Patient Information

University Hospitals
Coventry and Warwickshire
NHS Trust

Upper Gastro-Intestinal Service

Oesophagectomy - Patient's guide to surgery for cancer of the oesophagus which can be treated

The following information has been designed to help you to understand your operation and what to expect.

We hope it will help to reduce any anxiety you may have, answer some of your questions and offer some practical advice. This information may not answer all your questions. Everyone responds differently to surgery and also require varying amounts of information.

Throughout your illness, you will have access to an upper gastro-intestinal nurse specialist (upper GI nurse) for support and advice.

The oesophagus

The oesophagus, or gullet, is a long muscular tube. In adults it is approximately 12 inches (29 cm) long. It connects the back of your throat with your stomach. It is divided in to three parts: upper, mid and lower oesophagus.

The muscular layers of the oesophagus moves food or fluid towards the stomach by muscular contractions. At the lower end there is a muscular valve, which prevents stomach acid entering the gullet from below.

Once food has been swallowed it passes down the gullet and enters the stomach.

What treatments are available for cancer of the oesophagus?

- Surgery to remove the cancer is the most common way of treating **early** stages of oesophageal cancer.
- Chemotherapy (using drugs to contain or kill the cancer cells) sometimes given before surgery.
- Radiation (using high doses of X-rays to kill cancer cells)
- A combination of radiotherapy and chemotherapy
- A tube (stent) maybe passed to relieve difficulties in swallowing
- Dilatation (stretching) of the oesophagus
- Injections of alcohol to shrink the tumour
- A combination of any of the above or other endoscopic treatments

Surgical treatment

Your consultant surgeon will decide the best way to proceed. The cancer may be taken out using one of the following operations:

Ivor Lewis procedure

- Incisions are made into the abdomen and to the right side of your back, through which the affected part of the oesophagus with the surrounding lymph glands will be removed. A tube is then made out of the upper part of your stomach and this is drawn up into the chest where it is joined to the remainder of the oesophagus. This is known as an **Ivor Lewis procedure**.

Colonic interposition

- If it is not possible to use your stomach to replace your oesophagus it may be possible to use a piece of your bowel instead and this is called a colonic interposition.

If at the time of surgery it is found that the tumour is not suitable for removal, the surgeon may dilate (stretch) the oesophagus to aid swallowing.

Recurrence

Whilst surgery is the best chance of a cure, there is always a possibility that the cancer can reoccur. If you require any further information on rates of recurrence, please discuss with your clinical nurse specialist or consultant.

Written information can be made available on request.

What happens before surgery?

Before your admission to hospital, you will attend the pre-op assessment clinic. Here, you will have swabs taken to check for MRSA. The nurse will also ask you certain questions and check your blood pressure, pulse and further tests will be carried out such as blood tests, breathing test and heart recording (ECG) if not already done.

You will be admitted to Ward 11 the Cardiothoracic Unit a day before surgery. This is located in the East Wing on the first floor.

On admission, a doctor will complete medical documentation. You will also be asked to give your written consent to allow the doctors to operate. This is the time when you should ask questions about the type of surgery and the risks involved.

The Upper GI Nurse Specialist will also be available to visit before surgery if requested.

Four hours prior to surgery, your dietary and fluid intake will be restricted. The nursing staff will make sure you are aware of what you are allowed. This may be changed as directed by the doctors.

Carbohydrate drink

As part of your surgical treatment, we are using a protocol to prepare your body to recover better after surgery.

When we have a major surgery, our bodies become stressed. We ask patients to drink a carbohydrate solution the night before and the morning of your surgery.

This prepares your body and reduces its stress response immediately after surgery. It also helps you feel less uncomfortable while you fast before the surgery. This has been shown to help reduce post-operative complications and reduce length of hospital stay.

What are the risks?

As with any surgery there are certain risks. Some are associated with the anaesthetic, some with the type of surgery, and some with the recovery.

Some of the identified risks with this type of surgery are:

- Chest infection
- Heart problems
- Haemorrhage
- Blood clots
- Anastomotic leak
- Stroke
- Wound infection

These risks will be discussed with you by the doctor when they explain the planned surgery and ask you to give your written consent for them to proceed.

What happens after surgery?

Immediately after surgery, your recovery will be carefully monitored in the Cardio-Thoracic Critical Care unit on the 1st Floor East Wing.

When you come around after your operation, you will have some tubes attached. The type and number will vary depending on your operation:

- A tube in your neck vein to give you fluid
- A tube that passes through your nose and into the stomach - this allows us to keep your stomach empty
- Two drains into your chest - to allow the lung to expand and to allow the drainage of any fluid in the chest
- A catheter - a fine tube will have been placed into your bladder to collect your urine into a bag.

This means you do not have to worry about getting out of bed initially and we are able to monitor the amount of urine you are producing

- Possibly a tube in to the small bowel - this can be used for feeding if necessary - this will be flushed regularly even if it is not used for feeding

As you recover your drains and tubes will be removed as directed by the doctor.

All patients after surgery will be seen by the consultant regularly on the ward. If, at any time, you or your carers wish to speak to your consultant, an appointment can be made through their secretary.

Will it be painful?

The amount of pain felt is varied and very individual. We will work with you to ensure that pain is kept to the minimum. It is important you tell the nursing staff if you have pain, discomfort or if there is any change in the amount of pain felt.

