

## Patient Information

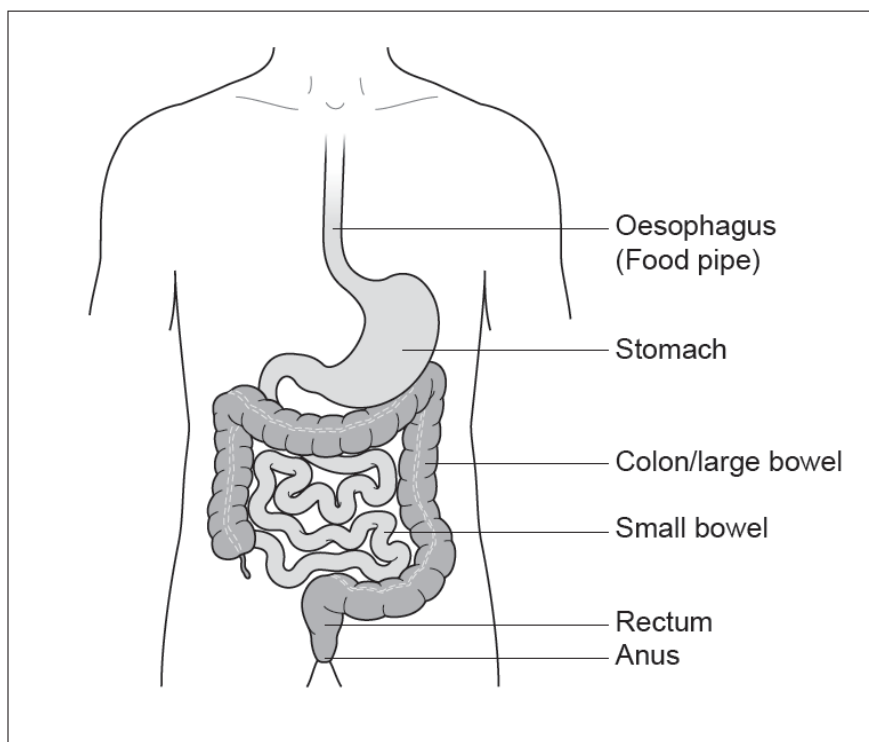
# Left hemicolectomy

## Introduction

This leaflet gives you information about the procedure known as a left hemicolectomy which is performed to remove a diseased area in your bowel. The leaflet will also explain what the procedure involves and list some of the common complications associated with it.

## The digestive system

To help you understand your procedure, it is helpful to have a basic knowledge of how the body works (see **Figure 1**).



**Figure 1: Digestive tract**

When food is eaten, it passes from the mouth down the oesophagus (food pipe) and into the stomach. The food is broken down and becomes semi-liquid. It then continues through the intestine (small bowel), which is many metres long, where it is digested and the nutrients are absorbed.

