Subtotal and Total Gastrectomy
Gastrointestinal Services Division
If you need a large print, audio or translated copy of the document, please contact us on 020 3447 9202. We will try our best to meet your needs.

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1 Introduction

This leaflet provides information on the investigation and management of stomach (gastric) cancer. It aims to answer most of your questions about this condition and its treatment at University College London Hospitals.

What is a Gastrectomy?

2 What is a Gastrectomy?

The Stomach: This is an organ in the upper abdomen that stores and helps digest food and drink.

Cancer of the Stomach: This is a cancer that grows in the stomach wall and may cause pain, vomiting and/or anaemia (low blood count) and can lead to weight loss. It is amongst the ten commonest cancers in the UK. Removing the cancer by surgery may cure it.

3 Before Surgery

To diagnose this cancer we use endoscopy to look down into the stomach directly. We also arrange a CT scan (imaging procedure) and occasionally another type of scan (PET). Finally we need to perform a laparoscopy (keyhole procedure) under general anaesthesia. After these tests are complete we can advise you on the need for an operation to remove the cancer. This operation is called either a “total gastrectomy” (removing all the stomach) or a “subtotal gastrectomy” (removing about two thirds of the stomach).

If surgery is required we shall explain to you the details of the operation and then recommend you undergo a course of chemotherapy which often lasts about nine weeks. After the
chemotherapy, we will arrange a new CT scan to ensure the cancer has not spread and then proceed to surgery within four weeks. You may also need chemotherapy after you have recovered from the operation. A visit to a hospital clinic is required to ensure all the tests before surgery are complete and that the anaesthetist has a chance to see you early if required.

4 Asking for your consent

By law we must ask for your consent and will ask you to sign a consent form. This confirms that you agree to have the operation and understand what it involves. Staff will explain all the risks, benefits and alternatives before they ask you to sign a consent form. If you are unsure about any aspect of the treatment proposed, please do not hesitate to speak with a senior member of staff again.

5 What are the potential early complications of a Gastrectomy?

A gastrectomy is a big operation. The commonest complications are:

• Those affecting the lungs such as a chest infection. It is, therefore, vital that you breathe comfortably after the operation and that you work closely with the physiotherapist.

• Wound infections which require only simple wound care or antibiotics.

• Loss of blood needing a blood transfusion.
• A leak from the new join that we make. This happens in about 10% of patients and mostly means delaying your ability to drink or eat until the leak heals by itself. Occasionally we have to perform another operation to deal with this problem.

• Weight loss. You may need to take nutritional supplements to help meet your nutritional requirements while you adjust to the changes made to your body.

In the long term, you will need to alter your diet as large, rich meals may give you pains and/or diarrhea (a symptom called “dumping”).

You may also need to have nutritional supplements to help prevent any further weight loss or to help maintain your nutritional status in the first few months following surgery. Again, your dietician can help and support you through this process.

6 What alternatives are available?

The only treatment that may provide cure for most stomach cancers is surgery combined with chemotherapy. However, there are other treatments that can help and can improve symptoms. These include radiotherapy, chemotherapy, removing a tumour by endoscopy and stents. Each person’s cancer is different and therefore there is no single treatment that is suitable for everyone.
7 What happens during the procedure?

The object of the operation is to remove the cancer with surrounding tissue to ensure that it’s all removed. The small bowel is then used to replace the removed stomach and to allow the food to pass through the bowels.

Before the operation starts the anaesthetist will spend time placing an epidural anaesthetic as well as starting the general anaesthesia. You will also have other tubes connected to you to drain urine, empty the stomach and at the end of the operation you will also have drains to empty the chest of any excess fluid and help re-expand the lungs.

There are different ways of performing a gastrectomy. Most patients will have a cut in the upper part of the abdomen and occasionally this may be extended into the chest on the left side. These details will be discussed with you before the operation.

We may also use a tube for feeding after the operation. This tube will either go directly into the small bowel through the nose or into a vein in the neck. However, this is not always necessary as we would expect you to start drinking a few days after the operation.
Before gastrectomy:

- Oesophagus (gullet)
- Liver
- Cancer
- Small intestine
- All of stomach removed
- Pancreas
After gastrectomy:

- Small intestine is used to replace the stomach
- Bile and pancreas juices enter intestine
7 Who will perform my operation?
Your surgery will be performed by a team of surgeons lead by a consultant. This is most often the consultant you met in clinic but on odd occasion may be another consultant from the same team. Your doctors will advise you on this.

