OAKVILLE COLORECTAL GROUP

General and MIS Colorectal Surgeons
3075 Hospital Gate, Suite 314
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Patient Information and Consent for Anterior Resection & TaTME

Important things you need to know

Patient choice is an important part of your care. You have the right to change your mind at any time, even after you have given consent and the procedure has started (as long as it is safe and practical to do so). If you are having an anaesthetic you will have the opportunity to discuss this with the anaesthetist prior to the procedure.

We will also only carry out the procedure that is described on your consent form unless, in the opinion of the health professional responsible for your care, a further procedure is needed in order to save your life or prevent serious harm to your health.

However, there may be procedures you do not wish us to carry out and these can be recorded on the consent form.

About anterior resection

You have been recommended to have an “anterior resection” or “TaTME” as the surgical treatment for your disease which involves removing some or all of the rectum and adjacent sigmoid colon. This operation is for cancers of the rectum and some cancers of the sigmoid colon. The same operation is also performed for some non cancerous bowel conditions. It will be performed under general anaesthetic.

The rectum is the lowest 15cms of the bowel. It is the place where the stool is normally stored prior to going to the lavatory so that its removal does alter bowel function afterwards. You would tend to have a more frequent, urgent and looser stool after surgery.

When an anterior resection is performed it is usually possible to join the two ends of the remaining bowel together afterwards. However, the more rectum that is removed, the greater is the possibility that you would need a temporary bag (stoma) to protect the join of the bowel. An ileostomy is the commonest temporary stoma used. This will be in place for a number of months and is reversed after an endoscopic and radiologic examination is performed to check that the bowel join is intact. If you need chemotherapy after your surgery the stoma will not be closed until after that has finished. There is also a chance of a permanent bag (a colostomy). If

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there is a likelihood of a stoma you will be counselled by your surgeon and stoma nurses prior to your surgery.

You may have been advised to have radiotherapy or chemoradiotherapy prior to your operation.

Intended benefits

The aim of the surgery is to remove the cancer – completely if possible. For most patients this will provide a cure or significant improvement of their bowel problems. For cancer operations, surgery gives the best chance of cure, and the treatment may need to be combined with chemotherapy and/or radiotherapy. Even in cancer surgery, where certainty of cure is difficult to guarantee, the benefits should be long lasting.

Who will perform my procedure?

The surgeon whose name is on the consent form will be the primary surgeon who performs your procedure. However, other suitably trained surgeons may also be involved in your care during your procedure as directed by your primary surgeon.

Before your admission

You will need to attend the pre-operative clinic, which is usually run by specialist nurses and anaesthesiologists. At this clinic, they will ask for details of your medical history and carry out any necessary clinical examinations and investigations. Please ask them any questions about the procedure, and feel free to discuss any concerns you might have at any time.

They will ask if you take any tablets or use any other types of medication either prescribed by a doctor or bought over the counter in a pharmacy.

Please bring all your medications and any packaging (if available) with you. Please tell the ward staff about all of the medicines you use. If you wish to take your medication yourself (self-medicate), please ask your nurse. Pharmacists visit the wards regularly and can help with any medicine queries.

Your operation will require a general anaesthetic. You will see an anaesthetist before your procedure to discuss the best options for you.

Most people who have this type of procedure will need to stay in hospital for 3 to 6 days after the operation. Those with medical problems or special needs may need to stay in hospital longer.

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Bowel Preparation

The day before admission you will need to take some 'bowel prep' to empty out the bowel as well as some antibiotic tablets. The prep instructions will be given to your separately, and the antibiotics will need to be picked up at the Origins Pharmacy on the first floor of our office building or at Oakville Trafalgar Memorial Hospital. The prep and antibiotics help to minimise complications after the surgery.

Day of surgery admission

Most patients are admitted on the day of surgery. If you not diabetic you will also be given some sugary drinks to drink the night before surgery and early on the morning of the operation

Hair removal before an operation

If you need hair removal from the surgical site this will be done using an electric hair clipper with a single-use disposable head, after you have been anaesthetised. Please do not shave the hair yourself or use a razor to remove hair, as this can increase the risk of infection. Your healthcare team will be happy to discuss this with you.