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**GHPI0580\_11\_22**

Department

**Colorectal**

Review due

**November 2025**

## Patient Information

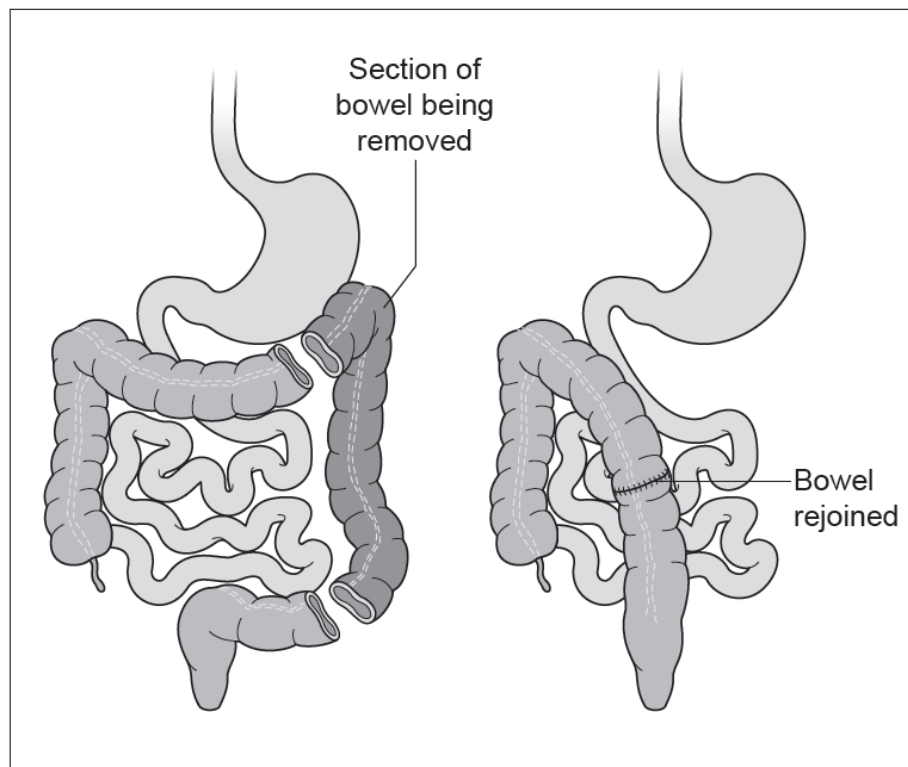
The semi-liquid food then passes into the colon (large bowel) where it becomes faeces (stools). The main job of the colon is to absorb water into our bodies making the stools more solid.

The stools then enter a storage area called the rectum. When the rectum is full, we get the urge to open our bowels. The stools are passed through the anus (back passage) when we go to the toilet.

## What is a left hemicolectomy?

A left hemicolectomy is an operation to remove the area of your bowel that is diseased. In this case, the left side of your colon will be removed.

The dark shaded area in the diagram on the next page (**Figure 2**) gives an indication of which part of the bowel is to be removed.



**Figure 2: Left hemicolectomy**

A cut will be made in your abdomen (tummy) and the surgeon will remove the diseased area of bowel. The two healthy ends of the bowel are then joined by stitching or stapling them together (anastomosis). The wound on the abdomen is usually closed with dissolvable stitches.

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## Will I need a stoma?

It is extremely uncommon for the ends of the bowel not to be joined together and a stoma 'bag' to be needed.

The surgeon may think it safer to bring the end of the bowel onto the abdominal wall as a stoma if the operation is performed as an emergency, if the bowel ends are unhealthy or if there is a risk of a join not healing due to low protein levels in your blood (an indicator of poor nutrition).

Before your operation, your consultant surgeon and colorectal nurse specialist will carefully explain the procedure involved, although details may vary according to individual cases. You will be asked to sign a consent form to confirm that you understand and agree to have the operation.

The procedure may either be performed as an 'open' operation, which involves making a relatively large cut in the abdomen or using laparoscopic (keyhole) surgery.

## What is keyhole surgery?

Keyhole surgery involves carrying out a procedure through small cuts in the abdomen. The surgeon inserts a narrow telescope attached to a camera and other special instruments through the incisions to remove the affected part of the bowel.

Most of the procedure is made through these incisions, but a slightly larger opening is needed to remove the section of bowel from the body (this is usually a bikini line cut).

The decision about whether to use open or keyhole surgery will be made after an informed discussion between you and your surgeon.

In particular, your surgeon has to consider whether your condition is suitable for keyhole surgery, together with the risks and benefits of both procedures.

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The benefits of keyhole surgery include:

- A reduction in the length of your hospital stay
- Reduced discomfort following surgery
- A smaller scar

The risks associated with keyhole surgery are the same as for open surgery. If for technical reasons it is not possible to complete your operation using keyhole surgery then the surgeon would need to proceed to an open operation. This will be discussed with you during the consent process.

## Potential risks and complications of the surgery

Removing part of the bowel is a major operation. Risks with this operation include:

### **Anastomotic leak**

Sometimes, the anastomosis (join in the bowel) leaks. Treatment with antibiotics and resting the bowel are generally enough to resolve the problem, however, this may be a serious complication which needs further surgery and formation of a stoma.

### **Ileus (paralysis of the bowel)**

Sometimes, the bowel is slow to start working after surgery. This causes vomiting and delays you from eating and drinking normally.

