Patient information and consent to oesophagectomy

Key messages for patients

- Please read your admission letter carefully. It is important to follow the instructions we give you about not eating or drinking or we may have to postpone or cancel your operation.

- Please read this information carefully, you and your health professional will sign it to document your consent.

- It is important that you bring the consent form with you when you are admitted for surgery. You will have an opportunity to ask any questions from the surgeon or anaesthetist when you are admitted. You may sign the consent form either before you come or when you are admitted.

- Please bring with you any medications you use and its packaging (including patches, creams, inhalers, insulin and herbal remedies) and any information that you have been given relevant to your care in hospital, such as x rays or test results.

- Take your medications as normal on the day of the procedure unless you have been specifically told not to take a drug or drugs before or on the day by a member of your medical team. If you have diabetes please ask for specific individual advice to be given on your medication at your pre-operative assessment appointment.

- Please call the oesophago-gastric cancer nurse specialist on 01223 596383 if you have any questions or concerns about this procedure.

After the procedure we will file the consent form in your medical notes and you may take this information leaflet home with you.

Important things you need to know

Patient choice is an important part of your care. You have the right to change your mind at any time, even after you have given consent and the procedure has started (as long as it is safe and practical to do so). If you are having an anaesthetic you will have the opportunity to discuss this with the anaesthetist, unless the urgency of your treatment prevents this.

We will also only carry out the procedure on your consent form unless, in the opinion of the health professional responsible for your care, a further procedure is needed in order to save your life or prevent serious harm to your health. However, there may be procedures you do not wish us to carry out and these can be recorded on the consent form. We are unable to guarantee that a particular person will perform the procedure. However the person undertaking the procedure will have the relevant experience.

All information we hold about you is stored according to the Data Protection Act 1998.

Oesophagectomy, CF194, V4, August 2015
About oesophagectomy
You have been advised to have surgery to remove most of the oesophagus – termed an oesophagectomy. An oesophagectomy is nearly always performed for a cancerous growth and sometimes for long standing benign problems.

The main function of the oesophagus is to transport food and liquid from your throat to your stomach. A replacement oesophagus has to be made so that you can continue to eat and drink and this is usually made from your stomach.

Intended benefits
The aim of the surgery is to remove the cancer or abnormality – completely if possible. For cancer operations, surgery gives the best chance of cure, but the treatment may need to be combined with chemotherapy and/or radiotherapy.

Who will perform my procedure?
This procedure will be performed or supervised by a consultant surgeon.

Before your procedure
Most patients attend a pre-admission clinic, when you will meet a member of the surgical team. At this clinic, we will ask for details of your medical history and carry out any necessary clinical examinations and investigations (see below). Please ask us any questions about the procedure, and feel free to discuss any concerns you might have at any time.

We will ask if you take any tablets or use any other types of medication either prescribed by a doctor or bought over the counter in a pharmacy. Please bring all your medications and any packaging (if available) with you.

This procedure involves the use of anaesthesia. We explain about the different types of anaesthesia or sedation we may use at the end of this leaflet. You will see an anaesthetist before your procedure.

You will usually be admitted to hospital early in the morning on the day of your operation.

You will have had a number of investigations including an endoscopy (telescope test), PET scan, CT scans and an EUS (endoluminal ultrasound scan). These give us a fairly accurate indication of whether there is a chance of curing you by radical surgery. In addition, you may have had some special tests to assess your lung and heart function to see whether you will cope with the anaesthetic. These are all designed to make sure that the operation is the right treatment for you.

Hair removal before an operation
For most operations, you do not need to have the hair around the site of the operation removed. However, sometimes the healthcare team need to see or reach your skin and if this is necessary they will use an electric hair clipper with a single-use
disposable head, on the day of the surgery. Please do not shave the hair yourself or use a razor to remove hair, as this can increase the risk of infection. Your healthcare team will be happy to discuss this with you.

**During the procedure**

The object of the operation is to remove most of the oesophagus with any cancer and associated lymph glands. We usually use the stomach to replace it but occasionally part of the colon (large bowel) is used instead.

