

# Patient agreement to investigation or treatment

## Anterior resection for rectal cancer

**Authors:** Colorectal Surgery

**Brief description:**

- You have been recommended to have an anterior resection as the surgical treatment for your rectal cancer. The procedure will be performed under general anaesthetic.
- Here, we explain some of the aims, benefits, risks and alternatives to this procedure (operation/treatment). We want you to be informed about your choices to help you to be fully involved in making any decisions.
- Please ask about anything you do not fully understand or wish to have explained in more detail.
- If you would like this information in another format or language or would like help completing the form, please ask a member of our staff.

**Please bring this form with you to hospital**

- You will be asked to read this form carefully, and you and your doctor (or other appropriate healthcare professional) will sign it to document your consent.
- All our consent forms are available on the Addenbrooke’s website: <http://www.addenbrookes.org.uk/consent>
- Remember, you can change your mind about having the procedure at any time.

**For staff use:**

Does the patient have any special requirements? (For example, requires an interpreter or other additional communication method)

.....

.....

## About anterior resection for rectal cancer

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.

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

## Before your procedure

- You will be invited to attend a pre-admission clinic, where you will be seen by one of the House Officers (junior doctors) or Specialist Nurse attached to the Colorectal Unit.
- At this clinic, we record details of your medical history and carry out any necessary clinical examinations and investigations. This is an opportunity to ask questions about your admission.
- You will be asked if you are taking any tablets or other types of medication - these might be ones prescribed by a doctor or bought over the counter in a pharmacy. It helps us if you bring with you details of anything you are taking (for example, bring the packaging with you).
- This procedure involves the use of general anaesthesia. See below for further details about the types of anaesthesia we shall use.
- Most people who have this type of procedure will need to stay in hospital for three to six days after the operation. Sometimes we can predict whether you will need to stay for longer than usual - your doctor will discuss this with you before you decide to have the procedure. Those with medical problems or special needs may need to stay in hospital longer.
- When you are admitted the day before the procedure you may need to take a powerful laxative to completely clear out your bowel. Alternatively you may be given an enema to clear the lower bowel prior to surgery.

## Prevention of Surgical Site Infection (SSI)

In order to prevent infection, hair from the area where you are being operated on may need to be removed.

Hair removal from the site of the operation up to sixty minutes before surgery reduces the risk of infection. This means that the hair removal procedure is usually carried out on the operating table. The skin is then cleaned with an appropriate skin preparation solution. This can leave a colouration to the skin which can be washed off.

You must not shave the area that is being operated on yourself; this will be carried out in the operating theatre. Shaving at home, or the night before surgery, increases the risk of infection as no matter how careful you are the skin may become irritated and this could increase the risk of infection.

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.

Reference:

Department of Health. High Impact Intervention No 3: Preventing surgical site infection. Saving Lives: reducing infection, delivering clean and safe care: DH June 2005.

## During the procedure

- Before your procedure, you will be given the necessary anaesthetic - see below for details of this. Your anaesthetist will have discussed post-operative pain relief and if you are having an epidural this may be put in before you are anaesthetised.
- The operation is usually done with an open approach (via an incision) but you may also be offered laparoscopic keyhole surgery.
- When all or part of the rectum is removed we usually make a vertical incision in your abdominal wall (tummy). Through this we can see the exact nature of the disease in your rectum and also check other parts of the abdomen – for example the liver, stomach, small intestine or ovaries.
- The rectum and colon above it are then mobilised (freed up from their surrounding attachments) so that the rectum can be safely removed, along with some of the mesorectum (fatty tissue that carries the blood vessels and lymph drainage to the bowel). Often the adjacent part of the colon is removed as well to enable better clearance of the disease. In most cases the remaining bowel ends can be joined up again either using special stapling instruments or sutures (stitches). If a stoma (where the bowel is brought out to the skin) is needed then this will have been discussed in advance. At the end of the operation the abdominal wall is stitched together and then the skin is closed, usually with absorbable sutures (so there is no need for stitches to be removed after the procedure).

