

Having a pelvic exenteration

This leaflet aims to answer your questions about having your exenteration. It explains the benefits, risks and alternatives, as well as what you can expect when you come to hospital. If you have any further questions, please speak to a doctor or nurse caring for you.

The medical words used in this booklet are printed in **bold** and there is a glossary on page 13 to explain words you may not be familiar with.

What is a pelvic exenteration?

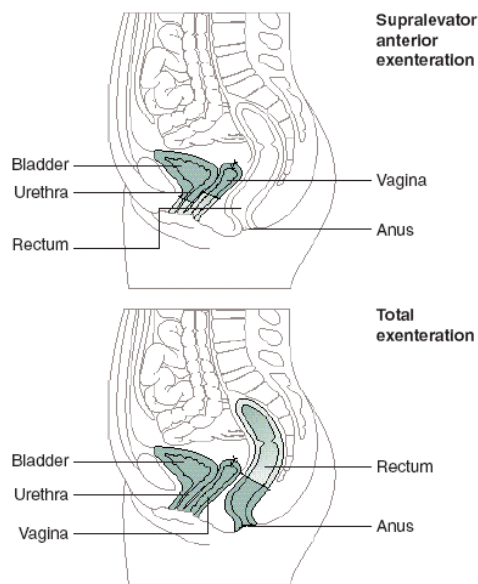
Pelvic exenteration is a major operation during which some of the organs of the pelvis are removed. This surgery is normally offered to women who have already had treatments for their gynaecological cancer. The cancer has either returned or had not been cured by the initial treatment.

The operation is very complex and takes many hours to carry out.

There are different types of pelvic exenteration and which type is needed depends on where your cancer is situated. Some women will already have had their womb or their ovaries, or both, removed in their initial treatment. Other women will not have had gynaecological surgery but received chemotherapy and radiotherapy. Some may have had both types of treatment.

- **Anterior pelvic exenteration** is used if the cancer is at the front of the pelvis. The reproductive organs and the bladder are removed.
- **Posterior pelvic exenteration** is used if the cancer is at the back of the pelvis. The reproductive organs and the bowel are removed.
- **Total pelvic exenteration** is used if the cancer is in the middle of the pelvis. The bladder, the reproductive organs and the bowel are removed.

This means that it will usually be necessary for you to have one or two stomas, or bags, to collect bowel and urine contents.



Where are my reproductive organs?

The uterus or womb is roughly the shape and size of a pear. It sits in the middle of the pelvis. The cervix – the part of the womb that stretches during childbirth – pokes into the top of the vagina. Please see figures 1 and 2.

