Plymouth Hospitals NHS
NHS Trust

Surgical treatment of the Pancreas

Information for you and your family

UGI oncology pt information series, review Oct 2010

Introduction

On the advice of your surgeon, you are coming into hospital for an operation on your pancreas. You may be having this operation due to chronic pancreatitis, or because you have a cyst in or nearby your pancreas, or to remove a cancer.

We appreciate that life may feel like an emotional roller coaster at the moment. You may have many questions and anxieties regarding the operation, your hospital stay, and financial concerns.

This booklet has been prepared to address many of these questions and more. It will hopefully supplement the information given to you by your doctors, dietitian, ward nurses and specialist nurses. It may not cover all your concerns so if you have any other questions or worries after reading this booklet, please don't hesitate to contact one of the staff listed on the last page.

This booklet is also meant for your relatives and close friends, to answer their questions and concerns, and to help them understand the treatment you will be undergoing.

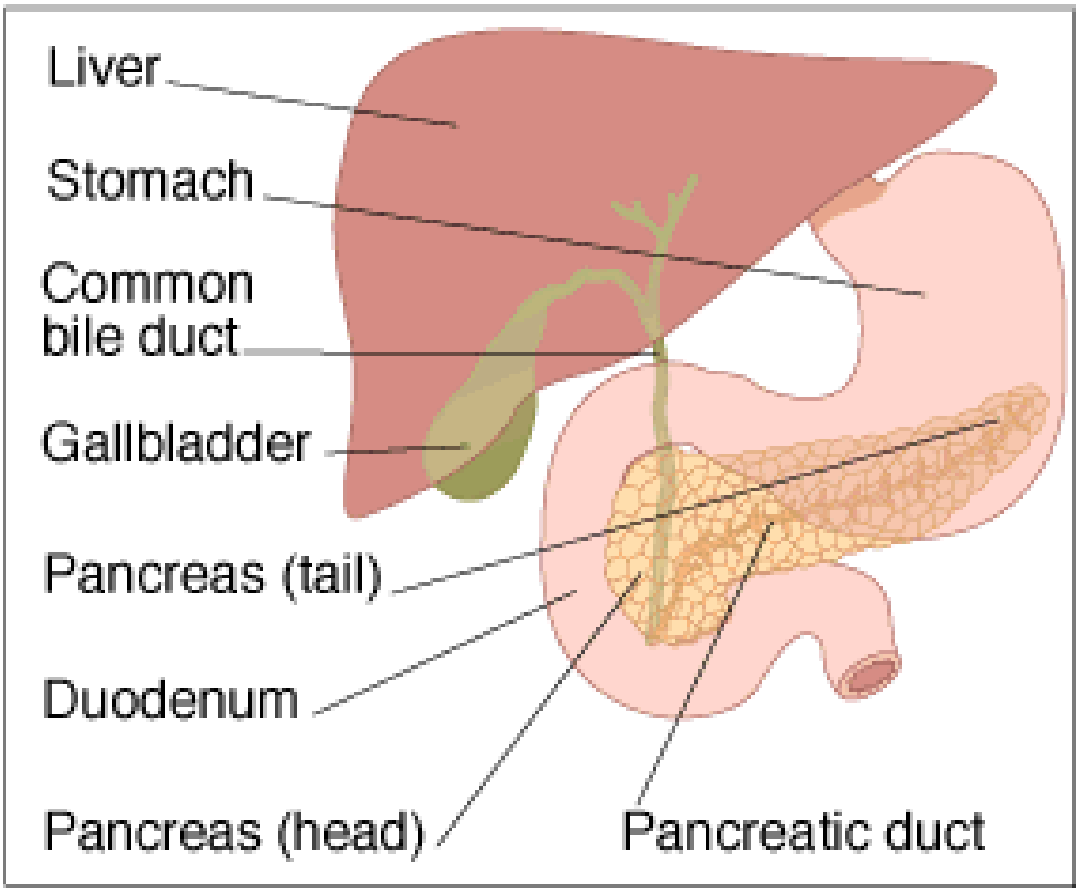
This leaflet is also available in large print and can be translated into other languages on request.

Please contact Patient Services

Tel : 01752 763031

What is the pancreas?

The Pancreas is a solid gland measuring 20-25cm (8-10 inches) in length, 4-6cm (1-2 inches) in width and 3-4cm (1-1.5 inches) in depth. It is firmly attached in the back of the belly behind the stomach. The pancreas is divided into 5 parts- the head, the uncinate process, the neck, the body and the tail (See picture below). Running behind the pancreas are many important blood vessels, which supply the liver.



What does the pancreas do?

- The pancreas is part of the digestive system.
- It makes enzymes which are necessary to digest food in the intestine.
- It produces insulin to enable every part of the body to use glucose (sugar) and store fats.

