

Supporting and empowering you



Stoma Reversal

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Colostomy UK

We are Colostomy UK. Here if you have questions, need support or just want to talk to someone who lives with a stoma.

Your voice on the bigger issues: advocates for your rights and campaigning to raise awareness of what matters to you; running projects to empower you; building communities to support you.

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Stoma Reversal

Medical and surgical advances mean that stoma surgery is increasingly seen as a temporary measure. Not everyone can have a reversal, but if you have a reversal booked, are about to discuss the possibility with your surgeon, or contemplating whether to go ahead with the surgery, then this booklet is for you.

In Part 1, Oliver Shihab, Surgical Registrar at the Pelican Cancer Foundation, begins by describing the different types of stoma and outlines what is involved in reversing them from a surgeon's point of view. He also talks about the likely length of hospital stays and complications that can sometimes arise.

In Part 2, Shelley Biddles and Diana Wilson, colorectal and stoma nurses with many years' experience, then consider the advantages and possible problems associated with a reversal. They provide guidance on how to prepare for a meeting with your surgeon and information to help you decide whether to proceed if reversal surgery is an option for you.

Part 1: A surgeon's perspective – Oliver Shihab MBBS MRCS (Eng), Surgical Registrar

Stomas formed from the colon (large bowel) are called colostomies. Those formed from the ileum (small bowel) are called ileostomies. In each case they can either be loop or end stomas. The diagrams overleaf provide more detail. Understanding which type of stoma you have is important, as it has implications for the type of reversal surgery necessary and post-operative recovery time.

Loop and end stomas

Temporary stomas usually take the form of a loop ileostomy (and less frequently the traverse loop colostomy). These are created when the bowel is obstructed and needs to be relieved in an emergency or where another section further down the bowel has had to be removed.

Occasionally, there are situations where an end colostomy will be created on a temporary basis. This is usually done as part of what is known as a Hartmann's procedure. In this operation an end colostomy is formed and the remaining part of the bowel below this is securely sealed and left in the abdomen. Hartmann's procedure is usually carried out for emergencies, such as a blocked bowel where there may have been perforation of the bowel or for complications of diverticular disease, where there has been infection in the abdomen and it is not safe to join up the bowel immediately.

Stoma reversal

Although ideally as many people as possible will have reversals, there may be several reasons why the surgeon looking after you is reluctant to do this.

Firstly, surgery is never without risk, no matter how small the procedure. Your surgeon needs to be happy that you are fit enough for another operation.

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Secondly, the bowel and the anal sphincters that control the flow from the bowels need to be working, so that incontinence will not develop as a result of reversal surgery. To help in his or her assessment, your surgeon is likely to perform a rectal examination and possibly arrange some further tests of anal tone if they have any doubts.

A small percentage of people who have a planned temporary stoma end up keeping it as a permanent stoma because reversal is not possible.

How soon can a reversal take place?

It is understandable that people want their normal bowel function restored as soon as possible. There have been several studies that have looked at the best time to do this. After any abdominal operation there is an inflammatory response, which results in the formation of adhesions. These adhesions are band-like structures, which are essentially scar tissue. If they are very dense, they can cause considerable problems for a surgeon, making some parts of the bowel very difficult to reach and safely operate on. The adhesions are at their worst in the weeks following an operation, so it is advised that surgery is postponed until at least nine weeks after this. This allows time for the adhesions to settle, the patient to recover and any swelling within the abdomen or stoma site to fully resolve.

The reversal

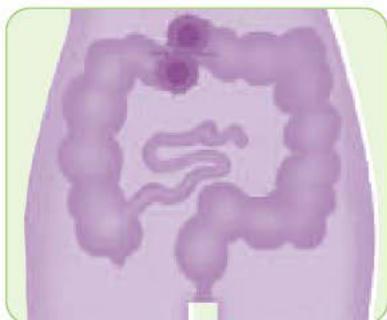
Closure of a loop colostomy or ileostomy is a reasonably simple procedure and in 95% of cases does not require any further incisions in the abdomen. A small rim of skin is cut around the stoma (about 2mm) and the incision is deepened until the abdominal cavity is reached. Once this has happened the bowel and abdominal cavity are checked to ensure that there is nothing still attached to the bowel. The bowel is then closed – either stitched by hand or stapled together.