The stomach tube is brought up into the chest and joined on to the remaining upper oesophagus, at the very top of the chest.

You may find the following diagrams useful in understanding the operation.

**Before oesophagectomy**

![Diagram of oesophagectomy before surgery](image)

**After oesophagectomy**

![Diagram of oesophagectomy after surgery](image)

Some patients will have a cut across the upper part of the abdomen under their ribs and one in the right side of their chest. Some patients have a single, continuous long cut across the left side of the chest, across the rib margin and onto the left side of the upper abdomen. **The consultant will discuss the exact details of the operation with you.**

**After the procedure**

Once your surgery is completed you will usually be transferred to the recovery ward where you will be looked after by specially trained nurses, under the direction of your anaesthetist. You will be in the fast track recovery next to the main theatres on level 3. The nurses will monitor you closely until the effects of any general anaesthetic have adequately worn off and you are conscious. They will monitor your heart rate, blood pressure and oxygen levels. You may be given oxygen via a facemask, fluids via your drip and appropriate pain relief until you are comfortable enough to return to your ward.

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After certain major operations you may be transferred to the intensive care unit (ICU/ITU), high dependency unit (HDU), intermediate dependency area (IDA) or fast track/overnight intensive recovery (OIR). These are areas where you will be monitored much more closely because of the nature of your operation or because of certain pre-existing health problems that you may have. If your surgeon or anaesthetist believes you should go to one of these areas after your operation, they will tell you and explain to you what you should expect.

If there is not a bed in the necessary unit on the day of your operation, your operation may be postponed as it is important that you have the correct level of care after major surgery.

**Pain and nausea:** If you have pain or feel sick tell your nurse who will adjust your medication to control these symptoms.

**Drain tubes:** You may have tube drains in your abdomen, chest and down your nose (naso-gastric). The chest drains are each attached to bottles containing water to create a one way valve allowing air and fluid out but nothing back in to the space around your lungs. The naso-gastric tube drain allows fluid to drain out of the new oesophagus and into a bag and prevents pressure building up inside the anastomosis joint which in turn helps prevent anastomotic leakage. It is important not to pull this drain out by accident. You will also have a catheter in your bladder until you are fully mobile so you do not need to get up to pass water.

**Feeding jejunostomy tube:** During surgery a fine plastic tube will be placed through the abdominal wall into the bowel beyond the stomach. This is called a feeding jejunostomy. Through this tube a special formulation of feed will be administered starting on the first day after surgery. Giving feed into the bowel hastens recovery. The tube is removed simply either on the ward before you go home or at your first clinic visit two weeks after you go home depending upon your progress.

### Expected pattern of progress

<table>
<thead>
<tr>
<th>Day</th>
<th>Expected progress</th>
</tr>
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<tbody>
<tr>
<td>0</td>
<td>The operation usually takes about five to six hours. You will spend your first night in fast track recovery.</td>
</tr>
<tr>
<td>1</td>
<td>You are moved to the intermediate dependency area (IDA) on level 4. Here you will be encouraged to get out of bed for a short period sitting in a reclining chair and have physiotherapy to help you cough. The nurses will monitor your pulse, blood pressure, temperature and oxygen levels frequently.</td>
</tr>
<tr>
<td>2–5</td>
<td>You will stay in IDA and will spend more time sitting in your chair each day. You will only be allowed small sips of water by mouth. Your feeding will be via the jejunostomy tube. You must work hard on doing deep breathing exercises and coughing.</td>
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If you have an epidural, this will usually be removed around day five to prevent infection. Your pain will then be controlled using a morphine drip that you control via a small button (‘patient controlled analgesia’ PCA). All your drains are usually removed by seven days after surgery. If you are well you will be allowed to drink water in unlimited volumes, progressing on to all fluids. You are often well enough to be moved to the ward by this stage of your recovery.

You will now start a light soft diet. While you are getting back to eating we usually continue giving you some feed via the jejunostomy but aim to stop this before you go home. You will be encouraged to walk around as much as possible. Your pain will now be controlled with pain killing tablets taken orally. You will also be taking a medicine to stop stomach acid (Omeprazole).