What are the causes and types cancer of the pancreas?

Cancer can arise in any part of the body when particular cells begin to multiply more than normally and spread into other tissues. Very little is known about the causes of pancreatic cancer. It affects about 12 per 100,000 people in the UK each year, so is not a common type of cancer. It occurs mainly in people between 60 and 80 years of age and is rare in people below the age of 50.

Tumours of the pancreas are grouped according to their position in the pancreas and the type of cell that the tumour originates from.

1. Ductal adenocarcinoma. This type of cancer accounts for 90% of pancreatic cancers
2. Tumours of the Ampulla of Vater.
3. Less common are the Neuroendocrine tumours.
4. Cystic neoplasms which may be benign or malignant.

What are the first signs of cancer of the pancreas?

1. Painless Jaundice Most commonly tumours of the pancreas arise in the head of the pancreas. This may block the bile duct (which passes through the pancreas) leading to jaundice, dark urine and pale stools. There is sometimes itching of the skin due to the jaundice. This rapidly disappears once the blockage has been cleared or bypassed.

2. Weight Loss The tumour may block the pancreatic duct leading to poor digestion, loose motions and weight loss. This may be relieved by clearing the blockage or by giving pancreatic enzymes.

3. Diabetes may be present in a number of patients prior to developing cancer or become apparent soon after it is diagnosed or following surgery.

How is it diagnosed?

Your doctor may need to do some tests to find out more about your particular problem. You may have already undergone one or more of them already.

Blood Tests

Ca19-9 is known as a tumour marker. Measuring the level of Ca19-9 in the blood can sometimes help in diagnosing cancer of the pancreas. It also helps in seeing how the pancreas responds to treatment. However, it is often not a very reliable test. Liver and kidney function tests are also done to assess the level of jaundice and to plan treatment.

Ultrasound examination (USS)

This is a simple, painless and relatively quick investigation used to obtain pictures of the inside of the abdomen using sound waves. These provide useful but basic information about the pancreas, liver, bile ducts and gallbladder. You will usually be asked not to eat or drink anything for at least 6 hours before the test.

Computerised Tomography (CAT Scan or CT Scan)

This is a type of x-ray, which builds up a three-dimensional picture of the pancreas. It is painless and can take up to 30 minutes. Special liquids are often used to allow particular areas of the body to be seen more clearly on the scan. The liquids may be given as a drink, as an injection, or both. If you are allergic to iodine or have asthma, it is important to tell your doctor and the person doing this test before having the injection or drink.

MRI scan (Magnetic Resonance Imaging)

An MRI scan is similar to a CT scan but uses a magnetic field instead of x-rays to build up an image the pancreas. Some people are given an injection of dye into a vein in the arm to improve the image. During the test you are asked to lie very still on a couch inside a long chamber for up to an hour. This can be unpleasant if you don't like enclosed spaces; if so, it may help to mention this to the radiographer. The MRI scanning process is also very noisy, but you will be given earplugs or headphones to wear.

Endoscopic retrograde cholangiopancreatography (ERCP)

This is a special investigation for taking pictures of the bile ducts and the pancreatic duct. Before the test you will be asked not to eat or drink anything before for about 6 hours so that the stomach and small bowel are empty. You will usually be given an antibiotic to prevent infection. You will also be given sedation to help you relax.

The doctor will them insert a special flexible telescope into the mouth, down the gullet and into the stomach, and then into the duodenum opposite the opening of the bile duct and pancreatic duct. A small tube (cannula) is then pushed into the opening and a contrast (dye) is injected into the ducts. A small tube (stent) may be left in the bile duct to relieve the blockage causing jaundice.

Endoluminal ultrasound (EUS)
This is an endoscopic procedure rather like an ERCP. Instead of x-ray pictures of the bile ducts, EUS takes pictures by ultrasound. This test will be performed under sedation.

Nuclear Medicine Tests
These tests are not routinely employed in the diagnosis and management of pancreatic cancer. They are carried out by injecting a radioactive tracer into the veins and watching its progress using a gamma camera or scanner. Octreotide scan and Positron Emission Tomography (PET scan) are some of the tests that may be used in the diagnosis and localisation of the rarer neuroendocrine tumours.

Needle biopsy
Occasionally a small piece of tissue from the pancreas needs to be taken and looked at under a microscope in an attempt to make a diagnosis, particularly where surgery is not being planned. This can be done during ERCP, EUS, an ultrasound scan or a CT scan. During the latter procedures, local anaesthetic is injected into the skin. A fine needle is then introduced and its tip positioned using pictures from the scan before any tissue is taken. In the pancreas it is often possible to get false negative results. This means that biopsies turn out to be negative even in the presence of cancer. Therefore, in about 95% of the

patients, the definitive treatment of pancreatic cancer is carried out without the aid of a biopsy

How are suspected cancers of the pancreas treated?

