Surgery for bowel cancer

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There are different types of surgery for bowel cancer. Which one you have depends on where the cancer is in the bowel, the type and size of the cancer and whether it has begun to spread. The doctor will also consider your age and general health.

Minimally invasive surgery

The term minimally invasive surgery, also called keyhole or laparoscopic surgery, means a surgical technique that involves several small cuts (incisions) instead of one large cut on the abdomen.

The surgeon passes a thin, flexible tube called a laparoscope through one of the cuts. The laparoscope is fitted with a light and camera so the surgeon can see into the abdomen and remove the cancer. This technique usually means less pain and scarring, a lower risk of infection and a faster recovery with less time spent in hospital.

Minimally invasive bowel surgery is often recommended for early stage cancers and if the surgeon is confident the tumour can be easily removed. This depends on the location of the cancer and its size. Ask your surgeon if this type of surgery is suitable for you and if it is available at your hospital or treatment centre.

Surgery for colon cancer

The most common type of colon cancer surgery is called a colectomy. There are different types of colectomies depending on where in the bowel the tumour is located.

Before the surgery, the operation and what to expect afterwards will be explained to you.

The surgeon will make a cut in the abdomen to remove the part of the colon containing the cancer. The lymph nodes near the colon are also removed. The surgeon joins the two ends of the colon back together.
Sometimes, to allow the area time to heal, the bowel isn’t joined but is brought out onto an opening on the outside of the body. This procedure is called a colostomy and the opening is called a stoma.

Another operation to rejoin the bowel can be done a few months later. In some cases, the surgeon will be unable to rejoin the ends of the colon and will connect the large bowel to a permanent stoma.

After surgery you will have a scar, usually running from your navel to your pubic area.

**Surgery for rectal and anal cancers**

If you have rectal or anal cancer, you may have part of the bowel removed, known as a resection. There are different types of resections depending on where in the rectum the cancer is located.

**Anterior resection**

For an anterior resection, the surgeon cuts out cancerous tissue in the rectum. You may have one large cut in your abdomen, or if your surgeon uses the minimally invasive technique, you will have small cuts. The type of surgery you have will depend on your situation.

During an anterior resection, the left part of the colon and the upper part of the rectum are removed, together with its blood supply and nearby lymph nodes. The ends of your bowel are rejoined.

**Ultra-low anterior resection**

If you have an ultra-low anterior resection, the left part of the colon and the entire rectum will be removed. Your surgeon will then perform a coloanal anastomosis. This means that your colon is joined to your anus. In some cases the surgeon may also create an internal pouch (called a colonic J-pouch) using the lining of the large bowel. The J-pouch will be connected to the anus and will work as a rectum. You may have a temporary stoma, which will be reversed once your J-pouch is healed.

**Abdominoperineal (AP) resection**
An AP resection is a less common type of rectal surgery. In this procedure, the entire rectum and anus are removed.

After an AP resection, you will have two wounds: one on your abdomen and one where your anus was removed.

Your doctor will also create a permanent stoma, and waste will be removed through this opening.

**Local excision**

This type of surgery is usually used for very early stage tumours. The surgeon removes the cancer without cutting into the abdomen. Instead the surgeon inserts an endoscope, like the one used to take a biopsy, into the rectum and lower colon and cuts the cancer out. There are several types of local excision. For example if the surgeon cuts out a cancerous polyp it is called a polypectomy. If a surgeon cuts out a tumour it is called a transanal excision.

The type of surgery you have will depend on the location of the cancer. For example if the cancer is in or near the anal sphincter muscles a transanal resection is not suitable.

**Having a stoma**

After treatment for bowel cancer some people need a temporary or permanent stoma. Usually a temporary stoma is only needed until the bowel has healed which is generally about three months. A permanent stoma is required in less than 10 per cent of cases.

If the surgeon removes the cancerous tissue and is unable to reconnect the bowel they will need to create a way to remove waste from the body. The surgeon creates a small hole in the abdomen and brings an end of the bowel out through the hole. The bowel is attached to the skin to create a stoma.

**Colostomy**

The most common type of stoma is a colostomy which is a stoma from an opening in the colon.

Stomas vary in size, but are usually about the size of a 20 cent coin. A stoma is soft, moist and red or pink in colour and is made of the same type of tissue as the inside of the mouth. It may be level with your skin or slightly raised. The stoma itself doesn't have any feeling but the skin around it does.

**Stomal therapy nurses**

If there is a chance you could need a stoma the surgeon will probably ask a stomal therapy nurse to talk to you before surgery.

Stomal therapy nurses have specialist training and will answer your questions about the surgery. They can talk to you about the best place for the stoma to be located and also provide information about adjusting to life with a stoma including how you can look after your stoma when you are out of hospital.

If you are not referred to a stomal therapy nurse talk to your surgeon or GP. You can also talk to an ostomy association or call Cancer Council 13 11 20 for more details.

**Support for people with a stoma**

A stomal therapy nurse may suggest that you join a stoma association which has a number of benefits.

The Australian Government has a Stoma Appliance Scheme, which supplies free stoma supplies such as colostomy bags and bag glue, to Medicare cardholders with a temporary or permanent stoma who belong to a stoma association. Visit the Australian Government's Department of Health and Ageing website at www.health.gov.au and type 'Stoma Appliance Scheme' into the search box for more information.

Stoma associations have information on all aspects of stoma care and provide products for people with a stoma. The other benefit of being a member of a stoma organisation is that you will be able to get in touch with other people who have a stoma. Talking to someone who also has one may help you adapt to life with a
Will I need a colostomy bag?