You will be discharged home. Some people recover faster and might be home before this. Any patient who has a complication like pneumonia may be in hospital a lot longer. You will not be allowed home until you are fit for discharge.

**Eating and drinking.** You will start on soft foods at first and will only tolerate small amounts. You will be seen by a specialist dietician who will advise you on what to eat and drink. As you become more confident you will manage larger portions of food and move on to normal meals but the portions will still be smaller than you could manage before and you will have to snack frequently through the day. Remember, ”little and often”.

**Getting about after the procedure.** We will help you to become mobile as soon as possible after the procedure. This helps improve your recovery and reduces the risk of certain complications. If you have any mobility problems, we can arrange nursing or physiotherapy help.

**Leaving hospital.** You will feel very tired at first, this is normal. Try to get up and dressed in the morning and keep active around the house. You will need a sleep in the middle of the day. Remember to eat frequently. Don’t eat late at night as this will give you indigestion. Get out for some short walks and take pain killers if you need to for the wounds if they are still sore. As you become stronger you can increase what you do each day. Most patients are not fit to drive for at least six weeks after surgery. If in doubt, call your specialist nurse for advice.

**Resuming normal activities including work.** As your strength improves and the discomfort in your wounds settles you will be able to do more. It can take between six and twelve months to feel back to normal again but many patients start back with part-time work three to four months after their operation. You will not harm yourself drinking alcohol.
Special measures after the procedure

Weight loss: Most patients will lose weight after an oesophagectomy. This will often be in the region of 10Kg (20lbs). It is important that this does not happen too quickly as it can make you very weak and affect your immune system. If you are losing weight rapidly and struggling to eat you must call your specialist nurse for advice.

Dumping Syndrome: During your operation, the main nerve (vagus nerve) to the intestines has to be cut. This usually has some effects on the bowel function and is called “Dumping syndrome”. One of the commonest effects is that you can have attacks of unexpected diarrhoea. This is sometimes associated with abdominal pain, severe tiredness and occasionally hot flushes. It usually occurs shortly after eating and the effects normally disappear within an hour or so.

Ordinarily, food is partially digested in the stomach and then released gradually into the intestines. Dumping syndrome occurs when the food you have eaten passes into your small intestine more rapidly as a consequence of the surgery. This does not affect everyone and those who experience it usually find that it improves with time. If you suffer with Dumping, avoid taking liquids at meal times and reduce the amount of sweet foods in your diet. Your dietician can advise you on changes to your diet that can reduce these effects.

Check-ups and results. We routinely give everyone a check up at two to four weeks in the outpatients department. Then we review you at three, six and twelve months from the date of your surgery and then yearly thereafter, for five years. Your prognosis will depend a lot on how advanced the tumour was and this information comes from the histology report. Your consultant will discuss this with you when you come to the clinic.

Significant, unavoidable or frequently occurring risks of this procedure

Chest infection – Major surgery carries with it a risk of developing an infection in the lungs or pneumonia and it is quite common following this procedure (25%). This is usually because you are a little immobile and not breathing deeply following surgery, resulting in the lower part of the lungs becoming stagnant.

Chest infections are treated with antibiotics and physiotherapy.

It is very important that you get up and move as soon as possible and work closely with the nursing staff or physiotherapist in making sure you are taking regular, deep breaths. You will be given deep breathing exercises to undertake. The risk of developing a chest infection is greatly increased if you smoke cigarettes (particularly within three months of surgery).

Anastomotic leak – This is the most important, serious complication following an oesophagectomy. Fortunately, it is rare (approx 5% risk). An anastomosis is where
the gastro-intestinal tract is rejoined after the operation. Surgeons take great care and time in constructing a water tight anastomosis that will not leak. However, in rare cases the anastomosis does not remain water tight. This is often because of a poor blood supply rather than any particular problem with the surgery. If a leak does occur, there is a significant risk of infection and you will require antibiotics and possibly a fine drain tube to be inserted (under local anaesthetic) next to the anastomosis to get rid of any excess fluid or infection. With an anastomatic leak you are not usually permitted to take anything by mouth as this may worsen the leak. Most anastomatic leaks are very small (pin head size) and resolve spontaneously after 10-14 days, without too many problems. In rare cases, patients can become very ill and need to be transferred to the intensive care unit or require further surgery.

