Gloucestershire Hospitals NHS Foundation Trust

Patient Information

Having a total or sub-total gastrectomy

Introduction

This leaflet aims to give you an overview of the procedures known as total or sub-total gastrectomies. It will explain what happens during the procedure, some of the complications that may arise and what you can expect afterwards.

The procedure

A total or partial gastrectomy is the removal of all or part of the stomach. The lower part of the gullet (food pipe) or the remaining part of the stomach is then joined to a section of small bowel to allow normal eating and swallowing.

The surgery is either carried out through an open cut (incision) or keyhole (laparoscopic) incisions. Open surgery involves a cut that will either pass from right to left across the top of your abdomen or run up through the middle of your abdomen (known as a mid-line incision). Your consultant will discuss with you the decision on whether you need a total or a partial gastrectomy and how the operation will be done.

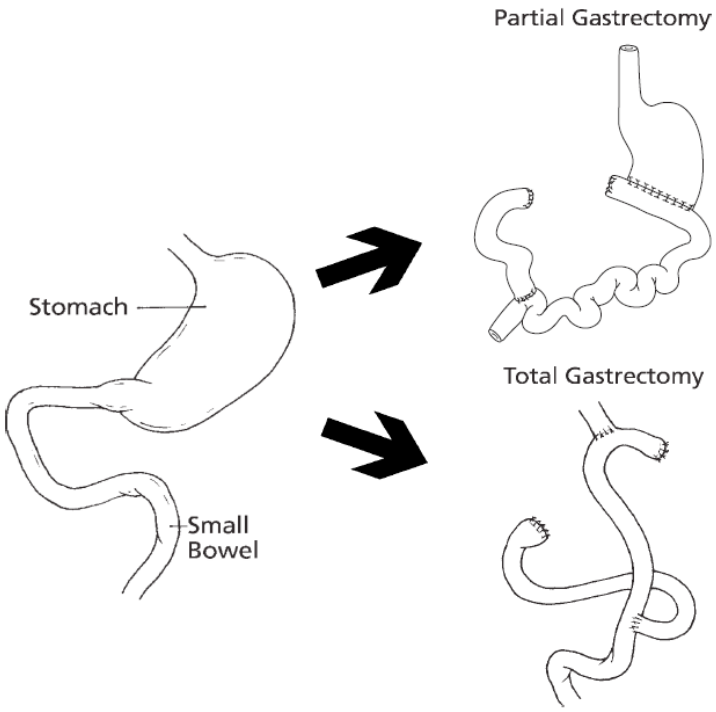

Figure 1: Total vs sub-total (partial) gastrectomy

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Benefits of having surgery

- Surgery is the most effective treatment for removing growths in the stomach
- Surgery can relieve problems such as bleeding, anaemia or blockages

Risks and complications

Removal of all or part of the stomach is a major operation which carries fairly high risks, such as leakage from the new join with the small bowel or, less commonly, bleeding.

The operation and anaesthetic puts a strain on the vital organs and there is a risk of:

- heart failure
- chest infection
- kidney failure
- thrombosis (blood clot)

Please be assured that all steps are taken to reduce these risks.

The overall chance of not surviving the operation is 1 in 33. This varies from patient to patient depending on general fitness and will be fully discussed with you.

What to expect

You will be admitted to hospital on the day of the operation and you should expect to be in hospital for at least 7 to 10 days.

Following your operation you will be taken to the Department of Critical Care (DCC). This is planned and it is important that you, your relatives and friends are aware that this is normal and not to be worried. It will be possible for you and your family to visit DCC before your operation if you wish, so that you know what to expect.

This often reduces anxiety about the amount of equipment and tubes that are used to monitor you over the first few days after your operation. You can expect to be in DCC until you are stable enough to be moved to a surgical ward.

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Medication

You will have some pain and discomfort after the operation and strong pain relief will be used to control this. After surgery on DCC, continuous pain relief is given through a tube going into your back called an epidural. The surgical and DCC teams will monitor you closely to make sure that the pain control is working well for you.

On day 4 after the operation, the epidural will be removed and you will have Patient Controlled Analgesia (PCA). PCA is a pain medication machine which you control by pressing a button on a hand-held device. Once you are drinking fluids, the PCA will be taken away and pain relief medication will be given to you by mouth at regular intervals.

Diet

You will be assessed on a daily basis and it may be a few days before we offer you fluids followed by diet. It is important that the join in the bowel is well on the way to healing before you start eating and drinking normally. During this time you will be given fluid and possibly a liquid diet through drips (tubes).

