Patient Information Leaflet

ST MARK'S HOSPITAL

Reversal of your ileostomy or colostomy

The Burdett Institute of Gastrointestinal Nursing

SM10/12

Reversal of your ileostomy or colostomy (stoma closure)

This leaflet has been provided to give you information about the reversal of your ileostomy or colostomy also known as stoma closure. Approximately 6000 people undergo a reversal of their stoma every year in the UK. This leaflet explains what the surgery involves; the problems that can be experienced after stoma reversal, and discusses the best way to manage them.

What you need to know about stoma reversal.

You currently have a temporary stoma – which may be an ileostomy or colostomy (usually a loop ileostomy). Temporary stomas are created for a minimum of six weeks, although they are often present for several months. This gives the scar tissue (or adhesions) time to settle and allows any swelling within the abdomen or stoma site to fully reduce. The length of time you have the stoma depends on your general health and recovery from the surgery, as well as the reason for this surgery. If it was performed for cancer, further treatment such as chemotherapy, may delay the reversal.

Closing or reversing the temporary stoma is no doubt something you are eagerly awaiting. Many people see it as an indication of getting back to normal. Whilst this operation may be more straightforward and much shorter than your initial operation, there are still a few things to consider about the surgery. It is also important to be prepared for any potential side-effects which could develop after the operation and know what you can do if they occur.

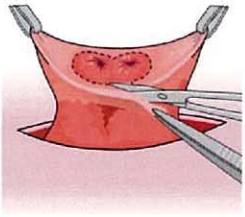
Ideally, as many people as possible will have their bowel joined back up, but there may be several reasons why your surgeon may be reluctant to do so. This will be discussed with you in person. There are also a few checks that need to be made before the operation. Firstly, the doctors must be happy that you are fit enough for another operation. Secondly, they need to check that the bowel has healed or improved since the first operation and thirdly that the bowel and the anal sphincters (which control the flow from your bowels) are working, so that loss of control of your bowels (or faecal incontinence) will not develop as a result. The surgeon is likely to perform a rectal examination, and may arrange further tests before making this decision.

Alternatives to surgery

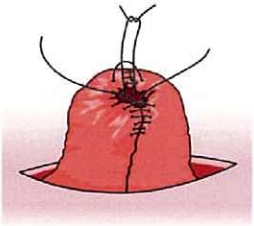
The alternative to this surgery is not having the stoma reversed and keeping the stoma. Around 1 in 12 patients who have had a planned temporary stoma for cancer of the rectum end up keeping it as a permanent stoma.

What does the operation involve?

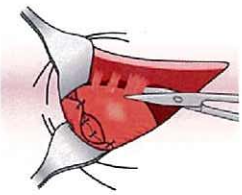
The closure of your stoma is 'technically' not as difficult as your previous surgery to create the stoma. This operation involves taking the two ends of the stoma and simply joining (stitching) them together, as illustrated in three diagrams below.



Step 1. The surgeon releases the stoma.



Step 2. The stoma is stitched together.



Step 3. The stoma is placed the abdomen and any adhesions cut away.

Since an incision (cut) is made around the stoma, you will be left with a small cut at the stoma site. Very occasionally (in less than 5 in a 100 cases), it is necessary to reopen the original laparotomy wound (centre scar). It is important to note that the surgeon still needs to cut through your abdominal wall for the reversal to happen, therefore after the operation you must take care and consideration when carrying out activities such as lifting and bending which use your abdominal muscles.

Possible risks of the operation:

As with any surgery, the operation to close your stoma has some risks and these will be explained in detail to you before signing the consent form for surgery. Your surgical team will also do everything they can to prevent them from happening. The general risks associated with surgery as indicated at your primary surgery include:

- Blood clot in the leg (a deep vein thrombosis or DVT) which can occasionally move through the blood stream to the lungs (pulmonary embolism or PE)

- Chest infection (Pneumonia)
- Urinary tract infection (UTI)
- Wound infection
- Bleeding from the operation site

Preparation for your surgery

Before coming into hospital you may be asked to attend a pre-admission clinic a couple of weeks prior to your planned surgery. At this appointment a nurse (and possibly a doctor) will ask a few questions about your general health, arrange a chest X-ray, E.C.G (heart tracing) and take blood samples if necessary. It may be helpful for you to meet up again with your nurse specialist to ask any further questions relating to your operation. If you would like to make an appointment for the stoma clinic, please ring 020-8235-4100.