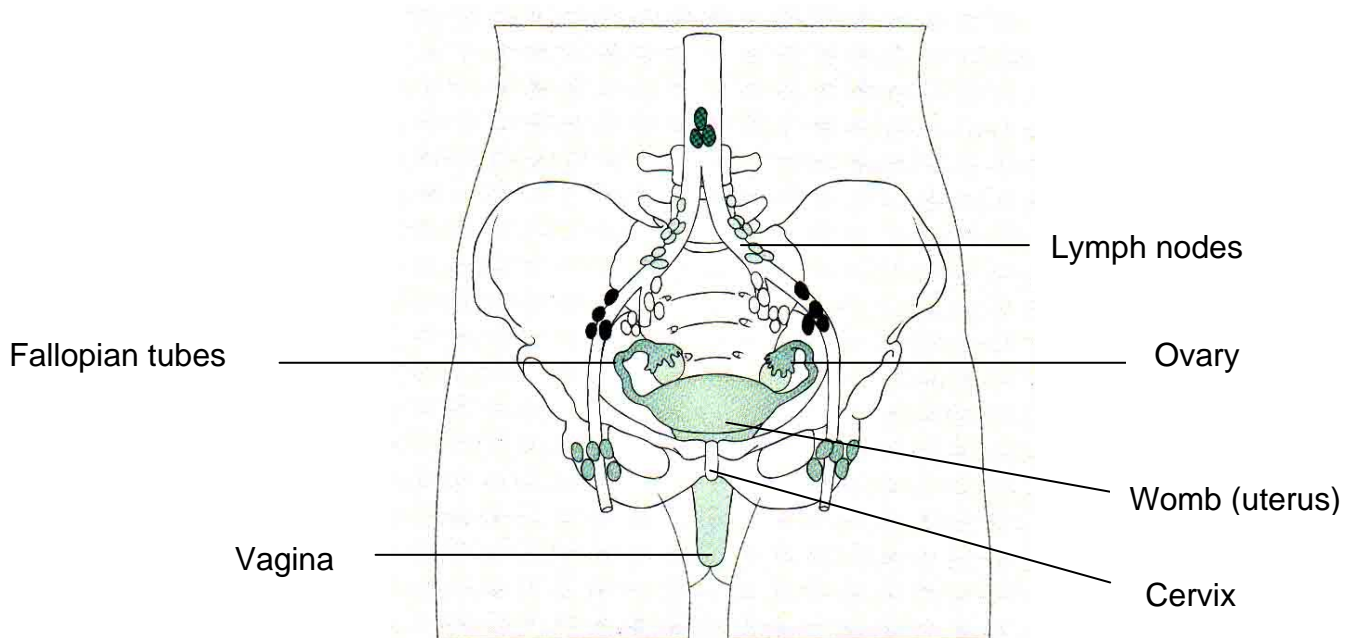


Fig. 1

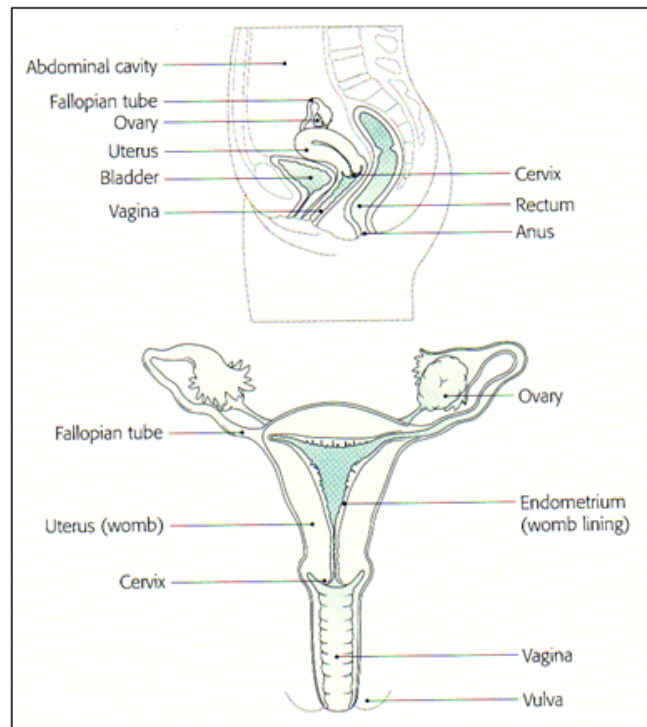


Fig. 2

Why should I have a pelvic exenteration?

This surgery is carried out on patients whose disease has come back after the initial treatment. The aim is to cure the patient of her disease. If a patient has symptoms in the area where the cancer has returned, the surgery may relieve some of these symptoms.

What are the risks?

There are risks associated with any surgical procedure. Your surgeon will explain these risks to you before you sign the **consent form**. This form confirms that you agree to have the operation and understand what it involves. Please ask questions if you are uncertain.

If you would like more information about our consent process, please speak to a member of staff caring for you.

Possible risks and complications from this surgery are:

- Bleeding during or after your operation: this may need to be treated with a blood transfusion.
- Blood clots: you will be given a month's supply of anticoagulant injections to decrease your chances of acquiring a blood clot. You will be taught how to give these to yourself or a carer or district nurse can give them to you.
- Problems caused by having a general anaesthetic: Please our leaflet, **Having an anaesthetic** for further information about the risks and side effects of anaesthesia. If you do not have a copy, please ask us for one.
- Infections: You will be given antibiotics to help prevent this.