It may be necessary during the procedure to shave other areas of your body if appropriate to allow equipment/machines, for example diathermy machines (used to seal blood vessels), to stick to your skin to achieve the best and safest performance.

During the procedure

Before your procedure, we will give you the necessary anaesthetic. Your anaesthetist will also discuss post-operative pain relief with you and if you are having an epidural this may be put in before you are anaesthetised. You will need to have a catheter inserted once you are asleep so we can measure urine output. This will be removed within the first few days after the operation.

Surgery for cancers of the rectum and sigmoid can be performed by an 'open' operation with an incision in the abdomen, by laparoscopic "keyhole" surgery, or by a combination of laparoscopic and transanal surgery. Laparoscopic surgery still requires an incision through which the tumour is removed. The choice of method depends on a number of factors including the part of the bowel to be removed, the reason for your surgery, your build and coexisting medical conditions, any previous operations on your abdomen, and surgeon preference. Please feel free to discuss this with your surgeon if you need clarification.

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With keyhole surgery it is sometimes not possible to complete the procedure using this technique. In these situations we would then convert to an open operation.

The first part of the procedure is to assess the abdominal contents. We can usually see the exact nature of the disease in your colon and also check other parts of the abdomen – for example the liver, stomach, small intestine or ovaries.

The rectum and colon is then mobilised (freed up from its surrounding attachments) so that the rectum can be safely removed, along with some of the mesorectum (a flat fatty sheet that carries the blood vessels and lymph drainage from the rectum). In most cases the remaining bowel ends can be joined up again either using special stapling instruments or sutures.

If a stoma (where the bowel is brought out to the skin) is needed, this will typically have been discussed in advance. Occasionally unexpected circumstances do occur where a stoma is required for your safety and wellbeing. This is a small, but unavoidable risk of this surgery.

At the end of the operation the abdominal wall is stitched together and then the skin is closed, often with absorbable sutures (so there is no need for stitches to be removed after the procedure).

During surgery, you may lose blood. If you lose a considerable amount of blood your doctor may want to replace the loss with a blood transfusion as significant blood loss can cause you harm. The blood transfusion can involve giving you other blood components such as plasma and platelets which are necessary for blood clotting. Your doctor will only give you a transfusion of blood or blood components during surgery, or recommend for you to have a transfusion after surgery, if you need it.

Compared to other everyday risks the likelihood of getting a serious side effect from a transfusion of blood or blood component is very low. Your doctor can explain to you the benefits and risks from a blood transfusion. Your doctor can also give you information about whether there are suitable alternatives to blood transfusion for your treatment.

After the procedure

Once your surgery is completed you will usually be transferred to the recovery unit (PACU) where you will be looked after by specially trained nurses, under the direction of your anaesthesiologist. The nurses will monitor you closely until the effects of any general

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anaesthetic have adequately worn off and you are conscious. They will monitor your heart rate, blood pressure and oxygen levels too. You may be given oxygen via a facemask, fluids via your drip and appropriate pain relief until you are comfortable enough to return to your ward. You will also have a tube (catheter) in your bladder to drain away urine – this enables careful measurement and avoids the need for you to get out of bed to urinate.

Enhanced Recovery After Surgery (ERAS)

Where possible we make use of 'enhanced recovery' principles to minimise the impact of surgery on the body and enable a rapid return to normal activity. There are many aspects to this process which includes preoperative, intraoperative and post operative procedures. We aim to minimise pain, perform careful surgery, avoid unnecessary IV fluids, tubes and drains, enable you to eat and drink straight after your operation, encourage early mobilisation to stimulate recovery and allow you to go home soon and safely. We want you to be involved with this and need your help to improve your recovery. Details of our Bowel ERAS program will be provided to your at your pre-operative clinic appointment.

Your Care Team.

During your hospital stay, your primary surgeon will be your most responsible physicians (MRP). However, an entire team of healthcare professionals will also be involved in your care. Hospitalists are specially trained GPs who will manage all non-surgical medical issues that you may have. The Surgical Ward nurses are experienced in managing postoperative patients, and can perform many bedside procedures including catheter insertion and removal, drain removal, wound management, and stoma care. During off-hours, on-call surgeons are also available to manage any acute surgical issues that may arise.