## After the procedure

- You will wake up in the recovery room after your operation. You might have an oxygen mask on your face to help you breathe. You might also wake up feeling sleepy.
- After this procedure, you will have a drip (small, plastic tube in one of the veins attached to a bag of fluid), which feeds your body with fluid until you are well enough to eat and drink by yourself. You will also have a 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. There may be other tubes inserted according to the nature of your condition and the surgery – for example, a nasogastric tube in your nose or a 'central line' which is a drip in your neck.
- While you are in the recovery room, a nurse will check your pulse and blood pressure regularly. When you are well enough to be moved, you will be taken to a

ward.

- 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 medicine to make you more comfortable.
- Pain control: This is usually with either an epidural or patient-controlled analgesia (see below for details).
- **Eating and drinking:** After your operation, you may have sips of water to drink straight away. You will be encouraged to drink and eat as much as you can tolerate over the next few days. You will not be forced to eat if you do not feel like it.
- **Getting around and about:** We will try to get you mobile (up and about) as soon as we can to help prevent complications from lying in bed. You will have daily injections which reduce the chance of blood clotting in you legs (DVT). Typically, you will be helped into a chair the following day. You will be given assistance from the nurses and physiotherapists.
- **When you can leave hospital:** Most people who have this type of procedure will need to stay in hospital for about a week. 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.
- **When you can resume normal activities including work:** Most people who have had this procedure can resume normal activities after six to eight weeks. You might need to wait a little longer before resuming more vigorous activity. When you will be ready to return to work will depend on your usual health, how fast you recover and what type of work you do. Please ask your doctor for his/her opinion.
- **Check-ups and results:** Before you leave hospital, you will be given details of when you need to return to see us, for example outpatient clinics or for the results of your surgery. At this time, we can check your progress and discuss with you any further treatment we recommend.

## Intended benefits of the procedure

- 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?

- Your surgery will be performed by a surgeon with particular skills and training in bowel surgery. This is usually a Consultant Surgeon or senior Specialist Registrar, often under consultant supervision.

## Alternative procedures that are available

- For most of the conditions where anterior resection 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. Occasionally it is possible to remove a rectal cancer from within the back passage without the need for major surgery; this form of surgery is only suitable for a small minority of patients. This option (trans-anal resection) will be discussed if appropriate.

## Serious or frequently occurring risks

- Surgery to remove part of the bowel 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) or kidney function (for example, kidney failure). Those specifically related to anterior resection include problems with the seal where the bowel has been joined ('anastomotic leak'), a transient blockage of the bowel, bleeding or infection in the abdominal cavity. Rarely, further surgery is required to put right such complications.
- 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 achieve the desired result. 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.
- 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. There is also a chance of a permanent bag (a colostomy). If there is a likelihood of this you will be counselled by your surgeon and stoma nurses before surgery.
- 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.

- 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.

## Information and support

- You might be given some additional patient information before or after the procedure for example leaflets that explain what to do after the procedure and what problems to look out for. If you have any questions or anxieties, please feel free to ask a member of staff including the doctor or Ward staff.
- If you have further questions please contact one of the Colorectal Specialist Nurses on Telephone no. 01223 217923.

## General anaesthesia

### Before your operation

Before your operation your anaesthetist will visit you in the ward, although occasionally this will happen in a pre-anaesthetic assessment clinic. The anaesthetist who looks after you on the day of your operation is the one who is responsible for making the final decisions about your anaesthetic. He or she will need to understand about your general health, any medication that you are taking and any past health problems that you have had. Your anaesthetist will want to know whether or not you are a smoker, whether you have had any abnormal reactions to any of the drugs or if you have any allergies. They will also want to know about your teeth, whether you wear dentures, have caps or a plate.

**Pre-medication** is the name given to medication (drugs) given to you some hours before your operation. These drugs may be given as tablets, injections or liquids (to children). They relax you and may send you to sleep. They are not always given. Do not worry if you do not have a pre-med, your anaesthetist has to take many factors into account in making this decision and will take account of your views on the topic if possible. When your anaesthetist visits you before your operation, this is the time to ask all the questions that you may have, so that you can forget your fears and worries.

