Patient Information Leaflet

Anterior Resection of the Rectum

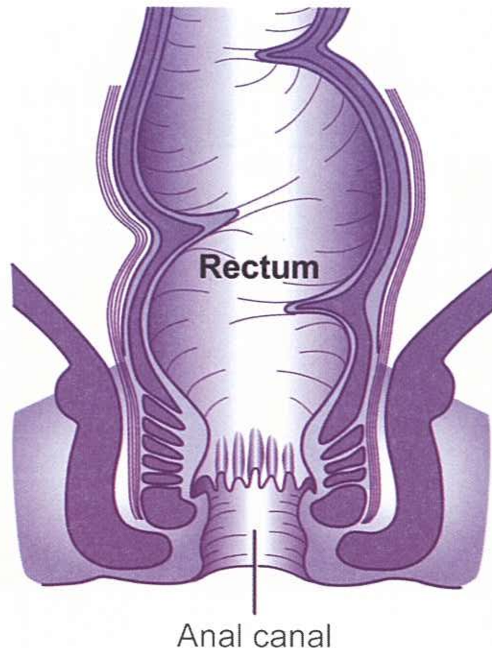
SM0708

The Burdett Institute
of Gastrointestinal Nursing

Anterior Resection of the Rectum

What is the rectum?

The large bowel is the last part of the intestines and consists of the colon and rectum. The colon runs up on the right side of the abdomen (the ascending colon), across the abdomen (the transverse colon) and down the left side (the descending colon), ending in a wider portion called the rectum. The rectum is the storage organ at the end of the bowel.



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The lower end of the bowel is usually empty, except for occasionally when a large pressure wave or mass movement propels the stool into the rectum. This mass movement is often stimulated by activity or eating. There is a great variation in bowel activity between people with normal bowel function. Some people always open their bowels several times per day; others only ever go once every two or three days, or even less often. Either can be normal, as long as there is a regular pattern to the bowel habit, the bowels are easy to empty and there is not excessive urgency or hurry to go.

What is an anterior resection?

An anterior resection of the rectum is an operation to remove part or the entire rectum. The surgeon will cut out this part of the bowel and sew or staple the two remaining ends together. Your surgeon may recreate the rectum by using the colon to form a colonic pouch. Sometimes it is necessary to rest the 'join' in the rectum and form a temporary stoma called an ileostomy (or very occasionally a colostomy). The purpose of the stoma is to keep the bowel motions away from the join whilst it heals. If you require a temporary stoma it is usual for you to meet a stoma care nurse before the operation to discuss this in more detail.

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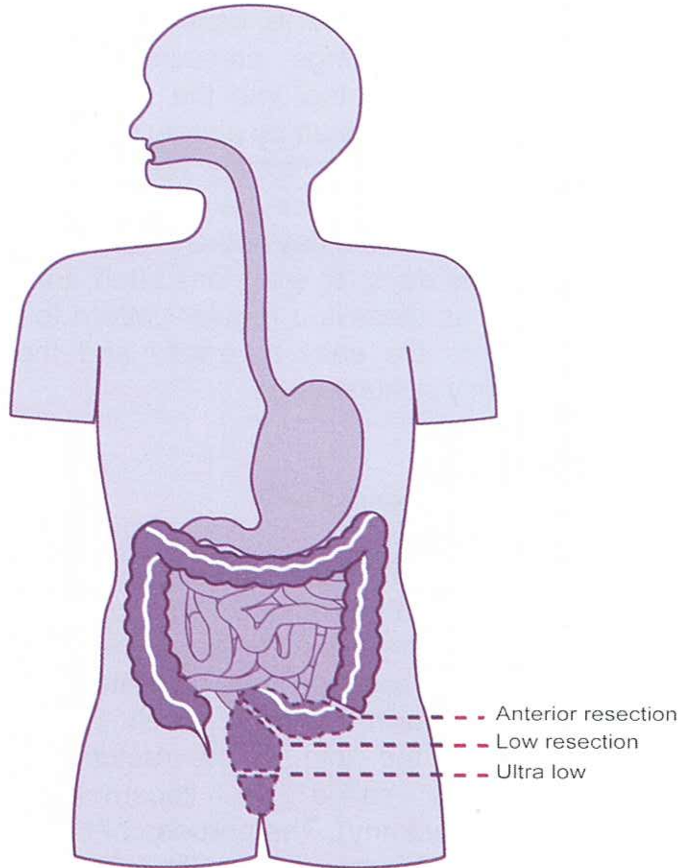

What preparation is needed before the operation?

The pre-operative preparation can be divided into two categories

- physical preparation
- psychological preparation

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Physical preparation

The ward nurse will assess you physically to understand your needs and plan your care accordingly. During this preparation period you will met other health care professionals such as the anaesthetist and physiotherapist.
You can drink as much as you like. You should keep up your calorie intake before the operation, so milk and sweet drinks are good. Fish oils may also be useful.