Cancers of the pancreas can be very difficult to treat. The type of treatment you are given will depend on a number of factors, including your age, your general health, the type of tumour you have, what it looks like under the microscope, its size and how far it has spread, (if at all).

- ❖ Surgery

Presumed early stage cancer can sometimes be cured with surgery where part or all, of the pancreas is removed. This is a major operation and is only suitable for people who are fit.

Unfortunately, in many cases the cancer is too large or has already spread beyond the pancreas when it is diagnosed, so this would make this kind of surgery not possible.

Occasionally a bypass operation instead of a curative operation needs to be performed if the cancer is found to be more advanced at the time of surgery than was originally thought.

- ❖ Chemotherapy

Sometimes Chemotherapy can be used **after surgery** for pancreatic cancer to try to reduce the chances of the cancer coming back.

Chemotherapy can also be used to treat cancers that have spread, but this would be with the intention of symptom relief and not cure. However for some people the treatment will have no effect upon the cancer and they will get the side effects without the benefits. Making decisions about treatment in these circumstances is always difficult and needs to be discussed in detail with your doctor and specialist nurse.

- ❖ Endoscopic treatment using stents to relieve jaundice

If the tumour has blocked the bile ducts, causing jaundice, a plastic stent (small flexible mesh tube) may be inserted to relieve jaundice prior to surgery. If it is not possible to undertake surgery, a more permanent metal stent may be inserted to relieve the blockage and allow bile to flow into the bowel again. The jaundice will then clear up.

Whatever treatment is chosen, alongside it you will have supportive care, with medicines to control symptoms/side effects and specialist nurses to help look after you and your family.

In simple terms, surgery may be used to remove the tumour completely (if it is small and has not spread beyond the pancreas area). It may also be used to bypass the tumour if it cannot be removed.

This booklet will focus on the surgical treatment of the Pancreas. Information regarding Chemotherapy treatment and Stenting can be obtained from your Specialist Nurse (see last page of booklet for contact details).

