Patient Information and Consent to Reversal of Hartmann's Operation

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About a reversal of Hartmann's operation

You have been recommended to have a reversal of Hartmann's operation to enable your bowel to be re-joined and get rid of the present stoma/colostomy. The procedure will be performed under general anaesthetic.

You have already had an operation called a Hartmann's procedure where part of your large bowel (colon) was removed and a stoma (a colostomy or occasionally an ileostomy) created.

The lower end of the large bowel (rectum) has been closed and left inside your abdomen.

In this reversal of Hartmann's operation the aim is to take down the stoma and join it back to the closed lower end (rectum). This will re-establish the continuity of your bowel to allow passage of stool (bowel motions) through the back passage (anus) again.

Although the aim of this operation is to remove the stoma, a small minority of patients may require a smaller temporary stoma (ileostomy) for three to six months to enable the new joint to heal safely. If this is likely, the stoma therapy nurse will see you to advise you about an ileostomy and to place a mark for a suitable position for the ileostomy on the right side of your abdomen.

Intended benefits

The aim of the surgery is to remove the stoma, re-join the cut ends of bowel and enable passage of stools/motions via the back passage again. For most patients this will be the last operation relating to this episode.

Who will perform my procedure?

Your surgery will be performed by surgeon with particular skills and training in bowel surgery. This is usually a consultant colorectal surgeon or senior specialist registrar under consultant supervision.

Before your admission

Most patients attend a pre-admission clinic, where you will meet one of the specialist nurses. At this clinic, we will ask for your details of your medical history and carry out any necessary clinical e xaminations and investigations. Please ask us any questions about the procedure, and feel free to discuss any concerns you may have.

We will ask if you take any tablets or use any other types of medication either prescribed by a doctor or bought over the counter in a pharmacy.

Please bring any relevant packaging with you. You may have a blood test and an ECG performed, as well as swabs taken for MRSA.

This procedure involves the use of anaesthesia but spinal or local anaesthetics are often used as well for pain control. We explain about the different types of anaesthesia or sedation we may use at the end of this leaflet. You will see an anaesthetist before your procedure.

You will also be invited to attend bowel school where the principles of enhanced recovery will be discussed with you and you will meet members of the MDT who are vital in your recovery.

You may also be given carbohydrate drinks to optimise your health state whilst in theatre.

Most people who have this type of procedure will need to stay in hospital for three to six days after the operation. Sometimes you will need to stay in 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.

Day of surgery admission

Most patients are admitted on the day of surgery. If you need to have a completely empty bowel you should take a ‘bowel prep’ (given to you at bowel school) at home the previous day. You may also be asked to have an enema to clear the back passage prior to surgery. These preparations are not always necessary.

Hair removal before an operation

For most operations, you do not need to have the hair around the site of the operation removed.

However, sometimes the healthcare team need to see or reach your skin and if this is necessary they will use an electric hair clipper with a single-use disposable head, on the day of surgery.

Please do not shave the hair yourself or use a razor to remove hair, as this can increase the risk of infection. Your healthcare team will be happy to discuss this with you.

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.

During the procedure

Before your procedure, we will give you the necessary anaesthetic – see below for more details.

Your anaesthetist will also discuss post-operative pain relief with you and if you are having a spinal or epidural this may be put in before you are anaesthetised. You will need to have a catheter inserted once you are asleep so we can measure urine output. This will be removed within the first few days after the operation.

The operation may be done either with an open approach via an incision or by laparoscopic keyhole approach. Your surgeon will discuss the best way of doing your surgery with you. If you re offered a keyhole operation, there is a chance that it may not be possible to do the operation safely by keyhole surgery, in which case the operation will be carried out through an incision.

The open approach usually uses a vertical incision through the previous scar in the abdominal wall. In the laparoscopic keyhole approach, three small holes are made in the tummy wall each about 1cm long. Through these we inflate your tummy with carbon dioxide gas which is harmless.