- Your wound could be slow to heal, or breakdown due to poor healing caused by previous treatments. If this occurs, the surgeon will see you and decide with you the best course of action.
- The joining inside of the bowel or stoma could come apart.
- The joining from the ureters (tubes coming from the kidneys) could come apart.
- A hole called a **fistula** can occur in the pelvis or abdomen due to having cancer treatments.
- The bowel could obstruct.
- Your kidneys could start to fail.
- Blockage to your ureters could occur.
- Reconstruction tissue may begin to break down. You will be monitored closely in hospital and if this starts to happen, measures will be taken to prevent or deal with it.
- Patients can have altered sensation following this surgery if they have any reconstruction of tissue from elsewhere in their body.

This is a long list of risks and complications, however not all of these occur with every patient. If you develop any of these complications, you will be seen by your medical team and a course of action discussed with you. This may lead to an extended period in hospital.

These complications are usually rare, but you must be aware of them. As with any operation, there is a risk of death, although this is very rare. Please talk to your doctor about any concerns you have before your operation.

Are there any alternatives?

This operation is only performed if there is a good chance of it curing your cancer.

You will probably have had radiotherapy already. The highest doses of radiotherapy will have been used and radiotherapy cannot usually be used again in the same place, as it will cause too much damage to your bowel and bladder.

Chemotherapy and hormone treatment might keep your cancer under control, but neither will cure it completely.

How can I prepare for my operation?

Please see the checklist on page 12 for details on what to bring with you.

What happens before my operation?

We will ask you to come to the hospital for a pre-admission appointment, so that we can do some tests and talk to you about your operation. Before your surgery you will see a doctor from your gynaecology team and also an **anaesthetist**. The anaesthetist will ask about your health and explain the different ways in which pain can be prevented and controlled after your surgery.

Please let us know if you are taking any regular medicines (including anything you buy yourself over the counter or any herbal or homeopathic medicines) and if you have any allergies to any medicines. If you are taking antiplatelet medicines (such as aspirin or clopidogrel) or any anticoagulant medicines (such as warfarin or rivaroxaban), then you may need to stop them temporarily before your surgery. We will review your medicines when you come in for your pre-assessment visit, and will let you know whether you need to make any changes before coming into hospital. Please ask us if you have any questions.

Who will I see before the operation?

- The gynaecological oncology surgeon.
- The clinical nurse specialist who will be your key worker, to give your support and information.
- The plastic surgeon if reconstruction is necessary.
- The urologist if you need surgery on your bladder.
- The stomas nurse specialists to prepare you (physically and psychologically) for having a **colostomy** or **ileal conduit** or **urinary diversion**.
- A counsellor to discuss how you feel about the surgery and possible coping methods. (This is optional but you can be referred if you would like).

All of these appointments will be before your surgery.

Giving my consent (permission)

We want to involve you in all the decisions about your care and treatment. If you decide to go ahead with the pelvic exenteration, you will be asked to sign a consent form that says you have agreed to the treatment and that you understand the benefits, risks and alternatives. If there is anything you don't understand or you need more time to think about it, please tell the staff caring for you.

Remember, it is your decision. You can change your mind at any time, even if you have signed the consent form. Let staff know immediately if you change your mind. Your wishes will be respected at all times. If you would like to read our consent policy, please ask a member of staff.

What happens during my ward admission?

You will usually come to the ward the day before the operation. Your ward nurse will help you get ready for your operation and can answer any questions you may have.

You will be shown around the ward on the day of admission. A nurse and a doctor will see you on the ward and take your history. They will also make sure that you have had your blood tests and that you are still fit for surgery.

You will be eating normally when you come into hospital. An individual plan will have been made with you regarding supplements to be taken at home before surgery.

While you are in hospital, we will prepare your bowels for surgery, and this will involve taking **laxatives**. Following this, you will be on clear fluids. This means water and some liquid food supplements. Up until two hours before surgery you can drink water and will have a carbohydrate drink.

What happens during the operation?

You will be given a general anaesthetic, which means that you will be asleep for the entire procedure. Usually, an epidural anaesthetic is used as well so that we can offer you pain relief following the procedure to make you more comfortable. The operation is carried out through a long vertical incision (see figure 3).

