



Queensland  
Government

# Abdominoperineal Resection of Rectum Consent

Adult (18 years and over)

Facility: .....

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth:

Sex:  M  F  I

## A. Does the patient have capacity?

- Yes → **GO TO section B**  
 No → **COMPLETE section A**

You must adhere to the Advance Health Directive (AHD), or if there is no AHD, the consent obtained from a substitute decision-maker in the following order: Category 1. Tribunal-appointed guardian; 2. Enduring Power of Attorney; or 3. Statutory Health Attorney.

Name of substitute decision-maker:

Category of substitute decision-maker:

## B. Is an interpreter required?

If yes, the interpreter has:

- provided a sight translation of the informed consent form in person  
 translated the informed consent form over the telephone

Name of interpreter:

Interpreter code:

Language:

## C. Patient/substitute decision-maker requests the following procedure(s)

Abdominoperineal resection of rectum

## D. Risks specific to the patient in having an abdominoperineal resection of rectum

(Doctor/clinician to document additional risks not included in the patient information sheet):

## E. Risks specific to the patient in *not* having an abdominoperineal resection of rectum

(Doctor/clinician to document specific risks in not having a abdominoperineal resection of rectum):

## F. Alternative treatment options

(Doctor/clinician to document alternative treatment not included in the patient information sheet):

## G. Information for the doctor/clinician

The information in this consent form is not intended to be a substitute for direct communication between the doctor/clinician and the patient/substitute decision-maker.

I have explained to the patient/substitute decision-maker the contents of this form and am of the opinion that the information has been understood.

Name of doctor/clinician:

Designation:

Signature:

Date:

DO NOT WRITE IN THIS BINDING MARGIN

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ABDOMINOPERINEAL RESECTION OF RECTUM CONSENT



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Adult (18 years and over)

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth:

Sex:  M  F  I

### H. Patient/substitute decision-maker consent

I acknowledge that the doctor/clinician has explained:

- the "Abdominoperineal resection of rectum" patient information sheet
- the medical condition and proposed treatment, including the possibility of additional treatment
- the specific risks and benefits of the procedure
- the prognosis, and risks of not having the procedure
- alternative treatment options
- that there is no guarantee the procedure will improve the medical condition
- that the procedure may involve a blood transfusion
- that tissues/blood may be removed and used for diagnosis/management of the condition
- that if a life-threatening event occurs during surgery, I will be treated based on documented discussions (e.g. AHD or ARP [Acute Resuscitation Plan])
- that a doctor/clinician other than the consultant/specialist may assist with/conduct the clinically appropriate procedure/treatment/investigation/examination; this may include a doctor/clinician undergoing further training under supervision
- that if the doctor/clinician wishes to record video, audio or images during the procedure where the recording is not required as part of the treatment (e.g. for training or research purposes), I will be asked to sign a separate consent form. If I choose not to consent, it will not adversely affect my access, outcome or rights to medical treatment in any way.

I was able to ask questions and raise concerns with the doctor/clinician.

I understand I have the right to change my mind regarding consent at any time, including after signing this form (*this should be in consultation with the doctor/clinician*).

**I/substitute decision-maker have received the following consent and patient information sheet(s):**

- "Abdominoperineal resection of rectum"
- "About your anaesthetic"
- "Epidural and spinal anaesthesia"
- "Fresh blood and blood products transfusion"

On the basis of the above statements,

#### 1) I/substitute decision-maker consent to having an abdominoperineal resection of rectum.

Name of patient/substitute decision-maker:

Signature:

Date:

### 2) Student examination/procedure for professional training purposes:

For the purpose of undertaking training, a clinical student(s) may observe medical examination(s) or procedure(s) and may also, subject to patient/substitute decision-maker consent, assist with/conduct an examination or procedure on a patient while the patient is under anaesthetic.

I/substitute decision-maker consent to a clinical student(s) undergoing training to:

- observe examination(s)/procedure(s)  Yes  No
- assist with examination(s)/procedure(s)  Yes  No
- conduct examination(s)/procedure(s)  Yes  No

# Abdominoperineal resection of rectum

Adult (18 years and over) | Informed consent: patient information

**A copy of this form should be given to the patient/substitute decision-maker to read carefully and allow time to ask any questions about the procedure. The consent form and patient information sheet should be included in the patient's medical record.**



## 1. What is an abdominoperineal resection of rectum and how will it help me/the patient?

An abdominoperineal resection of the rectum involves the removal of the lower part of the large bowel, the rectum (back passage) and the anal region through the abdomen and the perineum (the skin between the anus and the genitals). The anal area is stitched together and will remain permanently closed. The end of the large bowel is brought out through the wall of the abdomen as a colostomy. This is permanent and allows the bowel content to drain into a bag worn over the colostomy.