If this happens, the bowel may need to be rested and a drip (a tube into a vein in your arm) is used to replace fluids (instead of drinking). In addition, you may also need a nasogastric tube (tube in your nose which passes into your stomach) so that fluid collecting in your stomach can be drawn off. This helps to prevent nausea and vomiting and remains in place until the bowel recovers.

### **Adhesions (scar tissue)**

With any abdominal surgery, there will be some formation of scar tissue. This is known as adhesions. In some people, this can lead to further problems which may require more surgery, but this is rare.

**Patient  
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Pressure ulcers, also known as pressure sores are caused by a combination of pressure, shearing and friction. The nurses looking after you will assess your risk of developing a pressure ulcer daily and will check your pressure areas regularly. You will be encouraged to change your position at regular intervals for pressure area relief. You will be assisted by the nursing staff if you need help to move.

**Chest infection**

You can help by practicing regular deep breathing exercises and following the instructions of the physiotherapist who will see you, on the ward, after the procedure. If you smoke, we strongly advise you to stop.

**Wound infection**

If your wound becomes infected, this is usually not serious but may require treatment. You may be given antibiotics or if there is a collection of fluid, this may need to be released to allow your wound to continue to heal.

**Thrombosis (blood clot in the leg)**

Major surgery carries a risk of clot formation in the leg. To reduce this risk, a small dose of blood thinning medication will be given by injection each day until you go home. You will also be fitted with some support stockings to be worn during your hospital stay. You can help reduce the risk of thrombosis by moving around as much as you are able to and particularly by exercising your legs.

**Pulmonary embolism (blood clot in the lung)**

Rarely, a blood clot from the leg can break off and become lodged in the lungs. This would need treatment with blood thinning medication.

**Bleeding**

A blood transfusion may be needed during or after your operation. Very rarely, further surgery may be required if there is continued bleeding after your operation.

**Risk to life**

An operation to remove part of the bowel is classified as major surgery. It can carry a risk to your life. Your surgeon will discuss this risk with you.

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Most people will not experience any serious complications from their surgery. However, risks do increase with age and for those who already have heart, chest or other medical conditions such as diabetes or for those who are overweight or smoke.

### **What are the benefits of the procedure?**

The operation aims to remove the diseased bowel. In most cases this will give you the best chance of a cure or significant improvement in your bowel problems.

### **Alternative treatments**

If a left hemicolectomy has been recommended by your surgeon as the best treatment option, not having this surgery may lead to further worsening of your health. Depending upon what is wrong with you, you may develop a blockage in the bowel, leakage from the bowel into the abdomen or an abscess, all of which can be life threatening.

For most of the conditions where this surgery is advised, the only alternative is medical treatment. Where there is a cancer of the bowel, drug treatment such as chemotherapy alone will not cure the disease. Your surgeon will discuss any queries you may have.

### **How long does the operation take?**

This operation takes between 1½ and 3 hours, however you will be off the ward for longer than this because of the time spent in the anaesthetic room before your operation and time in the recovery room afterwards. When you are fully awake after your anaesthetic, feeling comfortable and your general condition is stable, you will be taken back to the ward.

### **How long will I be in hospital?**

During your admission, you will be following an enhanced recovery programme which aims to help you recover quickly and safely. We would estimate that you should be ready for discharge within 5 days if your recovery is uncomplicated.

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## **Pre-operative, post-operative and discharge advice**

For further information about what to expect when you come into hospital, what your recovery will involve and for discharge advice, please refer to leaflet GHPI0815 'Enhanced recovery programme for colorectal surgery'.

### **Results (if your operation has been performed to remove a cancer)**

During your operation, the bowel and surrounding tissue that is removed will be sent to the histology laboratory for analysis.

The analysis process is very detailed and it takes about 7 to 10 days for the histology results to return. These results will then be discussed at a colorectal cancer specialist multidisciplinary team meeting. At this meeting, a consultant histopathologist will discuss the stage of your tumour in detail.

The stage is a term used to describe the extent of the cancer in the body. A joint decision between all of the specialists will then be made about whether or not further treatment should be recommended for you, such as chemotherapy or radiotherapy.