If you have a stoma, your surgical nurses will help you care for the stoma and will begin teaching you how to use and change the stoma appliance. A specialized stoma nurse will also see you while you are in hospital and can help organize supplies for you once you are discharged. Upon discharge, home care (CCAC) will also be organized for you for ongoing care and education of your stoma in the community setting.

Eating and drinking.

After your operation, you may drink and eat as soon as you feel like it. As long as your body will accept it this will be good for you. If you feel sick or bloated then you should cut back on oral intake until you feel better.

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Getting about after the procedure.

We will help you to become mobile as soon as possible after the procedure. This helps improve your recovery and reduces the risk of certain complications. You will have daily injections which reduce the chance of blood clotting in your legs (a DVT). Typically, you will be helped into a chair the following day. If you have any mobility problems, we can arrange nursing or physiotherapy help.

Leaving hospital.

Most people who have this type of procedure will need to stay in hospital for two to five days. Sometimes complications arise and these will delay discharge. When you go home we would expect you to be mobile, comfortable and able to eat safely. The actual time that you stay in hospital will depend on your general health, how quickly you recover from the procedure and your doctor's opinion. We will keep you in hospital as long as necessary, however, until your surgeon has determined that it is safe for you to be discharged home.

Resuming normal activities including work.

Most people who have had this procedure can get back to normal activities within six to eight weeks. Initially you will feel more tired than usual but this should not stop you from doing anything, because activity is beneficial. For driving you need to feel safe and to be able to brake in an emergency – this often takes two to four weeks. When going back to work see if you can start half days or work a little from home until your energy levels are improved.

Special measures after the procedure.

Sometimes, people feel sick after an operation, especially after a general anaesthetic, and might vomit. If you feel sick, please tell a nurse and you will be offered medication to make you more comfortable.

Pain control.

This is usually with either an epidural, patient-controlled analgesia (PCA), or most typically multiple-modal analgesia combining oral and IV opioid and non-opioid medication.

Check-ups and results.

Prior to your discharge, your physician will tell you when they would like to see you again in follow up. This is typically within 3-4 weeks or 4-6 weeks.

Within a week of your discharge, please call your surgeon's office to book this appointment. At this time, we can check your progress and discuss with you any further treatment we recommend.

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Significant, unavoidable or frequently occurring risks of this procedure

Surgery to remove the sigmoid and rectum is a major operation and there are certain risks known to be associated with it. These include the risks of surgery in general, the risks particularly associated with bowel surgery and the risks of anaesthetic described in more detail over the page.

The general risks of surgery include problems with the wound (for example, infection), breathing (for example, chest infection), heart (for example, abnormal rhythm or occasionally a heart attack), blood clots (for example, in the legs or occasionally in the lung) and kidneys (for example, kidney failure).

Those specifically related to anterior resections and TaTME include problems with the seal where the bowel has been joined (for example, 'anastomotic leak'), a transient blockage of the bowel, bleeding or infection in the abdominal cavity, and injury to surrounding structures near the colon/rectum. Rarely, further surgery is required to correct such complications. If there is a leak from the bowel join (anastomotic leak) surgery is often required and this usually requires a stoma to be created; this is a serious complication but the risk is low, of the order of 5-7%.

Sometimes during the operation it becomes apparent that the disease is more complicated than was anticipated: the type of surgery may need to be altered to take this into account. This may mean removing more bowel or part of a nearby organ (for example small intestine, bladder or ovary). The consent form you sign will include this possibility. If there is any part of you which you specifically do not wish to be removed then this must be written clearly on the consent form before signing.

As explained earlier there may be a need for a stoma and this is usually predictable in advance. Rarely however, we may decide during the operation that a stoma is required and there is a remote risk this could be permanent.

In men there is a risk of impotence (failure to achieve an erection) in this kind of surgery. There is also a chance of retrograde ejaculation (semen going into the bladder instead of out of the penis during ejaculation). Obviously every effort is made to minimise this risk but you need to be aware of it. These risks are greater when radiotherapy and surgery are combined. In women, there is a risk of discomfort or dryness during sexual intercourse, and some women no longer experience sexual orgasm. Again, this risk is greater when radiotherapy and surgery are combined.