Nutrition may be given in the form of liquid food through a special tube called a jejunostomy which is placed into the small bowel during your operation. You will also have a fine tube that passes through your nose into your bowel. This tube is put in place during the operation and drains away digestive juices whilst your new join heals. The tube will stay in place until you are able to drink again.

The medical team will monitor you closely once you are eating and drinking. You will start on small amounts of liquids and then diet will slowly be introduced.

The stomach acts as a store for food and allows food to be released slowly into the gut to be absorbed and digested. The removal of part or all of the stomach will mean that you will have to change your eating habits. You will no longer be able to digest 3 large meals a day. Instead you will have to eat 5 to 6 small meals per day and take high protein drinks between meals.

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The dietitian will give you both verbal and written advice before you leave hospital. Poor nutrition and weight loss are common problems for patients following total or partial gastrectomy. You may have unpleasant symptoms if you eat large meals, so it is very important that you understand the advice the dietitian gives you before leaving hospital.

Wound care

Dissolving stitches are used to close the wound and while you are in hospital it will be checked and dressed regularly by a member of the ward team.

You may have a stitch in your skin that will be taken out on the 10th day after your operation. You will also have 1 or more tubes called drains coming out of your body, close to the wound, to drain any fluid from the surgery site. The drains will stay in place until the doctors decide that they can be taken out. The surgical team will check your wounds daily. It is likely that you will return home with the feeding tube in place, this will be taken out at an outpatient clinic. Taking out the feeding tube normally causes no pain. You will be able to shower and bathe normally before you go home.

Bowels and urination

You are unlikely to have your bowels open for the first few days after the operation, as the bowel slows down from being handled during surgery. Once it begins working again you may have diarrhoea, but this will settle down. A catheter (tube) will be passed into your bladder during the operation to drain the urine. This will be taken out once the epidural has been removed and when you are able to get out of bed to use the toilet.

Activity

Patients having major surgery are more likely to have complications and these include chest infections and blood clots in the calf or lungs. These can happen because you are not as active as you would normally be.

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The physiotherapist will visit you throughout your stay in hospital to encourage and support you with deep breathing exercises and becoming mobile again. It might be surprising to you but you may be encouraged to stand, walk and sit out in a chair as early as the day after surgery. This is good for your recovery.

While in hospital, you will wear special stockings that help with blood circulation and you will be given small blood thinning injections to help prevent blood clots from forming. The surgical team will get you up and about as quickly as possible to reduce the chance of developing any complications. It is important to remember that you will feel very weak after such a major operation and that this is perfectly normal.

Discharge home

Once you are independent again and are managing diet and fluids, arrangements will be made for you to go home. A community nurse will visit you at home if you need support. Once at home, it is important that you rest, but you must include some daily activity so you can gradually build up to what is normal for you.

Recovery from surgery varies from person to person, but usually takes about 3 to 6 months after the end of your treatment. Here is some basic advice:

- Do not do any heavy lifting for 2 to 3 months
- Do not drive until you can do an emergency stop without hesitation, (usually after about 4 weeks)
- Do not return to work until you have talked about it with your doctor about 3 months after you have completed your treatment

The consultant will advise you and your GP if there is a need for vitamin B12 injections at 3 monthly intervals following your operation.

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Follow up

You will be seen in an outpatients clinic, usually 4 to 6 weeks after you are discharged home. If you have any problems before this you should contact your GP or one of our Cancer Nurse Specialists. You will be followed up at regular intervals in the outpatient clinic and any further treatment will be discussed with you.

When to seek medical advice

If you have any of the following symptoms or have any concerns, please contact your GP, Cancer Nurse Specialist or telephone NHS 111:

- If your wound sites become red or painful or start to ooze liquid, this could mean you have a wound infection and may need antibiotics
- If you have a painful, red, swollen, hot leg or find it hard to bear weight on your legs, this may be caused by a Deep Vein Thrombosis (DVT)
- If you are breathless, have chest pain or cough up blood, it could be a sign that a blood clot has travelled to your lungs (pulmonary embolus)
- If you have abdominal pain that is getting worse and is not controlled by regular pain relief and have a fever along with shivers and shakes (rigor)
- If you have chest pain, are getting more breathless, have a cough, fever, rigor and mucky phlegm (sputum), this could mean you have a chest infection or a problem with your lung

In an emergency telephone 999 for the emergency services

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