

Patient agreement to investigation or treatment

Formation of ileo-anal pouch

Authors: Colorectal Surgery

Brief description:

- The aim of this surgery is to remove the diseased colon (large intestine) and rectum (storage pouch leading to the back passage) without the need for a permanent stoma. The ileo-anal pouch or reservoir is made from loops of ileum (part of the small intestine), which are then joined to the anus (back passage). This creates a new rectum made from small bowel. The new pouch needs time to expand after the surgery. The function of the pouch should become manageable in a very short time however, its function can improve for at least a year after surgery. You should expect to have a more frequent, urgent and looser stool after this surgery.
- The most commonly used alternative to this procedure is a permanent ileostomy. Further information on this can be found in the booklet titled '**Which operation? ileo-anal pouch versus permanent ileostomy**'.
- 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)

.....
.....

Before your procedure

- Most patients attend a pre-admission clinic where you will meet one of the colorectal medical team.
- At this clinic, we shall ask you for details of your medical history and carry out any necessary clinical examinations and investigations. This is a good opportunity for you to ask us any questions about the procedure, but please feel free to discuss any concerns you might have at any time.
- 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 this.
- Most people who have this type of procedure will need to stay in hospital for 7 to 14 days. 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.
- In some cases, you may need to have a temporary ileostomy (bag) to rest the join between the pouch and the anus. If this is the case, you will be seen by the Stomatherapy Specialist Nurse before your 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

- At the start of your procedure, you will be given the necessary anaesthetic and/or sedation - see below for details of this.
- The operation is performed through the abdomen and a mid line incision (wound) is made. At this point, if we are confident it is in your best interests to proceed, we remove the rectum. We make every attempt to preserve the nerves around the rectum. A new 'pouch' is then made from the bowel to replace the rectum, either by stapling the bowel together or sewing it. This is then joined to the anus, either by stitches or by staples. To protect the pouch, an ileostomy might be made, or you might have a tube in the pouch inserted through the anus to empty the new pouch for 10 days after surgery.

After the procedure

- After this procedure, you will wake up in the recovery room. You might wake up feeling sleepy and you might have an oxygen mask on your face to help you breathe.
- Most people will have a small, plastic tube in one of the veins of their arm. This might be attached to a bag of fluid (called a drip), which feeds your body with fluid until you are well enough to eat and drink by yourself.
- 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.
- **Eating and drinking:** You will be advised by your doctors about how much to drink and eat after your operation. If you have a temporary ileostomy, you will be allowed to drink and eat as soon as you feel able to do so. If you do not have a temporary ileostomy, you may have a tube inserted in your pouch (see above), which is designed to keep the pouch empty and allow initial healing. If you are allowed to eat while this tube is in place, you will be advised about a no-residue diet to prevent the tube from blocking.
- **Getting around and about:** After this procedure, we will try to get you mobile (up and about) as soon as we can to help prevent complications from not moving much. Typically, you will be able to get up the first day after surgery. If we think you will have problems getting about, we will arrange extra assistance for example, nursing help and physiotherapy advice/exercise.
- **When you can leave hospital:** 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 approximately six to eight weeks. You might need to wait a little longer before resuming activity that is more vigorous. 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.

- **Special measures you need to take after the procedure:** you will be given more detailed written and verbal information about any special measures you need to take after the procedure. You will also be given information about things to watch out for that might be early signs of problems (for example infection).
- **Check-ups and results:** Before you leave hospital, you will be given details of when you need to return to see us (outpatient clinics). 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 this surgery is to remove the diseased colon and rectum, without the need for a permanent stoma. The passing of stool via the anus (back passage) provides a sense of 'normality', although bowel movements will be more frequent.
- There are various reasons for recommending the formation of an ileo-anal pouch including inflammatory bowel disease (ulcerative colitis) and some types of bowel cancer syndromes (for example, familial adenomatous polyposis, FAP). This surgery provides a cure for the symptoms of ulcerative colitis and the risks of some types of bowel cancer are virtually eliminated.

Who will perform my procedure?

- This procedure will be performed or supervised by an experienced colorectal surgeon.

Alternative procedures that are available

- Potential alternatives to this procedure are panproctocolectomy or proctectomy. They will have already been discussed with you and you will have been given a leaflet on the benefits and risks of the different options.