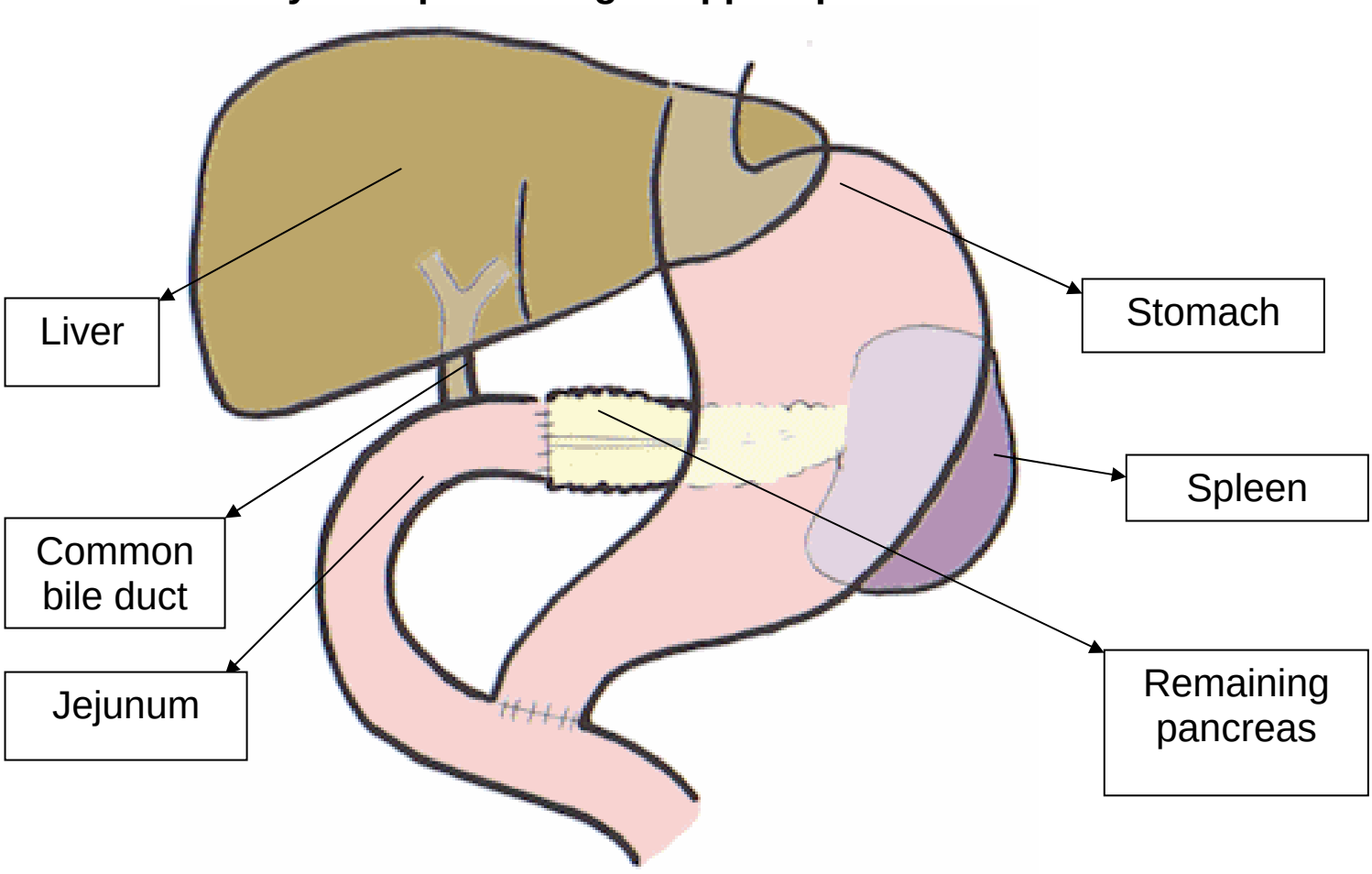
Surgery of the pancreas

The types of surgery you will be offered depends on the particular type and position of the tumour, its size and your general health.

Whipple operation (Pancreatoduodenectomy)

Dr Alan Whipple from New York Memorial Hospital was one of the first to describe this operation in the 1930's. The Whipple operation is performed for cancer that is located in the head of the pancreas. It involves removal of the head (first part) of the pancreas and usually about 40% of the pancreas is removed. The bottom half of the bile ducts and the first portion of the intestine called the duodenum is also removed and the stomach is preserved. This procedure is called the pylorus-preserving Whipple operation. Occasionally part of the stomach may be removed and this operation is called the standard Whipple operation.

The Pylorus-preserving Whipple operation



Pancreatectomy (Total or Distal)
Depending on the size of the tumour the whole pancreas may need to be removed (Total Pancreatectomy). If the tumour is located in the body or tail of the pancreas you will undergo a Distal Pancreatectomy.

Risks associated with surgery.

Giving your consent

Before you have any treatment your doctor will explain the aims of the treatment to you and you will be asked to sign a form saying you give permission for the hospital staff to

give you the treatment. No treatment can be given to you without your consent and before you are asked to sign you should have been given full information regarding the risks and benefits of the proposed treatment, plus possible alternatives.

Below, is an overview of the risks, in order to help you decide whether to go ahead with any surgery.

1. With any new joins (anastamosis) in the gut there is a chance that one of these joins will leak (anastamotic leak). To minimise this risk we keep the stomach empty by the use of a draining tube. If a leak does occur you may well need a second operation to repair it. Sometimes the leaks heal by themselves, but it takes time. Particularly serious are leaks from the pancreatic anastomosis as the pancreas releases digestive enzymes which can break down local tissue.

2. With any operation there is a possibility of bleeding postoperatively. This can be treated conservatively but occasionally you may need a second operation to locate and repair a bleeding blood vessel or may need intravenous blood products.

3. Developing a chest infection is possible especially if you have previously smoked cigarettes. To minimise any risks the physiotherapist will visit you after your operation to help you to cough and breathe properly. It is important to carry out the breathing exercises you are shown

4. You will have gone through a series of tests to make sure that an operation on your pancreas is the appropriate treatment for you, and that you are fit to withstand this operation. Even so the complication rate is around 40%. Although most of these complications

can be dealt with, between 5-10% of patients will not survive the operation (This figure is consistent with the published results for the rest of the UK).

What are the likely outcomes from surgery?

Even with surgery tumours of the pancreas are difficult to cure, the stage and extent of the cancer will be known after the operation.

Tumours arising in the bile duct, ampulla and duodenum have a much better outcome. (See 'Will I need further treatment?' At the end of this booklet)

What will happen if I don't have the surgery?

Cancer cells can spread to other organs and grow into secondary tumours, if left untreated. This is therefore almost always a fatal disease. If you decide not to go for the operation, and the tumour proves to be cancerous, it is possible to shrink the tumour by use of chemotherapy, but not to get rid of it completely. Palliative chemotherapy is an option.

How can I prepare for the surgery?

- Avoid alcohol completely
- Try to stop smoking
- Regular exercise e.g. walking up to 3 miles a day
- Take a healthy diet, plenty of red meats, fruit and vegetables. Avoid fatty foods, e.g. sweets, cakes and pastries.

NB If you are taking Aspirin, Clopidogrel or Warfarin please let your specialist nurse or surgeon know as

eary as possible as sometimes these medicines need to be stopped before surgery.

Admission to hospital for your operation

You will come onto the ward one or two days prior to the operation. Some of the following tests may be carried out, either at a pre-admission clinic or on the day of admission.