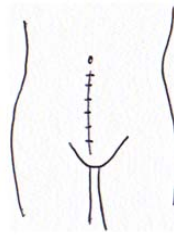


Fig.3

The inside of abdomen is examined to make sure that the cancer has not spread. Sometimes biopsies (small pieces of tissue and lymph glands) are taken and sent immediately to the pathologist, who examines them also to make sure there has been no cancer spread.

If the cancer has spread beyond what can be removed, the operation is stopped and the incision is closed without doing any more surgery. If the biopsies are negative and there is no spread, the operation continues.

Several doctors are involved in the surgery, including:

- a gynaecological cancer surgeon
- a bowel surgeon (sometimes called a colorectal surgeon)
- a urologist
- a plastic surgeon
- an anaesthetist.

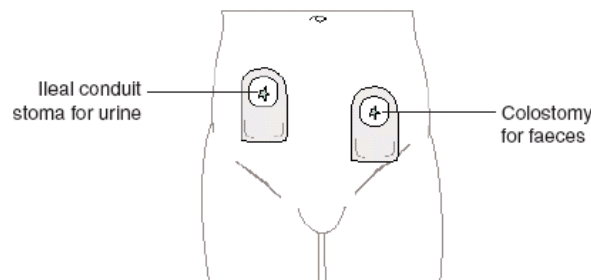
Each of these doctors has their own responsibilities and will discuss them with you before the operation.

The length of the surgery varies from patient to patient, but it can take between eight and twelve hours to complete.

Will I have to wear a bag (stoma)?

If your bowel is removed you will need to wear a bag to collect the faeces. This may be a permanent stoma, however on some occasions this can be reversed. Sometimes the bowel can be reconnected at the time of the surgery. Your surgeon will discuss options with you.

If your bladder is removed, you may have to wear a bag to collect the urine. It may be possible to create a **continent pouch** (a channel connecting part of your small intestine to the wall of your abdomen) which you would need to drain with a tube. Your surgeons will discuss these options with you.



What happens after my operation?

The following information is a guide as to what may happen after your operation. Everyone recovers at a different pace, but if you have any concerns, please talk to your doctors or nurses.

Waking up from your operation

When you wake up you will have:

- an oxygen mask on your face to help you breathe after the general anaesthetic
- a **drip** in your arm to give you fluids
- a small clip on your finger to check your oxygen levels
- a temporary **bladder catheter**, as you will feel sleepy and not be able to get out of bed to pass urine. The catheter also gives an accurate measurement of your urine
- one or more **drains** coming from your wound.

You may also have a tube down your nose which goes into to your stomach. This is in case you feel or are sick after the surgery.

Depending on your surgery, you may have a stoma (colostomy) to help you pass stool (poo), a stoma (urostomy or ileal conduit) to help you pass urine, or you may have a newly reconstructed vagina or tissue to cover where the vagina was. If skin is used to cover the vagina, you will no longer have a vagina. You will have discussed your options in regards to this with your consultant and plastic surgeon before the surgery. The counsellor and your nurse specialist will talk to you about how this may feel for you after the surgery. You will also have the opportunity to talk to them outside of the consultation, before and after your surgery, on the ward, at outpatient appointments and by phone.

You might have a pain relieving pump. There are two types:

- An epidural pump, which delivers painkillers into your back you to desensitise the pain nerves (this may make your legs feel heavy and numb, temporarily); or
- A PCA (patient controlled analgesia) pump, which delivers a dose of painkiller into your vein whenever you press a button, allowing you to control when you receive a dose. Your nurse will explain how to use this pump.

The anaesthetist will discuss these options with you in more detail before you have your surgery.

You will feel very tired and it is important that you do not have too many visitors in the first few days after your operation. The nursing staff will help you if you need anything.

You will stay in overnight recovery for at least the first night after your surgery. This is attached to the recovery room and it is somewhere you can be closely observed and have one to one nursing care overnight. When you are stable you will be transferred back to the ward. You will be looked after in a specialist ward after your surgery.