Reversal of an end colostomy or ileostomy is more difficult because one end of the bowel that is to be rejoined is in the abdomen. This usually means that the surgeon has to open the abdomen via the old scar to be able to safely access the bowel. As a result of the increased surgery (compared to the closure of a loop stoma), there will be a longer stay in hospital and a greater recovery time before normal activities can be resumed.



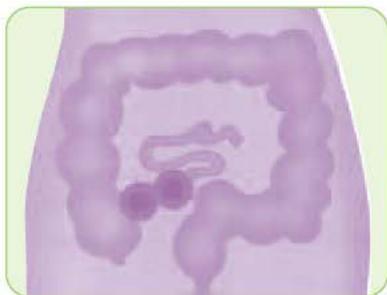
End Colostomy

This is usually sited in the left side of the abdomen. With this type of colostomy the colon (large bowel) is severed and the functioning end is brought to the skin. The distal end, which leads to the anus, is sealed and left inside the abdomen.



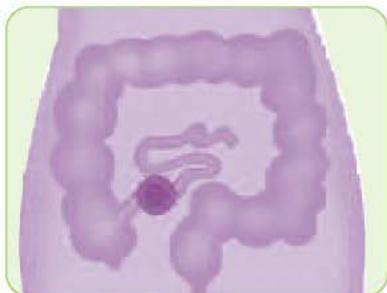
Loop Colostomy

To form a loop colostomy a loop of large bowel is brought out usually in the upper abdomen, and then opened and stitched to the skin. This gives two openings. The upper, or proximal, limb links up with the stomach and intestines higher up and produces stool, the other, distal, limb leads to the anus and only produces small amounts of mucus.



Loop Ileostomy

A loop ileostomy is formed from a loop of ileum (small bowel). Today they are more commonly used than the loop colostomy, if a temporary diversion of bowel contents is required, when a join in the bowel (e.g. after cancer surgery for the large bowel) needs to be rested and given time to heal.



End Ileostomy

The end ileostomy is usually sited on the right side of the abdomen. It is more commonly reserved for those who have had all or most of their colon removed, usually due to inflammatory bowel disease or multiple polyps of the large bowel.

Illustrations reproduced courtesy of Coloplast

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It is possible to reverse an end colostomy using keyhole surgery (laparoscopy), but this is dependent on a surgeon's training. Even when this attempted, there is no guarantee that it won't be necessary to convert to the open operation, as the aforementioned adhesions can cause severe problems laparoscopically. If this type of surgery is carried out successfully then it is likely that there will be less post-operative pain and a shorter stay in hospital.

How long in hospital?

Length of hospital stay depends on the type of operation performed. For the closure of a loop colostomy it will be around three to five days. For the closure of an end colostomy you can expect a stay of between five and ten days. The surgeons caring for you will want to be sure that you cope with your bowel movements once again, as it is fairly common to pass looser and more frequent stools than you may have been used to in the past. They will also want to ensure that the area where the join (anastomosis) was formed has not narrowed (strictured) as a result of scarring, as this can lead to a partial or full blockage of the bowel. If this happens, then it may be necessary to have the area stretched. This is normally carried out using a colonoscope.

Recovery following hospital discharge

When you get home, your return to normal activities will be determined by your physical condition before the operation and, again, on the type of operation you had. It can be at least ten weeks before you are able to lift heavy weights or fully use your abdominal muscles. Driving will be allowed only when you can perform an emergency stop without any pain, or fear of pain.

Initially, your diet might require adjustment. The period after a reversal can be similar to the time the stoma was originally formed, with loose bowels and sudden urges to go. Some people develop inflammation of the lower part of the colon. This sometimes occurs when part of the colon hasn't been used for time. This can lead to loose stools, with some bleeding and mucus, but this usually settles down without the need for treatment.