There are several ways of reducing pain, including:

- Epidural which is used in the Critical Care Area
- Patient Controlled Analgesia (this should be explained to you before surgery)
- Pain killing injections, which can be given regularly usually every 3-4 hours
- Simple painkillers can be given in the form of suppositories or tablet once you are able to drink

When can I get out of bed?

We will encourage you to get up as soon as you are able. To help with this, you will be visited by the physiotherapist who will give tips on moving about and breathing exercises.

It is important to do these exercises. They help reduce the risk of blood clots and chest infections after surgery. The sooner you become mobile the better it is for your recovery.

When can I eat after the operation?

Immediately after the operation, you will not be allowed to eat or drink. The site of the operation is rested to allow the body a chance to heal.

During this time you will receive intravenous fluids. The doctors will assess this on a daily basis and fluids will be gradually introduced on the doctor's instructions.

The doctor may decide to organise a special X-ray at around five to seven days after surgery to make sure everything has healed inside before allowing you to eat or drink.

A feeding tube in your small bowel may be used soon after surgery. Most patients start to take small amounts of fluids by mouth at around three to five days after surgery.

When you are able to tolerate fluids, soft food will be introduced gradually. You will be taught how to care for this tube before you are discharged.

The tube is usually removed around three months following surgery or on completion of chemotherapy after your surgery. Further information will be given you by the nutrition nurse.

Over the next few weeks, you will gradually return to a normal diet. But this will be in smaller quantities. This means you will need to eat small amounts and often.

To help you with more in depth dietary advice, a dietitian will visit you during your hospital stay. They will contact you regularly when you are discharged.

Will surgery alter my eating pattern?

You may feel full for longer after meals. This is because your stomach is taking longer to empty. If this happens, you should let the doctors or nurses know. You may be able to take tablets to help relieve this.

Because the shape and size of your stomach has altered, you will need to eat smaller meals more often. It is important to eat regular small meals and snacks, 5-6 times throughout the day. The nursing staff will arrange for you to receive advice from a dietitian.

On occasions, patients have also complained about diarrhoea. This can be due to the body settling down. If the diarrhoea persists, you may need some tablets prescribing to reduce the number of times you go to the toilet.

Occasionally food may feel like it is sticking. This is due to surgical swelling of the area where the oesophagus has been attached to the stomach. If this continues to be a problem, a gentle stretch of the gullet may be organised six weeks after surgery. This will be done using the endoscopy procedure that you had previously.

What happens when I go home?

Your recovery will continue after you are discharged. The nursing staff will discuss with you and your family the arrangements for going home. Any support you need to assist you at home will be identified before your discharge and will be provided by the appropriate agencies.

Your GP and the district nurse in your area will be notified on your discharge. If you have any worries, you should contact them or alternatively contact the ward staff who will do their best to advice you.

Lots of rest with gentle exercise and a healthy diet are important for a good recovery. Do not forget that oesophageal surgery is a major operation and it will take up to six months for you to recover fully.

When can I drive?

You must not lift any heavy objects or drive a car until you have had a chance to fully heal. This will be at least six weeks. This is because the surgery has involved incisions (cuts) into the large stomach muscles

It is recommended you check with your insurers, as many policies will not cover you to drive in this period. Some extend this until you have been seen by your consultant in clinic and informed you can drive again.

Check list of dos and don'ts

Do

- eat small meals often
- contact us if you experience any problems with swallowing
- contact us with any questions, worries or concerns
- take gentle exercise and build up gradually
- give yourself time to recover
- try sleeping on your side if desired (preferably the right)
- wear your support stockings until reasonably mobile
- consider using the support group 1st Thursday of the month based in the hospital (ask your specialist nurse for details)

Don't

- do any heavy lifting
- drive without seeking medical advice
- stay on a fluid type diet
- drink large quantities of fluid when eating
- return to work too early

Long term follow-up care

The Upper GI nurse specialist will telephone you within three days of your discharge to offer advice and support and answer any questions you may have at this time.

Three weeks after discharge from hospital, an appointment will be made for you to see the specialist nurse and a dietitian in clinic.

Six to eight weeks after surgery, you will see the consultant in the outpatient's clinic. If you have a feeding tube in your small bowel at this time and if it is not being used a date will be booked to remove it.

Alternate outpatient appointments will then be with the Upper GI Nurse.

Where possible and an agreement has been reached, we aim to refer you back to your local hospital for follow up within 12 months after surgery.

Patients from Redditch will be followed up at Redditch Hospital.

When you have read this leaflet, if you have any queries or if there is something you would like explained in more detail, please ask any of the medical or nursing staff looking after you.

Contact numbers

Hospital Switchboard:	024 7696 4000
Cancer Information Centre	024 7696 6052
Macmillan Cancer Support	0808 808 0000
Nurse specialist	024 7696 6475
Health Information Centre	024 7696 6050
Mr Menon's Secretary	024 7696 5278
Mr Tan's Secretary	024 7696 5151
Mr Grocock's Secretary	024 7696 5272
Mr McLaughlin's Secretary	024 7696 5272

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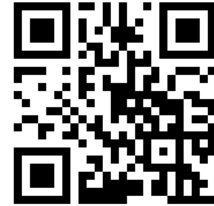

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