




SW9087

 <b>Queensland Government</b>  <h2>Resection of Colon</h2>  Facility: _____	(Affix identification label here)
	URN: _____
	Family name: _____
	Given name(s): _____
	Address: _____
Date of birth: _____	Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> I

**A. Interpreter / cultural needs**

- An Interpreter Service is required?  Yes  No  
If Yes, is a qualified Interpreter present?  Yes  No  
A Cultural Support Person is required?  Yes  No  
If Yes, is a Cultural Support Person present?  Yes  No

**B. Condition and treatment**

The doctor has explained that you have the following condition: *(Doctor to document in patient's own words)*

.....  
.....

This condition requires the following procedure.  
*(Doctor to document - include site and/or side where relevant to the procedure)*

.....  
.....

The following will be performed:

To remove a tumour, a part of the large bowel will be removed through a cut in the abdomen.

Occasionally a piece of the bowel may be brought out through the wall of the abdomen as a colostomy. This is usually temporary and allows the bowel content to drain into a bag worn over the colostomy until the join in the bowel has healed.

**C. Risks of a resection of colon**

There are risks and complications with this procedure. They include but are not limited to the following.

General risks:

- Infection can occur, requiring antibiotics and further treatment.
- Bleeding could occur and may require a return to the operating room. Bleeding is more common if you have been taking blood thinning drugs such as Warfarin, Aspirin, Clopidogrel (Plavix or Iscover) or Dipyridamole (Persantin or Asasantin).
- Small areas of the lung can collapse, increasing the risk of chest infection. This may need antibiotics and physiotherapy.
- Increased risk in obese people of wound infection, chest infection, heart and lung complications, and thrombosis.
- Heart attack or stroke could occur due to the strain on the heart.
- Blood clot in the leg (DVT) causing pain and swelling. In rare cases part of the clot may break off and go to the lungs.
- Death as a result of this procedure is possible.

Specific risks:

Please read **Resection of Colon information sheet** for detailed information about the risks involved. If you have not been given an information sheet, please ask for one.

- Leakage where the bowel was stitched together. This may need further surgery.
- Deep bleeding in the abdomen. This may need fluid replacement or further surgery.
- Bowel is paralysed, causing abdominal bloating and vomiting. This is usually temporary.
- The wound may become infected. This is usually treated with antibiotics or the wound may need to be opened.
- Urinary tract infection. Antibiotics may be used to control the infection.
- Infection in the abdominal cavity. This may form an abscess may need drainage and antibiotics.
- The bowel may be unable to be joined and may be brought to the surface as a stoma, with the following problems:
  - The blood supply to the stoma may fail and cause damage. This may need further surgery.
  - Excess fluid loss from the stoma.
  - Stoma prolapse - the bowel protrudes past skin.
  - Parastomal hernia - the bowel pushes through a weak point in the muscle wall, causing pain.
  - Local skin irritation - reddening of the skin and a rash in reaction to the stoma bag glue.
- Bleeding into the abdomen. A blood transfusion and further surgery may be necessary.
- Damage to the tube bringing the urine from the kidney to the bladder.
- Abnormal emptying of the bladder. It may empty without control or may not empty at all.
- Inability to have and/ or maintain an erection in men. In women, it can cause pain during or after intercourse.
- The wound may be abnormal and the wound can be thickened, red and painful.
- The bowel actions may be much looser after the operation than before.
- Adhesions (bands of scar tissue) develop in the abdominal cavity and the bowel may block.
- Death within 30 days of surgery is estimated at 1 in 16 to 1 in 63.



