our commitment to confidentiality

We keep personal and clinical information about you to ensure that you receive appropriate care and treatment. Everyone working in the NHS has a legal duty to keep information about you confidential.

We will share information with other parts of the NHS to support your healthcare needs, and we will inform your GP of your progress unless you ask us not to. If we need to share information that identifies you

with other organisations, we will ask for your consent. You can help us by pointing out any information in your records which is wrong or needs updating.

Additional sources of information:

Go online and view NHS Choices website for more information about a wide range of health topics:

<http://www.nhs.uk/Pages/HomePage.aspx>

You may want to visit one of our Health Information Centres located in:

- Main entrance at Birmingham Heartlands Hospital.
Tel: **0121 424 2280**
- Treatment centre at Good Hope Hospital. Tel: **0121 424 9946**
- Clinic entrance Solihull Hospital. Tel: **0121 424 5616**
or contact us by email: **healthinfo.centre@heartofengland.nhs.uk**
- The Patrick Centre, in the Cancer Centre, Queen Elizabeth Hospital Birmingham. Tel: **0121 371 3537, 0121 371 3539** or
via email on **cancerinfo@uhb.nhs.uk**

Dear Patient

We welcome your views on what you thought of this patient information leaflet and also any suggestions on how you feel we can improve. Please send your feedback through to:
patientinformationleafletfeedback@uhb.nhs.uk

If you would like to contact the PALS Team at the Queen Elizabeth Hospital (QEHb), please call: **0121 371 2000**.

If you wish to make any other comments this can be done through the links listed below:

- Patient opinion: **www.patientopinion.org.uk**
- I want great care: **www.iwantgreatcare.org** (here you can leave feedback about your doctor)

Be helpful and respectful: think about what people might want to know about our patient information and this hospital and how your experiences might benefit others. Remember your words must be polite and respectful, and you cannot name individuals on the sites.

If you have any questions you may want to ask about your condition or your treatment or if there is anything you do not understand and you wish to know more about, please write them down and your doctor will be more than happy to try and answer them for you.

Please use the space below to write down any questions you may have and bring this with you to your next appointment.

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Upper GI/Sarcoma

University Hospitals Birmingham NHS Foundation Trust
