Abdomino Perineal Excision of the Rectum (APER)

Introduction

This booklet tells you about the procedure known as an Abdomino Perineal Excision of Rectum (APER). It explains what the procedure involves and also some of the common complications associated with it.

The digestive system

To help you understand your operation, it is helpful to have a basic knowledge of how the body works (see Figure 1). 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 semiliquid. It then continues through the intestine (small bowel) which is many feet long where food is digested and nutrients are absorbed.

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 finally passed through the anus (back passage) when we go to the toilet.

What is an APER?

APER is an operation to remove the area of the bowel that is diseased. The operation removes the rectum. The diagram below gives an indication of which part of the bowel is to
be removed (see Figure 2).

Figure 2: Abdomino Perineal Excision of the Rectum (APER)

Two cuts will be made – one in your abdomen (tummy) and one around the anus. The surgeon will remove the diseased area of bowel and anus and make a colostomy. A colostomy (stoma) is the end of the colon brought to the surface of your abdomen and stitched to the skin. Stools are then passed through the stoma and collected in a bag that covers it. Once the rectum has been removed, the skin and muscles of your bottom are sewn up. The wounds on the abdomen and bottom are usually closed with dissolvable stitches.

Before your operation, a specialist stoma nurse will mark your abdomen with a skin marker pen (known as siting). This is to guide your surgeon to the best possible place to bring out the stoma. Your stoma care nurse will also discuss with you in more detail what having a stoma will involve, and answer any questions you may have. Before your operation, your consultant surgeon, colorectal and stoma care nurse specialist will carefully explain the procedure you will be having. You will need to sign a consent form to confirm that you understand and agree to have the surgery.

The surgery may either be done as an ‘open’ operation which involves making a relatively large cut in the abdomen, or using laparoscopic (keyhole) surgery.
Why do I need a stoma?

Unfortunately, it is not possible to remove the diseased part of your bowel without removing the muscles and tissues of the anus (bottom). This means that there would be nothing left behind to try to make a new back passage with. The healthy bowel which remains must therefore be brought out onto the abdominal wall as a stoma. This will be permanent.

What is keyhole surgery?

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

Most of the operation is made through these cuts, but a slightly larger opening is needed to remove the section of bowel from the body (this is usually a bikini line cut). As previously mentioned, due to the position of the part of bowel which need to be removed, part of your operation will also be performed through your bottom.

The decision about whether to use open or keyhole surgery should 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, and the risks and benefits of both procedures.

The benefits of keyhole surgery include:

• A reduction in the length of 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:

**Nerve damage**

The piece of bowel operated on is very close to the bladder and the nerves responsible for sexual function. These nerves may get damaged during the operation. Bladder function may also be disturbed.

Men may experience difficulty with erection and ejaculation, and some may also have problems passing urine.

Women may feel a different sensation in their vagina when having intercourse. There may be pain, vaginal tenderness, dryness or vaginal discharge for some months.

These complications may be temporary or permanent. If you experience any of these problems after your operation please discuss them with your surgeon or colorectal nurse specialist as there may be treatments available to help.

**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.

**Stoma problems**

- A necrotic stoma (reduced blood supply to the stoma). This may need further surgery
- Stoma prolapse (when the stoma comes out too far past the skin). In serious cases further surgery may be needed
• Parastomal hernia (when the bowel pushes through a weak point in the abdominal muscle wall). Small hernias can be treated with a support garment or belt. Surgery may be needed for larger hernias.

**Slow wound healing**

The wound on your bottom can sometimes take a long time to fully heal. This is more likely to happen if you have received radiotherapy to the pelvic areas before your operation. For this reason, it is very important that you are careful not to put too much pressure on your bottom wound while it is healing. You may be provided with a pressure relieving cushion and mattress while you are in hospital. You can also help by changing your position frequently while you are in bed, and by not sitting in a chair for long periods without relieving the pressure.

**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.

**Chest infection**

You can help by practising regular deep breathing exercises and following the instructions of the physiotherapist. 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 until you go home. You will also be fitted with some support stockings for the duration of your hospital stay. You can help 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
Surgery 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. 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 an APER has been recommended by your surgeon as the best treatment option, not having this surgery may lead to bleeding, rectal discharge or incontinence, pain and possibly a complete blockage of the bowel. If you have cancer, the longer it remains the more likely it is to spread and become incurable. If you choose not to have surgery, radiotherapy and/or chemotherapy may be offered. This may control your symptoms but will not cure the disease. Occasionally, it is possible to remove a rectal cancer using surgery directly from within the back passage. This type of surgery is only suitable for a small number of patients.
How long does the operation take?
This operation takes between 3 and 4 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 7 days if your recovery is uncomplicated and you are able to manage your stoma.

About your stoma
The faeces (stool/poo) may start being passed directly into the pouch (bag) within 24 to 48 hours, but can take longer. When faeces initially pass into the pouch, it will be very liquid, this is normal. You will have a pouch over your stoma so it can be emptied regularly. As you start to eat and drink a little more and build up your appetite, the faeces will thicken up to a thick ‘porridge like’ consistency. By the time you go home, your stoma pouch will need to be emptied, by you, on average up to 3 times per day. Eventually the motions passed into the pouch will thicken up and become more like normal stools.

Between the stoma nurse specialist and the ward nurses, they will show you on a daily basis what to do with your stoma. By the time you go home, you will know how to change your stoma bag. It will feel fiddly at first, but the more you do it, the easier it will get.

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 pathology laboratory for analysis. The analysis process is very detailed and it takes approximately seven to ten 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 specialist's
- Other specialists such as stoma nurses, the palliative care team, 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.

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 approximately 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 two 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 and will plan to visit you at home about a week after to check the stoma or to see you in an outpatient clinic.

**Contact information**

**Colorectal Nurse Specialist**
Cheltenham General Hospital  
Tel: 0300 422 3586  
Monday to Friday, 9:00am to 4:00pm

Gloucestershire Royal Hospital  
Tel: 0300 422 5617  
Monday to Friday, 9:00am 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, 9:00am to 4:00pm

Gloucestershire Royal Hospital  
Tel: 0300 422 6702  
Monday to Friday, 9:00am to 4:00pm  
Outside of these hours, please leave a message and someone will return your call the next working day.

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

**Hospital Switchboard**  
Tel: 0300 422 2222

**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)
Beating Bowel Cancer
Tel: 020 8973 0011
Monday to Thursday, 9:00am to 5:30pm
Friday 9:00am to 4:00pm
Website: www.beatingbowelcancer.org.uk

Information Prescription System (IPS)
The Information Prescriptions System (IPS) is accessible by anyone with internet access and is designed to help provide tailored information.
Website: www.nhs.uk/ips

Other sources of support and information
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

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