You may either be admitted on the morning of your planned operation or a day before your operation. You will receive this information in your hospital letter confirming your admission date.

The day of the operation

On the day of your operation you must not eat or drink anything for a minimum of two hours before your surgery. You will not be required to have a special bowel cleansing drink. It is however important that you drink plenty of fluids and eat well during the previous day. The anaesthetist will see you before your operation to discuss your pain relief options.

How long does the operation take?

This operation usually takes 60 minutes. After your operation you will be taken to the recovery area for close observation before returning to your hospital ward.

What to expect after surgery

You will probably have a drip in your arm to give you fluids. Following the operation you will be allowed to drink once fully awake. Once you are drinking satisfactorily, you will be able to eat. Usually small light meals are better tolerated.

You may also have a urinary catheter to drain the urine from your bladder which will keep the bladder empty until you are able to get up and go to the toilet.
This operation is in principle less complicated than your previous surgery, but you will still feel sore and uncomfortable following the operation. Most people describe feeling bruised and bloated but as the swelling decreases, this discomfort will get less. On discharge from hospital you will have some pain killers to take home with you. Information will be provided about your medicines but make sure you understand how to take it before you leave hospital.

Possible side effects related to this operation:

Ileus and bowel obstruction - Initially after the surgery, there is the risk of the bowel not working properly - a symptom you may hear being referred to as an ileus. There may be a delay in the bowel making its usual movements or contractions known as peristalsis. It can take a few days before the bowel movements occur normally again and you start to pass both wind and then stool from your back passage.

During this time, the bowel movements may start and then stop again, and if this happens you can experience:

- abdominal pain
- nausea
- vomiting

The severity of these symptoms will depend on whether your bowel is partly or completely blocked or obstructed. If it is only partly obstructed, these symptoms may come and go. If you are at home and worried about any symptoms or side effects you may be feeling, you should call the hospital ward for initial support or seek advice from your GP who may well recommend that you just drink liquids, until symptoms improve.

The cause of this condition is generally the handling of the bowel during the surgery as the bruising creates swelling of the bowel and is to be expected after an

operation. For most patients the treatment is simple and by resting the bowel the obstruction will usually resolve over the next 48-72 hours.

An ileus affects approximately 1 in 8 individuals after this surgery with less risk of developing an obstructed bowel. Readmission to hospital may be necessary if severe and constant symptoms occur and /or there is deterioration in your general health such as you can no longer tolerate fluids. Hospital care will include investigation, fluids, painkillers as required and probably a tube via the nose into the stomach to relieve any tightness (commonly referred to as 'Drip and Suck'). Those experiencing more persistent and complete obstruction need be carefully monitored to identify the small percentage that will require a further operation. If further surgery is necessary, this is generally because adhesions or bands of scar tissue have developed.

Diarrhoea - Initially after the reversal, your bowel will be unused to working properly. Also if a long section of bowel was removed at the first operation, it will also need to adjust to now being a shorter length. This may cause any bowel contents to rapidly speed through it, which results in diarrhoea. Some individuals experience liquid bowel motions for the first two or three days and then everything settles down, however many people find it can take at least 6 months following the operation before the bowel motions become more firm. It is fairly common to pass looser and more frequent stools than you may have been used to previously. Adjusting which food you eat and taking medication such as Loperamide can help.

Frequency and urgency – It is normal to have erratic bowel movements for several weeks after this operation. You may find that you need to go to the toilet more urgently and also more often. This can be more of a problem for those who have had a low join or anastamosis in the bowel and also following a course of pelvic radiotherapy.