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Most people will not experience any serious complications from their surgery. The risks increase for the elderly or overweight and for those who already have heart, chest or other medical conditions such as diabetes or kidney failure. There is a tiny risk of death. You will be cared for by a skilled team of doctors, nurses and other health care workers who are involved in this type of surgery on a daily basis. Any problems that arise can be rapidly assessed and appropriate action taken.

Alternative procedures that are available

For most of the conditions where anterior resection/TaTME is advised the only alternative to surgery is medical treatment with drugs. Where there is a cancer of the bowel, drug treatment alone will not cure the disease. If you were to decide against surgery then your cancer would progress, though usually quite slowly over months.

This could result in bleeding, the development of a blockage in the bowel and eventually the spread of cancer to other parts of the body. Unfortunately, as this is not a curative treatment option, patients will ultimately succumb to their disease.

For inflammatory conditions surgery is usually recommended when medical treatment has failed to control the symptoms. Where there is a narrowing of the bowel it is sometimes possible to stretch this from within using a special balloon, though often surgery is the better option.

Anaesthesia

Anaesthesia means 'loss of sensation'. There are three types of anaesthesia: general, regional and local. The type of anaesthesia chosen by your anaesthetist depends on the nature of your surgery as well as your health and fitness. Sometimes different types of anaesthesia are used together.

Before your operation

Before your operation you will meet an anaesthetist who will discuss with you the most appropriate type of anaesthetic for your operation, and pain relief after your surgery.

To inform this decision, they will need to know about:

- Your general health, including previous and current health problems
- Wehther you or anyone in your family has had problems with anaesthetics
- Any medicine or drugs you use

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- Whether you smoke
- Whether you have had any abnormal reactions to any drugs or have any other allergies
- Your teeth, whether you wear dentures, or have caps or crowns

Your anaesthetist may need to listen to your heart and lungs, ask you to open your mouth and move your neck and may review your test results.

Preoperative Checklist

Before starting your anaesthesia the medical team will perform a check of your name, personal details and confirm the operation you are expecting.

You will change into a gown before your operation and we will take you to the operating room. When you arrive in the operating room, monitoring devices may be attached to you, such as a blood pressure cuff, heart monitor (ECG) and a monitor to check your oxygen levels (a pulse oximeter). An intravenous line (drip) may be inserted and you may be asked to breathe oxygen through a face mask.

General anaesthesia

During general anaesthesia you are put into a state of unconsciousness and you will be unaware of anything during the time of your operation. Your anaesthesiologist achieves this by giving you a combination of drugs.

While you are unconscious and unaware your anaesthesiologist remains with you at all times. They monitor your condition and administers the right amount of anaesthetic drugs to maintain you at the correct level of unconsciousness for the period of the surgery. Your anaesthesiologist will be monitoring such factors as heart rate, blood pressure, heart rhythm, body temperature and breathing. They will also constantly watch your need for fluid or blood replacement.

What will I feel like afterwards?

How you will feel will depend on the type of anaesthetic and operation you have had, how much pain relieving medicine you need and your general health.

Most people will feel fine after their operation. Some people may feel dizzy, sick or have general aches and pains. Others may experience some blurred vision, drowsiness, a sore throat, headache or breathing difficulties.

When the effects of the anaesthesia wear off you may need pain relieving medicines.

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What are the risks of anaesthesia?

In modern anaesthesia, serious problems are uncommon. Risks cannot be removed completely, but modern equipment, training and drugs have made it a much safer procedure in recent years. The risk to you as an individual will depend on whether you have any other illness, personal factors (such as smoking or being overweight) or surgery which is complicated, long or performed in an emergency.

The specific risks of anaesthesia will be discussed with you by your anaesthesiologists at your preoperative clinic appointment.

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Acknowledgement

By signing below and the attached surgical consent form, you acknowledge that you have read and understood the patient information about this procedure, that the procedure has been discussed with you by your surgeon, and that you have no further questions and wish to go ahead with the procedure.

Name (Print): ……

Signature: …… Date: ……