



Providing *excellence...*
in *bowel care*

Making An Appointment

GP Zone

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Home Conditions Investigations **Treatments** The Team Patient Information Blog Contact Us News

▼ Surgery

- Laparoscopic (Keyhole) Surgery
- Right Hemicolectomy
- **Ileocolic Resection**
- Extended Right Hemicolectomy
- Sigmoid Colectomy
- Left Hemicolectomy
- Hartmann's Procedure
- Sub Total Colectomy
- Pan-proctocolectomy
- Ileo-anal Pouch Procedure
- Anterior Resection of Rectum
- Abdomino Perineal Excision of Rectum (APER)
- Colostomy formation
- Ileostomy formation
- Rubber Band Ligation of Hemorrhoids
- Haemorrhoidal Artery Ligation Operation (HALO)
- Haemorrhoidectomy
- Altemeire's Procedure (Perineal Rectosigmoidectomy)
- Anal Sphincter Repair
- Delorme's Procedure
- Rectocele Repair
- Sacral Nerve Modulation
- Percutaneous posterior tibial nerve stimulation
- Ventral Rectopexy

► Interventional Radiology

► Oncology

► Pathology and Molecular Pathology

Ileocolic Resection

This is an operation to remove the terminal ileum, the last part of the small intestine and first part of the colon. It is usually performed for conditions such as [Crohn's disease](#) which affects the terminal ileum and first part of the colon. In most cases the operation can be performed via a [laparoscopic \(keyhole\)](#) surgical technique.

What does the operation involve?

This operation can be performed as an open or [laparoscopic \(keyhole procedure\)](#). During the operation the part of the right side of the colon and the diseased part of the terminal ileum are removed. The surgeon then makes a join (anastomosis) between the small intestine and the remaining part of the colon. The surgeon may use either sutures or special staples to make this join.

This type of surgery does not require the formation of a stoma i.e. ileostomy or colostomy.

If there are any special circumstances that mean that a stoma may be required the surgeon will discuss these issues beforehand.

The operation time may vary for this type of surgery but is usually around 2 hours.

The piece of bowel that is removed is sent to the pathology department where the pathologist carefully examines it. The results are usually available within two weeks of the operation.

What are the risks?

There are risks associated with any abdominal operation. Pre-operative assessment of heart and lung conditions are made, as well as any coexisting medical conditions. During the hospital admission patients wear stockings and are given a regular tiny injections to prevent thrombosis (blood clots).

Bleeding if very rare in this type of surgery, blood is always available if a transfusion is required.

Wound infections can occur in any form of intestinal surgery, open or laparoscopic. Wound infections rarely cause serious problems but may require treatment with antibiotics.

Occasionally the join that the surgeon makes in the bowel can leak. This is known as an anastomotic leak. The risk of leakage is greater in patients who have Crohn's disease and in patients who are on steroids. If a leak occurs sometimes this can be managed with antibiotics and/ or a drain placed through the abdominal wall, usually in the x-ray

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What our patients think...



Almost 3 months after my surgery I am happy with the outcome. I found Mr Radley to be an exceptional surgeon with a very confident, approachable and calming manner and someone who you would certainly recommend. "

Mr S. Birmingham. February 2014

Get in contact

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department. If the leak is larger and peritonitis develops another operation will be necessary and the surgeon will need to create a stoma ([ileostomy](#)).

Sometimes the bowel may take longer than normal to start working, this is known as ileus. Patients may develop abdominal distension and vomiting. If this happens the surgeon will normally recommend a period of bowel rest with continued intravenous fluids and sometimes a tube passed via the nose to the stomach (nasogastric tube).

When the bowel doesn't start working properly, there may be a kink, twist or an adhesion causing a blockage. This is known as obstruction. Patients may develop colicky abdominal pains, abdominal distension and vomiting. If this happens the surgeon will normally recommend a period of bowel rest with continued intravenous fluids and sometimes a tube passed via the nose to the stomach (nasogastric tube). In most cases the obstruction settles spontaneously occasionally an operation is required to relieve the blockage.

Sometimes during the operation the surgeon discovers that it is not possible to carry out the procedure using a wholly keyhole approach. In this situation a cut is made and the operation is done as an open procedure. This is known as conversion.

What happens after the operation?

After the operation patients will have an intravenous drip, which is normally in place for 24 hours, or until, a normal fluid intake is resumed. A catheter (tube inserted to drain the bladder) is normally kept in place for 24 hours.

Occasionally an abdominal drain is used (small tube passing through the abdominal wall). This is normally removed after a few days.

An epidural is often used in keyhole and open surgery to provide pain relief after the operation and is usually continued at least until the next day. The anaesthetist will be able to discuss this with you before the operation.

Patients are allowed to eat and drink as soon as they feel able after the operation (usually the same day).

Patients are encouraged to mobilise as soon as possible after the operation.

Hospital stay is usually 2-5 days for keyhole surgery and 5-7 days for open surgery although this may vary.

Following discharge from hospital, patients are encouraged to keep mobile. They should avoid heavy lifting or increased physical activities for about 6 weeks.

Patients can normally resume driving after about 2 weeks but this may vary particularly if the operation is done as an open procedure.

A follow up consultation is usually arranged after about two weeks.

Patients can always be seen sooner if there are problems.

To download this information as a PDF information sheet, please click [here](#).

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