# Resection of Colon

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Address:

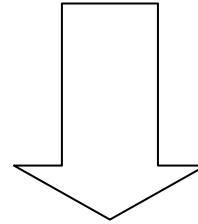
Date of birth:

Sex:  M  F  I

## D. Significant risks and procedure options

*(Doctor to document in space provided. Continue in Medical Record if necessary.)*

- This consent document continues on page 3 -



## E. Risks of not having this procedure

*(Doctor to document in space provided. Continue in Medical Record if necessary.)*

## F. Anaesthetic

This procedure may require an anaesthetic. *(Doctor to document type of anaesthetic discussed)*

DO NOT WRITE IN THIS BINDING MARGIN



Queensland Government

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Family name:

Given name(s):

Address:

Date of birth:

Sex:  M  F  I

## G. Patient consent

I acknowledge that the doctor has explained;

- my medical condition and the proposed procedure, including additional treatment if the doctor finds something unexpected. I understand the risks, including the risks that are specific to me.
- the anaesthetic required for this procedure. I understand the risks, including the risks that are specific to me.
- other relevant procedure/treatment options and their associated risks.
- my prognosis and the risks of not having the procedure.
- that no guarantee has been made that the procedure will improve my condition even though it has been carried out with due professional care.
- the procedure may include a blood transfusion.
- tissues and blood may be removed and could be used for diagnosis or management of my condition, stored and disposed of sensitively by the hospital.
- if immediate life-threatening events happen during the procedure, they will be treated based on my discussions with the doctor or my Acute Resuscitation Plan.
- a doctor other than the Consultant may conduct the procedure. I understand this could be a doctor undergoing further training.

**I have been given the following Patient Information Sheet/s:**

- About Your Anaesthetic**
- Resection of Colon**
- Blood & Blood Products Transfusion**

- I was able to ask questions and raise concerns with the doctor about my condition, the proposed procedure and its risks, and my treatment options. My questions and concerns have been discussed and answered to my satisfaction.
- I understand I have the right to change my mind at any time, including after I have signed this form but, preferably following a discussion with my doctor.
- I understand that image/s or video footage may be recorded as part of and during my procedure and that these image/s or video/s will assist the doctor to provide appropriate treatment.

On the basis of the above statements,

## I request to have the procedure

Name of Patient: .....

Signature: .....

Date: .....

### Patients who lack capacity to provide consent

Consent must be obtained from a substitute decision maker/s in the order below.

Does the patient have an Advance Health Directive (AHD)?

Yes ▶ Location of the original or certified copy of the AHD: .....

No ▶ Name of Substitute Decision Maker/s: .....

Signature: .....

Relationship to patient: .....

Date: ..... PH No: .....

**Source of decision making authority (tick one):**

- Tribunal-appointed Guardian
- Attorney/s for health matters under Enduring Power of Attorney or AHD
- Statutory Health Attorney
- If none of these, the Adult Guardian has provided consent. Ph 1300 QLD OAG (753 624)

## H. Doctor/delegate statement

I have explained to the patient all the above points under the Patient Consent section (G) and I am of the opinion that the patient/substitute decision-maker has understood the information.

Name of Doctor/delegate: .....

Designation: .....

Signature: .....

Date: .....

## I. Interpreter's statement

I have given a sight translation in

.....  
 (state the patient's language here) of the consent form and assisted in the provision of any verbal and written information given to the patient/parent or guardian/substitute decision-maker by the doctor.

Name of Interpreter: .....

Signature: .....

Date: .....

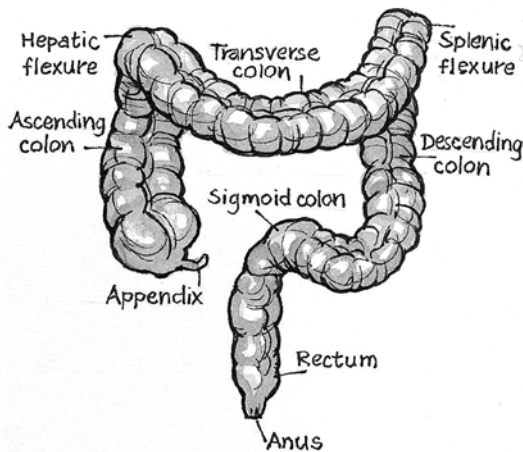


## PLEASE READ THIS SHEET BEFORE YOU CONSENT TO YOUR SURGERY

*This information sheet provides general information to a person having bowel cancer surgery. It does not provide advice to the individual. It is important that you talk about this with your Doctor who understands your level of fitness and your medical condition.*

### 1. What do I need to know about this condition?

The large bowel (intestine) is made up of the colon and rectum (back passage). This part of the digestive tract carries the remains of digested food from the small bowel and gets rid of it as waste through the opening to the back passage (anus). Cells that line the colon and rectum may begin to grow out of control, forming a tumour (a growth of cancer cells).



