Patient Information

University Hospitals Coventry and Warwickshire NHS Trust

Upper Gastro Intestinal Service

Patients guide to surgery of the stomach

The aim of this leaflet is to provide you with a starting point and the following information has been designed to help you to understand your operation and what to expect.

We hope it will assist in reducing any anxiety you may have, answer some of your questions and offer some practical advice.

It is by no means intended to be comprehensive. Everyone responds differently to surgery and requires 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 stomach

The stomach is a muscular organ, which lies at the lower end of the gullet (oesophagus). The stomach also helps

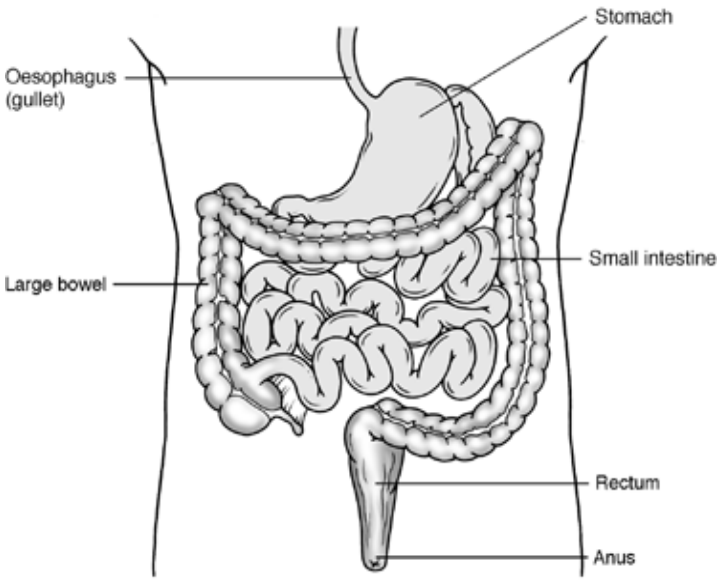

Diagram to show the position of the stomach

Once food has been swallowed it passes down the gullet and enters the stomach. The stomach wall produces fluid and acid to soften the food and begins the digestion process. The stomach churns and mixes the food and when it leaves the stomach it is in a semi-solid form and enters the small intestine.

Types of stomach tumours

There are different types of stomach tumours (growth) which may require surgical intervention

They can be either:

- **Benign tumours** (non cancerous) these are less likely to grow back or spread to other parts of the body.
- **Malignant tumours** these are cancers and are able to spread to other parts of the body or to the lymph nodes. Malignant tumours can be removed but they may sometimes grow back.

What treatments are available for cancer or benign tumours of the stomach?

- Surgery is the most common treatment (taking out the tumour or relieving the symptoms)
- Chemotherapy (using drugs to contain or kill the cancer cells). Chemotherapy can be given before surgery with the possibility of further chemotherapy afterwards.
- Or a combination of the two.

Surgical treatment

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

- A wedge resection where only the lesion is removed (this is more commonly used for small lesions)
- Removal of part of the stomach is referred to as a partial gastrectomy.
- Removal of all of the stomach along with the lower part of the gullet and occasionally the spleen is called a total gastrectomy.

- Sometimes it is not possible to remove the tumour at the time of operation. Instead of removing the stomach it may be possible to redirect the flow of food to overcome any blockages and relieve symptoms, this is commonly known as a gastric bypass.

Note 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?

Prior to admission for surgery you will meet with your Clinical Nurse Specialist who will ask you questions about previous medical problems and your social circumstances. Blood tests will be organised at this time and routine swabs will be taken, in readiness for your admission. You will also be given written information to take home about breathing exercises pain relief and this document.

You will be admitted to one of the surgical wards at University Hospital on the day of surgery. Your blood pressure, pulse and temperature and weight will be recorded

A doctor will examine you and complete all relevant documentation any further tests will be carried out if indicated.

If not already done, you will also be asked to give your written consent to allow the doctors to operate and this is the time when you should ask questions about the type of surgery and the risks involved as with any surgery there are certain risks. Some risks are associated with the anaesthetic, some with the type of surgery and some with the recovery. Risks may be higher if you already have other medical problems.

Some of the identified risks with this type of surgery are

- Haemorrhage (bleeding)
- Leak at the site of a join (anastomotic leak)
- Wound infection
- Heart problems
- Blood clots in the leg
- Chest infection

You might want to discuss the risks further with the doctor when he explains the planned surgery and asks you to give your written consent for them to proceed.

The Upper GI Nurse Specialist will aim to visit you before surgery and answer any questions you may have.

Four hours prior to surgery you will be advised not to eat or drink. This will be according to the doctor's instructions.

You will also be measured and fitted with white stockings to try and prevent clots due to reduced activity.

What happens after surgery?

Immediately after surgery your recovery will be carefully monitored in the General Critical Care central area 1st Floor or the Enhanced Care Unit on ward 22 2nd floor.

