West Hertfordshire Teaching Hospitals NHS Trust

A guide to...

The Watford LAR pathway

Patient Information

How to contact us
Colorectal Surgery
West Hertfordshire Teaching Hospitals NHS Trust
Vicarage Road, Hertfordshire WD18 0HB

Tel: 07741 165312 **/** 01923 217755
Email: Deborah.sumner5@nhs.net

If you need this leaflet in another language, large print, Braille or audio version, please call **01923 217 198** or email **westherts.pals@nhs.net**

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Author	Deborah Sumner
Department	Cancer, Surgery & Anaesthetics
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The Watford Low Anterior Resection (LAR) pathway is for patients having anterior resection surgery for colorectal cancer.

Please read this information carefully as it explains how you can play an active role in the recovery from your anterior resection surgery, but more importantly in the preparation for the reversal of your ileostomy.

The LAR pathway and clinic is run by an experienced senior nurse who works alongside the colorectal consultants.

The LAR pathway has been designed to ensure that all patients undergoing anterior resection surgery who have had a temporary ileostomy are supported both before and after the reversal of their ileostomy and are actively encouraged to be involved in all aspects of this.

The pathway focuses on:

- Ensuring you understand the anterior resection surgery that has been performed and its possible impact on your bowel function after reversal of your ileostomy.
- Advice on physical activity, general wellbeing and diet.
- The importance of daily and regular pelvic floor exercises, starting as soon as possible after your anterior resection surgery, continuing up to and after reversal of your ileostomy.
- Encouraging you to be involved in the preparation for your reversal surgery using daily bowel irrigation to improve anal tone and bowel control.
- Improved bowel control after reversal surgery.
- Advice and support in the management of any ongoing bowel control issues.

After your anterior resection surgery

You should follow the advice of your consultant, the ward staff and the Enhanced Recovery Nurse as you recover from this surgery in hospital.

However, it is important that you begin regular pelvic floor exercises as soon as you feel able to do so; a strong pelvic floor will play a huge part in regaining bowel control after your reversal surgery.

The Gastro-Graffin enema

Some time after your anterior resection surgery and prior to reversal of your ileostomy your consultant will arrange for you to have a Gastrograffin enema. This examination of the colon and rectum, performed in the X-ray department, allows assessment of the join in your lower bowel to ensure that everything has healed completely.

In the rare case that the join is not completely healed, the test will be repeated several weeks later. This may delay reversal of your ileostomy. Your consultant will arrange your reversal surgery once they are confident that the bowel is fully healed.

Preparation for ileostomy reversal surgery

Unfortunately, some patients may experience ongoing bowel control problems after their reversal surgery, however, the LAR pathway empowers you to be proactive in working to reduce the instances of this as much as possible.

After your Gastrogaffin enema and before your reversal surgery, an appointment will be made for you to see the LAR specialist nurse in clinic.

The LAR specialist nurse will explain all aspects of the reversal surgery; explaining your recovery after the surgery and can answer any questions you may have.

She will talk to you about the importance of pelvic floor exercises and advise you to start to use the Qufora Mini-Go bowel irrigation system on a daily basis. This minimally invasive system allows you to focus on your pelvic floor and train your bowel to better control function after reversal of your ileostomy.

We have received very positive feedback from patients who have used this system before their reversal surgery.

The importance of pelvic floor exercises

Doctors, nurses and physiotherapists all agree that exercising the pelvic floor muscles greatly helps to improve bladder and bowel control.

Completing regular pelvic floor exercises will help you to strengthen and control these muscles which in turn will help improve your bowel control after reversal of your ileostomy.

The floor of the pelvis is made up of the layers of muscles and other tissues, these layers stretch from the “tailbone” and the back of the pelvis to the pubic bone at the front. A man’s pelvic floor supports the bladder and the bowel, a woman’s pelvic floor also supports the womb.

The urethral (bladder outlet) and rectum pass through the pelvic floor and play an important part in control of the bladder and bowel.

Pelvic floor exercises for women

Finding the pelvic floor muscles is not easy as they cannot be seen from the outside; however if the exercises are completed correctly you will be able to feel the muscles as they work.