**Diagram showing the parts of the bowel**

The bowel has four sections: the ascending colon, the transverse colon, the descending colon and the sigmoid colon. Tumours can start in any of these areas or in the back passage. Tumours start in the innermost layer and can grow through some or all of the other layers.

### 2. What do I need to know about the procedure?

Surgery is the main treatment for tumours of the bowel. Usually, the tumour and a length of normal bowel on either side of the tumour (as well as nearby lymph nodes) are removed. The healthy parts of the bowel are then stitched or stapled together (anastomosis).

If the doctor is not able to join the bowel back together, an opening (stoma) will be made on the outside of the body for waste to pass out of the body.

This is called a colostomy. A colostomy is made to allow waste to pass through an opening in the abdominal wall.

Sometimes, a temporary colostomy is needed until the joined bowel has healed, and then it can be put back.

This is done by further surgery. However, in some cases, the colostomy is permanent, which means it can never be put back, and there will always be an opening on the skin for bowel waste to pass through.

A number of different surgical procedures are used depending on where the tumour is. These include:

**Right Hemicolectomy:** Removal of the last part of the small bowel, the caecum, ascending colon and a small part of the transverse colon

**Left Hemicolectomy:** Removal of the descending colon and sigmoid colon.

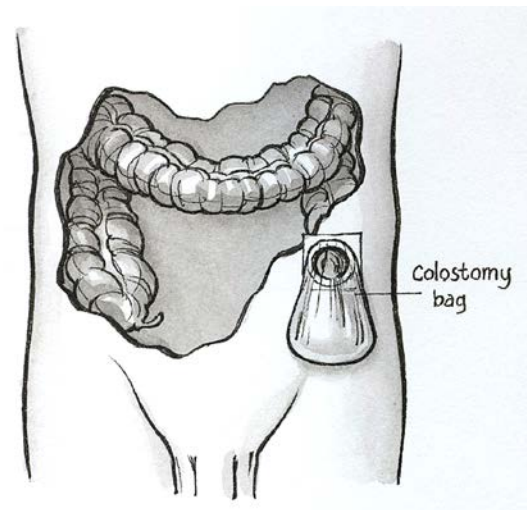
**Sigmoid Colectomy:** Removal of the sigmoid colon and nearby large bowel.

A number of different surgical procedures are available to treat tumours of the back passage, the choice depending on where the tumour is and how far it has spread:

**Low Anterior Resection:** Used for most tumours of the back passage, except when the tumour is very close to the anal muscles (sphincter). The bowel and the back passage are joined together so that the back passage is spared.

**Abdomino-Perineal Resection:** This is done when the tumour is in the lowest part of the back passage. The back passage and the opening to the back passage are removed and the area is stitched up and will remain permanently closed.

The waste collects in a disposable bag (a colostomy bag) which is stuck over the opening.



**A cut-away picture showing a colostomy**

### 3. What do I need to do to prepare for this procedure?

Before surgery, the bowel must be prepared to lower the risk of infection. You may be told to have a low fibre diet 2-3 days before surgery. You will be then be on a clear fluid diet and given a medicated drink to help clean the large bowel. This can cause diarrhoea and cramps, and may be tiring.

The medicated drink will completely empty your bowel. You will then fast for at least 6-8 hours before your surgery. If you are having a colostomy, the surgeon or a stoma nurse will discuss with you the best site for your colostomy and will mark the area with a marker pen. It is usually placed below your belt line, away from any other scars you may have and at least 8 - 10 cm away from your wound, depending on your size and shape.

### 4. My anaesthetic

This procedure will require an anaesthetic.

See **About Your Anaesthetic information sheet** for information about the anaesthetic and the risks involved. If you have any concerns, discuss these with your doctor.

*If you have not been given an information sheet, please ask for one.*

### 5. What are the benefits of having the procedure?

Removal of the diseased bowel is the first treatment for a tumour of the bowel. The goal of the surgery is to give you the best chance of cure through total removal of the tumour.