When the bowel moves, wind and waste material (faeces) come out through your stoma. A small, disposable, flat plastic bag collects this waste. This is called a colostomy bag.

Colostomy bags have adhesive on the back, so they should stick firmly to the skin around the stoma and provide a leak-proof, odour-proof system. They are usually not visible under clothing. In humid weather or during vigorous physical activity you may have to use extra glue to ensure the stoma bag does not fall off.

When the bag is full you will have to empty the contents down the toilet, discard the bag and fit a new bag to the stoma.

Will I be able to live a normal life?

Having a stoma, even temporarily, is a big change in a person's life and takes some adjustment. However thousands of Australians have a stoma and most lead a relatively normal life.

Having a stoma may sometimes impact on your travel plans, sexual relationships and social life but these issues can be managed. To you the colostomy bag may seem very obvious. However most people won’t notice unless you tell them. The stoma’s location may make some clothes less comfortable e.g. tight waist bands or belts but you will generally be able to continue wearing your normal clothes.

You can discuss changes to aspects of your everyday life with a stomal therapy nurse. Your stomal therapy nurse can provide you with advice and written material. Your family may also need information and support and can be included in discussions with the stomal therapy nurse.

Surgery for advanced cancer

A small number of people will have two separate cancers in their large bowel at the same time. Doctors may find the cancers using diagnostic tests or during surgery.

In this case there are three options for surgery:

- Remove the two small sections of the bowel
- Remove one larger section of the bowel, containing both areas with cancer
- Remove the entire colon and rectum (proctocolectomy) to prevent any chance of another cancer forming.

The type of surgery you have depends on your doctors’ recommendations and what you want.

In some cases the cancerous part of the large bowel will be attached to another organ such as the uterus or bladder. This may be caused by inflammation or by the cancer spreading. Your surgeon may remove the attached organ and the large bowel. If you need this type of operation talk to your surgeon about what to expect. For example, the removal of a woman's uterus (hysterectomy) causes infertility, so it is important to talk to a doctor or a fertility counsellor before treatment. This person can help you address your feelings and explore your options.

After surgery you will need regular checkups for the rest of your life as the chance of developing another primary cancer is higher than average. For more information about surgery for advanced bowel cancer call Cancer Council Helpline.

Recovery after bowel surgery

The recovery time after bowel surgery varies depending on the type of surgery. You will probably be in hospital for five to 10 days. However it can take six weeks or more to fully recover especially if the surgeon made a cut down your abdomen.

While in hospital, and when you return home, you may have:

Blood clots
People who have abdominal surgery are at risk of developing blood clots in their legs which can be life-threatening. During surgery your surgeon may apply pressure to your calves using special stockings. Afterwards you may be given regular injections of a blood-thinning substance. It is important to get out of bed and walk around as soon as you are able and move your legs if you are resting in bed.

Changes in bowel function

Many people find they have softer and more frequent bowel movements and may need to go to the toilet immediately when they feel the urge. Bowel function usually improves within a few months however for some people, it can take longer. It may help to talk to a continence nurse or dietitian.

Fatigue

Try to get plenty of rest and do only what is comfortable. You may have to remind your family and friends that you are still recovering, even several months after surgery.

Diet after bowel surgery

After any type of bowel cancer surgery you don't have to follow a strict diet but some foods can cause discomfort for people.

Foods can affect people differently so you may need to experiment to work out which foods cause problems for you. It is best to limit, not eliminate, these foods from your diet.

Foods that make bowel motions too soft and more frequent include:

- Fruit (fresh or dried) – grapes, stone fruit such as apricots, peaches and plums, and most berries (except blueberries)
- Vegetables – capsicum, cabbage, onions, beans, peas, corn, brussels sprouts and broccoli
- Alcohol – beer and red wine
- Bran, seeds and fibre – multigrain, wholemeal and high-fibre breads and many breakfast cereals
- Spicy foods – chilli and curry
- Caffeine – coffee, tea, chocolate and cola-type soft drinks and energy drinks
- Sugar-free foods and drinks – the sweetener sorbitol has a laxative effect.

Foods that produce wind/gas include:

- Eggs
- Vegetables – broccoli, brussels sprouts, cabbage, cauliflower, asparagus and onions
- Fried fish
- Dairy – some strong cheeses, milk
- Melon
- Fizzy drinks – soft drinks and beer.

For people with a stoma some foods can cause blockages:

- High-fibre foods – oranges, strawberries and apples
- Raw vegetables – coleslaw, celery, carrot and tomatoes
- Cooked vegetables – spinach, green beans, broccoli and cauliflower
- Foods with seeds or kernels – popcorn, nuts, coconut, corn
- Spicy foods
- Fruit and vegetable skins – apples, grapes and tomatoes
- Meat casing – sausages.

Tips for helping to reduce discomfort

- Eat regular meals
- Cut food into small pieces
- Chew food slowly and thoroughly. Lumps of food may cause a blockage for people with a colostomy.
- Try charcoal tablets and natural yoghurt to help reduce wind and odour
- Reintroduce one type of food at a time. If you experience any problems avoid the food for two to three weeks then try it again. If you still have problems you may want to avoid that food.
- Drink up to eight glasses of fluid a day to reduce constipation and replace the water lost with
diarrhoea, e.g. water, fruit juice, weak tea

- Eat and drink at regular times. Reducing fluid and food intake will not reduce leakage from the bowel.
- Try to maintain a balanced diet so your body is nourished. If you have trouble eating a certain type of food talk to a dietitian who can help you find the best diet