The first day after your operation:

You will be on the enhanced recovery pathway. This is a process to try and help your recover well post surgery and reduce the chance of problems following your surgery. To assist with this, the ward team will encourage you to:

- Sit up-right, especially out of bed. This lets your lungs open up fully, makes it easier to cough and helps to prevent you getting a chest infection.
- Start moving around as soon as possible. This is good for your blood circulation and, along with your anti-embolic stockings, can help prevent blood clots (deep vein thrombosis or DVT). **Please do not get out of bed until your nurse has told you it is safe to do so.**

The plastic surgeons (if they have taken part in the surgery) may have specific instructions on bed rest or exercise.

After an exenteration, it can take a little while for your gut to start working again. This means you will begin drinking with just small sips of water.

It is important that you stop smoking for at least 24 hours before your operation, or as soon as possible, to reduce the risk of chest problems. Smoking can also delay wound healing because it reduces the amount of oxygen that goes to the tissues. You can speak to your GP about referring you to a smoking cessation clinic.

We have a no-smoking policy in our hospitals. For more information on giving up smoking, please speak to your nurse or call the NHS Smoking Helpline on 0800 169 0 169. There is also a Guy's and St Thomas' stop smoking service which you can call on 020 7188 0995.

During the rest of your time on the ward:

Each day you will be encouraged to move around (mobilise) more and to become more independent. Your women's health physiotherapist will show you the easiest way to start moving again. She will also show you some gentle exercises that will help you to regain your pre-surgery fitness levels.

You may see an occupational therapist who will check that you will be able to adapt to your normal life following your surgery and assess whether anything in your home needs to be modified to help you cope.

Once you are able to drink normally, your drip will be taken away. Drinking plenty of fluids and walking around will also help your bowels to start working again. You will be given oral medicines (those taken by mouth) to control any pain and your pump will be stopped. Your catheter will also be removed.

In the days after your operation, and perhaps for some time afterwards, it is very probable that you will feel low, or have difficulty coming to terms with the surgery and the alterations to your body. This can be caused by the hormonal changes in your body, the anaesthetic you were given, or your feelings about the operation in general. How long these feelings will last varies from woman to woman. Please do not hesitate to talk to the staff about how you are feeling. If you have already seen a counsellor, they will be happy to come and see you on the ward following surgery and will arrange for follow up appointments as an outpatient if you so wish. You can decide with the counsellor what kind of follow up you will need to help you deal with your emotions. The nurse specialists will also be available by phone and happy to talk to you about how you are feeling after the surgery.

The stoma nurses will see you after the surgery and during your inpatient stay, and will offer education on how to look after stoma(s). They will organise stoma supplies (bags) for you and for a stoma nurse to support you in the community. Alternatively, they may arrange for you to visit them in hospital after you have been discharged.

They will also give you emergency contact details to use if you have any problems with your stoma once you are discharged.

When can I go home?

You will usually stay in hospital for two to three weeks.

What do I need to do after I go home?

Below are some guidelines to give you an idea of how much you can do at home:

In the first weeks after your operation, you will not be able to do much. It is advised that you get out of bed and walk around during the day, but you may need to spend your time alternating between rest and activity. You should not lift anything heavier than a half-full kettle.

Weeks three to six

- Continue to gently increase the amount of physical activity you are doing – walking is good.

- How you recover and what you can do will depend on what kind of surgery you have had. Generally it is advisable not to do house work or lift shopping bags for at least six weeks after the surgery.
- If you have a vagina, it is advisable that you do not have intercourse for at least six weeks, or until you have been examined by the surgeon.
- Allow for rest time in your daily routine.
- At six weeks, if you are feeling recovered, you can start to drive again.
- You can also return to your normal, everyday activities.

Some women tell us that it can take up to four to six months before they feel fully recovered after an exenteration, but it is different for everyone.

What should I do if I have a problem?

If you have any of the following symptoms, you should contact your GP immediately. If your GP surgery is closed, call our switchboard on **020 7188 7188** and ask to speak to the doctor on call for your surgeon. If it is during office hours and you are not sure who to call, you can contact the nurse specialists on **020 7188 2707**. A call centre is answering all their calls, Monday to Friday, 9am to 5pm.