**Pleural effusion** – Fluid that collects between the lung and the chest wall is called a pleural effusion. The chest drains are designed to allow this fluid to drain out. After the drains are removed there is a small risk that fluid can collect again around the lung and you will become breathless. If this happens it will need to be drained under local anaesthetic.

**Chyle leak** – A chyle leak is a rare (3%) but serious complication of surgery performed in the chest. In order to remove all the appropriate lymph glands it is necessary to also take out the “thoracic duct” which is a vein like tube which drains fat from the intestines. If the clips or ligature used to seal it fail to do so, fluid called chyle accumulates in the chest. This fluid also contains immune cells and is critical in the absorption of necessary fats from the gut. If chyle leakage does occur we will feed you via the feeding jejunostomy as this will often dry up the chyle leak. In rare cases the chyle leak does not stop and another operation is required to find the leaking duct and ligate it again.

**Stomach necrosis** – This severe complication is very rare (1% risk). If the blood supply to the stomach tube is very poor, over a few days it may die (“necrosis”). As a result, a second operation is required and the stomach tube needs to be removed from where it is has been brought up into the chest. If this problem is not dealt with by surgery there is a risk that you can become critically ill. If stomach tube necrosis occurs, the upper oesophagus is sewn to the skin in the neck and covered with a drainage bag. This means you temporarily will not be able to eat or drink. Swallowing liquids will be allowed as they will come out into the drainage bag. You will be fed via the feeding jejunostomy. After around three months another operation can be needed to reconnect the gut so that you are able to swallow normally again.

**Complications relating to the heart** – Major surgery places considerable stress on the body and there is a small risk of a problem relating to the heart. This may take two forms and varies from very minor to severe. Firstly, the heart may develop an abnormal rhythm (usually beating excessively quickly). You may notice a fluttery feeling (palpitations) in the chest or nothing at all. Usually, simple measures such as balancing the body’s salt concentrations, or administering medications, resolves these problems. Secondly and more seriously, suffering a heart attack (damage to the heart muscle) is possible. Because of these risks you are very closely monitored (including Oesophagectomy, CF194, V4, August 2015
continuously recording the rhythm of the heart) for the first five days following your surgery. Therefore, if a problem arises it can usually be treated early and effectively. The risk of developing a heart problem is increased if you have a history of heart problems, smoke cigarettes (particularly within three months of surgery) or have other risk factors for heart disease.

**Complications related to the feeding jejunostomy** – A feeding jejunostomy is routinely inserted during this procedure. It is a fine tube that passes through the skin into the bowel beyond where the surgery has been performed. It allows us to feed you during the first week or so following surgery when you are unable to eat. There are, however, small risks of complications specifically relating to the feeding tube (1%). These risks include the tube moving or leakage from the bowel where the tube has been inserted. In rare cases, the bowel may twist around the tube causing an obstruction. These complications can sometimes be managed with antibiotics or removal of the tube. In rare cases an operation may be required to correct the problem.

**Deep vein thrombosis (DVT) and pulmonary embolus** - All surgery carries varying degrees of risks of thrombosis (clots) in the deep veins of your leg. In the worst case a clot in the leg can break off and travel to the lung (pulmonary embolism). This can significantly impair your breathing. To prevent these problems around the time of your operation and following your operation we give you some special injections to `thin’ the blood. We also ask you to wear compression stockings on your legs before and after surgery and also use a special device to massage the calves during the surgery. Moving about as much as you can, including pumping your calf muscles in bed or sitting out of bed as soon as possible reduces the risk of these complications.

**Altered Voice** - A rare complication of oesophagectomy is damage to the nerves of the voice box. This can result in hoarseness of the voice. This is nearly always temporary and is due to bruising of the nerve. Very rarely, permanent damage is done, resulting in a change in the quality of the voice. It is not uncommon to have a slightly hoarse voice following your anaesthesia. This is because of slight swelling as a result of the breathing tube used in your operation. This will usually recover over a few days to weeks. In rare cases it may slowly resolve over several months.

