NHS
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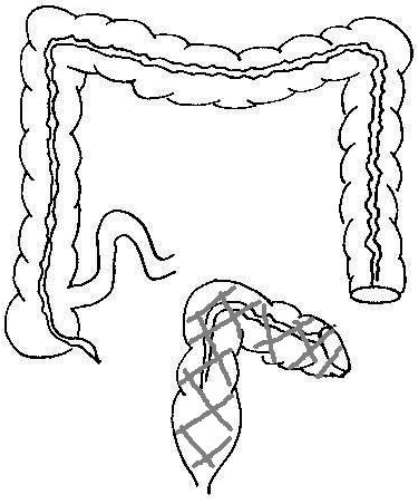
Abdomino-perineal resection of the rectum (APER)

This leaflet will explain what will happen when you come to the hospital for your operation. It is important that you understand what to expect and feel able to take an active role in your treatment. Your surgeon will have already discussed your treatment with you and will give advice about what to do when you get home.

What is an APER?



This operation involves removing the rectum (the last part of the bowel before the back passage) and anal canal (back passage). The bottom is then sewn up so that you no longer have a back passage and the bowel is brought out to the skin to form a permanent colostomy. This is a piece of bowel on the outside of your abdomen where stool will drain into a bag. The diagram opposite shows the bowel that is removed (hatched area) and the bowel which is left behind is the piece of bowel which drains onto the skin.

This operation is done with you asleep (general anaesthetic). The operation not only removes the bowel containing the tumour but also removes the draining lymph glands from this part of the bowel. This is sent to the pathologists who will then analyse each bit of the bowel and the lymph glands in detail under the microscope.

This operation can normally be completed in a “keyhole” manner which means less trauma to the abdominal muscles, as the biggest wound is the one on your bottom. However if we can’t, we do the same operation but through a bigger incision. It does take longer to recover with an open operation but, if it is necessary, it is the safest thing to do.

What are the possible risks of this operation?

1. **Infection:** this happens in the wounds most commonly but can also occur deep in the tummy cavity in some circumstances, requiring either antibiotics or sometimes even drains to be inserted by the radiology doctors. Infection occurs after bowel surgery in up to 20% of people (2 out of 10 cases). Chest infections can also occur and so we encourage people to do breathing exercises afterwards to help avoid this.
2. **Bleeding:** significant bleeding is always possible in bowel surgery but is not common. In particular bleeding from the prostate in men or from the pelvic veins and pelvic floor muscle in both sexes can be an issue.
3. **Blood clots in the legs and lungs:** deep vein thrombosis and pulmonary embolus can occur as a result of being immobile during your operation and then being less mobile afterwards. We reduce this risk by giving you compression stockings to wear, injecting you

with blood-thinning medication every evening while you are in hospital and getting you mobile as quickly as possible.

4. **Damage to other structures:** there is a 1% chance of damaging something we didn't mean to – especially in keyhole surgery. Although not usually a problem if we notice it, the danger occurs if we damage something but don't recognise this. Common things to get damaged are: bowel, ureter (the tubes that run from your kidney to your bladder), bladder, the urethra (tube from bladder to the penis or vagina), the vagina in women and the prostate in men.
5. **Sexual and bladder dysfunction:** the nerves that run from your spine to your penis, prostate, clitoris, vagina and bladder run very close to the back/sides of the rectum. As such they can get bruised during this operation and not work so well afterwards for some months. However, occasionally they are damaged permanently. In men, this can lead to some trouble with erection and /or ejaculation. In women this nerve damage can lead to vaginal dryness, a less intense orgasm and it can take much longer to achieve orgasm. In both men and women it can also very occasionally cause a problem with bladder function.
6. **Ileus:** this is where the bowel stops working and effectively "goes on strike". It is a common problem in any bowel operation but is particularly a problem in this operation. Occasionally it lasts only 24 hours but can be considerably longer. This can require a tube placed through your nose to drain the stomach contents whilst we wait for the bowel to start working again.
7. **Colostomy problems:** the colostomy can cause some problems, especially in the first couple of weeks after surgery. It can sometimes fall back into the tummy wall slightly (retraction), or fall out a bit too far (prolapse). It can also have a problem with getting enough blood to allow it to heal and sometimes this requires further surgery to correct it. Over time, people often get hernias around their colostomy – these are rarely dangerous but occasionally can cause symptoms such as pain or difficulty fitting the bag. Occasionally these hernias require surgery to fix them although the recurrence rate is high.

This isn't a comprehensive list of all the risks of surgery but explains those most common to bowel surgery.

What are the alternatives to surgery?

Surgery is not the only option for treating bowel cancer but for the majority of cancers it is the only chance of potential cure for the cancer. If there is a potential for being cured without surgery, this will be discussed with you along with the risks of a non-operative approach. However, if we believe surgery is the only possibility of curing your cancer, we will recommend this operation.

When will I be admitted?

You will be admitted on the day of surgery. You will be given an enema before surgery to clear the lower part of the bowel. Following surgery you will be taken to the recovery area or to the Intensive Care Unit – this is quite routine after this sort of major surgery.

What happens after the operation?

Providing all has gone well we try to get your gut back to normal as soon as possible. This means starting you drinking and occasionally eating on the day of your operation. Diet in the first few weeks needs to be slightly different, avoiding foods which are too rich, fatty or fibrous. "Bland" food is usually ideal in the first week – e.g. mashed potato, fish, minced meat, rice,

pasta etc. These are foods which are easy to digest but have some nutritional value.

We will try to get you mobile the following day, even though it is sore, as we know that mobility helps get your bowel working and reduces the risk of complications. The bottom wound is often the most difficult to get to heal and can be uncomfortable for a few weeks afterwards, especially as it is the area you often sit on.

You'll get plenty of advice and help from the colorectal nurses, stoma nurses, nurses on the ward and physiotherapists as well as from your surgeon and the medical staff.

If all goes well and you don't have any complications after your operation, we expect you to be in hospital for five days although we will ensure you are confident with the stoma before discharge. However, it may be a shorter or longer stay depending on your recovery.

Aftercare advice at home

Before discharge the staff looking after you will tell you any important specific information. Your recovery is often gradual and generally you will feel better week by week. However, you are unlikely to be back to **full** fitness for some months after surgery.

Useful numbers

Intensive Care Unit	0118 322 7257
South Block Recovery	0118 322 7621
General Surgical Unit	0118 322 7535 or 7539
Surgical Assessment Unit	0118 322 7541
Colorectal Nurse Specialists	0118 322 7182
Stoma Care Clinical Nurse Specialists	0118 322 7640
Clinical Admin Team 3:	0118 322 6890 or email rbb-tr.cat3@nhs.net
Pre-operative Assessment:	07899 065590 or email: rbft.pre-opsouthwing@nhs.net

If you have any concerns in the 24 hours after leaving hospital, please phone the ward to which you were admitted. After 24 hours; please seek advice from your GP.

Useful organisations

Beating Bowel Cancer Tel: 0845 0719 300 www.beatingbowelcancer.org email: info@beatingbowelcancer.org
Bowel Cancer UK Tel: 020 7940 1760 www.bowelcanceruk.org.uk email: admin@bowelcanceruk.org.uk
Colostomy Association (Reading) Tel: 0800 328 4257 (Helpline) Tel: 0118 9391 537 (General enquiries) www.colostomyassociation.org.uk email: cass@colostomyassociation.org.uk

To find out more about our Trust visit www.royalberkshire.nhs.uk

Please ask if you need this information in another language or format.

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