Complications

All surgery carries risks, but fortunately life-threatening complications with stoma reversals are rare. As with any surgery there will be general complications that can arise from undergoing a surgical procedure. Your surgeon will discuss these with you before your operation. There are also some that are specific to stoma reversals:

- **Ileus** (temporary paralysis of the bowel). Sometimes the bowel is slow to start working after surgery, particularly if it has been handled by the surgeon. Disturbances in your body's salt balance and some pain medications can also increase the risk of this occurring. If this happens the bowel will need to be rested, which involves stopping food and taking minimal amounts of water. Fluid given via a vein (a drip) is used to replace fluids and you may need a tube down your nose to your stomach (nasogastric tube) which decompresses the bowel and helps it to start up again.
- **Bowel obstruction.** If there is a physical blockage or problems with adhesions causing a blockage another operation may be required. Fortunately this type of physical blockage is rare immediately after an operation.
- **Anastomotic leak** (breakdown of the join in your bowel). If this is suspected you will be started on antibiotics and it is likely that another operation will be required. However, this complication can take a controlled form, whereby an abscess forms. If this is the case there may not be a need for surgical intervention, as it may be possible to control it with antibiotics and drainage under X-ray guidance.
- **Urinary and sexual function.** This may be affected temporarily but the risk of this being permanent is higher in surgery to reconnect an end colostomy, as the nerves controlling these functions lie in this region.

Hopefully this has given you a clearer picture of the types of temporary stoma used and the processes involved in reversing or 'closing' them. Before the operation the surgeon looking after you has a duty to inform you of the potential risks involved. Rather than being designed to create doubt and fear, this is to allow you to make an informed decision about your treatment. It should not be forgotten that every year many thousands of stoma reversals are carried out and the vast majority are successful.

Part 2: A nurse's perspective – Shelley Biddles RGN RMN, and Diana Wilson RGN RM

The idea of further surgery can be a nerve racking thought, especially if, for whatever reason, the previous occasion is an unpleasant memory.

All stoma reversals are performed as planned operations. This minimises the risk of post-operative complications. The surgical team (including the anaesthetist) will assess all possible risks beforehand and put measures in place to try and prevent any problems occurring.

Recovery time: things to consider

With enhanced recovery programmes in place, inpatient hospital stays are getting shorter and shorter; stoma reversals are even being performed as day-cases in some hospitals. For most people, a reversal means a hospital stay, even when there are no post-operative complications. As Oliver Shihab detailed earlier, stays can range from a few days to a couple of weeks, depending on the procedure.

Once you get home a period of recovery is also necessary. As was mentioned previously, the length of this will again vary according to the procedure you have undergone. Time off work may, therefore, be a consideration when deciding whether or not to have a reversal.

Whilst length of hospital stay and recovery times are imprecise, the most variable aspect of rehabilitation is the attainment of acceptable bowel function. This can make getting back to 'normal' unpredictable.

Function following stoma reversal

It takes time for bowel function to settle into some sort of pattern. How long varies from person to person, as does the perception of what is satisfactory function. During the first few weeks following a reversal, bowel function can be erratic.

The following are quite common at first:

- Loose motions (which can swing to constipation).
- Going to the toilet to pass faeces more frequently.
- Having some degree of urgency when going to the toilet.
- Difficult determining wind from a motion.
- Sore skin around the back passage (anus).

It is often difficult to predict exactly how problematic bowel function will be. It is not usually due to the type of stoma that you had, but more likely to be:

- The amount of colon and/or rectum removed.
- Treatments and the health of the remaining colon and/or rectum.
- Other previous pelvic surgery and/or any previous or co-existing pelvic disease.
- The distance of the join in the colon/rectum from the back passage.
- Capability of anal sphincters.
- Personal perceptions about whether function is satisfactory.

The reasons why the above occur are many. Having an understanding of these will be useful when discussing the possibility of a reversal with your surgeon and making a decision about whether to proceed.

Faeces enters the colon as a liquid and one of the main functions of the colon is to re-absorb water back into the body. When a significant section of the colon is removed, the consistency of waste matter will become more liquid. This may in turn result in the need for more frequent toilet visits and, with this, concerns regarding control. Exercises which build up and strengthen the anal sphincter muscles can help in preventing the leakage of gas and stools from the back

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passage.

Treatments such as chemotherapy and radiotherapy to the pelvis can delay the return of acceptable bowel function. In some cases the damage may make function more unpredictable and for some it may be painful.

Previous pelvic disease or abdominal surgery may make stoma reversal difficult and may also affect long-term function.

