Berwick Colorectal & Surgical Specialists

SMALL BOWEL TUMOURS

What are small bowel tumours?

Lesions found in the small bowel. They may be either benign or malignant (cancers).

Anatomy

The small bowel is a tubular structure that aids in food digestion and fluid absorption. It measures several meters in length.

What are the symptoms?

Can be asymptomatic and discovered on imaging for another reason. If symptomatic these lesions may cause abdominal pain, nausea, vomiting or changes in bowel habits. Other symptoms include bleeding from the back passage or symptoms from a low blood count (feeling tired or short of breath).

What tests are required?

Usually confirmed on a CT of the abdomen and pelvis. If a malignancy is suspected, then staging is completed to determine the extent of disease and a CT chest performed. Blood tests known as tumour makers may be useful to identify the type of tumour present.

Occasionally a special scan known as a PET scan may be performed to identify a specific tumour subset. Alternatively, further evaluation by an endoscopic camera or endoscopic camera with an ultrasound may be useful in very select circumstances.

What are the options of management?

Conservative or surgical. A conservative approach avoids surgery. This option is preferable for obviously benign lesions in patients who have no symptoms. Additionally, for tumours located in the small bowel closer to the stomach in the presence of advanced disease a stent may be placed using an endoscopic camera.

Alternatively, where there are concerns for malignancy, your surgeon will present your case in a multi-disciplinary meeting for further discussion. A multi-disciplinary meeting is a meeting of multiple experts from different specialties who review potential malignancies and formulate a decision that is both patient-centred and evidence-based. In the meeting the patients are discussed and in their absence their imaging and biopsies (if applicable) are reviewed. A consensus is reached, and the plan communicated to the patient by the treating doctor and the patient's general practitioner. Treatments recommended are either for curative or palliative intent (symptom management). The treatment intent depends on patient factors (age, medical problems) and disease factors (stage of disease, liver function)

Surgical management is generally preferred, particularly if symptomatic due to the risks of complications such as bowel perforation (bowel bursting) or obstruction (bowel blockage). Surgery can be performed assisted by laparoscopy (keyhole), the segment of abnormal bowel removed with the mass (or the lesion itself only depending on the type of tumour) and the bowel joined back together through a larger incision in the abdomen. An open procedure may be preferred where an incision of 20-30 cm made in the midline of the abdomen vertically and a similar procedure performed as described above.

For malignant lesions, systemic treatment is given for some patients instead of surgery, before or following surgery by an oncologist (cancer specialist).

What are the possible complications?

- Infection of the wound or inside the abdomen (abscess). This is managed with antibiotics. Surgery may rarely be required.
- Bleeding
- Damage to other surrounding structures (bowel, bladder)
- Hernias of the surgical incision

What to expect following your procedure?

You will wake from anaesthesia with dressings over dissolvable sutures. It is normal to experience some pain from the procedure which is easily managed with painkillers. You will be encouraged to ambulate after surgery and will be discharged from

hospital if you are tolerating a diet, able to pass urine, your pain is controlled with painkillers, and you are ambulating independently.

Gentle exercises are encouraged. Avoid heavy lifting for 2-4 weeks. You may drive if you are able to put your foot on the brake in an emergency or have ceased taking any painkillers. Usually this occurs after 1-2 weeks. Post-operative follow-up usually occurs in two weeks and will be arranged on discharge with your surgeon.

An open procedure will extend your stay by 5-10 days. You will awake from anaesthesia with a dressing over your incision covering dissolvable sutures. It is normal to experience pain from the procedure and require additional painkiller medications. It is also not uncommon for patients to experience nausea after their surgery which is controlled with medications. You will be encouraged to ambulate after surgery and will be discharged from hospital if you are tolerating a diet, able to pass urine, your pain is controlled with painkillers, and you are ambulating independently. The dressing should remain intact for seven days.

Gentle exercises are encouraged. You may drive if you are able to put your foot on the brake in an emergency or have ceased taking any painkillers. Usually this occurs after 4-6 weeks. Post-operative follow-up usually occurs in two weeks and will be arranged on discharge with your surgeon.