Before your operation you will usually be changed into a gown and taken to the operating suite into an anaesthetic room. This is an ante-room outside the theatre. The anaesthetist, his or her assistant and nurses are likely to be present. An intravenous line (drip) may be inserted. Monitoring devices may be attached to you, such as a blood pressure cuff or a pulse oximeter. A pulse oximeter is usually a little red light in a small box, which is taped to your finger. It shows how much oxygen you have in your blood and is one of the vital monitors that an anaesthetist uses during your operation to ensure that you remain in the best of health. You may be given some oxygen to breathe.

## During your operation

While you are unconscious and unaware your anaesthetist remains with you at all times. Your anaesthetist is constantly aware of your condition and trained to respond. Your anaesthetist will be monitoring such factors as heart rate, blood pressure, heart rhythm, body temperature and breathing. He or she will also constantly watch your need for fluid or blood replacement. If you have any other medical conditions, your anaesthetist will know of these from your pre-operative assessment and be able to treat them during surgery.

## After your operation

You will probably be transferred to a recovery ward where specially trained nurses, under the direction of anaesthetists, will look after you. Your anaesthetist and the recovery nurses will ensure that all the anaesthetic effects are reversed and that you are closely monitored as you return to full consciousness. You may be given some oxygen to breathe in the recovery area, and may find that intravenous drips have been inserted whilst you are unconscious in theatre and that these will be replacing fluids that you might require.

You are likely to feel drowsy and sleepy at this stage. Some patients feel sick, others may have a sore throat related to the insertion of the breathing tube during surgery. During this time it is important that you relax as much as you can, breathe deeply, do not be afraid to cough, and do not hesitate to ask the nursing staff for any pain relief, and about any queries you may have. You are likely to have hazy memories of this time and some patients experience vivid dreams. Once you are fully awake you will be returned to the ward, and if you are a day patient will be allowed to go to the waiting area to fully recover before you are accompanied home. Do not expect to feel completely normal immediately!

## What are the risks of general 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 done in an emergency. Please discuss any pre-existing medical condition with your anaesthetist.

- Very common and common side effects (1 in 10 or 1 in 100 people)

Feeling sick and vomiting after surgery, sore throat, dizziness, blurred vision, headache, itching, aches, pains and backache, pain during injection of drugs, bruising and soreness, confusion or memory loss.

- Uncommon side effects and complications (1 in 1000 people)

Chest infection, bladder problems, muscle pains, slow breathing (depressed respiration), damage to teeth, lips or tongue, an existing medical condition getting worse, awareness (becoming conscious during your operation).

- Rare or very rare complications (1 in 10,000 or 1 in 100,000)  
Damage to the eyes, serious allergy to drugs, nerve damage, death, equipment failure.

## Pain relief

### Epidural:

An epidural is one way of delivering effective pain relief after abdominal surgery. It is done by injecting local anaesthetics through a fine plastic tube into the space in your spine where the nerves from your spine pass to your lower body. As a result, the nerve messages are blocked. This causes numbness, which varies in extent according to the amount of local anaesthetic injected. Epidurals are usually inserted in the anaesthetic room before putting you off to sleep. You will be asked to lie on your side or to sit on the edge of the bed to have this done. Local anaesthetic is injected into the skin first and this may sting briefly. There is also slight discomfort as the catheter is inserted into the back. Occasionally, an electric shock-like sensation or pain occurs during needle or catheter insertion. If this happens, you must tell your anaesthetist immediately. A sensation of warmth and numbness gradually develops, like the sensation after a dental injection. You may still be able to feel touch, pressure and movement. Sometimes your legs may feel heavy and become difficult to move, but this effect wears off in the days after the operation. The Pain Relief Team doctors and nurses will visit you, to check your epidural is working properly. The epidural will be stopped when you no longer require it for pain relief.

### Benefits

The main benefit of an epidural is very good pain relief, particularly when you move. There are also benefits in terms of quicker return in bowel function and reduced risk of chest infection after surgery. Not everyone is suitable for an epidural (for example, if you take blood-thinning drugs or severe arthritis in the spine). Your anaesthetist will discuss this with you.

The epidural occasionally does not provide adequate pain relief.