- Sit comfortably with your knees slightly apart, imagine that you are trying to stop yourself from passing wind from your bottom; to do this you must squeeze the muscles around your back passage. You should be able to feel the muscles move as you do this. Your buttocks and legs should not move at all, though you should be aware that the area around your back passage is tightening and being pulled up and away from the chair.

- Now imagine you are sitting on the toilet passing urine and try to stop yourself doing so by tightening and lifting the muscles of your pelvic floor. Again, you should be aware of the muscles squeezing and lifting as you do so.

- Try to tighten the muscles around your back passage, vagina and urethra; lifting and squeezing them to stop yourself passing urine and passing wind at the same time. You should not need to squeeze your legs together, neither should you be holding your breath. The lower area of your tummy should feel as if it is being pulled away from the zip of a pair of tight trousers.

Now that you can isolate your pelvic floor muscles, you can complete the exercises as follows.

- Sit or stand with your knees slightly apart. Slowly tighten and pull up the pelvic floor muscles, holding them like this for as long as you can. Rest for four seconds and then repeat the contraction. You can build up your stamina so that you can complete 10 slow contractions at a time, holding them for at least 10 seconds.

- You can also complete quick contractions, lasting one or two seconds, ten times in quick succession. This exercise is particularly useful in helping manage sudden stresses such as coughing or sneezing, laughing or exercise that puts pressure on the bladder and/or the bowel.

Ideally you should aim to complete both sets of exercises several times a day, combining both in succession, starting as soon as you feel able after your anterior resection surgery, and continuing them daily. These exercises can be carried out during many normal day to day activities, for example, whilst cleaning your teeth or waiting for the kettle to boil.

It is also advisable to watch your weight as extra weight puts an extra strain on the pelvic floor. Constipation can also increase pressure on the muscles of the pelvic floor if you have to strain to open your bowels.

Pelvic floor exercises for men

Ideally you should aim to complete both sets of exercises several times a day, combining both in succession, starting as soon as you feel able after your anterior resection surgery, and continuing them on a daily basis. These exercises can be carried out during many normal everyday activities, for example, whilst cleaning your teeth or waiting for the kettle to boil.

- Sit comfortably with your knees slightly apart, now imagine that you are trying to stop yourself from passing wind from your bottom; to do this you must squeeze the muscles around your back passage. You should be able to feel the muscles move as you do this. Your buttocks and legs should not move at all, though you should be aware that the area around your back passage is tightening and being pulled up and away from the chair.

- Imagine that you are trying to draw your penis back toward your body to shorten it, whilst at the same time, lifting your scrotum upwards. If your technique is correct, you will be aware that every time you tighten the pelvic floor muscles, your penis and scrotum move slightly.

Now that you can isolate your pelvic floor muscles, you can complete the exercises as follows.

- Sit or stand with your knees slightly apart. Slowly tighten and pull up the pelvic floor muscles, holding them like this for as long as you can. Rest for four seconds and then repeat the contraction. You can build up your stamina so that you can complete 10 slow contractions at a time, holding them for at least 10 seconds.

- You can also complete quick contractions, lasting one or two seconds, ten times in quick succession. This exercise is particularly useful in helping manage sudden stresses such as coughing or sneezing, laughing or exercise that puts pressure on the bladder and/or the bowel.

It is also advisable to watch your weight as extra weight puts an extra strain on the pelvic floor. Constipation can also increase pressure on the muscles of the pelvic floor if you must strain to open your bowels.

Use of the Qufora Mini-Go system alongside pelvic floor exercises

The specialist nurse will demonstrate and explain the use of the Qufora Mini-Go system when you see her in clinic ahead of your reversal surgery.

This minimally invasive system is used to instil approximately 160mls of water into your rectum on a daily basis; once instilled you should aim to retain the water for as long as you can, up to a total of five minutes. By doing so, you will allow your bowel, and your brain, to recognise contents in the rectum and will also enable you to defer opening your bowels and improve bowel control following reversal surgery.

You will be provided with a starter pack of the Mini-Go system in clinic, so that you can start to use it straight away. With your consent the specialist nurse will register you with Qufora who will provide you with a monthly supply of the system.