8 What should I expect after the procedure?
You will wake up in the Intensive Care Unit (ICU). We plan to keep you there for a short while until the medical team decide when it is safe to transfer you to the surgical ward.

We aim to control the pain from your wounds as well as possible so that you are able to take deep breaths and cough comfortably. This is vital in reducing the risk of chest infections and you must tell the nurse looking after you if your pain interferes with this. The physiotherapists will help you from very early on to exercise your breathing and coughing muscles. We aim to get you out of bed as quickly as possible and keep you mobile to minimise the risk of infections and blood clots. It is vital that you cooperate with your carers and maximise the time you spend out of bed.

The plastic tubes attached to you will be assessed on a daily basis and removed when appropriate.

You will be allowed sips of water from when you are awake. We will advise you on when to start drinking and eating properly and this often takes a week. This is a stage by stage approach which your dietician will give you further information to help you gradually get back to eating normal consistency foods. In some cases we may arrange a special swallow X-ray
before advising you to start drinking or eating. The move to a surgical ward will be decided upon by the team looking after you.

The clips holding your skin wound closed will be removed after about 10 to 12 days.

9 Getting back on your feet
We encourage you to get active as soon as possible after the operation. A team of physiotherapists will help you achieve this.

10 When can you leave hospital?
On average patients stay for a period of 10 to 14 days after this operation. If there are complications then this stay may be prolonged. On the day of discharge most patients go home using their own transport and may need to wait in a discharge lounge after 11am to ensure the bed is ready for the next patient requiring admission.

11 When can you return to normal activities and work? It is normal for you to feel exhausted for a few months after this operation. Keeping this in mind will help as many patients find the fatigue very frustrating. Returning to work may take a couple of months and you will find that your energy levels improve gradually over the few months after the operation.

12 What should you eat?
Immediately after the operation you will be allowed sips of
water. After about five days we would expect you to start eating if the recovery has progressed normally. Once you start eating your dietician will advise you of the appropriate consistency of foods and fluids you should be eating and drinking during this time. You will need to change your eating habits. It will be necessary to have much smaller meals very often (between six to eight small meals per day) and not three large meals. This is because a large volume of food is likely to make you feel sick. Your dietician will help you by tailoring the advice about portion sizes and the number of meals you require each day to your specific needs. It helps if you sit up or have a walk after every meal as this will aid the movement of food down into the rest of the bowels.

**Follow up after discharge**

We will arrange to see you in clinic two weeks after you leave hospital. At this point we can discuss the need for any further treatment. After that we normally see you every three months for the first year and then every 6 to 12 months for the next four years. We do not arrange any routine tests but if your symptoms require it we shall arrange the appropriate test. You will need to have your blood count (haemoglobin) measured at least once a year and have regular vitamin injections to prevent you becoming anaemic (low blood count) after such an operation. Your GP will help with this. If you have concerns once home, then either contact your GP or use the contact details given to you during your hospital stay.
8 Where can I get more information?

Macmillan:
Website: www.macmillan.org.uk

The Oesophageal Patient’s Association:
Website: www.opa.org.uk

Cancer Research UK:
Website: www.cancerResearchUK.org

16 Contact details
The Oesophagogastric Surgery Team:
The team is made up of nurses, doctors, dieticians, physiotherapists and other supporting staff.

Consultant Surgeons
Professor Muntzer Mughal
Mr Khaled Dawas
Mr Majid Hashemi
Mr Borzoueh Mohammadi
Ms Frances Hughes
Mr Bijen Patel
Mr Ashish Rohatgi

Clinical Nurse Specialists
Nathalie Osborn  Clinical Nurse Specialist

Direct line: 020 3447 5023 (Clinical Nurse Specialists)

Dietician: Krupa Patel  Upper GI Dietician

Ward Sisters and Matron
Lauren Molyneux  T9 South Ward
Ebenezer Philips  T9 North Ward
Sally Beyzade                                     Matron

Direct Telephone:  020 3447 9202
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17 Space for notes and questions
18 How to find us

Bus Stops
- N: 10, 14, 24, 29, 73, 134, 390
- V: 18, 27, 30, 88, 205
- P & Q: 10, 18, 30, 73, 205, 390
- Z: 18, 30, 205
- S, T, U & R: 24, 27, 29, 88, 134

- Congestion Charge Zone
- Main entrance