The large bowel (intestine) is made up of the colon and rectum (back passage). This part of the digestive tract carries the remains of digested food from the small bowel and gets rid of it as waste through the opening to the back passage (anus). Cells that line the colon and rectum may begin to grow out of control, forming a tumour (a growth of cancer cells).

The bowel has four sections: the ascending colon, the transverse colon, the descending colon and the sigmoid colon. Tumours can start in any of these areas or in the back passage. Tumours start in the innermost layer and can grow through some or all of the other layers.

Surgery is the main treatment for tumours of the bowel. Usually, the tumour and a length of normal bowel on either side of the tumour (as well as nearby lymph nodes) are removed. The healthy parts of the bowel are then stitched or stapled together (anastomosis).

If the doctor/clinician is not able to join the bowel back together, an opening (stoma) will be made on the outside of the body for waste to pass out of the body. This is called a colostomy. A colostomy is made to allow waste to pass through an opening in the abdominal wall.

Removal of the diseased bowel is the first treatment for a tumour of the bowel. The goal of the surgery is to give you the best chance of cure through total removal of the tumour. However, your recovery depends on how far the disease has spread at the time of your operation.

Surgery can also be used as a measure to ease symptoms.

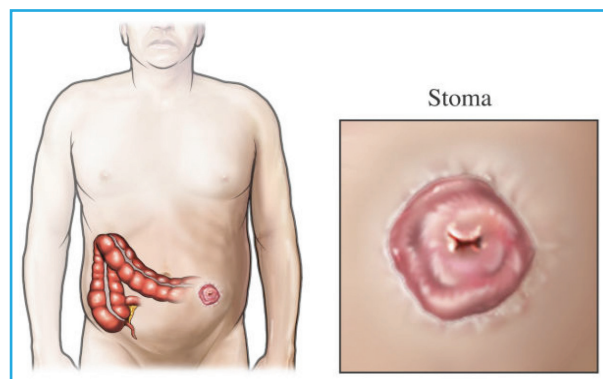


Image 1: Colostomy.  
Illustration Copyright © 2019 Nucleus Medical Media, All rights reserved. [www.nucleusmedicalmedia.com](http://www.nucleusmedicalmedia.com)

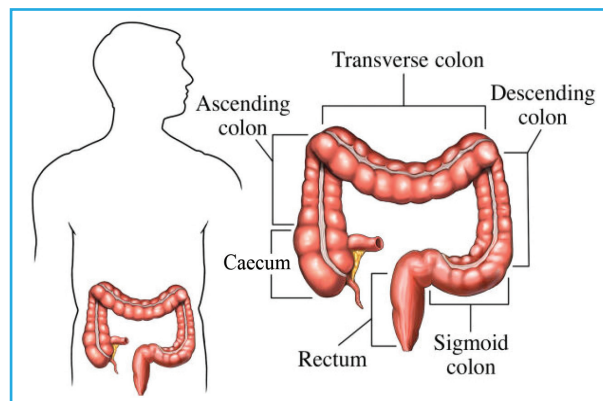


Image 2: Parts of the large intestine.  
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## Types of surgery

A number of different surgical procedures are used depending on where the tumour is. These include:

- **Right hemicolectomy** – removal of the last part of the small bowel, the caecum, ascending colon and a small part of the transverse colon.
- **Left hemicolectomy** – removal of the descending colon and sigmoid colon.
- **Sigmoid colectomy** – removal of the sigmoid colon and nearby large bowel.

A number of different surgical procedures are available to treat tumours of the back passage, the choice depending on where the tumour is and how far it has spread:

- **Low anterior Resection** – used for most tumours of the back passage, except when the tumour is very close to the anal muscles (sphincter). The bowel and the back passage are joined together so that the back passage is spared.
- **Abdomino-perineal resection** – this is done when the tumour is in the lowest part of the back passage. The back passage and the opening to the back passage are removed and the area is stitched up and will remain permanently closed. The waste collects in a disposable bag (a colostomy bag) which is stuck over the opening.