We then use special long instruments and operate visualising on a TV screen by a miniature camera inserted through one of the three keyholes. Sometimes additional keyholes may have to be made if necessary.

The first part of the operation involves freeing the loops of bowel from adhesions (scar tissue which sticks bowel together or to other structures inside the belly (abdomen). The closed lower end of the bowel also needs to be found and freed to allow a join to be made.

The stoma is freed up from its attachment to the skin by making an incision around it on the abdominal wall. The upper end of the bowel and the rectum are then joined together either using special stapling instruments or sutures (stitches). If a smaller temporary stoma is thought to be necessary, then this will be made.

At the end of the operation the abdominal wall is stitched together at the site of the previous stoma and at all incisions. The skin is closed, usually with dissolvable sutures, so there is no need for the stitches to be removed after the wound heals. Glue dressings are used to seal the skin. Occasionally a temporary drain may be placed which is removed a couple of days after surgery.

After the procedure

Once your surgery is complete, you will usually be transferred to the recovery ward where you will be looked after by specially trained nurses, under the direction of your anaesthetist. The nurses will monitor you closely until the effects of any general anaesthetic have adequately worn off and you are conscious. They will monitor your heart rate, blood pressure and oxygen levels. You may be given oxygen via a facemask, fluids via a drip and appropriate pain relief until you are comfortable enough to return to your ward.

After certain major operations you may be transferred to the intensive care unit (ICU/ITU), high dependency unit (HDU). These are areas where you will be monitored much more closely because of the nature of your operation or because of certain pre-existing health problems that you may have. If your surgeon or anaesthetist believes you should go to one of these areas after your operation, they will tell you and explain to you what you should expect.

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.

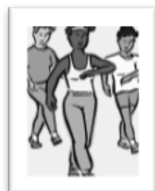
If there is not a bed in the necessary unit on the day of your operation, your operation may be postponed as it is important that you have the correct level of care after major surgery.

Enhanced recovery

Where possible we make use of ‘enhanced recovery’ principles to minimise the impact of surgery on the body and enable a rapid return to normal activity. There are many aspects to this process which includes preoperative (before), intraoperative (during) and postoperative (after) procedures.

We aim to minimise pain; perform careful surgery; avoid unnecessary drips, tubes and drains; enable you to eat and drink straight after your operation; encourage early mobilisation to stimulate recovery and allow you to go home soon and safely. We want you to be involved with this and need your help to improve your recovery.

Eating and drinking. It is safe drink and even eat after surgery providing you feel the desire to do so. You should not eat or drink if it makes you feel sick or bloated.



Getting about after the procedure. We will help you to become mobile as soon as possible after the procedure. This helps improve your recovery and reduces the risk of certain complications. You will have daily injections which reduce your chance of blood clotting in your legs (DVT). Typically, you will be helped into a chair the following day. If you have any mobility problems, we can arrange nursing or physiotherapy help.

Leaving 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 doctors opinion.

Resuming normal activities including work. Most people who have had this procedure can get back to normal activities within six weeks. Initially you will feel more tired than usual but this should not stop you from doing anything, because activity is beneficial. For driving you need to feel safe and to be able to brake in an emergency – this often takes two to four weeks. When going back to work see if you can start half days or work a bit from home until your energy levels are improved.

Special measures after the procedure. 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).

Check-up and results. Before you leave hospital, we will give you 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.

Significant, unavoidable or frequently occurring risks of this procedure

Reversal of Hartmann's operation 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).

There is a risk of leakage where the bowel has been joined ('anastomotic leak') after reversal of Hartmann's procedure. The risk of leakage depends on several factors including how close the join is to the anus, medical problems, adhesions (scar tissue) etc.

The risk of a leak is about 5% but may be higher if the join is low or technically difficult. If the risk is thought to be high, you may need a temporary ileostomy to allow the join to heal safely. If a leak occurs, further intervention with drains being inserted placed in the x-ray department or occasionally surgery may be required.