The use of stapling guns for rejoining bowel has allowed surgeons to make a lower join (anastomosis) in the rectum, thus reducing the necessity to remove the back passage and form a permanent colostomy. However, this can have an impact on subsequent bowel function and control. The rectum acts as a reservoir or 'holding area' for faeces. When a significant portion is removed and the scar line is close to the sphincter muscles, what is commonly known as anterior resection syndrome can result. It is characterised by the following symptoms:

- Increased frequency.
- Urgency and a feeling of the need to defecate.
- Fragmentation of the motion (a feeling of not having completed passing faeces).
- Inability to distinguish 'wind' from motion resulting in soiling or possible incontinence.

The above settles down for most people, but can take a significant time to do so. Childbirth, age and trauma are just some of the processes that can have a detrimental effect on sphincter control in general. If the initial stoma surgery causes a looser output or reduces 'holding' capacity, then control of bowel function following a reversal can be more difficult. Pelvic floor and sphincter exercises to aid bowel control can help.

Further considerations and advice

It is important to remember that what is acceptable to one person may be intolerable to another. Some people may expect bowel function to return to exactly how it was prior to any disease process and surgery. This is often unrealistic and unachievable. Also, time to heal must be taken into consideration.

Medication

Anti-diarrhoea medication, softeners, or bulking agents may be required to improve consistency.

Dietary Advice

Following a reversal it may take time to get back to eating a normal, healthy diet. The digestive system may be quite upset and temperamental. This will mean that a 'settling-in' period is required for both the stomach and bowel. During this period it is sensible to limit the intake of foods that can irritate the gut. These include:

- Acidic/ citrus fruits e.g. grapefruit, oranges, strawberries or grapes.
- Highly spiced foods e.g. curry or chilli con carne.
- Big fatty meals.
- Vegetables with a high 'flatulence factor' such as, cabbage, Brussel sprouts or onions.
- Large amounts of beer or lager.

Skin care

When bowel movement is loose or if problems occur with soiling in the area around the back passage, irritation or soreness can occur. To prevent skin excoriation, diligent skin care is essential. Washing thoroughly with warm water and 'patting' dry with a soft cloth after each bowel movement is necessary. Applying a protective cream will help minimise any skin problems. If these measures prove inadequate then you should contact your stoma care nurse for specialist advice.

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Stoma reversal – your choice

Not every person with temporary stoma has a reversal. This might be because the patient decides against further surgery or are advised that it is not possible by their surgical consultant.

Some patients experience problems following a reversal and in some cases have their stoma reformed. Likewise, there will always be those for whom the outcome of a reversal isn't what they desired. However, most people find having a reversal to be a worthwhile procedure with a very successful outcome.

Your surgical team will always assess in depth your surgical complication risks, the potential success of a reversal and the likelihood of acceptable function before deciding if you are suitable for the procedure. These facts must be outlined and discussed with you prior to surgery. This is called informed consent.

As you should now realise, there is much to consider when deciding whether to have a reversal. We would like all reversals to have a successful outcome and, with this in mind, have produced a simple checklist (below) which we hope you will find useful in discussions with your consultant:

- Make sure you understand why your stoma was formed in the first place.
- Ask your consultant or stoma care nurse to provide you with detailed information regarding the proposed surgery and the realistic outcome you can expect in relation to hospital stay, length of recovery and expected bowel function – both in the short and long-term.
- Consider what your quality of life is like with your stoma.
- Consider what your quality of life would be without a stoma, taking into account all the surgery and treatment that you have had.
- Speak to people who have undergone a reversal (Colostomy UK can help you here).
- Ask for a written summary of your consultant's plan.

Support from Colostomy UK

We hope that you have found this booklet useful and that it will help you come to an informed decision about the course action most appropriate for you. If you would like to speak to one of our volunteers who has had a reversal, then please e-mail us or call our helpline and we will be pleased to arrange this for you.

We provide:

- A 24-hour free helpline: 0800 328 4257.
- Information booklets, leaflets and factsheets about all aspects of living with a colostomy.
- *Tidings*, a quarterly magazine full of the latest news, articles by stoma care professionals, product information and real-life stories from other ostomates.
- A closed Facebook group for supporting each other and exchanging hints and tips.
- A website that provides practical information, details of open days and a directory of organisations, support groups, products and services.

This booklet is intended for general information and guidance only. Colostomy UK would like to take this opportunity to thank:

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Colostomy UK's flagship magazine *Tidings*, is hailed by ostomates and healthcare professionals alike for the support and information that it provides readers with on a quarterly basis.

Visit our website or call us to sign up for your free copy.

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