Symptoms to look out for:

- a temperature of 38°C or above (100.4 Fahrenheit)
- severe pain or increasing pain
- nausea and vomiting
- increased bleeding from your vagina (bright red blood or clots)
- offensive smelling, itchy, yellow/green discharge from your vagina
- burning pain or discomfort when passing urine
- unable to pass urine either from the stoma or the continent pouch
- constipation which lasts longer than three or four days and does not get better after taking an oral laxative
- wound pain, or swelling/redness of your wound area
- discharge (pus) from your wound
- your wound opening or any of your wounds breaking down
- pain, swelling or redness in your calf
- a sudden feeling of shortness of breath and/or chest pain.

Common questions

Below are some general questions and answers about having an exenteration. If you need any more details or have other questions or concerns, your nurse or doctor will be happy to help (contact details are on page 16).

Will my life be different with a stoma to pass urine through (ileal conduit or urostomy) and/or a stoma to pass bowel motion through?

Your life will be different and it will take some adjusting to. Your gynaecological-oncology team will be here to support you and your nurse specialist (key worker) is available to talk to you. If you leave her a message she will get back to you.

If you have met the counsellor before surgery and during your hospital stay, you will have the opportunity to continue seeing this counsellor to help you adapt to life after the operation if this is helpful to you. If you have not met the counsellor, you can be referred if you so wish.

The stoma nurses will be here to support your learning of how to physically look after your stoma(s) and how to deal with them psychologically.

You may have some difficulty coming to terms with how your body looks with the stomas. You may choose to discuss these with the counsellor (if you would like), stoma nurses, and/or your gynaecological-oncology team.

Will my life be different now that I don't have a vagina?

Your life will be different now that you don't have a vagina, and this will take some adapting to. You will have discussed your options with your consultant before the surgery, and you will have had a say as to whether your vagina would be replaced by grafted tissue so that you no longer have a vagina. You will be able to discuss this with your gynaecological-oncology team or your plastic surgeon. If you have seen a counsellor prior to surgery, you can continue to see them if you need to.

Will my life be different now I have a neo (new) vagina?

The plastic surgeons and your clinical nurse specialist will have explained what this will mean for you, and will have addressed some of the differences between your old and new vaginas and also how to take care of your new vagina. Having a new vagina will take some adjusting to. You will be able to contact your nurse specialist if you have concerns and can also continue seeing your counsellor if this is helpful for you.

Do I still need to have smear tests?

If you have had pelvic radiotherapy already you will not have been having cervical smears. After an exenteration where the uterus (womb) and cervix (neck of the womb) and possibly the vagina (either partial or total) have been removed, it will not be necessary to have smear tests.

Will I be able to have sex?

Usually after a pelvic exenteration, most of the vagina is removed. By using skin from the abdominal wall it is generally possible to restore the vagina to normal, although the skin is not the same as normal vaginal skin. If this is the case then you would be able to have sexual intercourse. Your nursing team can explain to you about the use of dilators and intercourse to keep the vagina open.

Checklist

Before your operation:

- ☐ Stop taking your oral contraceptive pill six weeks before your operation. You must use another method of contraception instead, such as condoms.
- ☐ Stop smoking or at least cut down. Try using nicotine patches or gum – for more information contact your nurse or the NHS Smoking Helpline on 0800 160 0 160. There is also a Guy's and St Thomas' stop smoking service which you can call on 020 7188 0995.
- ☐ Write down any unanswered questions you have using the space given below (for example: What type of exenteration am I having?) and bring this into hospital with you.
- ☐ Make arrangements for time off work and support for when you come home.
- ☐ Try to take regular exercise and eat a varied, balanced diet.
- ☐ If you are overweight, speak to your GP about the best way to lose weight. If you cannot lose weight, please try not to gain any more weight.