However, your recovery depends how far the disease has spread at the time of your operation. Surgery can also be used as a measure to ease symptoms.

### 6. What are the risks of not having the procedure?

Symptoms including pain and bleeding may become worse and your bowel may completely block or burst. Without surgery, the disease may spread to other areas of your body.

### 7. What are the general risks of having a procedure?

There are risks and complications with this procedure. They include but are not limited to the following.

#### General risks:

- Infection can occur, requiring antibiotics and further treatment.
- Bleeding could occur and may require a return to the operating room. Bleeding is more common if you have been taking blood thinning drugs such as Warfarin, Aspirin, Clopidogrel (Plavix or Iscover) or Dipyridamole (Persantin or Asasantin).

- Small areas of the lung can collapse, increasing the risk of chest infection. This may need antibiotics and physiotherapy.
- Increased risk in obese people of wound infection, chest infection, heart and lung complications, and thrombosis.
- Heart attack or stroke could occur due to the strain on the heart.
- Blood clot in the leg (DVT) causing pain and swelling. In rare cases part of the clot may break off and go to the lungs.
- Death as a result of this procedure is possible.

***For specific risks of this procedure please refer to the tables on pages 3 & 4 of this information sheet.***

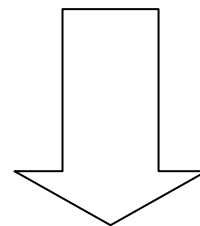
### 8. What are the alternative treatments?

Radiation Therapy has been used for some people as the main treatment for rectal tumours but is not normally used in colon tumours.

Radiation therapy is not as effective as surgery for patients who could normally be treated by bowel removal.

Chemotherapy (use of drugs to treat tumour) is usually used together with surgical removal and may not be offered as the only treatment

**- This consent document continues on page 3 -**





**9. What are the specific risks of this procedure?**

The Risk	What Happens	What can be done about it
<b>Leakage of bowel fluid inside the abdomen</b>	Leakage of bowel fluid at the site where the bowel was stitched or stapled back together. The rate of risk is about 1 in 22 to 1 in 20.	Further surgery may be required.
<b>Ileus</b>	The bowel is paralysed leading to abdominal bloating, and vomiting. The rate of risk is about 2 in 100.	Treatment is to deflate the bowel with suction, using a tube (nasogastric tube) put up the nose, down the back of the throat and into the stomach or bowel.
<b>Wound Infection</b>	The wound may become infected. The rate of risk is about 1 in 9.	This may be treated with antibiotics. These may be given by a drip into a vein or by mouth. The wound may need to be opened to drain.
<b>Urinary Tract Infection</b>	Germs enter the tube leading to the bladder and cause inflammation and infection. The rate of risk is about 1 in 20.	Mild cases may clear up without treatment. Usually antibiotics are used to treat the infection.
<b>Possible stoma problems:</b> <b>1. Loss of blood supply</b>  <b>2. Stoma Prolapse</b>  <b>3. Parastomal Hernia &amp; Local Skin Irritation</b> (Stoma is the opening of the bowel onto the skin) (Hernia is the same as a rupture)	<ol style="list-style-type: none"> <li>1. The blood supply to the stoma may fail and cause damage to the bowel.</li> <li>2. Stomal prolapse when some of the bowel sticks out too far past the skin.</li> <li>3. Parastomal hernia when the bowel pushes through a weak point in the muscle wall and causes pain and bulging of the skin near the stoma.</li> <li>4. Local skin irritation including reddening of the skin and a rash in reaction to the glue used to stick the stoma bag.</li> </ol>	<ol style="list-style-type: none"> <li>1. This may need further surgery.</li> <li>2. For minor prolapses, no treatment is needed. For more serious cases, more surgery may be needed.</li> <li>3. Minor hernias may need no treatment. Larger hernias may need more surgery.</li> <li>4. Changing the type of stomal bag usually treats this.</li> </ol>
<b>Post operative bleeding</b>	Bleeding inside the abdomen. The wound drain may measure this. The risk is about 1 in 35 to 1 in 28.	A blood transfusion may be needed to replace lost blood. Sometimes more surgery is needed to stop the bleeding.
<b>Damage to the ureter (tube from kidney to bladder)</b>	Rarely, during surgery, the ureter, which brings urine from the kidney to the bladder, may be damaged.	This may need more surgery.
<b>Bladder may not empty properly or may empty without warning</b>	A urinary bladder problem where there is abnormal emptying of the bladder. It may empty without warning or may not empty at all.	A tube (catheter) into the bladder may be used to drain the urine away.
<b>Sexual problems</b>	Men may be unable to get an erection or keep an erection. It may also mean that they cannot ejaculate. In women it may cause pain during or after intercourse.	For both men and women, time may improve the condition. Treatment for men may include counselling and medication. For women, counselling and use of water-soluble lubricants during intercourse may help.