**Damage to the spleen** - During the operation, the small blood vessels between the spleen and the upper part of the stomach (fundus) are cut using special instruments that seal the blood vessels before they are divided.

Very rarely, damage to the spleen can occur that results in bleeding. Most times, this is not serious and can be controlled simply, however, if the spleen were to sustain more severe injury the spleen may have to be removed to prevent further bleeding. Removing the spleen normally has few complications. If your spleen is removed you will be given some vaccinations prior to leaving hospital. Additionally, you will be advised to stay on a low dose of preventative antibiotic for at least two years.
**Bleeding** – This very rarely occurs after any type of operation. Your pulse and blood pressure are closely monitored after your operation as this is the best way of detecting this potential problem. If bleeding is thought to be happening, you may require a further operation to stop it. This can usually be done through the same scar(s) as your first operation. It is possible that you also may require a blood transfusion.

**Wound haematoma** - Bleeding under the skin can produce a firm swelling of blood clot (haematoma), this may only become apparent several days after the surgery. It is essentially a bruise. This may simply disappear gradually or leak out through the wound without causing any major consequences to you.

**Wound Infection** – This affects your scars ('wound infection'). If the wound becomes red, hot, swollen and painful or if it starts to discharge smelly fluid then it may be infected. It is normal for the wounds to be a little sore, red and swollen as this is part of the healing process and represents the body’s natural reaction to surgery. It is best to consult your doctor if you are concerned. A wound infection can happen after any type of operation. Simple wound infections are easily treated with a short course of antibiotics.

**Deep Infection** – A rarer and more serious problem with infection is where an infection develops inside your tummy or chest cavity. This will often need a scan to diagnose, as there may be no obvious signs on the surface of your body. Fortunately, this type of problem will usually settle with antibiotics. Occasionally, it may be necessary to drain off infected fluid. This is most frequently performed under a local anaesthetic by our colleagues in the X-ray department. In the worst case scenario a further operation is required to correct this problem.

**Anastomotic stricture** - The join between the remnant of your oesophagus and your new stomach tube (“anastomosis”) can sometimes narrow down during its healing phase during the first few months after surgery. A stricture is a technical term that simply means a narrowing. This narrowing can cause problems with swallowing, particularly with solid foods. If this happens you might need to have the join stretched gently to make it wider again. This can be done as an outpatient in the endoscopy unit under gentle sedation.

**Death** – All major surgery carries a risk of death related to the procedure and the anaesthetic. The risk of death with this procedure at Addenbrookes Hospital is 1-2% for fit patients but may be higher for those with pre-existing medical conditions. The national average risk of death in hospital after oesophagectomy is 5%.

**Other complications** – We have tried to describe the most common and serious complications that may occur following this surgery. It is not possible to detail every possible complication that may occur following any operation. If another complication that you have not been warned about occurs, we will treat it as required and inform you as best we can at the time. If there is anything that is unclear or risks that you are particularly concerned about, please ask.
Alternative procedures that are available

Surgical removal of the gullet is currently the only known way of curing most oesophageal cancers. In many cases surgery is combined with chemotherapy +/- radiotherapy before, and sometimes after, surgery to maximise the chances of cure. You may be one of the patients who will benefit from this and it will have been discussed with you prior to any surgery. Not everyone is suitable for this treatment so do not worry if you are just having surgery.

Some very early, small oesophageal cancers can be removed via a gastroscopy that is passed via the mouth and therefore does not require any cuts. This technique is only appropriate for very early or precancerous growths.

Information and support

We may give you some additional patient information before or after the procedure, such as leaflets that explain what to do after the procedure and what problems to look out for. If you have any questions or anxieties, please feel free to ask a member of staff including your consultant, one of the senior trainees or the oesophago-gastric cancer nurse specialist on 01223 596 383.

Anaesthesia

Anaesthesia means ‘loss of sensation’. There are three types of anaesthesia: general, regional and local. The type of anaesthesia chosen by your anaesthetist depends on the nature of your surgery as well as your health and fitness. Sometimes different types of anaesthesia are used together.