The My Qufora team and the specialist nurse are available to provide you with ongoing support and guidance in use of the system. Contact details for the My Qufora team are included in your Mini-Go pack.

You should not use the Qufora System following your reversal surgery; it is important to allow your bowel to naturally settle into its new pattern of opening.

Reversal of your temporary ileostomy

When a temporary ileostomy is formed, a loop of healthy bowel is pulled up onto the surface of the abdomen to create an artificial opening where faeces can be passed out of the body. Temporary ileostomy are formed during anterior resection surgery to allow the bowel to heal properly. These temporary stomas are formed at the end of the small bowel, hence the contents of your stoma bag being a more liquid/porridge like consistency.

Having a ileostomy reversal operation involves re-joining the ends of the bowel and closing the opening (stoma site) that was formed during the anterior resection surgery.

Many people believe that after ileostomy reversal, their bowel habits will return to how they were before their surgery. However, after stoma reversal, there will be a piece of your rectum missing and this will change the way your bowel works in the longer term. The rectum is responsible for storing/holding stool until such time as you can go to the toilet to open your bowels. As part of your rectum has been removed that capacity is less and it may result in you needing to open your bowel more urgently and with less notification of the need to do so.

It is usual to have your stoma reversed between three and 12 months after your anterior resection surgery. However, this will depend on whether you have received any other treatments for example chemotherapy, your general health and other individual factors. It is important that you continue to remain active, eat a healthy and varied diet and complete regular pelvic floor exercises several times a day.

There is no need to take bowel preparation ahead of reversal surgery, which is reassuring for many people who found this unpleasant ahead of the anterior resection surgery.

Once the reversal surgery is complete, your consultant will want you to eat, drink and mobilise as soon as possible and this will encourage your bowel to work. It is advisable to eat little and often, sticking to a low fibre diet in the first couple of weeks after surgery to allow your bowel to settle; however, they may still be unpredictable and urgent. It is not uncommon to experience a looser stool in the immediate post operative period.

You will have a small wound at the site of your ileostomy; the wound is not 100% closed and is usually left “open” at the skin to allow the wound to heal from the bottom up, which lessens the risk of wound infection. There are two options to dress these wounds, either a traditional dressing of the wound started in the hospital and continued once you go home by either your practice or district nurse, or a vacuum dressing (called PICO) which dresses and heals the wound in a slightly different way. The nurses on the ward will advise you on managing your wound and will arrange its ongoing care.

No surgery is without risk, though these issues are rare.

- Ileus – a temporary shock reaction by your bowel to the surgery and sometimes to medication, the bowel becomes paralysed or is slow to start working again. The most usual management of this is to wait and allow the bowel to rest, sometimes by not eating or drinking anything until flatus/wind is passed. You may need an intravenous infusion to ensure you do not become dehydrated during this time.

- Bowel obstruction – a physical blockage of the bowel causing narrowing, either because of inflammation or scar tissue. A bowel obstruction may involve further surgical intervention.

- Anastomotic leak – where the newly joined ends of the bowel don’t heal properly, causing a leak of bowel contents into the abdomen. This can be caused by inflammation, infection or sometimes by a poor blood supply to the bowel tissue at the join. This can often be treated by antibiotics and resting the bowel but sometimes an anastomotic leak requires further surgery to repair the bowel.

Most patients are discharged from hospital between two and seven days after the surgery, once you have passed flatus (wind) or opened your bowels. The pattern or opening your bowels may take a while to settle and frequency and urgency are not uncommon. If you have concerns about this, please contact the specialist nurse for advice.