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

- A tube in the vein to give you fluids.

- A tube that passes through your nose and beyond the newly created join in the stomach/small bowel. This allows us to monitor any drainage and takes the pressure off the join allowing it to heal.

- Near to the site of operation (your wound), you may find one or two drainage tubes (drains) that go under the skin. These drain off fluid to prevent swelling.

- 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 how much urine you are producing.

- Possibly a tube in to the small bowel which will be used for feeding. This is most likely to occur when all your stomach is removed and is in accordance to the consultants' preference. If

you do have a feeding tube, we will aim to send you home on overnight pump feeding (full training will be given)

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

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 or discomfort and if there is any change in the amount of pain felt.

There are several ways of reducing pain. These include:

- Epidurals are used in the Critical Care Area or on the Enhanced Care Unit.
- Patient Controlled Analgesia (this will be explained to you before surgery).
- Pain killing injections, which can be given regularly usually every 3-4 hours.
- Simple painkillers such as suppositories and once you are able to drink, another alternative is tablets.

When can I get out of bed?

We will encourage you to get up as soon as you are able. Whilst inactive you will be visited by the physiotherapist. The physiotherapist will encourage you to do leg and breathing exercises. It is important to do these exercises as they help reduce the risk of blood clots and chest infections after surgery. The sooner you can become mobile the better for your recovery.

When can I eat after the operation?

Immediately after the operation you will not be allowed to eat or drink. The body is rested allowing the site of the operation to heal. This will be assessed on a daily basis and fluids will gradually be introduced on the

doctor's instructions according to the type of surgery you have had. During this period you will receive intravenous fluids.

If you have a feeding tube in your small bowel this maybe used soon after surgery. You will be taught how to give yourself some feed through this tube prior to discharge to support your oral intake. The tube is usually removed three months following surgery or when you have completed your chemotherapy post-operatively. Further information and necessary training will be provided by the nutrition nurse.

Most patients start to take small amounts of fluids by mouth at around 3-5 days after surgery. The doctor may decide to organise a special X-ray at around 5-7 days in some cases to make sure everything has healed inside before allowing you to eat or drink. When you are able to tolerate fluids, soft food will be introduced gradually. Most patients build up to free fluids and diet is gradually introduced between 7-10 days after surgery.

Following gastric surgery you will be able to eat a normal diet although in smaller quantities. To assist you with more in depth dietary advice, a dietitian will visit you during your hospital stay.

Will there be any side effects?

When all or part of the stomach has been removed you may find it difficult to eat a large meal. The key to this is to eat little and often, up to six small meals a day. (3 Main meals with snacks in between)

To avoid feeling full at mealtimes it is advisable not to drink for about an hour before and for half an hour after each meal. You will be referred to a dietician before or soon after surgery who will offer further dietary advice.

Dumping syndrome can occur after a large meal and is a potential side effect of gastric surgery. This is when your stomach may empty rapidly, which leads to a drop in your blood pressure or blood sugar. If this happens there may be a sense of faintness, flushing, sweating and palpitations and feeling tired. Eating little and often is the best way to avoid this. The Dietitian or Specialist Nurse should be able to give you further advice if you suspect you are experiencing any dumping symptoms.

Following removal of all of your stomach the ability to absorb Vitamin B_{12} will be affected and this could lead to a form of anaemia. Therefore three monthly injections of vitamin B_{12} will be needed because it cannot be absorbed when taken by mouth.

Please note that all patients following 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. (Please see telephone contact numbers at the end of this information.

What happens when I go home?

Your recovery will continue on discharge. 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 agency.

Your GP and the District Nurse in your area will be notified of your discharge. If you have any worries you should contact him/her or alternatively contact the ward staff who will do their best to advise you.

The Upper GI Nurse Specialist will contact you within 3 days of your discharge to offer advice and support and answer any questions you may have at this time.

When can I drive?

Because the surgery has involved an incision (cut) into the large stomach muscles 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.

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

Check list of do's and don'ts

Do

- eat small frequent meals
- contact us with any questions, worries or concerns
- take gentle exercise and build this up gradually
- give yourself time to recover
- 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 before eating
- return to work too early
- stay in bed or sit for long periods

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.

At around three weeks following discharge you will be seen by the Specialist Nurse and Macmillan Dietitian in the Nurse-Led clinic to assess your progress. Appointments will then alternate between the consultant and the Specialist Nurse.

Six to eight weeks after surgery you will see the consultant in the out patients clinic

Patients from Redditch will be followed up at Redditch Hospital.

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

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

Main Hospital Switchboard: **024 7696 4000**

Cancer Information Centre: **024 7696 6502**

Macmillan Cancer support: **0808 808 0000**

Nurse specialist: **024 7696 6475**

Macmillan Dietitian	**024 7696 6161**
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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The trust operates a smoke free policy

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