Before your operation

Before your operation you will meet an anaesthetist who will discuss with you the most appropriate type of anaesthetic for your operation, and pain relief after your surgery. To inform this decision, he/she will need to know about:

- your general health, including previous and current health problems
- whether you or anyone in your family has had problems with anaesthetics
- any medicines or drugs you use
- whether you smoke
- whether you have had any abnormal reactions to any drugs or have any other allergies
- your teeth, whether you wear dentures, or have caps or crowns.

Your anaesthetist may need to listen to your heart and lungs, ask you to open your mouth and move your neck and will review your test results.

Pre-medication

You may be prescribed a ‘premed’ prior to your operation. This is a drug or combination of drugs which may be used to make you sleepy and relaxed before...
surgery, provide pain relief, reduce the risk of you being sick, or have effects specific for the procedure that you are going to have or for any medical conditions that you may have.

Not all patients will be given a premed or will require one and the anaesthetist will often use drugs in the operating theatre to produce the same effects.

**Moving to the operating room or theatre**

You will usually change into a gown before your operation and we will take you to the operating suite. When you arrive in the theatre or anaesthetic room and **before starting your anaesthesia, the medical team will perform a check of your name, personal details and confirm the operation you are expecting.**

Once that is complete, monitoring devices may be attached to you, such as a blood pressure cuff, heart monitor (ECG) and a monitor to check your oxygen levels (a pulse oximeter). An intravenous line (drip) may be inserted. If a regional anaesthetic is going to be performed, this may be performed at this stage. If you are to have a general anaesthetic, you may be asked to breathe oxygen through a face mask.

**General anaesthesia**

During general anaesthesia you are put into a state of unconsciousness and you will be unaware of anything during the time of your operation. Your anaesthetist achieves this by giving you a combination of drugs.

While you are unconscious and unaware your anaesthetist remains with you at all times. He or she monitors your condition and administers the right amount of anaesthetic drugs to maintain you at the correct level of unconsciousness for the period of the surgery. Your anaesthetist will be monitoring such factors as heart rate, blood pressure, heart rhythm, body temperature and breathing. He or she will also constantly watch your need for fluid or blood replacement.

**Regional anaesthesia**

Regional anaesthesia includes epidurals, spinals, caudals or local anaesthetic blocks of the nerves to the limbs or other areas of the body. Local anaesthetic is injected near to nerves, numbing the relevant area and possibly making the affected part of the body difficult or impossible to move for a period of time. Regional anaesthesia may be performed as the sole anaesthetic for your operation, with or without sedation, or with a general anaesthetic. Regional anaesthesia may also be used to provide pain relief after your surgery for hours or even days. Your anaesthetist will discuss the procedure, benefits and risks with you and, if you are to have a general anaesthetic as well, whether the regional anaesthesia will be performed before you are given the general anaesthetic.
Local anaesthesia

In local anaesthesia the local anaesthetic drug is injected into the skin and tissues at the site of the operation. The area of numbness will be restricted and some sensation of pressure may be present, but there should be no pain.

Local anaesthesia is used for minor operations such as stitching a cut, but may also be injected around the surgical site to help with pain relief. Usually a local anaesthetic will be given by the doctor doing the operation.

Sedation

Sedation is the use of small amounts of anaesthetic or similar drugs to produce a ‘sleepy-like’ state. Sedation may be used as well as a local or regional anaesthetic. The anaesthesia prevents you from feeling pain, the sedation makes you drowsy.

Sedation also makes you physically and mentally relaxed during an investigation or procedure which may be unpleasant or painful (such as an endoscopy) but where your co-operation is needed. You may remember a little about what happened but often you will remember nothing. Sedation may be used by other professionals as well as anaesthetists.

What will I feel like afterwards?

How you will feel will depend on the type of anaesthetic and operation you have had, how much pain relieving medicine you need and your general health.

Most people will feel fine after their operation. Some people may feel dizzy, sick or have general aches and pains. Others may experience some blurred vision, drowsiness, a sore throat, headache or breathing difficulties.