Coming into hospital:

- ☐ You should have received the leaflet, **Preparing for your stay**. If you have not, please contact us to ask for a copy. The **Preparing for your stay** leaflet includes a checklist – please look at the checklist to make sure you have packed everything you need. Here is a list of items you can possibly take with you:
 - ☐ comfortable sanitary pads
 - ☐ larger fitting pants
 - ☐ nicotine patches – if you smoke and are trying to stop. Please give them to your nurse when you arrive
 - ☐ loose fitting nightdresses – the waist-line of pyjamas can be uncomfortable over your wound
 - ☐ supportive shoes or slippers.

Going home:

- ☐ Do you have a clinic appointment?
- ☐ Date: _____ Time: _____ Clinic: _____
- ☐ Have you had advice on exercises post surgery?
- ☐ Have you got an 'inpatient sick' certificate for work?
- ☐ Do you know when you can return to work?
- ☐ Have you been given your medicines to take home? Do you know what your tablets are for and how and when to take them?
- ☐ Are there any other questions you need to ask before going home?

Glossary

Anaesthetist	A specially trained doctor with skills in controlling pain and using an anaesthetic so you will be asleep during your operation.
Abdomen (tummy)	The area of the body below the chest, which contains the stomach, bowel and reproductive organs.
Abdominal	Describes something which relates to the area of the body below the chest called the abdomen.
Abnormality	Something which is not normal.
Anti-embolic stockings	Stockings that are worn to reduce the risk of getting blood clots.
Bladder	This is an organ which helps store urine until the body is ready to pass it.
Bladder catheter	A small rubber tube that is placed into your bladder during your operation. The tube can feel a little uncomfortable but should not be painful. It allows urine to drain away into a bag so that an accurate measurement of your urine can be taken. It also means you do not need to get up to go to the toilet to pass urine.
Cancer	Cancer is a disease of the cells that make up the parts of the body. Normally these cells repair, reproduce themselves and die in an orderly way. If this process gets out of control, the cells that are no longer functioning normally are described as cancer cells.
Cervix (neck of the womb)	The lower part of the uterus where it joins the top end of the vagina.
Chemotherapy	This is a drug therapy used to stop cells multiplying, usually used as a cancer treatment.
Colorectal surgeons	These are surgeons that specialise in operating on the lower bowels.
Drain	This is a small tube, which is placed at your wound site to remove any extra fluid from inside your body into a bag or bottle outside.
Drip	A bag of fluid connected to a small tube in your vein. Used to give your body fluid when you are not able to drink.
Epidural pump	This allows local anaesthetic to be administered into a space in the spine for pain relief usually after surgery.
General anaesthetic	Is the administration of a drug that brings about a temporary loss of consciousness so that you can sleep through your surgery.
Gynaecological	Linked to gynaecology (see below).
Gynaecology	The study of women's illnesses/conditions which affect the parts of the body involved in reproduction (making babies).
Hormone replacement therapy (HRT)	Putting back the hormones that a woman's ovaries no longer make, using manufactured (man-made) hormones.
Ileal conduit (or urostomy)	Where the bladder is removed and a piece of ileum (small bowel) is removed and transferred to the abdomen. The ureters (kidney tubes) are then transplanted into the piece of ileum to help you pass urine.

Incision	A surgical cut.
Laxative	Medicine used to help your bowels work as normal. Used to relieve constipation.
Lymph node (or gland)	Lymph nodes are found throughout the body and can be anything up to the size of a baked bean. They are part of the body's system which helps fight infection.
Mitrofanoff	Where the bladder is removed and a continent pouch is created. A channel is made through the abdomen into the continent pouch. It is drained by the patient by placing a catheter into the channel.
Occupational therapist	A health care professional who makes assessments and uses purposeful activities to help patients regain or maintain their wellbeing, usually after surgery.
Patient advice & liaison service (PALS)	A service which offers support, information and help to patients, their families and visitors.
Patient controlled analgesia (PCA)	A method of allowing a patient in pain to administer their own pain relief by an electronically controlled infusion pump that delivers a prescribed amount of intravenous pain killer when the patient activates a button.
Pelvis	Lower part of the abdomen.
Physiotherapist	A health professional that is skilled in treating physical problems using techniques such as manual therapy and exercise.
Radiotherapy	The medical use of radiation as part of cancer treatment to control malignant cells.
Rectum	The final straight portion of the large intestine which acts as a temporary storage facility for faeces.
Stoma	A surgically created opening which connects a portion of the body cavity to the outside environment (for example, a colostomy, which is an opening in the large intestine, allowing the removal of faeces out of the body to drain into a pouch).
Supporting tissue	(also call parametrial tissue) Holds organs, such as the womb, in place.
Surgeon	A doctor with special skills and trained/training to practice surgery (carry out operations).
Urinary continence	Being able to pass urine normally (for example, only when you want to, and without leaking).
Urology	The surgical specialty that focuses on the urinary tract (kidneys, ureters, urinary bladder and urethra).
Uterus	A female reproductive organ, also known as the womb.
Vagina	A muscular tube or canal leading from the uterus to the exterior of the body.