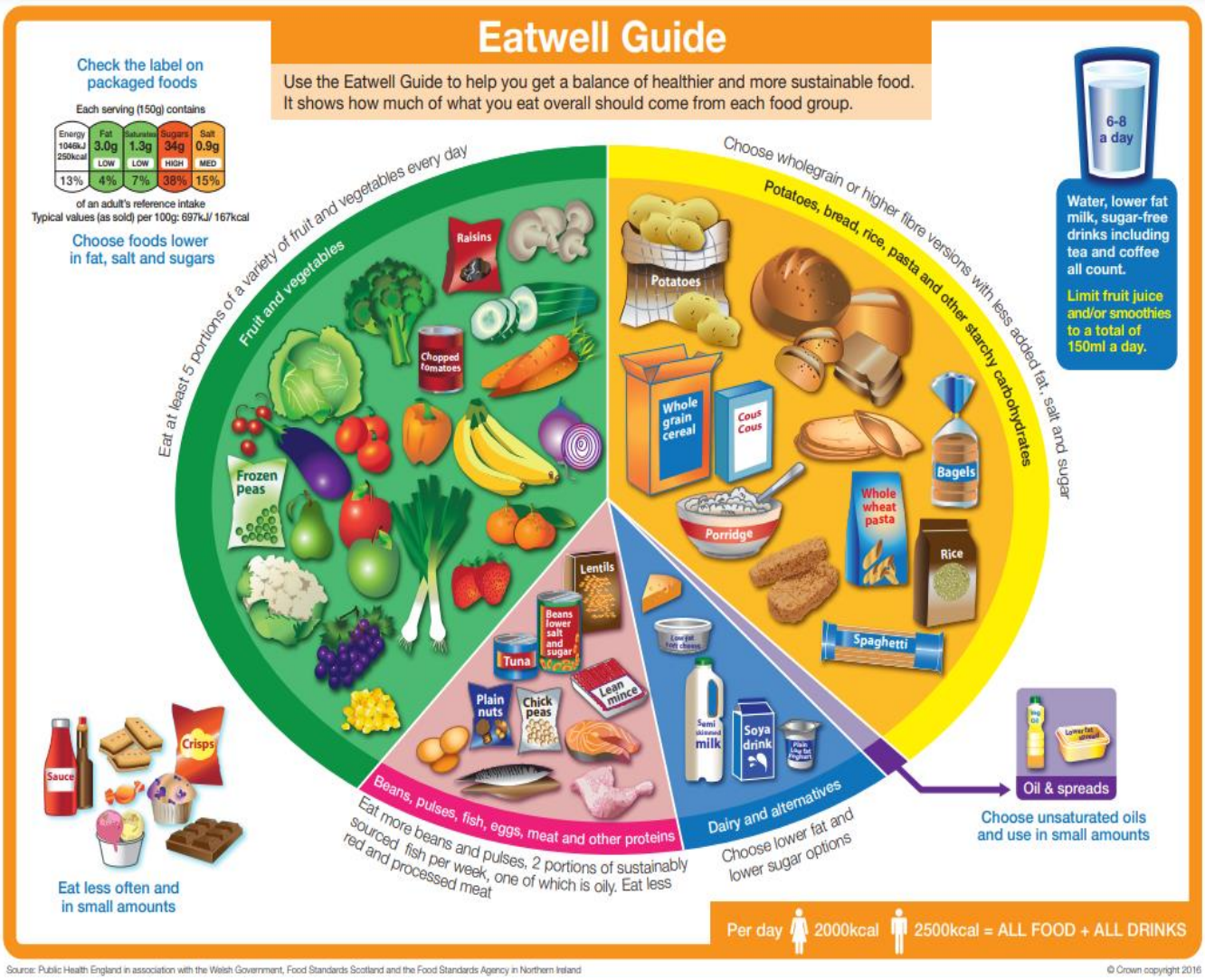
Diet and Low Anterior Resection Syndrome

After rectal cancer surgery, many people will experience changes to the frequency they open their bowels, as well as changes to the type and consistency of the stools they pass – this group of issues/symptoms is called Low Anterior Resection Syndrome (LARS).

Your bowel anatomy is not the same as it was prior to your surgery; a part of your rectum has been removed, it will be smaller and therefore its capacity less and the way that your bowel acts in response to diet will be different.

It can be difficult to know what to eat when you have had rectal surgery, especially if you have bowel symptoms such as loose stools.

The type of diet you eat may help manage some of the symptoms you, my experience.



Ideally your diet should contain starchy foods (such as bread and potatoes) as well as proteins such as meat, pulses and beans, dairy and dairy alternatives such as milk, cheese and yoghurt and fibre such as wholemeal, wholewheat and fruit and vegetables with their skins. A varied diet will also provide you with the vitamins and minerals you need for your body to heal after surgery.