## Preparing for the procedure

Before surgery, the bowel must be prepared to lower the risk of infection. You may be told to have a low fibre diet 2-3 days before surgery. You will be then be on a clear fluid diet and given a medicated drink to help clean the large bowel. This can cause diarrhoea and cramps, and may be tiring.

The medicated drink will completely empty your bowel.

You will then fast for at least 6–8 hours before your surgery. If you are having a colostomy, the surgeon or a stoma nurse will discuss with you the best site for your colostomy and will mark the area with a marker pen. It is usually placed below your belt line, away from any other scars you may have and at least 8–10 cm away from your wound, depending on your size and shape.



## 2. What are the risks?

There are risks and complications with this procedure. There may also be risks specific to each person's individual condition and circumstances. Please discuss these with the doctor/clinician and ensure they are written on the consent form before you sign it. Risks include but are not limited to the following:

### Specific risks

- leakage where the bowel was stitched together. This may need further surgery
- bleeding into the abdomen. A blood transfusion and further surgery may be necessary
- bowel is paralysed, causing abdominal bloating and vomiting. This is usually temporary
- the wound may become infected. This is usually treated with antibiotics or the wound may need to be opened
- urinary tract infection. Antibiotics may be used to control the infection
- infection in the abdominal cavity. This may form an abscess which may need drainage and antibiotics
- the bowel may be unable to be joined and may be brought to the surface as a stoma, with the following problems:
  - the blood supply to the stoma may fail and cause damage. This may need further surgery
  - excess fluid loss from the stoma
  - stoma prolapse – the bowel protrudes past the skin
  - parastomal hernia – the bowel pushes through a weak point in the muscle wall, causing pain
  - local skin irritation – reddening of the skin and a rash in reaction to the stoma bag glue
- damage to the tube bringing the urine from the kidney to the bladder
- abnormal emptying of the bladder. It may empty without control or may not empty at all
- inability to have and/ or maintain an erection in men. In women, it can cause pain during or after intercourse
- the wound may be thickened, red and painful

- bowel actions may be much looser after the operation
- adhesions (bands of scar tissue) may develop in the abdominal cavity and the bowel may block
- death as a result of this procedure is possible.

### General risks

- infection can occur, requiring antibiotics and further treatment
- bleeding could occur and may require a return to the operating room. Bleeding is more common if you have been taking blood thinning drugs, such as warfarin, aspirin, clopidogrel (Plavix, Iscover, Coplavix), prasugrel (Effient), dipyridamole (Persantin or Asasantin), ticagrelor (Brilinta), apixaban (Eliquis), dabigatran (Pradaxa), rivaroxaban (Xarelto) or complementary/alternative medicines, such as fish oil and turmeric
- small areas of the lung can collapse, increasing the risk of chest infection. This may need antibiotics and physiotherapy
- increased risk in obese people of wound infection, chest infection, heart and lung complications, and thrombosis
- heart attack or stroke could occur due to the strain on the heart
- blood clot in the leg (DVT) causing pain and swelling. In rare cases part of the clot may break off and go to the lungs.

This procedure will require an anaesthetic.

For more information about the anaesthetic and the risks involved, please refer to the anaesthetic information sheet that has been provided to you. Discuss any concerns with the doctor/clinician.

If you have not been given an anaesthetic information sheet, please ask for one.

### What are the risks of not having an abdominoperineal resection of rectum?

Symptoms including pain and bleeding may become worse and your bowel may completely block or burst.

Without surgery, the disease may spread to other areas of your body.

If you choose not to have the procedure, you will not be required to sign a consent form.

If you have signed a consent form, you have the right to change your mind at any time prior to the procedure/treatment/investigation/examination. Please contact the doctor/clinician to discuss.



### 3. Are there alternatives?

Radiation Therapy has been used for some people as the main treatment for rectal tumours but is not normally used in colon tumours.

Radiation therapy is not as effective as surgery for patients who could normally be treated by bowel removal.

Chemotherapy (use of drugs to treat tumour) is usually used together with surgical removal and may not be offered as the only treatment.



### 4. What should I expect after the procedure?

After the operation the nursing staff will closely watch you until you have recovered from the anaesthetic.

You may even be cared for in the intensive care unit immediately following your surgery.

