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TRANSANAL ENDOSCOPIC MICROSURGERY (TEMS)

This general guide is designed to provide background information to the operation that you will shortly undergo. It aims to supplement verbal discussion, to answer common questions and to be readily available as an *aide memoir*. It cannot cover in detail every aspect of your individual operation and may not deal with some areas that are of particular concern to you. These can be dealt with individually.

You should feel free to ask about any aspect of your care. All your questions will be answered fully, honestly and in as much detail as you wish. In the heat of the moment it is easy for questions that you intended to ask to slip from your mind. You should note on paper any questions that you may have.

Further information is available at the web site above. This site also provides links to other sites that may provide additional information.

What is involved with TEMS.

Most patients undergo TEMS because they have a benign, non-cancerous, polyp in the rectum. Once the patient is anaesthetised a sigmoidoscope is passed into the rectum. Long instruments are passed down the scope and the polyp removed. It is similar to laparoscopic (key hole) surgery, but performed through the anus.

Pre-operative preparation.

It is important that we know every medical issue that might affect you. What may appear unimportant to you may be essential for us to know. In particular, we need to know all the drugs you are taking and you should bring them to hospital in their original packet. Unless advised specifically to the contrary you should take all your drugs up to and including the morning of surgery. The exceptions to this are blood thinning agents, such as warfarin, and diabetic drugs. These require special arrangements. Stop any aspirin containing drugs 10 days prior to surgery.

You will need to have full bowel preparation, just like before your colonoscopy. Details of how to do this are available on another advice sheet.

Pain relief.

You will have minimal pain after this operation. You may feel as if your bowel is full of gas (which it is). Simple Panadol will be adequate.

Going home.

Selected patients can go home the same day. However, if you wish to go home the same day you must have the necessary back up. Patients going home the same day of surgery must not drive, operate machinery, make important decisions or sign legal documents for at least 24 hours after the operation conclude. These restrictions also apply to patients who have had an overnight hospital stay and still within the 24 hour post-operative period.

Almost all others go home the next day. You will feel no different from when you have your colonoscopy. There are no sutures (stitches) to be removed. You can return to work within 48 hours.

What can go wrong?

In surgical terms this is a minor to intermittent operation. Although major complications are a rare event, other adverse events are possible, as after any surgical procedure. These include drug reactions, post-operative bleeding, deep vein thrombosis, heart and lung complications and wound infections. This list is not exhaustive and if you have any concerns about the possible side-effects or complications you should ask about them before you sign the consent form.

There are two specific potential problems specifically related to TEMS. The first is that the bowel can be perforated at the time of surgery. Normally this can be repaired via the sigmoidoscope. You will need to remain in hospital for 48 hours so we can monitor your progress. A small number of perforations cannot be managed through the sigmoidoscopy and the perforation has to be repaired through an abdominal incision. This makes the operation a major procedure. Patients are in hospital for a week and full recovery takes six to ten weeks.

Follow-up

TEMS is ideal for benign, non-cancerous, polyps. If the pre-operative biopsies show the polyp is a cancer it is likely that TEMS will only be suitable for a small number of highly selected rectal cancers. Even small cancers are best treated by abdominal surgery, usually an anterior resection. Once the polyp has been removed it will be fully assessed by the histopathologist. Despite taking multiple biopsies prior to the TEMS some polyps, when fully studied, are found to be cancer. Depending on the histology it may not be necessary to undergo further surgery. In other patients a formal resection of the bowel (an anterior resection) may be required. Careful consideration has to be given to each of these polyps on an individual basis.

You will need to have the site of the polyp inspected by rigid sigmoidoscopy in the rooms at three, six and twelve months. Thereafter you will be followed by colonoscopy