The multidisciplinary team will include:

- Colorectal consultant surgeons
- Clinical consultant oncologists
- Consultant radiologists
- Consultant pathologists
- Colorectal clinical nurse specialists
- Other specialists such as stoma nurses, the palliative care team, and consultant gastroenterologists

Depending on your wishes, you can either be informed about your histology results by a telephone call from your specialist nurse or at an outpatient appointment with your consultant or specialist nurse.



**Patient  
Information****Follow-up**

Once you are discharged, your colorectal nurse specialist will make telephone contact to assess your general well-being.

You will be seen for an outpatient appointment about 6 weeks following your discharge. You will either be seen by your consultant or one of the colorectal nurse specialists who will assess how well you are recovering from your operation and check your wounds.

If your operation was performed for cancer and you have requested to receive your histology results in clinic, then you may be seen 2 weeks following your discharge. Your consultant or colorectal nurse specialist will also discuss with you, your individualised ongoing surveillance programme.

The stoma nurse specialist will telephone you after your discharge. This will be to plan to visit you at home about a week after discharge to check the stoma or to see you in an outpatient clinic.

**Contact information****Colorectal Nurse Specialist**

Gloucestershire Royal Hospital

Tel: 0300 422 5617

Monday to Friday, 8:00am to 4:00pm

Outside of these hours, please leave a message and someone will return your call the next working day.

**Stoma Nurse Specialist**

Cheltenham General Hospital

Tel: 0300 422 4363

Monday to Friday, 8:00am to 4:00pm

Gloucestershire Royal Hospital

Tel: 0300 422 6702

Monday to Friday, 8:00am to 4:00pm

Outside of these hours, please leave a message and someone will return your call the next working day.



## Patient Information

If you have an urgent problem, the stoma nurses can be contacted via the hospital switchboard.

### **Hospital Switchboard**

Tel: 0300 422 2222

When prompted please ask for the operator then the stoma nurses.

## **Further information**

### **Macmillan Cancer Support**

Tel: 0808 808 00 00

Monday to Friday, 9:00am to 8:00pm

Website: [www.macmillan.org.uk](http://www.macmillan.org.uk)

### **Bowel Cancer UK**

Website: [www.bowelcanceruk.org.uk](http://www.bowelcanceruk.org.uk)

### **FOCUS Cancer Information Centre**

Cheltenham General Hospital

Tel: 0300 422 4414

Monday to Friday, 8:30am to 4:30pm

### **Maggie's Centre**

College Baths Road, Cheltenham

Tel: 01242 250 611

Monday to Friday, 9:00am to 5:00pm

### **'Mini' Maggies**

The Main Place

Old station Way,

Coleford

GL16 8RH

Tel: 01242 250611

Offering practical and emotional support, facilitated and peer support groups as well as fitness and relaxation classes.

Sessions run on the third Friday of each month from 10:00 am to 2:00 pm.

## Patient Information

### Macmillan Information Hub

Gloucestershire Royal Hospital

Tel: 0300 422 8880

Monday to Friday, 9:00am to 4:00pm

Email: [ghn-tr.macmillanhub@nhs.net](mailto:ghn-tr.macmillanhub@nhs.net)

To access the service either drop in (no appointment needed), call or email.

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## Making a choice

### Shared Decision Making

If you are asked to make a choice, you may have lots of questions that you want to ask. You may also want to talk over your options with your family or friends. It can help to write a list of the questions you want answered and take it to your appointment.



### Ask 3 Questions

To begin with, try to make sure you get the answers to three key questions if you are asked to make a choice about your healthcare.

1. What are my options?
2. What are the pros and cons of each option for me?
3. How do I get support to help me make a decision that is right for me?

These resources have been adapted with kind permission from the MAGIC Programme, supported by the Health Foundation

\* Ask 3 Questions is based on Shepherd HL, et al. Three questions that patients can ask to improve the quality of information physicians give about treatment options: A cross-over trial. Patient Education and Counselling, 2011;84: 379-85



<https://aqua.nhs.uk/resources/shared-decision-making-case-studies/>