You may have fewer of these effects after local or regional anaesthesia although when the effects of the anaesthesia wear off you may need pain relieving medicines.

What are the risks of anaesthesia?

In modern anaesthesia, serious problems are uncommon. Risks cannot be removed completely, but modern equipment, training and drugs have made it a much safer procedure in recent years. The risk to you as an individual will depend on whether you have any other illness, personal factors (such as smoking or being overweight) or surgery which is complicated, long or performed in an emergency.

Very common (1 in 10 people) and common side effects (1 in 100 people)

Feeling sick and vomiting after surgery
Sore throat
Dizziness, blurred vision
Headache
Bladder problems
Damage to lips or tongue (usually minor)
Patient Information

Itching
Aches, pains and backache
Pain during injection of drugs
Bruising and soreness
Confusion or memory loss

**Uncommon side effects and complications (1 in 1000 people)**
Chest infection
Muscle pains
Slow breathing (depressed respiration)
Damage to teeth
An existing medical condition getting worse
Awareness (becoming conscious during your operation)

**Rare (1 in 10,000 people) and very rare (1 in 100,000 people) complications**
Damage to the eyes
Heart attack or stroke
Serious allergy to drugs
Nerve damage
Death
Equipment failure

Deaths caused by anaesthesia are very rare. There are probably about five deaths for every million anaesthetics in the UK. For more information about anaesthesia, please visit the Royal College of Anaesthetists’ website: [www.rcoa.ac.uk](http://www.rcoa.ac.uk)
Information about important questions on the consent form

1 Creutzfeldt Jakob Disease (‘CJD’)
We must take special measures with hospital instruments if there is a possibility you have been at risk of CJD or variant CJD disease. We therefore ask all patients undergoing any surgical procedure if they have been told that they are at increased risk of either of these forms of CJD. This helps prevent the spread of CJD to the wider public. A positive answer will not stop your procedure taking place, but enables us to plan your operation to minimise any risk of transmission to other patients.

2 Photography, Audio or Visual Recordings
As a leading teaching hospital we take great pride in our research and staff training. We ask for your permission to use images and recordings for your diagnosis and treatment, they will form part of your medical record. We also ask for your permission to use these images for audit and in training medical and other healthcare staff and UK medical students; you do not have to agree and if you prefer not to, this will not affect the care and treatment we provide. We will ask for your separate written permission to use any images or recordings in publications or research.

3 Students in training
Training doctors and other health professionals is essential to the NHS. Your treatment may provide an important opportunity for such training, where necessary under the careful supervision of a registered professional. You may, however, prefer not to take part in the formal training of medical and other students without this affecting your care and treatment.

4 Use of Tissue
As a leading bio-medical research centre and teaching hospital, we may be able to use tissue not needed for your treatment or diagnosis to carry out research, for quality control or to train medical staff for the future. Any such research, or storage or disposal of tissue, will be carried out in accordance with ethical, legal and professional standards. In order to carry out such research we need your consent. Any research will only be carried out if it has received ethical approval from a Research Ethics Committee. You do not have to agree and if you prefer not to, this will not in any way affect the care and treatment we provide. The leaflet ‘Donating tissue or cells for research’ gives more detailed information. Please ask for a copy.

If you wish to withdraw your consent on the use of tissue (including blood) for research, please contact our Patient Advice and Liaison Service (PALS), on 01223 216756.
Privacy & Dignity

Same sex bays and bathrooms are offered in all wards except critical care and theatre recovery areas where the use of high-tech equipment and/or specialist one to one care is required.

We are now a smoke-free site: smoking will not be allowed anywhere on the hospital site.
For advice and support in quitting, contact your GP or the free NHS stop smoking helpline on 0800 169 0 169.

Other formats:

If you would like this information in another language, large print or audio, please ask the department where you are being treated, to contact the patient information team:
patient.information@addenbrookes.nhs.uk.
Please note: We do not currently hold many leaflets in other languages; written translation requests are funded and agreed by the department who has authored the leaflet.
The aim of the surgery is to remove the cancer or abnormality completely if possible.