Chest X-ray
This will look at the size and shape of the heart and the general condition of your lungs.

Electrocardiogram (ECG)
This shows the electrical activity of the heart and is routine for anyone undergoing an anaesthetic.

Blood tests
A blood sample is taken from your arm and various tests are carried out including your blood group.

More specific tests e.g. CPX (exercise tolerance), Lung Function Tests
These are breathing and exercise tests, which measure how well your heart and lungs are working so that your anaesthetic and operation can be performed as safely as possible.

People you will meet

A Doctor (surgeon)-
Will examine you and ask you questions about your illness. He/she will explain the operation to you and ask you to sign a consent form. This indicates that you agree

to the operation so make sure you have discussed it fully with the doctor and understand what is involved (See ‘Risks associated with surgery’ on previous page).

An Upper Gastrointestinal Cancer Nurse Specialist-
She will be your key worker throughout your surgical experience and during your follow-up. She is available for advice and information about any queries you have about your surgical journey. She is the main means of communication between parties involved.

Ward Nurses -
Will help you settle in to the ward. He/She will also discuss factors regarding preparation for your operation. They will provide expert surgical nursing care during your hospital stay and facilitate your discharge home.

An Anaesthetist-
Is responsible for your anaesthetic. He/she will ask you questions about your medical history, what drugs you are on and if you have any allergies. They will also discuss the types of pain control available.

A Physiotherapist-
He/she will teach you important deep breathing and coughing exercises, which you will be encouraged to do after your operation. These exercises will help your lungs re-expand and help prevent chest infections from occurring. Following the operation the physiotherapist will also help you with your walking, posture, and climbing stairs. He/she will help you to become as fit as possible before going home.

A Dietitian –
You may be referred to a dietitian prior to surgery. Please inform a nurse if you have been worried about weight loss, or would like dietary advice in preparation for your surgery.

What happens after surgery?

Recovery Area
Your operation will take approximately 6-8 hours following which you will wake up in the recovery/critical care area. There will be a nurse in attendance that will be monitoring you very closely. Occasionally it may be necessary to spend some time in the High Dependency or Intensive Care Units. When the doctors are satisfied with your recovery you will be moved to the ward, where nurses will continue to monitor you closely.

Breathing
While you are still sleepy you will be given some oxygen to breath. It is important that you take deep breaths and cough. This will help to keep your lungs free from infection.

Tubes/drains
When you wake up after your operation you will have some tubes attached to you. These will have been placed whilst you were asleep under anaesthetic. The type and number will vary depending on your operation, but will include:

- A tube in the vein in your neck to give you fluid and certain medications.
- A tube in your vein in your arm to give additional fluids and medication.

- A tube that passes through your nose and into your stomach. This allows us to drain off digestive juices in your stomach that might make you feel uncomfortable, and are likely to make you feel sick.
- Near to the site of the operation (your wound), you may find one or two drainage tubes (drains) that go under the skin. These drain off fluid to prevent swelling.
- A catheter, a fine tube will have been placed into your bladder to collect your urine into a bag. This means you do not have to worry about getting out of bed initially and we are able to monitor what you are producing.

As you recover your drains and tubes will be removed as directed by your doctor.

Will it be painful?

The amount of pain you will experience is variable and individual, but we will work with you to ensure that pain is kept to the minimum. It is important you tell the nursing staff if you have pain, discomfort, or if there is any change in the amount of pain felt.

There are several ways of reducing pain including:

- Epidurals (the same as for pregnant women in labour) which may not be removed for 5 days.
- Patient controlled analgesia (this will be explained before your surgery).
- Pain killing injections, which can be given regularly around every 3-4 hours.
- Some painkillers can be given in suppository form. Once you are able to drink, your painkillers will be gradually changed to soluble tablets. It is advisable to take these regularly to prevent the pain coming back. You will also be shown how to support your wound when you cough.

Personal Hygiene

Initially you will require help with your personal hygiene, however in a few days you will regain your independence. Bowel function returns 4-5 days after surgery. Once your drains have been removed and you are feeling well enough, a nurse will help you have a bath.

Mobilisation

Initially you will be encouraged to get out of bed and sit in the chair, with short walks at frequent intervals. This will help prevent stiffness, bed sores and constipation and help keep your chest clear. You will be given a pair of elastic stockings to wear, to help the blood flow in your legs. You will also be given a small injection of clexane (anti-coagulant) into your abdomen. This will help the blood flow freely around your body and help prevent clots forming.

Wound

Your stitches resemble ‘staples’ and are called clips. They will be removed (around day 10) after your surgery. Sometimes this is done in GP surgery after discharge. Dressings around your drains will be renewed daily or often removed completely. It is important to report if there is any discharge from your wounds so that it may be treated appropriately.

When can I eat after the operation?

