



## **Bowel Surgery and IBD**

### **Patient Information Sheet**

This leaflet is aimed at providing some answers to questions you may have about your surgery. It should be used with your Patient Information Pack. If you feel you require further information please contact your Colorectal Nurse Specialist/Stoma Nurse.

#### **What are the chances on me needing surgery?**

70-80% of all IBD patients will require surgery at some point in their lifetime {British Society of Gastroenterology Guidelines. Gut 2004;53(Suppl V):v1–v16}

#### **Why do I need surgery?**

- 1) Useful to remove diseased bowel, that is either scarred or irreparable.
- 2) It can also be used to prevent or treat the complications that can occur from IBD.
- 3) To remove enough diseased bowel to allow medication to be more effective in bringing about remission.
- 4) To prevent blood loss from the bowel which may cause anaemia.

#### **What preparation will I need for surgery?**

You may attend a pre-admission clinic. The purpose of this is to check your general health before surgery because your operation will normally be done under general anaesthetic. This allows the Anaesthetist or the nursing staff to organise any tests required before surgery. It also gives you the opportunity to discuss any problems or fears you may have regarding the operation, such as the need for an anaesthetic, pain control and what happens when you go home. How much care you will need when you go home after your operation will be discussed and assessed on an individual basis.

If you take any medication, including anticoagulant therapy or if you have any illnesses e.g. diabetes or allergies, please inform the Anaesthetist and nursing staff.

**Please bring all current medication that you are taking to the clinic.**

#### **What bowel preparation will I need?**

If your bowel needs to be cleared of any faeces / bowel motions before surgery this will be decided on an individual basis.

## **Will I need a stoma?**

If you require a stoma, (a small bowel opening on the wall of the abdomen) or there is a possibility you may need a stoma, you will be seen by the Stoma Nurse. The Stoma Nurse is skilled in caring for patients who have a stoma and will be able to answer any questions you may have.

## **Surgery**

The part of the bowel that is diseased will be removed during surgery and the two ends of the bowel joined back together. In a few cases this may not be possible and the surgeon may need to make a stoma (a bowel opening on the wall of the abdomen). If this applies in your case, the surgeon will discuss this with you before your operation.

## **Is there a risk I could die from surgery?**

Yes, but there is also a considerable risk in delaying surgery or trying to avoid it once the physicians feel that medical therapy is failing. The timing of the decision as to whether to try another medication or hand over to the surgeons is crucial, and is possibly the hardest part of managing IBD patients. Some people delay surgery until a major complication occurs. If a colectomy (removal of the colon) is performed as an emergency, the procedure can carry a death rate of 13% {BMJ 2007 ; 335 : 1033}. The risk of death would, however, be considerably higher if surgery was not performed in these states. If however the acute problem can be calmed down and the patients nutritional status and general physical wellbeing can be improved the mortality rate from an elective colectomy drops to 1% {*BMJ Open* 2012;2:e000823 doi:10.1136/bmjopen-2012-000823}

## **Common risks of surgery include:**

- 1) Chest infection (particularly if you are a smoker).
- 2) Wound infection. Antibiotics will usually be given through a drip (intravenous infusion) to help reduce the risk of this happening.
- 3) Urinary infection.
- 4) Bleeding and the need for a blood transfusion.
- 5) Blood clot in the leg (deep vein thrombosis).

## **Less common risks of surgery include:**

- 1) Post-operative bleeding (haemorrhage).
- 2) Breakdown (dehiscence) of wound.
- 3) Heart attack (myocardial infarction).
- 4) Blood clot in the chest (pulmonary embolism).
- 5) Incomplete removal of the cancer or none of the cancer being removable.
- 6) Occasionally the bowel can be slow to start working again (this is known as an "ileus"). This requires patience but usually resolves in time.

- 7) Risk of internal join (anastomosis) leaking. Treatment with antibiotics and resting the bowel is generally successful.
- 8) Damage or bruising to the nerves which control the bladder and sexual function.
- 9) Formation of internal scarring (adhesions). These may occasionally need further treatment.
- 10) Damage to the spleen, which may result in it being removed if it cannot be repaired.
- 11) Damage to the tubes which drain urine from the kidneys (ureters).

### **Where will I go after my operation?**

After your operation you may come back to the ward, Intensive Care, or High Dependency Unit. Usually this will have been planned before surgery.

### **What can I expect when I return from my operation?**

When you get back you may have the following:-

**a) An intravenous drip**

Small tube in your arm or hand to give you fluid into a vein following the operation.

**b) Naso-gastric tube**

A small tube passed into your nose in theatre when you are asleep, down your throat and into the stomach. This helps to keep your stomach empty to stop you feeling sick.

**c) Bladder catheter**

A small tube is passed into your bladder and attached to a bag which collects your urine. This helps to monitor your kidneys. Again, this is passed in theatre when you are asleep. You will usually have this catheter bag attached to you for a few days after theatre. It will be removed when you are getting up and about.

**d) Oxygen**

Continuous oxygen by a face mask or small tube placed under your nose.

**e) Pain Control Device**

A tube connected to a device either in your arm or in your back (epidural), slowly releasing medication to ease any pain. This is known as Patient Controlled Analgesia (PCA) as you can control the amount of pain killer you receive.

**f) Wound**

The type of wound you have will depend upon what operation you have had. You may have stitches or staples. These will usually be removed about ten days after your operation. This may cause some short term discomfort.

**g) Wound drain**

A small tube placed near your operation wound. This will drain away any excess fluid. Following your operation these tubes, drips, drains etc. will gradually be removed over the next few days, with little or minimal discomfort. You will be advised by the medical staff when it is safe to start eating and drinking again.

### **Will I need a special diet?**

After your operation you will be started on a light diet which will be increased gradually as you are able to tolerate it. If you require special dietary advice this will be given to you in hospital by the Dietician or the Colorectal Nurse Specialists.

### **How will the risk of blood clots be reduced after my operation?**

Whilst you are in hospital you will be asked to wear special support stockings. You will also receive an injection to help thin your blood. These measures are to help prevent the development of clots in the deep veins of your legs whilst your mobility is restricted. Once you are up and about again these will be discontinued.

### **What can I expect during my recovery period in hospital?**

Following your operation, any tubes, drips, drains etc. will be gradually removed over the next few days with little or minimal discomfort. You will be advised by the medical staff when it is safe to resume eating and drinking.

### **How long will I stay in hospital ?**

Your stay in hospital will normally be between seven to ten days but may be shorter or longer depending on the type of surgery and how quickly you recover.

### **Will the operation affect my bowel habits?**

After any major bowel operation the function of the bowel can change. You may experience urgency, diarrhoea or loose stools. In most cases patients return to a normal bowel action, although this may take three to six months and is dependent on how much of the bowel has been removed. Post-procedure there can also be an increased risk of bile acid malabsorption and small bowel bacterial overgrowth (particularly if the ileo-caecal valve is removed). Once you are eating after your operation, it is advisable to eat light, small, regular meals and build up slowly. You may find some foods irritate your bowel. Refrain from eating them and gradually introduce them back into your diet slowly. If your bowels remain troublesome please contact your GP or IBD nurse specialist (01582 498368)

**Please also refer to Patient information leaflet After Abdominal surgery.**