Other risks specifically related to reversal of Hartmann's operation include transient blockage of the bowel, bleeding or infection in the abdominal cavity. Rarely further surgery is required to put right such complications.

It is very occasionally apparent during the operation that it is not possible or safe to reverse the stoma. The chances of this are about 1%. In this case, the stoma would be left and not reversed. Injury to other organs (for example, small intestine) may require repair. The risk of this is greater if there is a lot of scar tissue from the previous surgery.

A small minority of patients undergoing reversal of Hartmann's operation may need a further smaller temporary stoma to cover the join. Such patients will need to have a further operation to close this stoma once the join has healed. This will usually be after three months.

Bowel function may be erratic or more frequent after reversal of Hartmann's operation. The majority of patients settle into a regular bowel pattern by about a month after the operation. Occasionally patients may suffer frequency or urgency after this type of surgery.

Long term risks include hernias in the surgical incisions and bowel blockages from adhesions (scar tissue).

Most people will not experience any serious complications from their surgery. The risks increase for the elderly or overweight, for smokers, and for those who already have heart, chest or other medical conditions such as diabetes or kidney failure. There is a small 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.

Alternative procedures that are available

The majority of patients with Hartmann's procedure undergo reversal particularly as they are keen to get rid of the stoma. The only other alternative is not to undergo the operation for the reversal and keep the stoma.

Anaesthesia

Anaesthesia means 'loss of sensation'. There are three types of anaesthesia: general, regional and local. **The type of anaesthesia chosen by your anaesthetist depends on the nature of your surgery as well as your health and fitness.** Sometimes different types of anaesthesia are used together.

Before your operation

Before your operation you will meet an anaesthetist who will discuss with you the most appropriate type of anaesthetic for your operation, and pain relief after your surgery. To inform this decision, he/she will need to know about:

- Your general health’ including previous and current health problems
- Whether you or anyone in your family has had problems with anaesthetics
- Any medicines or drugs you use
- Whether you smoke
- Whether you have had any abnormal reactions to any drugs or have any other allergies
- Your teeth, whether you wear dentures, or have caps or crowns.

Your anaesthetist may need to listen to your heart and lungs, ask you to open your mouth and move your neck and will review your results.

Moving to the operating room or theatre

You will usually change into a gown before your operation and we will take you to the operating suite. When you arrive in the theatre or anaesthetic room and **before starting your anaesthesia, the medical team will perform a check of your name, personal details and confirm the operation you are expecting.**

Once that is complete, monitoring devices may be attached to you, such as blood pressure cuff, heart monitor (ECG) and a monitor to check your oxygen levels (a pulse oximeter). An intravenous line (drip) may be inserted. If a regional anaesthetic is going to be performed, this may be performed at this stage. If you are to have a general anaesthetic, you may be asked to breathe oxygen through a face mask.

General anaesthesia

During general anaesthesia you are put into a state of unconsciousness and you will be unaware of anything during the time of the operation. Your anaesthetist achieves this by giving you a combination of drugs.

While you are unconscious and unaware your anaesthetist remains with you at all times. He or she monitors your condition and administers the right amount of anaesthetic drugs to maintain the correct level of unconsciousness for the period of the surgery. 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.

Regional anaesthesia

Regional anaesthesia includes epidurals, spinals, caudals or local anaesthetic blocks of the nerves to the limbs or other areas of the body. Local anaesthetic is injected near to nerves, numbing the relevant area and possibly making the affected part of the body difficult or impossible to move for a period of time. Regional anaesthesia may be performed as the sole anaesthetic for your operation, with or without sedation, or with a general anaesthetic. Regional anaesthesia may also be used to provide pain relief after your surgery for hours or even days.

Your anaesthetist will discuss the procedure, benefits and risks with you and, if you are to have a general anaesthetic as well, whether the regional anaesthesia will be performed before you are given the general anaesthetic.