The recovery period after colon surgery varies. It usually involves a stay in the hospital from 3–10 days in uncomplicated cases. On return from your surgery you will have a catheter (plastic tube) in the bladder to measure and drain your urine.

After surgery you will be given intravenous fluids (a drip) through which antibiotics may be given. The drip will remain in place until you are able to drink enough fluids.

#### Diet

During the first few days of recovery, you will not be able to eat until the bowel has begun to work again.

You know the bowel has started to work again when you pass wind and/or have a bowel movement. You will then begin to take liquids by mouth and then solid food.

## Colostomy

The colostomy drains bowel waste from the bowel into the colostomy bag. Most colostomy waste is softer and more liquid than normally passed bowel waste.

The thickness of the bowel waste depends on where the stoma is. You will be taught how to clean around the colostomy and change the colostomy bag.

The colostomy bag sticks to the skin around the stoma with special glue, and can be thrown away when dirty. This bag does not show under clothing, and most people learn to take care of these bags themselves.

## Wound

Your wound will have stitches and/ or staples and is usually covered with a dressing, which may be adhesive plaster or a spray-on plastic covering.

## Drain

You may also have a small tube that drains into a bag or a bottle from near your wound. This is called a drain. The wound drain removes fluid from your wound and helps in the healing process. It is taken out when the drainage has dried up.

## Your lungs and blood supply

It is likely that on your return from surgery you will be wearing elastic (anti-embolism) stockings. These are tight fitting stockings that are used to reduce the risk of blood clots forming in your legs.

It is very important after surgery that you start moving as soon as possible. This helps to prevent blood clots forming in your legs and possibly going to your lungs. This can be fatal.

Also, you need to do your deep breathing exercises. Take ten deep breaths every hour to prevent secretions in the lungs from collecting. If this happens, you may develop a chest infection. At all costs, avoid smoking after surgery as this increases your risk of chest infection. Coughing is painful after abdominal surgery.

## Exercise

Expect to feel tired for some time after surgery. You need to take things easy and gradually return to normal duties, as you feel able to. It usually takes at least 6 months to get over the operation. You should not drive during the first 2–3 weeks.

Do not lift heavy weights for at least six weeks after surgery. This is to prevent a rupture where the cuts were made and allow healing to take place inside.

### Tell your doctor/clinician if you have:

- large amounts of bloody leakage from the wound
- blood in your stools
- fever and chills
- pain that is not relieved by prescribed pain killers
- swollen abdomen
- swelling, tenderness, redness at or around the cut.



## 5. Who will be performing the procedure?

A doctor/clinician other than the consultant/specialist may assist with/conduct the clinically appropriate procedure/treatment/investigation/examination. This could be a doctor/clinician undergoing further training, however all trainees are supervised according to relevant professional guidelines.

If you have any concerns about which doctor/clinician will be performing the procedure, please discuss with the doctor/clinician.

For the purpose of undertaking professional training in this teaching hospital, a clinical student(s) may observe medical examination(s) or procedure(s) and may also, subject to your consent, assist with/conduct an examination or procedure on a patient while the patient is under anaesthetic.

If you choose not to consent, it will not adversely affect your access, outcome or rights to medical treatment in any way. You are under no obligation to consent to an examination(s) or a procedure(s) being undertaken by a clinical student(s) for training purposes.



## 6. Where can I find support or more information?

Hospital care: before, during and after is available on the Queensland Health website [www.qld.gov.au/health/services/hospital-care/before-after](http://www.qld.gov.au/health/services/hospital-care/before-after) where you can read about your healthcare rights.

You can also see a list of blood thinning medications at [www.health.qld.gov.au/consent/bloodthinner](http://www.health.qld.gov.au/consent/bloodthinner).

Staff are available to support patients' cultural and spiritual needs. If you would like cultural or spiritual support, please discuss with your doctor/clinician.

Queensland Health recognises that Aboriginal and Torres Strait Islander patients will experience the best clinical care when their culture is included during shared decision-making.



## 7. Questions

Please ask the doctor/clinician if you do not understand any aspect of this patient information sheet or if you have any questions about your/the patient's medical condition, treatment options and proposed procedure/treatment/investigation/examination.



## 8. Contact us

**In an emergency, call Triple Zero (000).**

If it is not an emergency, but you have concerns, contact 13 HEALTH (13 43 25 84), 24 hours a day, 7 days a week.