### Side effects

Common side effects or complications of an epidural include inability to pass urine, low blood pressure, itching, nausea or vomiting, backache and headache. Occasionally a severe headache occurs after an epidural because the lining of the fluid filled space surrounding the spinal cord has been inadvertently punctured (a 'dural tap'). The fluid leaks out and causes low pressure in the brain, particularly when you sit up. If this happens, it may be necessary to inject a small amount of your own blood into your epidural space. This is called an 'epidural blood patch'. The blood clots and plugs the hole in the epidural lining. It is almost always immediately effective. Uncommon complications include slow breathing and infection in the catheter, which means the epidural has to be removed. Rare complications of an epidural include convulsions (fits), breathing difficulty and temporary nerve damage. Permanent nerve damage, epidural abscess, epidural haematoma (blood clot) and cardiac arrest (stopping of the heart) are very rare indeed.

For further information on epidurals, please refer to the following patient information leaflets:

Epidurals for pain relief after surgery:

[http://www.addenbrookes.org.uk/patient\\_visitors/information\\_leaflets/library/list\\_e.html](http://www.addenbrookes.org.uk/patient_visitors/information_leaflets/library/list_e.html)

## **Patient Controlled Analgesia (PCA)**

PCA is a method of pain control that allows you to give yourself some pain relief as and when you need it. The PCA system is attached to you through an infusion into a vein in your arm. You control the system with a hand held button, but other ways of activating the system are available if you do not have full use of your hands. When you feel pain, you push the button on your PCA handset and a small amount of pain killer will be delivered directly into your bloodstream. You are the only person who knows when you are in pain, so you are the only person who should press the PCA button.

The PCA has alarms set to alert your nurse of any problems. It is carefully programmed to deliver only a specific amount of painkiller so you cannot overdose. The nurses and doctors will follow your progress carefully. There will be frequent checks on your blood pressure, pulse, breathing and level of sedation. A PCA is not addictive if you are in pain. It is realistic to expect some pain when coughing or moving about in bed but it should never be more than bearable. Pressing the PCA button before mobilising, deep breathing or coughing will help to prevent your pain level from rising.

### **Side effects**

The most common side effects with a PCA are nausea, vomiting, itching and drowsiness. These side effects do not occur in everybody. If they occur, report them to the nurse looking after you. Medications can be given to counteract the side effects. A PCA is not always entirely effective on its own in managing pain after abdominal surgery, and so you may need other forms of pain relief as well.

For further information on Patient Controlled Analgesia, please refer to the following patient information leaflet:

[http://www.addenbrookes.org.uk/patient\\_visitors/information\\_leaflets/library/list\\_p.html](http://www.addenbrookes.org.uk/patient_visitors/information_leaflets/library/list_p.html)



We are currently working towards a smoke-free site. Smoking is only permitted in the designated smoking areas.

For advice and support in quitting, contact your GP or the free NHS Stop Smoking helpline on 0800 169 0 169

## Help with this leaflet:



If you would like this information in another language, large print or audio format, please ask the department to contact

Patient Information: 01223 216032 or

[patient.information@addenbrookes.nhs.uk](mailto:patient.information@addenbrookes.nhs.uk)



## Document history

Authors	Department of Colorectal Surgery
Department	Cambridge University Hospitals NHS Foundation Trust, Hills Road, Cambridge, CB2 0QQ <a href="http://www.cuh.org.uk">www.cuh.org.uk</a>
Contact number	01223 245151
Publish/Review date	February 2011/February 2014 (no changes made)
File name	General_surgery_anterior_resection_for_rectal_cancer
Version number/Ref	5/CF133

# Consent Form (Adults)

Patient agreement to  
investigation or treatment

<b>For staff use only:</b>
Surname:
First names:
Date of birth:
Hospital no:
Male/Female:
(Use hospital identification label)

Responsible health professional/job title  
.....

Special requirements .....  
(For example, other language/other communication method)

**Name of proposed procedure or course of treatment**

**Anterior resection for rectal cancer**

**Statement of health professional**

(To be filled in by a health professional with an **appropriate knowledge of the proposed procedure**, as specified in the Hospital's consent policy)

I have explained the procedure to the patient. In particular, I have explained:

- The intended benefits of the procedure .....  
.....To remove the cancer .....

- Any serious or frequently occurring risks from the procedures including those specific to the patient .....