Bowel leak - There is a very small risk that after your stoma reversal, the join (anastamosis) formed during the first operation when the bowel was removed operation may still leak. This risk is generally ruled out prior to closure, by performing a contrast enema X-ray examination. These leaks can be minor and can usually be

detected and treated before discharge from hospital. The risk of a leak occurring becomes much less likely after the first week from surgery. On rare occasions, they can result in more serious problems such as infection within the abdomen or a fistula (see explanation on page 7). People at risk of this development are those who have had an operation low down in the rectum and a history of previous pelvic radiotherapy.

If there is a leak, you will probably feel a dull pain in your pelvis (the area below your belly button and above your hips), have a fever and lethargy. Acute and persisting symptoms will require readmission to hospital for observation with investigations such as MRI/CT scans and blood tests to establish a diagnosis. Early detection of a leak leads to a better recovery so we would encourage you to contact the hospital ward or Colorectal/Stoma nurse if you experience these symptoms.

There is also a very small risk of a leak from the stoma closure site - it occurs in less than 1 percent of cases (1 out of every 100 operations) and becomes much less likely after the first week from surgery.

Fistula formation - A fistula is an abnormal connection between two parts of the body which in this case is often from the bowel to the surface of the skin. This is an uncommon complication of this surgery. The fistula can heal without treatment, or surgery may be needed. Surgery will be considered if fistula does not close within a few months.

Hernias - A hernia occurs when the bowel sticks out through the wall of your abdomen causing a bulge at the stoma site. This risk is small but is more likely in those who:

- have a large abdomen
- are older
- have strained their bodies
- have undertaken too much exercise in the first few weeks following surgery
- have a history of hernias.

Most hernias appear over subsequent months, generally developing within the first two postoperative years. This may be seen as a bulge around the stoma or laparotomy site which may reduce in size when lying and increase in size when sitting or standing.

Management includes applying a hernia support belt or binder that offers support for the hernia, decreases the protrusion, and assists in maintaining a good posture. However surgical repair may be necessary in the longer-term.

Managing your bowel care

As mentioned earlier, the bowel needs time to settle. Also, after such surgery your pelvic floor muscles and the anal sphincters around your back passage (rings of muscles) can become weaker. This is not a problem for most people. If you have weak muscles you may leak gas, liquid or solid stools. Performing pelvic floor exercises also help to regain continence but need to be practiced at least five times a day and over a few months to be of benefit. Separate leaflets on how to exercise the pelvic floor are available. When done correctly, these exercises can build up and strengthen the muscles to help you to hold both gas and stool in the back passage.

Expect to open your bowels more frequently after your stoma closure than you used to – up to four times a day is not uncommon. However for some days to weeks, you may need to open your bowels a few times more than this and your bowel pattern may seem erratic. For most, over time, and possibly with a few changes to their diet, the bowel will settle back into a more usual and predictable pattern of movement. All these symptoms should improve over the first year after reversal. In the meantime, support and practical strategies are available to improve your bowel control, bowel motion consistency and decrease any frequency and urgency you may be experiencing. Detailed bowel assessment, dietary advice, medications and specific muscle training exercises can help and require specialist nurse input. If symptoms remain difficult to live with at three months after the surgery, you can ask you GP to refer you for Biofeedback.

If you do need to go to the toilet regularly you can get a sore bottom, so we would advise you to wash your bottom every time you have your bowels open – some

people find moist wipes the most soothing, and then pat dry. Generally good hygiene and a light barrier cream e.g. Sudocream are sufficient to prevent the skin being sore. If necessary, use a very small amount of barrier cream to protect the skin but please avoid any Lanolin based creams.

Exercise

It is very important that you start to walk around as soon as you can after the surgery, as this helps your breathing and circulation, as well as helping you to regain your strength. It is normal to feel tired after surgery so consider what help or support you may need when you go home.

When you first get home after your operation, initially plan your day to have a rest in the afternoon. It takes time to regain your normal strength, so try to build up to the amount of exercise you do slowly. Some people find it helpful to set goals to reach each week, for instance start by going for a short walk each day and increase this distance once you feel able. For some their fitness returns in a matter of days to weeks and for some it takes a couple of months. Taking some gentle exercise each day will help you get back to your normal activities and work quicker. If you participate in any more strenuous sports or exercise, you should generally wait six weeks and then increase this back into your lifestyle gradually.