In some cases your surgeon would like your bowel to be empty. To achieve this, the day before your operation we would like you to take clear fluids only. This means that you should eat no solids foods at all and take only drinks that you can see through, not milk or fruit juice. Clear soup and squash are fine as are black tea and coffee, and again sweet drinks will help you to keep up your strength and calorie intake.

On admission your physical preparation continues. Shortly after your arrival, the ward nurse, may give you some medicine to empty your bowels thoroughly. You may experience some abdominal cramping and you will usually open your bowels several times very urgently – so make sure you know where the toilets are! The nurses will give you some soothing cream and a pad if you need one. Passing a lot of stool means that you also lose a lot of fluid, so try to drink at least one glass of fluid per hour. Some patients may be given an enema.

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Blood will be taken for routine tests and you will be asked some questions about your general state of health by both nurses and doctors. You will be visited by the anaesthetist who will check that you are fit for an anaesthetic and discuss suitable pain relief for after the operation. A surgeon will visit you to discuss your operation and you will be asked to sign a consent form. It is important that you fully understand what operation is planned and what the likely benefits and possible side-effects are. This is a good time to discuss any further questions that you have about the operation.

You will usually be given some white stockings to wear during and after the operation. It is also usual for you to be given a small injection called *fragmin* once a day. Both of these measures help prevent blood clots in your legs.

Psychological preparation

Your psychological preparation starts in the outpatients clinic when the diagnosis and choices of treatment are discussed with you. It may be appropriate to include any relevant family members as you wish. This will help to reassure you and aid your recovery.

What will happen when I come back from the operating theatre?

On return to the ward you will feel quite sleepy but will be aware of the drips and drains that are present. You are

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likely to have a dressing over the surgical wound on your abdomen. This will be protecting the wound from the risk of infection and will be renewed by the nurse as necessary. As you will not be allowed to drink, initially a drip will be placed in your arm in order to maintain your hydration and give you some energy. A catheter is placed into your bladder in order to drain urine away. This is so the nurse can monitor your fluid balance to ensure you remain hydrated.

Sometimes it may be necessary for a tube to be inserted through the nose and into the stomach to stop you from feeling sick. It may also be necessary for a tube to be left to drain blood from the abdomen. The creation of an ileostomy may also have taken place. If so, a clear drainable bag will be adhered to your skin in order to collect any effluent. Both the ward nurse and the stoma care nurse will be able assist you in the early days until you have learnt the skills of stoma care to be independent.

We will aim for you to be as pain free as possible. Some discomfort is to be expected. Painkillers will usually be given either through an epidural or via a pump called patient controlled analgesia (PCA). After the first few days following your operation your painkillers will be changed to be given as and when you need them. Please discuss with your nurse if you feel that your pain is not well controlled.

You may not be allowed to drink until bowel sounds can be heard, however you may clean your teeth or gargle.

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Some surgeons, but not all, wait until they can hear sounds in your bowel through a stethoscope and you have passed wind. This can take a few days. As your bowel sounds begin you will be allowed small amounts of fluid each hour, gradually building up to being able to drink as much as you like. Some patients are encouraged to eat and drink earlier. This will be decided by your individual surgeon. Once you are drinking normally (over a litre per day) and you have no sickness or hiccups, the drip will be removed and you will usually be able to start eating a light diet.

We will usually get you up into a chair the first day after your operation. This is to help get your circulation moving. The stockings on your legs may feel hot, but they are very important whilst you are not fully mobile, to help to prevent blood clots. We recommend that you try to avoid crossing your legs whilst lying in bed or sitting in a chair. While you are in bed it is also a good idea to point your toes up and down and to gently exercise your legs. You should sit up rather than lying flat and take six deep breaths an hour, expanding your chest as fully as possible. The physiotherapist will probably visit you and show you some chest exercises and help you cough any phlegm up off your chest. If deep breathing is painful you should discuss pain relief with your nurse and try to get as comfortable as possible before the physiotherapist visits.

You can have a bath or shower as soon as you feel able, often within a day or so after the operation. You are bound to feel a little wobbly at first, so ask for help as you

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need it or at least let your nurse know where you are going and use the nurse call button if you need to.

After the first few days the amount of nursing care you receive will decrease as you become increasingly independent. The catheter will usually stay in your bladder for one or two days until you are able to get to the toilet yourself. Your stitches will be taken out after 10 days. It can be difficult to sleep well in hospital due to the change of surroundings, the need for observation and the tubes attached to you. Some patients also experience strange dreams in the first few nights after the anaesthetic. You should find that your sleep improves after the first week or once you have returned home. In the first few days you will therefore feel tired and may want to request only close family and friends visit and to keep visits quite short.

When will my bowels start to work again?

Your bowels will usually start to take sounds after 2 – 3 days. It may take 4 – 5 days to have a bowel action. This is not cause for concern. At first your bowel may only be able to hold a small amount of motion at any one time as its storage capacity has been reduced. Whilst the bowel will adapt over the first three months after the surgery, initially you may open your bowels up to 4 times a day.

If you have had an ileostomy formed you may first notice wind passing into the bag followed by loose motions, one or two days after the operation. Although the bowel

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