Full details are set out in the information leaflet provided and include:

- Anastomotic leak, chest infection, pleural effusion, chyle leak, stomach necrosis, complications related to the heart, death, complications related to the feeding jejunostomy, deep vein thrombosis (DVT) and pulmonary embolus, damage to the spleen, altered voice, bleeding, wound haematoma, wound Infection, deep infection and anastomotic stricture, inoperability, mortality (death 2%).
- What the treatment or procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient:
Consent Form

Two phase oesophagectomy

d) any extra procedures that might become necessary during the procedure such as:
   □ Blood transfusion       □ Other procedure (please state)

2 The following information leaflet has been provided:

Two phase oesophagectomy

Version, reference and date: Version 4, CF194, August 2015

or □ I have offered the patient information about the procedure but this has been declined.

3 This procedure will involve:
   □ General and/or regional anaesthesia       □ Local anaesthesia       □ Sedation       □ None

Signed (Health professional): ___________________________ Date: ____________

Name (PRINT): ______________________________________ Time (24hr): ____________

Designation: ______________________________________ Contact/bleep no: ____________

C Consent of patient / person with parental responsibility

I confirm that the risks, benefits and alternatives of this procedure have been discussed with me and that my questions have been answered to my satisfaction and understanding.

Important: please read the patient information about this procedure and then put a tick in the relevant boxes for the following questions:

1 Creutzfeldt Jakob disease (CJD)
Have you ever been notified that you are at risk of CJD or variant CJD for public health purposes? If yes, please inform your health professional.

□ Yes □ No

2 Photography, Audio or Visual Recording
   a) I agree to the use of any of the above type of recordings for the purpose of diagnosis and treatment.

□ Yes □ No

   b) I agree to unidentified versions of any of the above recordings being used for audit and medical teaching in a healthcare setting.

□ Yes □ No

3 Students in training
   I agree to the involvement of medical and other students as part of their formal training.

□ Yes □ No

Patient safety – at the heart of all we do

Addenbrooke’s Hospital    Rosie Hospital

File: in the procedures and consents section of the casenotes

Oesophagectomy, CF194, V4, August 2015
Use of Tissue

a) I agree that tissue (including blood) not needed for my own diagnosis or treatment can be used and stored for ethically approved research which may include ethically approved genetic research.

b) Where additional clinical information is needed for the purposes of ethically approved research, I agree that relevant sections of my medical record may be looked at by researchers or by relevant regulatory authorities. I give permission for these individuals to have access to my records.

I have listed below any procedures that I do not wish to be carried out without further discussion.

I have read and understood the Patient Information about this procedure and the above additional information. I agree to the procedure or treatment.

Signed (Patient): .................................................. Date: D.D./M.M./Y.Y.Y.Y.
Name of patient (PRINT): ............................................................

If signing for a child or young person; delete if not applicable.
I confirm I am a person with parental responsibility for the patient named on this form.
Signed: ................................................................. Date: D.D./M.M./Y.Y.Y.Y.
Relationship to patient: ..........................................................

If the patient is unable to sign but has indicated his/her consent, a witness should sign below.
Signed (Witness): .......................................................... Date: D.D./M.M./Y.Y.Y.Y.
Name of witness (PRINT): ......................................................
Address: ...........................................................................
Two phase oesophagectomy

D Confirmation of consent

Confirmation of consent (where the treatment/procedure has been discussed in advance)
On behalf of the team treating the patient, I have confirmed with the patient that she/he has no further questions and wishes the treatment/procedure to go ahead.

Signed (Health professional): ___________________________ Date: ____________
Name (PRINT): ___________________________ Job title: ___________________________

Please initial to confirm all sections have been completed:

E Interpreter’s statement (if appropriate)

I have interpreted the information to the best of my ability, and in a way in which I believe the patient can understand:

Signed (Interpreter): ___________________________ Date: ____________
Name (PRINT): ___________________________

Or, please note the language line reference ID number:

F Withdrawal of patient consent

☐ The patient has withdrawn consent (ask patient to sign and date here)

Signed (Patient): ___________________________ Date: ____________
Signed (Health professional): ___________________________ Date: ____________
Name (PRINT): ___________________________ Job title: ___________________________