Having had surgery on your abdomen, you are advised not to lift for the first six weeks. It is important that you do not do any heavy lifting (no heavier that a half-filled kettle) for at least two weeks following the operation, and build up gradually. The concern is that if you put too much stress on your abdominal muscles, you may cause a permanent weakness, which may lead to a hernia in the old stoma site.

Eating and drinking

You will usually start to take sips of water the day of your operation, increasing as tolerated, (but not fizzy liquids) to soup, jelly and a light diet (which means low fibre foods). As you increase your intake, you may find your sense of taste and smell is altered following the surgery. This can be because of the antibiotics, anaesthetic and painkillers. Be reassured that your taste and appetite will return to normal within approximately six weeks.

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In general, you are advised that for the first couple of weeks after your operation you should often reduce the amount of fruit, salad and vegetables that you eat. These types of food contain fibre and will be hard for your bowel to digest initially. Mid meal snacks like crisps and biscuits are good to nibble on when you start eating. The main advice is to eat little and often until your appetite returns to normal and you feel able to return to a healthy balanced diet. Your nurse specialist will discuss this in more detail with you if you ask.

A good fluid intake of eight cups a day (some of which should be water) is advised. However if you experience constipation, you may need to drink more.

You can still have an alcoholic drink again introduce gradually and enjoy in moderation. If any particular food does seem to cause problems (such as frequency) just stop eating it for a while, then try again at a later date.

Caring for your wound

It is good idea to inspect your stoma site wound daily after discharge and to keep it dry and clean to try to limit any infection. Initially a dry dressing may be used for the first week which is usually changed after showering. If signs of infection occur - redness around the wound or a discharge of fluid from it, call the ward for advice or visit either the GP or the practice nurse. This is usually a minor complication generally treated with antibiotics.

Driving

You can drive as soon as you are able to concentrate fully and can make an emergency stop without discomfort in your abdomen. A minimum of two weeks is suggested however it is advisable to check with your own insurance policy as some insurance companies state that you will not be covered for six weeks after any abdominal surgery.

Resuming sexual intimacy

The anxiety and all the stress your body has been through with this operation often reduces your sex drive. This is quite normal and in time it should return. It is important that you and your partner share time talking about your feelings, being close and enjoy being intimate without necessarily having penetrative sex.

Once your body feels fitter and more relaxed, you may feel more confident resuming your usual sexual activity again. If you do experience any problems in resuming sex with your partner, please do discuss this with your doctor/nurse specialist.

Follow up care

When you are initially discharged home, some people find it helpful to have family member or friend to stay. Extra help for this first week at home will allow you to rest when you will feel tired and may help you recover sooner. After this, you may still need help with the shopping, cooking and cleaning for a couple more weeks.

An outpatient appointment (OPA) will be made for you approximately six to eight weeks after your discharge to see your surgical team. If you have any questions, this is a good opportunity to discuss them. A useful tip is to write down the questions and bring them with you to the clinic. If you have any queries or questions, do not hesitate to contact your nurse specialist, GP or surgical team.

Contact details:

St Mark's Hospital, Watford Road, Harrow, Middlesex HA1 3UJ

Frederick Salmon Ward South 020 8235 4022
Frederick Salmon Ward North 020 8235 4191
Robert and Lisa Sainsbury Wing 020 8869 3399
www.stmarkshospital.org.uk

The ileostomy and internal pouch support group.

Website: www.iasupport.org.

Telephone: 0800 0184 724 (free)

Inside out support group

Website: http://www.iossg.org.uk

Lifestyle Ostomy Association

Website: http://www.ostomylifestyle.org

Telephone: 0800 731 4264 or 0118 324 0089. Lines are open Monday - Friday 10am - 3pm

Stoma care helpline: 020-8235-4110.

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With thanks to the Friends of St Mark's Hospital for funding the production of this information leaflet

Author: Claire Taylor, Lecturer in GI Nursing
Date: November 2010
Review date: November 2012