Sir Thomas Browne Academic Colorectal Unit
Division of General Surgery

Transanal Endoscopic Operation (TEO) / Transanal Minimally Invasive Surgery (TAMIS)

What are TEO and TAMIS?

Transanal Endoscopic Operation (TEO) and Transanal Minimally Invasive Surgery (TAMIS) are specially designed techniques which allow surgery to be performed within the back passage (rectum) using special equipment which provides an excellent view inside the rectum.

What is it used for?

It can be used to remove small early cancers or benign (non-cancerous) polyps from the rectum, avoiding major surgery. It may also be used for patients who are unfit for major surgery.

Preparation for the operation

You will be asked to attend the pre-admission assessment clinic prior to admission where a nurse will assess your fitness for surgery, allowing time for the necessary pre-operative tests, which may include blood tests, cardiogram (ECG) and a chest x-ray. You will also be screened for MRSA. You may also see an anaesthetist.

In the pre-assessment clinic, you will be given Carbohydrate drinks to be taken the night before surgery (approximately 10pm) and early in the morning of your procedure (before 6 am). You may be given strong laxatives (usually 2 sachets of picolax to be mixed into a drink to be taken the day before surgery) to prepare your bowel for the surgery. Some patients also require an enema on the day of surgery. You will be admitted on the day of surgery.

The surgery is usually carried out whilst you are asleep (under general anaesthetic). You may have a urinary catheter (tube in the urinary bladder), which will be often removed the following day.

The surgeon inserts a telescope through the back passage; this instrument has a camera connected to a TV screen, it has channels for instruments to be inserted and a channel to insufflate (expand) the rectum. Using the magnifying lens the surgeon can locate the area to be removed. This is done using small surgical instruments. The lining of the bowel can be repaired at the end using stitches although this is not always necessary.

The removed growth will be sent for analysis under a microscope (histology). Based on the result of this test, we can then decide if any further treatment is needed.

What are the risks/complications of surgery?

- **Bleeding** – a bit of bleeding from the site of surgery happens for up to 2 days afterwards. It almost always stops by itself without further surgery. Occasionally if this bleeding persists and shows no signs of stopping it may become necessary to stop the bleeding by carrying out another operation. Sometimes bleeding may occur 2-3 weeks after surgery but will often stop spontaneously.

- **Pelvic inflammation/infection** – the raw area in the rectum where the polyp has been removed can lead to inflammation around the back passage. This is usually treated by a course of antibiotics and hospital observation, but rarely causes problems.

- **Once discharged from hospital, if you suffer any of the following: marked pain in the lower abdomen, back passage or low back, or you feel generally unwell; you should either see your doctor or consult the hospital promptly, as these can be signs of an infection developing.**

- **Incontinence** – you may experience slight staining of underwear and seepage of mucus for a few days after the operation and at home. This is not uncommon and is due to the gentle stretching of the tail end (anus) during the operation. This almost always comes back to normal without any treatment.

- **Major surgery** – sometimes it is not possible to complete the operation using the TEO/TAMIS procedure technique. Very occasionally this means using conventional major surgery to remove the small cancer or polyp. If this is a possibility it will be discussed with you by the surgeon.

- **Bowel perforation** – occasionally, this surgery may result in injury ('hole in the bowel wall') to the bowel; often this can be repaired using the same technique. Rarely, it may be necessary to repair through the abdomen to stop you developing peritonitis. This may require formation of a colostomy (stoma).

These risks/complications will be explained and discussed with you when the surgeon asks you to sign the consent form.

After the operation

On returning to the ward after your operation the nurses will perform regular observations to monitor your recovery from surgery.

You may have a continuous infusion (a drip) in your arm through which you will be given fluids. However, once you are drinking normally this will be discontinued and then you can eat and drink normally.

You will be wearing TED stockings and will be prescribed blood thinning medication (low molecular weight heparin) to minimise risk of clots in legs or lungs.

After the operation you may feel some rectal discomfort, but you should not feel any pain unless the polyp that we removed was very near the anus itself. If you do experience any pain or discomfort, please let the nurses know so that they can give you pain killers as required.

A little bit of bleeding is not unusual for the first few days after the operation, but this should not be greater than a little spotting, which is probably most noticeable when having your bowels open for the first time.

Some patients may experience a fever for up to one week, this is not usually a cause for worry; but it is advisable to contact your GP or the hospital if this lasts longer or is associated with abdominal pain or feeling generally unwell.

It is very important to avoid constipation by drinking plenty of fluid and taking adequate fibre in your diet. You may wish to soften the motion with Lactulose; this is a mild laxative, which can be bought over the counter at the chemist.

Following the operation bowel function may be somewhat disturbed but this should settle over the next few weeks. Because of the size of the instrument that is passed during the operation, the anal sphincter muscles may be stretched, and this may lead to some leakage or incontinence. You may wish to wear a pad for protection until normal continence resumes, as it does in virtually all cases.

Your expected length of stay is 1-3 days; when you are allowed home will depend on your Individual recovery. On discharge from hospital, you may resume normal activities as soon as you feel able. It may be advisable to take approximately 2 weeks off work, if you require a certificate for work, please ask a member of staff before you leave hospital.

It may not be advisable to drive in the first week, it's important that you are comfortable, and your concentration is not impaired, some people require a little longer. However, please check with your insurance company, as policies sometimes contain restrictions that vary from individual companies.

It is advised you may resume sexual activities as soon as it feels comfortable to do so.

When you return home, you should seek medical advice if you notice any of the following:

- Persistent nausea and vomiting
- High temperature
- Increased abdominal pain
- Persistent bleeding from the rectum

Please retain this information leaflet throughout your admission, making notes of specific questions you may wish to ask the Doctor and/or Nurses before discharge.

Points of contact:

If you have any queries prior to the procedure outlined and the implications for your relatives/carers, please contact the Surgical Pre-Admission Assessment Clinic on **01603 287819**.

If you have any problems during your time at the Norfolk and Norwich University Hospital or after discharge please do not hesitate to get in touch with any member of the Colorectal team, who will be more than happy to deal with them. Dilham ward's telephone number is **01603 289957.**

The Colorectal Specialist Nurses can be contacted on
01603 287828 Mon- Friday 08.30-17.00.

For Help Giving Up Smoking: Smokefree Norfolk 0800 0854 113

This sheet describes a medical condition or surgical procedure. It has been given to you because it relates to your condition; it may help you understand it better. It does not necessarily describe your problem exactly. If you have any questions, please ask your doctor.

IN TRAN
communication for all