...The type of surgery may need to be altered to achieve the desired result. This may mean removing more bowel or part of a nearby organ (for example, small intestine, bladder or ovary); 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. There is also a chance of a permanent bag (a colostomy); In men there is a risk of impotence and retrograde ejaculation; In women, there is a risk of discomfort or dryness during sexual intercourse, and some women no longer experience sexual orgasm; A tiny risk of death

- Any extra procedures that might become necessary during the procedure
- Blood transfusion  Other procedure (please specify) .....

I have discussed what the treatment / procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient.

- The following information leaflet has been provided: .....  
..... Version/Date/Ref: 5, February 2011, CF133 .....

This procedure will involve:

- General and/or regional anaesthesia       Local anaesthesia       Sedation

Health professional's signature: ..... Date: .....

Name (PRINT): ..... Job title: .....  
Contact details (if patient wishes to discuss details later)

- I have offered the patient information about the procedure but s/he has declined information.

**Statement of the interpreter (if appropriate)**

I have interpreted the information to the best of my ability, and in a way in which I believe s/he can understand:

Interpreter's signature..... Date: .....

Name (PRINT): .....

**Important notes: (tick if applicable)**

- The patient has withdrawn consent (ask patient to sign/date here) .....
- See also advance directive/living will (eg Jehovah's Witness form)

**Statement of patient**

<b>For staff use only:</b>
<b>Surname:</b>
<b>First names:</b>
<b>Date of birth:</b>
<b>Hospital no:</b>
<b>Male/Female:</b>
<b>(Use hospital identification label)</b>

Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy, which describes the benefits and risks of the proposed treatment. If not, you will be offered a copy now. Do ask if you have any further questions. The staff at Addenbrooke's are here to help you. **You have any time before the procedure is undertaken, including after**

Training doctors and other health professionals is essential to the continuation of the Health Service and improving the quality of care. Your treatment may provide an important opportunity for such training, where necessary under the careful supervision of a senior doctor. You may, however, decline to be involved in the formal training of medical and other students without this adversely affecting your care and treatment.

**Please read the following:**

**I understand** that I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of my situation prevents this. (This only applies to patients having general or regional anaesthesia.)

**I understand** that you cannot give me a guarantee that a particular person will perform the procedure. The person undertaking the procedure will, however, have appropriate experience.

**I understand** that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.

**I have been told** about additional procedures which may become necessary during my treatment. I have listed below any procedures that **I do not wish, without further discussion, to be carried out.**

**I understand** that any tissue (including blood) removed as part of the procedure or treatment will be anonymised and may be used for teaching or quality control, and stored or disposed of in a manner regulated by appropriate, ethical, legal and professional standards.

**I understand** that all research will be approved by a research ethics committee and undertaken in accordance with appropriate ethical, legal and professional standards.

**I understand** that the research may be conducted within a hospital, university, not for profit organisation or a company laboratory.

**Please tick boxes to indicate you either agree/disagree to the three points below.** **Yes**  **No**

**I agree** that tissue (including blood) not needed for my own diagnosis or treatment can be used for **research which may include genetic research.** **If you wish** to withdraw your consent for the use of your tissue (including blood) for research, please contact the Patient Advice and Liaison Service at Addenbrooke's Hospital.

**I agree** to the use of photography for the purpose of diagnosis and treatment.

**I agree** to anonymised photographs being used for medical teaching.

**I confirm** that the risks, benefits and alternatives of this procedure have been discussed with me and I have read and understood the above and agree to the procedure (or course of treatment) on this form.

**Patient's signature:** ..... **Date:** .....

**Name (PRINT):** .....

If the patient is unable to sign but has indicated his/her consent, a witness should sign below. Young people may also like a parent to sign here (see guidance notes).

**Witness' signature:** ..... **Date:** .....

**Name (PRINT):** .....

**Confirmation of consent** (to be completed by a health professional when the patient is admitted for the procedure, if the patient has signed the form in advance)

On behalf of the team treating the patient, I have confirmed with the patient that s/he has no further questions and wishes the procedure to go ahead.

Signature Date: .....

Name (PRINT): ..... Job Title: .....

Copy accepted by patient: yes / no (please circle)