Gastrectomy

Information for patients

Working with you to make Highland the healthy place to be
This leaflet provides information about gastrectomy (removal of the stomach). It has been produced to help you understand what the operation involves.

Cancer of the stomach (gastric)

Cancers of the stomach are not all exactly the same and can affect any part of the stomach. Gastrectomy (often in combination with pre-operative chemotherapy) is presently considered the best treatment for stomach cancer. It gives good symptom relief and offers the best chance of cure.

Surgery for Gastric Cancer (gastrectomy)

The operation to remove the stomach cancer will depend on the stage of the cancer, its position and size.

Most cancers are in the highest part of the stomach (near to the oesophagus) and this is treated by removing the entire stomach; known as a total gastrectomy.

If the cancer is near the exit to the stomach; a partial gastrectomy is performed. This will remove at least 50-75% of the stomach.

Occasionally the upper part of the stomach is removed only; this is called a proximal gastrectomy.

A palliative gastrectomy is where part of the stomach is removed to improve symptoms rather than to specifically remove the tumour. This type of surgery will not cure the cancer or have any effect on the progress of the disease.

The type of operation you need will be discussed with you by your surgeon.

The operation is carried out under general anaesthetic. You will be asleep for the entire operation.

If you have any further queries regarding this operation please contact:

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secretary: 01463 705276

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If you require further information you can access the Cancer Backup website @ www.cancerbackup.org.uk
Is there an alternative?

Gastrectomy is presently considered the best treatment for potentially curable stomach cancer. A specialist multidisciplinary team (including your consultant) has also discussed your case and they believe surgery is the most appropriate treatment. Chemotherapy or endoscopic procedures are potential alternatives but are considered palliative (non-curative) only.

Before surgery

You will have had a number of tests and scans before your surgery including an endoscopy and CT scans. It is sometimes necessary to perform a laparoscopy prior to surgery. The surgeon will pass a small tube with a camera and light, through a cut in the wall of your abdomen (stomach). This is carried out under general anaesthetic. This is to help decide the extent of the cancer.

The day before your surgery you will be admitted to ward 4C.

The surgeon and anaesthetist will see you before the operation. The surgeon will once again explain how the operation will be done and you will have to sign a consent form. If you have any questions or are worried about anything it is important to ask at this stage. The anaesthetist will explain the anaesthetic to you and discuss pain control options with you.

The evening before your surgery you may eat and drink as normal. Usually you will have no food 6 hours before your planned operation. You will have a drip in your arm. If you are diabetic you will be given an infusion of glucose and insulin to control your blood sugar.

You will be given a pair of stockings to wear and given an injection of Clexane (medicine that thins the blood), to help reduce the risk of deep vein thrombosis (blood clotting in the vein). You will change into a theatre gown and remove any jewellery.

You will be taken down to theatre to a waiting area and then taken to the anaesthetic room. In the anaesthetic room you will be given an epidural if this has been discussed and agreed with the anaesthetist. This is a fine plastic tube that is placed into your back near your spinal cord, to allow continuous painkillers to be given through. The anaesthetist will then give you an injection through a drip in your hand, which will send you to sleep.
After your operation

After your operation you will be taken to the Surgical High Dependency Unit (HDU), where you will be closely monitored. This is normal and does not mean anything has gone wrong. You will spend a few days there and then be transferred to a surgical ward, usually 4C.

When you wake up there will be several tubes in place. Try not to be alarmed. They may include:

- A drip (intravenous infusion) used to maintain the body’s fluids until you are able to eat and drink
- A plastic drain from the wound to allow fluid to drain
- A small tube down your nose (nasogastric tube) to allow any fluid to be removed so that you don’t feel sick
- A feeding jejunostomy placed in the intestine to allow us to feed you
- A catheter in your bladder to drain urine until you are able to walk

There will be some discomfort and pain in the area of the operation. We aim to control your pain by using an epidural. Pain relieving drugs are given through the epidural. The drugs numb the pain. This is important as it will allow you to cough and move around as much as possible.

After the operation you will be encouraged to move around as soon as possible. This is to help prevent chest infections and an essential part of your recovery.

Depending on the surgery you have had, some patients may have a contrast swallow. This special x-ray is to check that the join inside has sealed and that there is no leak. You will not be able to drink until you have had this test. This will be gradually increased and after a few days you will be allowed to commence a light diet.

You will usually be ready to go home about 7-14 days after your operation. However you will need to rest at home and it usually takes some months to return to normal activity.

Before you leave hospital you will be given an appointment for a check up at the outpatient clinic (usually 6 weeks after you go home). The feeding tube you have will remain in place until your appointment, where it will be removed.

Are there any complications from this surgery?

This operation is major surgery and there are risks attached to it, but it is done to try and remove your cancer, so you may feel that some risks are worth taking. Your surgeon will have already discussed the risks associated with this type of surgery and we make all attempts to minimise the risk.

- The main risk from this operation is a leak. This is a disruption of the join between the stomach and the small bowel. This is a serious complication.
- Risk of bleeding is associated with all surgery and bleeding from this type of surgery is usually minimal.
- Infection can occur at the wound site
- Chest infection
- DVT (deep vein thrombosis)

Complications can be serious and would delay your recovery, lengthening your hospital stay. They are becoming less common as more of the operations are done in specialist centres, but even so, as many as 5-10% of people who have this type of surgery die directly as a result of complications after surgery.

Occasionally it is not possible to remove the cancer, even though the surgeon thought resection was possible. This would be because the cancer is more advanced than the staging investigation revealed. If the cancer can not be removed, sometimes other procedures may be possible to help.