The Risk	What Happens	What can be done about it
<b>Bowel blockage</b>	Adhesions (bands of scar tissue) may develop inside the abdomen and the bowel may block. This is a short term and long term complication.	This may need more surgery.
<b>Change in bowel habits</b>	Bowel habits will change. Stools may be looser, smaller and more frequent. There may be some leakage of stools particularly at night depending on the type of surgery.	In most people, this improves with time, without further treatment.
<b>Increased risk in smokers</b>	An increased risk of wound infection, chest infection, heart and lung complications and thrombosis.	Giving up smoking before the operation will help reduce the risk.
<b>30 day death rate: The rate of risk is about 1 in 63 depending on the type of surgery.</b>		

### 10. What happens after the procedure?

After the operation the nursing staff will closely watch you until you have recovered from the anaesthetic. You may even be cared for in the intensive care unit immediately following your surgery.

The recovery period after colon surgery varies. It usually involves a stay in the hospital from 3-10 days in uncomplicated cases. On return from your surgery you will have a catheter (plastic tube) in the bladder to measure and drain your urine.

After surgery you will be given intravenous fluids (a drip) through which antibiotics may be given. The drip will remain in place until you are able to drink enough fluids.

#### Diet

During the first few days of recovery, you will not be able to eat until the bowel has begun to work again. You know the bowel has started to work again when you pass wind and/ or have a bowel movement. You will then begin to take liquids by mouth and then solid food.

#### If you have a colostomy

The colostomy drains bowel waste from the bowel into the colostomy bag. Most colostomy waste is softer and more liquid than normally passed bowel waste.

The thickness of the bowel waste depends on where the stoma is. You will be taught how to clean around the colostomy and change the colostomy bag.

The colostomy bag sticks to the skin around the stoma with special glue, and can be thrown away when dirty. This bag does not show under clothing, and most people learn to take care of these bags themselves.

#### Wound

Your wound will have stitches and/ or staples and is usually covered with a dressing, which may be adhesive plaster or a spray-on plastic covering.

#### Drain

You may also have a small tube that drains into a bag or a bottle from near your wound. This is called a drain. The wound drain removes fluid from your wound and helps in the healing process. It is taken out when the drainage has dried up.

#### Your lungs and blood supply

It is likely that on your return from surgery you will be wearing elastic (anti-embolism) stockings. These are tight fitting stockings that are used to reduce the risk of blood clots forming in your legs.

It is very important after surgery that you start moving as soon as possible. This helps to prevent blood clots forming in your legs and possibly going to your lungs. This can be fatal.

Also, you need to do your deep breathing exercises. Take ten deep breaths every hour to prevent secretions in the lungs from collecting. If this happens, you may develop a chest infection. At all costs, avoid smoking after surgery as this increases your risk of chest infection. Coughing is painful after abdominal surgery.

#### Exercise

Expect to feel tired for some time after surgery. You need to take things easy and gradually return to normal duties, as you feel able to. It usually takes at least 6 months to get over the operation. You should not drive during the first 2-3 weeks.

Do not lift heavy weights for at least six weeks after surgery. This is to prevent a rupture where the cuts were made and allow healing to take place inside.

### 11. Tell your doctor if you have:

- large amounts of bloody leakage from the wound.
- blood in the stool.
- fever and chills.
- pain that is not relieved by prescribed pain killers.
- swollen abdomen.
- swelling, tenderness, redness at or around the cut.