You should also aim to drink 1500 to 2000 mls of fluid each day; though where your stool is particularly loose, you may benefit from avoiding water and drinking squash or isotonic drinks.

No two people's bowel functions are the same, before or after cancer surgery, so no single approach to dietary management will work for everyone. It may take a little time and some trial and error to find a diet that is suitable for you.

There are often common foods that cause bowel control issues, such as spicy foods, rich, oily foods or foods high in fat. Drinks containing alcohol or caffeine. You may not need to avoid these foods but in the immediate post reversal period you may need to consume these in moderation.

In the first few weeks after reversal of your ileostomy, it is advisable to eat a bland low fibre diet to allow your bowel to settle into its new routine.

You can gradually eat a more varied diet and reintroduce fibre in the next few weeks. You should keep in mind that some foods may increase the likelihood of diarrhoea or constipation; if you think that a particular food upsets you, try it again in smaller portions or avoid it for a longer period.

In general, people with LARS may find foods such as raw fruit and vegetables are less well tolerated than well cooked fruit and vegetables. Root vegetables, such as potatoes and carrots are often better tolerated than green leafy vegetables.

It is important to remember that our bodies can adapt over time, which means that the impact of your dietary needs and choices in the first few weeks might be different to those made a few months later. Chewing your food well, limiting rich and fatty or spicy foods and drinking alcohol in moderation can sometimes have a positive impact on bowel function.

There are two common problems that you might encounter after your operation: loose motions or difficulty in opening your bowels.

If your motions are loose, the following may help

- Eating less fibre; eating white bread, white based cereals, white rice and pasta. Avoiding or limiting nuts and dried fruit. Limiting your intake of beans and pulses.
- Cutting down on rich or fatty foods, including fast foods, chips, pies, batter, cheese, pizza, creamy sauces, snacks such as crisps, chocolate, cakes and biscuits, spreads and cooking oils.
- Cutting down on fatty meats, such as burgers and sausages. Small amounts of fat, however, are essential for the absorption of vitamins A, D and E and therefore fat should not be completely excluded from your diet.
- Drinking less tea and coffee, cola and energy drinks; caffeine free versions are often better tolerated.
- Drinking full sugar squash or isotonic sports drinks rather than water.

If you are finding it difficult to open your bowels, you may benefit from increasing the fibre in your diet.

- Adding oat-based foods to your diet, such as porridge, Ready Brek, oat flakes etc.
- Ensuring you are drinking 1500 to 2000mls of fluid per day.
- Keeping mobile and active. Any form or exercise such as walking, swimming, Pilates and yoga can improve bowel motility and help manage constipation.

Some people need to use medication to help them maintain regular bowel function, both when stool is too loose or when they are constipated.

Loperamide (Imodium) can be used to make stool firmer and it may be necessary to take this to allow you to eat and enjoy a varied diet. It is available over the counter and should be taken 30 minutes before eating. However, it should be taken with caution as it is easy to push your bowels toward constipation. Loperamide is available as mg capsules, bought over the counter, but this dosage might be too much; it can be obtained in a liquid preparation, but this requires a prescription. Taking liquid loperamide allows you to better titrate it to your needs.

Mild laxatives such as lactulose, dulcolax and senna can be taken to soften hard stool and make its passage through the bowel easier and more comfortable. Fybogel can also be helpful, it works by adding bulk to the stool which may make it easier to pass.

All laxatives require you to drink more fluids as this makes them work better.

In some rare cases, it may be necessary to refer you to a specialist dietician, particularly if you are struggling to eat a varied diet, are diabetic, are not maintaining your weight, have food allergies or intolerances or have other bowel conditions that may impact your bowel function such as Chron’s disease or ulcerative colitis.

Ongoing monitoring and support

Some people will unfortunately experience ongoing issues with bowel control or other symptoms of LARS; there are lots of options to address these issues and the specialist nurse is available to provide ongoing support and advice.

The LARS clinics are held bi-monthly at St Albans City Hospital.