Serious or frequently occurring risks

- Everything we do carries some risk. Surgery to remove part of the bowel is a major operation, and there are 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, which are 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), and blood clots (for example, in the legs or occasionally in the lung).
- **The risks specifically related to ileo-anal pouch formation surgery** include infection in the pelvis (an abscess or leak from the join-up of the pouch to the anus), poor function of the pouch (for example incomplete emptying or frequency and urgency), fistulae formation (abnormal channel caused by infection), blockage of the bowel, and inflammation of the pouch (pouchitis). Further surgery is sometimes required to put right such complications.
- Sometimes during the operation, it becomes apparent that the existing disease is more complicated than was anticipated (for example Crohn's Disease in the small intestine).

If this is the case, the type of surgery might need to be altered to achieve the desired result. This can mean we need to make a temporary or permanent stoma, even if it was not the planned intention. Your surgeon will have discussed with you whether it is intended to have a temporary stoma for this stage of treatment. It might also mean removing part of a nearby affected organ (for example bladder or ovary). When you complete this consent form, there is a section where you can write in any part of you that you specifically do **not** wish to be removed.

- In men, there is a risk of impotence (failure to achieve an erection) following 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). Every effort is made to minimise this risk, but you need to be aware of it. Sometimes, you can make use of a sperm 'banks' before the surgery – this will be discussed by the surgeon or specialist nurse before your admission. In women, there is a risk of discomfort or dryness during sexual intercourse, and some women no longer experience sexual orgasm.
- The formation of a pouch is associated with a risk of infertility in women. There is a threefold increase in infertility in women with ulcerative colitis who undergo pouch surgery, even though great care is taken during the operation to protect the tubes and ovaries. The risk of infertility in women with familial adenomatous polyposis (FAP) who have pouch surgery is twofold.
- Most people will not experience any serious complications following 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. 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 should already have been given and had explained an information booklet titled 'Which operation? Ileo-anal pouch versus permanent Ileostomy'. This booklet is aimed to be complimentary to this consent form. If you have any questions or anxieties, please feel free to ask a member of staff including the Clinical Nurse Specialist Monday to Friday 08:00 – 16:00 on 01223 216 505.

General anaesthesia

Your procedure will be carried out under general anaesthesia (GA). This means you will be in a state of 'controlled sleep' until we reverse (stop) the effects of the anaesthetic. While you are under the anaesthetic, you will be unaware of what is happening. The doctor who gives you this type of anaesthetic is called an anaesthetist. Their role is to care for all aspects of your health and safety over the period of your procedure, and immediately afterwards.

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. Your anaesthetist will need to understand about your general health, any medication that you are taking and any past health problems that you have had, 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. Your anaesthetist needs to know all these things so that he or she can assess how to look after you in this vital period.

Pre-medication is the name given to medication (drugs) which may be given to you some hours before your operation. These drugs may be given as tablets or injections. They relax you and may send you to sleep.

Do not worry if you do not have a pre-med, your anaesthetist has to consider many factors in making this decision and if possible will take account of your views on the topic. Do not be worried about your anaesthetic. 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 wheeled into an anaesthetic room of the operating suite. 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 your anaesthetist remains with you at all times. Your anaesthetist is constantly aware of your condition and trained to respond and 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

After your operation, your anaesthetist continues to monitor your condition carefully. 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 may be given medication for any pain that you might feel, and systems, such as Patient Controlled Anaesthesia (PCA) may be set up to continue pain control on the ward.

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. Once you are fully awake you will be returned to the ward. 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 that 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 have 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 leaflet: Epidurals for pain relief after surgery:

http://www.addenbrookes.org.uk/patient_visitors/information_leaflets/library/list_p.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



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



Document history

Authors	Department of Colorectal Surgery
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Consent Form (Adults)

Patient agreement to
investigation or treatment

For staff use only: 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

Formation of ileo-anal pouch

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 diseased colon and rectum
- Any serious or frequently occurring risks from the procedures including those specific to the patient

...Infection in the pelvis (an abscess or leak from the join-up of the pouch to the anus); poor function of the pouch (for example incomplete emptying or frequency and urgency); fistulae formation (abnormal channel caused by infection); blockage of the bowel; inflammation of the pouch (pouchitis); the type of surgery might need to be altered to achieve the desired result - this can mean making a temporary or permanent stoma or removing part of a nearby affected organ (for example bladder or ovary); 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; threefold increase in infertility in women with ulcerative colitis who undergo pouch surgery; risk of infertility in women with familial adenomatous polyposis (FAP) who have pouch surgery is twofold.

- 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: CF270, version 5, February 2011

This procedure will involve: General and/or regional anaesthesia

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)

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

Statement of patient

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 the right to change your mind at any time before the procedure is undertaken, including after you have signed this form.**

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)