Immediately after the operation you will not be allowed to eat or drink in order to allow your intestinal tract and pancreas to heal, this may continue for 7 days. The doctors will assess this on a daily basis, introducing sips of fluids and subsequently diet gradually. This is very individual and so just a guide.

During your surgery you ***may*** have a feeding tube placed in your abdomen. This tube allows the delivery of nutrition

directly into your small bowel. This will be removed after you have ***fully*** recovered from your surgery and are eating and drinking well.

Dietary guidelines at home following pancreatic surgery.

After an operation it is important to make sure that your diet is nourishing, to help promote wound healing.

If you have lost weight recently or have a small appetite then you need to eat more foods rich in protein. You may find it difficult to cope with a lot of fat causing you to have pale loose stools.

1. Try to have 5-6 small meals, snacks or nourishing drinks throughout the day rather than 3 meals.
2. Try to drink some full cream milk daily. Fortifying milk with skimmed milk powder can be helpful. This can be used in drinks, cereals, sauces, puddings and to make up packet soups.
3. Add extra butter/margarine to mashed potatoes and vegetables.
4. Add grated cheese to mashed or jacket potatoes, stews, baked beans, scrambled eggs, and white savoury sauces.
5. Have snacks between meals e.g. cheese and biscuits, thick and creamy yoghurt, scone and butter, toasted tea cakes, milky drinks.
6. Extra sugar or glucose can be added to drinks cereals and desserts **only if you do not have a problem with your blood sugar levels e.g. diabetes.**
7. Take a mid afternoon snack with a hot drink such as scones with jam and clotted cream, or a toasted teacake with plenty of butter or margarine.

Nutritional supplements are available in hospital or from your GP if you are losing weight and unable to get everything you need from your dietary intake. Please contact your dietitan if you would like to discuss the range of products available and quantity recommended.
If you have been advised to take enzymes to help digest your food you may need to adjust the amount you take depending on your diet (see overleaf for further information)

Eating well and keeping well with diabetes

Some people develop diabetes following pancreatic surgery. You may be started on insulin injections to replace the insulin your pancreas would have normally produced.
A diabetes nurse specialist can provide information to help you to manage your insulin injections.
If you are at home following surgery and have the symptoms of diabetes including thirst, rapid weight loss and passing a lot of urine and you are not on insulin then you should contact your G.P.
A good diet will help you to control your diabetes in combination with regular insulin injections.

- Eat regular meals. Have a breakfast, lunch, evening meal and supper. Depending on your regime you may also be advised to have a bedtime snack
- Have starchy food such as bread, potatoes, rice, pasta or cereals at every meal. Try to choose wholemeal or wholegrain varieties if possible.
- Include meat, chicken, fish, well-cooked eggs, milk, yogurt, cheese or pulses, such as lentils or baked beans, at least three times a day.

- Avoid adding sugar and honey to foods and sugar coated cereals.
- If you are feeling unwell or run down you must still try to eat and drink regularly. Enriched drinks (such as ensure plus or build up) can be useful if you do not feel able to cook. Keep a supply handy in the cupboard.
- **Never** stop taking your insulin. Consult your GP or diabetes specialist nurse if you are concerned about your blood sugar levels.
- If your blood sugar level drops low or below a certain level (usually lower than 4 mmol/l) take something sweet or a drink containing sugar.This should be followed by a meal or substantial snack containing a starchy food as listed in point 2 above.

Dietary guidelines for those taking pancreatic enzymes

After pancreatic surgery some people need to take enzymes to help them digest their food. A few people need to take enzymes **and** insulin.

Pancreatic enzymes are particularly important for the digestion of fat. Undigested fat in the stools makes them pale, bulky and may smell bad. This may lead to diarrhoea or passing pale stools. Contact your G.P. if you have these symptoms and are not taking an enzyme preparation.

Your medication may include pancreatic enzymes that help to break down and digest the foods (protein, fat and starchy food e.g. bread and pasta) that you eat. Without them your body will not be able to obtain the nourishment

it needs. An example of an enzyme drug is Creon, Pancrex V.

- Take half the dose of capsules prescribed for each meal at the start of your meal and the rest halfway through the meal or between the main course and pudding.
- The amount of enzymes required vary enormously from patient to patient partly because of the different level of secretion by the remaining pancreas following the operation, and partly because there are still some enzymes secreted by the salivary glands, tongue, stomach and small intestine. Also your requirement will be affected by:

1. The amount of food you eat e.g. large meals containing fat will require more enzymes than small meals.
2. A meal with a pudding/dessert will require more enzymes.
3. The type of food eaten e.g. meals, which contain a lot of fat, for example fried fish and chips, will require more enzymes than a meal containing boiled potatoes and steamed fish.
4. Remember some foods/drinks do not require enzymes e.g. fresh or tinned fruit, jelly fizzy drinks and squash.
5. Additional enzymes may be required if snacks are taken between meals. E.g. crisps, chocolate, cheese.