Useful sources of information

Benefits Enquiry Line

t: 0800 882200 (freephone)

www.dwp.gov.uk

British Association for Sexual and Relationship Therapy

t: 020 8543 2707

www.basrt.org.uk

Daisy Network (for women suffering premature menopause)

www.daisynetwork.org.uk

For women who have cancer:

Cancer Black Care

t: 020 7249 1097

www.cancerblackcare.org

Cancer Research UK

t: 020 7009 8820

www.cancerresearchuk.org

Jo's Trust (for those affected by cervical cancer)

www.jotrust.co.uk

Macmillan Cancer Support

t: 0808 808 0000 (freephone)

www.macmillan.org.uk

Contact us

If you have any questions or concerns about your operation, please contact the gynae-oncology nurses on **020 7188 2707** (Monday to Friday, 9am to 5pm). Out of hours, please contact the switchboard on **020 7188 3026** and ask to speak to the doctor on call for your consultant if you have a medical problem related to your operation.

Guy's and St Thomas' hospitals offer a range of cancer-related information leaflets for patients and carers, available at www.guysandstthomas.nhs.uk/cancer-leaflets. For information leaflets on other conditions, procedures, treatments and services offered at our hospitals, please visit www.guysandstthomas.nhs.uk/leaflets



Dimbleby Cancer Care provides cancer support services for Guy's and St Thomas'. We have a drop-in information area staffed by specialist nurses and offer complementary therapies, psychological support and benefits advice for patients and carers.

Dimbleby Cancer Care is located in the Welcome Village of the Cancer Centre at Guy's. **t:** 020 7188 5918 **e:** DimblebyCancerCare@gstt.nhs.uk

Pharmacy Medicines Helpline

If you have any questions or concerns about your medicines, please speak to the clinical nurse specialist or other member of staff caring for you or call our helpline.

t: 020 7188 8748 9am to 5pm, Monday to Friday

Your comments and concerns

For advice, support or to raise a concern, contact our Patient Advice and Liaison Service (PALS). To make a complaint, contact the complaints department.

t: 020 7188 8801 (PALS) **e:** pals@gstt.nhs.uk

t: 020 7188 3514 (complaints) **e:** complaints2@gstt.nhs.uk

Language and Accessible Support Services

If you need an interpreter or information about your care in a different language or format, please get in touch:

t: 020 7188 8815 **e:** languagesupport@gstt.nhs.uk

NHS 111

Offers medical help and advice from fully trained advisers supported by experienced nurses and paramedics. Available over the phone 24 hours a day.

t: 111

NHS Choices

Provides online information and guidance on all aspects of health and healthcare, to help you make choices about your health.

w: www.nhs.uk

Get involved and have your say: become a member of the Trust

Members of Guy's and St Thomas' NHS Foundation Trust contribute to the organisation on a voluntary basis. We count on them for feedback, local knowledge and support.

Membership is free and it is up to you how much you get involved. To find out more, and to become a member:

t: 0800 731 0319 **e:** members@gstt.nhs.uk

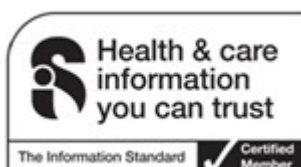
w: www.guysandstthomas.nhs.uk/membership

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