

Patient
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Abdomino Perineal Excision of the Rectum (APER)

Introduction

This leaflet gives you information 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 related to 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 semi-liquid. It then continues through the intestine (small bowel), which is many feet long, where it is digested and the 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.

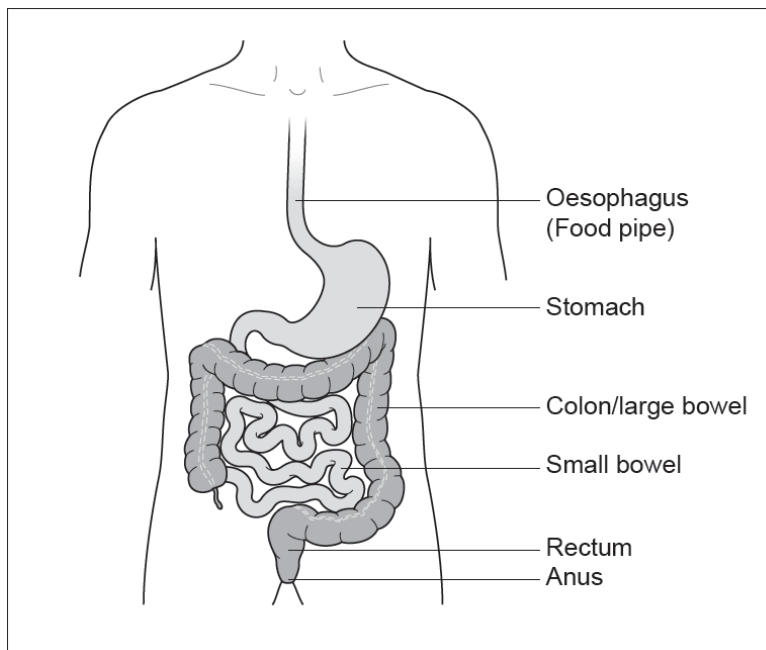


Figure 1: Digestive tract

Reference No.

GHPI581_11_22

Department

Colorectal

Review due

November 2025

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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 in **Figure 2** (on the next page) shows you which part of the bowel is to be removed.

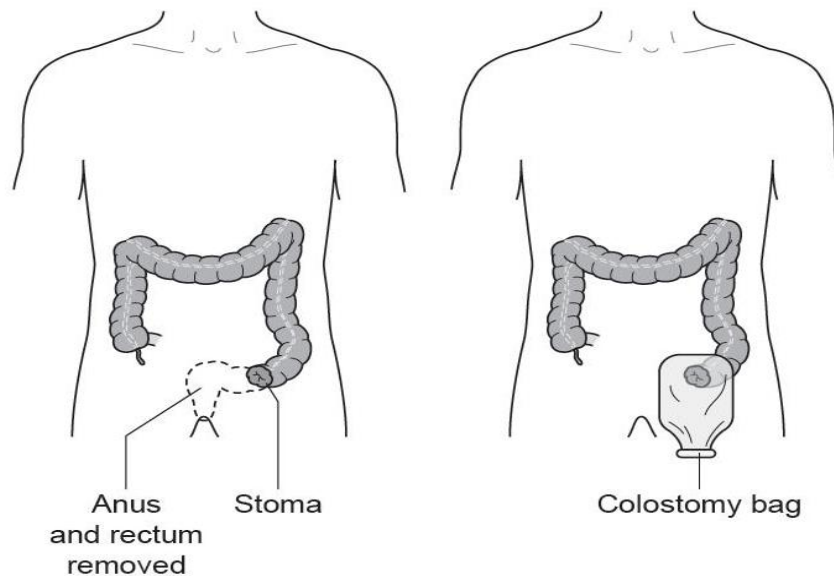


Figure 2: Abdomino Perineal Excision of the Rectum (APER)

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 (known as siting) with a skin marker pen. 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.

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Before your operation, your consultant surgeon and colorectal and stoma care nurse specialist will carefully explain the procedure you will be having. You will be asked 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 large cut in the abdomen, or using laparoscopic (keyhole) surgery.

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 section of the bowel which needs to be removed, part of your operation will also be performed through your rectum.

The decision about whether to use open or keyhole surgery will be made after an informed discussion between you and your surgeon. Your surgeon will 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 your hospital stay
- Reduced discomfort following the 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.

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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. The healthy bowel which remains must therefore be brought out onto the abdominal wall as a stoma. This will be permanent.

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, 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 give you 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.

**Patient
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- 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 reduce the pressure to your bottom by changing your position often while you are in bed and by not sitting in a chair for too long

Adhesions (scar tissue)

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

Chest infection

You can help by practicing regular deep breathing exercises and following the instructions of the physiotherapist to reduce the risk of a chest infection. 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.

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Thrombosis (blood clot in the leg)

Major surgery carries a risk of blood clot formation in the leg. To reduce this risk, a small dose of blood thinning medication will be given once a day by injection until you go home. It is likely that you will need to continue these injections for a short period of time at home. The nurse on the ward will help to train you so that you are able to do this safely or provide alternative arrangements with the community nursing team, if needed. You will also be fitted with some support stockings to be worn during your hospital stay. You can help to reduce the risk of blood clots forming by moving around as much as you are able to and 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. 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.

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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 will take 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 the 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

You will have a pouch over your stoma so it can be emptied regularly. The faeces (stool/poo) may start being passed directly into the pouch (bag) within 24 to 48 hours, but can take longer. When faeces first pass into the pouch, it will be liquid, this is normal. 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.

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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'. You will be given this leaflet by your colorectal nurse specialist before the 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 (investigation). The analysis process is very detailed and it will take about 7 to 10 days for the 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 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 results by a telephone call from your specialist nurse or at an outpatient appointment with your consultant or specialist nurse.

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Follow-up

Once you are discharged, your colorectal nurse specialist will make telephone contact to assess your general well-being within 24 to 48 hours. Alternatively, they will provide details while you are in hospital as to who you can contact if you have any concerns.

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 to remove 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 follow up programme.

After discharge the stoma nurse specialist will telephone you to arrange a visit to your home or to see you in an outpatient clinic to check the stoma.

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.

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

Gloucestershire Hospitals Switchboard

Tel: 0300 422 2222

When prompted ask for the operator then for 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

Bowel cancer UK

Website: 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, 10:00am to 2:00pm

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Macmillan Information Hub

Gloucestershire Royal Hospital

To access the service either drop in (no appointment needed) or telephone 0300 422 8880

Email: ghn-tr.macmillanhub@nhs.net

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

Content reviewed: November 2022

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/>