If you are taking enough enzymes your stools should return to a more normal appearance. Weight gain is a good sign that you are taking enough.

It is a good idea to monitor your weight at home. Only weigh yourself once a week as weighing yourself more frequently than this will record fluid balance changes. When weighing yourself, use the same scales, at the same time of day, and with the same amount of clothing.

	Date	**Weight**
Week 1		
Week 2		
Week 3		
Week 4		
Week 5		
Week 6		

Please contact your dietitian if you are having any difficulty with your diet, if you are losing weight or if would like further information on nutritional supplements.

Before your Discharge

Medication

When you are ready for discharge your nurse will explain the drugs which you will need to take home with you. You will be given 2 weeks supply of tablets.

You will have some painkilling tablets, which you should take regularly to allow you to cough and breathe deeply without discomfort. Consult your GP if your painkillers are not working. When you feel ready to cut them down, try taking one tablet instead of two (i.e. reducing the dose of medication before reducing the frequency).

You may have some acid reducing tablets as pancreatic juices normally counter the acid of the stomach. In the absence of the pancreas there may be excess acid which can cause dyspepsia. (There is also some evidence that

this type of medication helps the action of pancreatic enzyme supplements).

Recovery

You should expect to remain in hospital for 2-3 weeks. This may vary according to the individual. Your progress will be assessed closely by the doctors and nurses. During your first week following discharge you may feel quite vulnerable, so it is an advantage to have someone at home with you. If you are worried about returning straight home please speak to your nurse as a period of convalescence could be arranged for you in a cottage hospital close to your own home. The surgeon will see you approximately 2 weeks after your operation after discharge home. Risk of pancreatic fistula and prolonged stay sometimes months.

Exercise

Your physiotherapist will give you information about how to build some form of exercise into your lifestyle. When you go home, you may become quite tired at times, so continue to have a rest after lunch for an hour or so. Don't be afraid to go out. Start with walks around the garden or up the street. You should aim to be able to walk at least 1-2 miles after 6-8 weeks. If it is raining or too cold to go out use your stairs to exercise. Remember the exercises the physiotherapist has discussed with you to help reduce any stiffness.

AT HOME

The following information has been designed to assist you following discharge from hospital after pancreatic surgery. It covers the main areas commonly asked by patients, but

please ask a member of staff if there is any information you require has not been included.

Rest and Activity
It is quite normal to feel very tired after discharge from the hospital.
Most people benefit from having a planned “rest time” during the day and actually resting on your bed is more relaxing than using a chair.

Moving and Exercise
Gradually increase the amount of exercise you take. Short walks everyday, gradually increasing in distance over a period of weeks is very beneficial.

Movement such as gentle bending and stretching are good but pushing or pulling can cause discomfort, as does standing for long periods of time. Try to avoid these for the first few weeks.

Housework
Light work (e.g. dusting or drying up) can be introduced into your routine when you feel fit and able for it, usually within the first 1-2 weeks you are at home. Avoid any heavy lifting, pushing or pulling for the first 6-8 weeks.

Alcohol
There should be no reason why alcohol cannot be taken but the effect may be felt a little earlier than before - so be careful - always consult with your own doctor first. Remember that certain medications can react with alcohol - always read the label.

Gardening
Light gardening such as weeding may be done 2 weeks after discharge. Mowing the lawn and heavy digging should not be done for 8 weeks.

Driving

You should be able to safely resume driving 6 weeks after discharge.

Sexual Activity

Resume sexual intercourse once you feel confident. If you remain relaxed and possibly adopt a more passive role, you may return more easily to your normal routine.

Wound Healing

Healing of your wound will take place over a period of time as all wounds progress through stages of natural healing.

- DO NOT pull off scabs as these protect new tissue underneath.
- SEEK ADVICE if the wound becomes very painful, if it starts to discharge or becomes red or inflamed.
- IT IS NORMAL for the wound to tingle, itch or feel slight numb.
- IT IS NORMAL for the wound to feel slightly hard and lumpy.
- IT IS NORMAL to experience a slight pulling around the wound.

Gaining Weight

It is quite common to continue losing weight after leaving hospital. Try not to worry about it. You will probably find that you will not return to the weight you were before you became unwell. You will establish a new weight (it may take 6 months to a year for your weight to stabilise). The ‘little and often’ eating routine will be a good way to achieve this. When you do not feel like eating much, supplementary drinks such as Complan, Build Up, Fortijuice, Ensure plus, Ensure Plus juice, etc may help to ensure a balanced intake of nutrients, which is very important. Some of these supplements are available on

prescription from your GP. Some can be bought from supermarkets eg Build up, Complan, milkshakes, soup. Your dietitian will be pleased to advise you about what is suitable for your needs.