Local anaesthesia

In local anaesthesia the drug is injected into the skin and tissues at the site of the operation. This area of numbness will be restricted and some sensation of pressure may be present, but there should be no pain. Local anaesthesia is used for minor operations such as stitching a cut, but may also be injected around the surgical site to help with pain relief. Usually a local anaesthesia will be given by the doctor doing the operation.

Sedation

Sedation is the use of small amounts of anaesthetic or similar drugs to produce a 'sleepy-like' state. Sedation may be used as well as a local or regional anaesthetic. The anaesthesia prevents you from feeling pain and the sedation makes you drowsy. Sedation also makes you physically and mentally relaxed during an investigation or procedure which may be unpleasant or painful (such as an endoscopy) but where your co-operation is needed. You may remember a little about what happened but often you will remember nothing. Sedation may be used by other professionals as well as anaesthetists.

What will I feel like afterwards?

How you will feel depends on the type of anaesthetic and operation you have had, how much pain relieving medicine you will need and your general health.

Most people will feel fine after their operation. Some people may feel dizzy, sick or have general aches and pains. Others may experience some blurred vision, drowsiness, a sore throat, headache or breathing difficulties.

You may have fewer of these effects after local or regional anaesthesia. When the effects of the anaesthesia wear off you may need pain relieving medicines.

What are the risks of general or regional 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 factor (such as smoking or being overweight) or surgery which is complicated, long or performed in an emergency.

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

- Feeling sick and vomiting after surgery
- Sore throat
- Dizziness, blurred vision
- Headache
- Bladder problems
- Damage to lips or tongue (usually minor)
- 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
- Muscle pain
- Slow breathing (depressed respiration)
- Damage to teeth
- An existing medical condition getting worse
- Awareness (becoming conscious during your operation)

Rare (1 in 10,000 people) and very rare (1 in 100,000 people complications

- Damage to the eyes
- Heart attack or stoke
- Serious allergy to drugs
- Nerve damage
- Death
- Equipment failure

Deaths caused by anaesthesia are very rare. There are probably about five deaths for every million anaesthetics in the UK. For more information about anaesthesia, please visit the Royal College of Anaesthetists' website: www.rcoa.ac.uk

Pain relief

Pain relief (analgesia) after major bowel surgery may be provided by regional analgesia, either by an epidural, caudal or spinal injection (depending upon your particular operation), or by strong pain killers such as morphine, usually administered into the vein by a patient controlled analgesia system. The latter is a system whereby you control the administration of pain killer into your intravenous drip by pressing a button. Local anaesthetic injections around nerves which supply the abdominal wall may also be used e.g. TAP blocks.

Your anaesthetist will discuss pain relief with you prior to surgery, along with the risks and benefits of the techniques.

The risks of the epidural and spinal pain relief are similar to the risks of regional anaesthesia, as listed above.

Other analgesics may also be administered as injections, tablets or suppositories (if appropriate), particularly after a day or two, when the pain will be decreased and the epidural or patient controlled analgesia are stopped.

This hospital has an 'Acute pain team', who are a team of a nurse and anaesthetists who specialise in pain relief after surgery. One of the team may visit you after your surgery to help and advise the ward team with the management of any pain you may have.

Information and Support

We might give you 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.

Important things you need to know

Patient choice is an important part of your care. You have the right to change your mind at any time, even after you have given consent and the procedure has started (as long as it is safe and practical to do so). If you are having an anaesthetic you will have the opportunity to discuss this with the anaesthetist, unless the urgency of your treatment prevents this.

We will also only carry out the procedure on your consent form unless, in the opinion of the responsible health professional, a further procedure is needed in order to save your life or prevent serious harm to your health. However, there may be procedures you do not wish us to carry out and these can be recorded on the consent form. We are unable to guarantee that a particular person will perform the procedure. However the person undertaking the procedure will have the relevant experience.

All information we hold about you is stored according to the Data Protection Act 1998.

Privacy & Dignity

Same sex bays and bathrooms are offered in all wards except critical care and theatre recovery areas where the use of high-tech equipment and /or specialist one to one care is required.

Notes

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