Diarrhoea

You may experience some changes in bowel habit. Diarrhoea or constipation is not uncommon. If you have severe diarrhoea it can be treated so be sure to tell your nurse or GP. If you feel you need dietary advice contact your dietitian.

Fatigue (Feeling exhausted most of the time), emotional impact

Everyone has good days and bad days, but due to this operation and any treatment you may have undertaken after the surgery, fatigue is a very common experience. This can last for several weeks or months after treatment has completed. There are many ways of combating fatigue and many strategies which can help you manage your everyday activities. For more information contact Oncology specialist nurses Marilyn Bolter or Claire Downing (See numbers on the last page of this booklet).

Similarly, fear, anxiety, depression, changes in mood is all possible for patients undergoing this operation. Your life may feel like it has been turned upside down, and that all your future plans are on hold. Everyone needs support through difficult periods in their life. See below for information on who to contact for advice.

Back to Work

This depends on your job and on your recovery. Returning to work can be discussed at your clinic appointment. A time frame of 3 to 4 months after you have returned home is reasonable, but remember it is individual.

If you require advice regarding work and benefits whilst in hospital, ask your nurse who can arrange for you to see a social worker.

Who can I contact if I have any questions?

The whole team are always willing to answer any questions you have, in an open and honest manner. The team includes your surgeon, ward nursing staff, your dietitian, physiotherapist occupational therapist, and your Oncology Specialist Nurse.

This whole team can be contacted via the Oncology or Hepatobiliary specialist nurses, Claire Downing and Girlie Garcia. They are available to you, your relatives and close friends for any questions, concerns or worries throughout the whole of your treatment and after your treatment has ended. They are the main means of communication between all parties involved, and can be contacted Monday to Friday 9-5 via the hospital switchboard on: **01752 517905.** An answer phone is available for messages.

Your GP and the district nurse in your area will be notified on your discharge. There is also the option of having access to a cancer specialist nurse in the community. They are called Macmillan nurses, and are specially trained in all aspects of cancer treatments and its problems. They can visit you at home on an agreed basis (This referral can be arranged by your oncology specialist nurse or GP).

If you wish to comment on the service provided you can contact Patient and Consumer Affairs, level 7, Derriford hospital

The Mustard Tree - Cancer Support Centre, Derriford Hospital, Plymouth.

If you would value the opportunity to talk to someone about how you feel or just want need a break from the usual routine we invite you to visit the Mustard Tree. The centre is available to anyone affected by cancer at any stage of the illness and offers a comfortable space where you can share your concerns, ask questions and receive support. It is staffed by professionals and trained volunteers many of whom have a personal experience of cancer. The centre is open Mon–Fri 09.30–4.30 (Contact details on the back page).

Web pages/telephone numbers:

Pancreatic Cancer UK ---www.pancreaticcancer.org.uk

Digestive disorders Foundation----
www.digestivedisorder.org.uk

Cancerbacup----------www.cancerbacup.org.uk (0808 800 1234)

Cancer care society-www.cancercaresoc.demon.co.uk (01794 830300)

Cancerlink----------www.cancerlink.org (0808 808 0000)

Macmillan Cancer Relief------www.Macmillan.org.uk (0845601 6161)

This booklet and more local information can be found on --
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www.plymouthhospitals.nhs.uk

EUROPAC (European Register for Familial Pancreas Cancer and Hereditary Pancreatitis). -------
www.liv.ac.uk/surgery/europac.html

Write to: EUROPAC Co-ordinator, Department of Clinical Services, Alder Hey Children's Hospital, Eaton Road, Liverpool, L122AP

Will I need any further treatment?

The surgeon will be able to tell you immediately after the operation some details about what was found and what he did, but it can take two weeks for the laboratories to study the samples sent to them and to interpret the findings. This will give a clearer picture and may enable the surgeon to tell you more clearly about the stage of the disease removed.

A few patients may need further treatments such as chemotherapy. The uses of these treatments are being improved all the time by asking patients to participate in clinical trials. If you would like more information about this and other treatments please ask your Surgeon, Oncologist or your Oncology Nurse Specialist (Contact details on the back page).

CONTACT DETAILS

Stonehouse Ward----------(01752) 431488

Professor Kingsnorth's ----------(01752) 763017

Mr Stell's secretary----------(01752) 439288

Dr Pasco's secretary----------(01752) 763982

Marilyn Bolter:
UGI Oncology Specialist Nurse----------(01752) 517905

Claire Downing
UGI Oncology Specialist Nurse----------(01752) 517905

Girlie Garcia
Hepato-biliary nurse practitioner--------(01752) 517886

Diabetic Specialist Nurse----------(01752) 792962

Dietitian: ----------(01752) 792266

Derriford Hospital switch ----------08451558155