Routine Colorectal Presentations
– The Bottom Line!

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The London Rectal Clinic
Overview of Discussion

• What we offer at 108 Harley St
• Symptoms needing further investigation
  - The 10% or less
• Common Anorectal Conditions
  - The majority 90%
Outpatient Management

- History and Examination
- Rectal Exam
- Blood tests
- Haematinsics
  - Ferritin, B12, Folate
- Rigid Sigmoidoscopy
- Proctoscopy
Outpatient Treatment

• Haemorrhoids (injection), suction banding, evacuate haematoma
• Lesions excision (local anaesthetic), biopsy for Dx
• Anal Fissure
• Pruritus Ani
• Idiopathic anal pain
• Perianal Crohn’s
Digital Examination

- Engage Brain
- Inspect
- Palpate
- Insert
- Anal canal
- Function
- Rectum
- Prostate/RV septum
Common presenting symptoms

• Bleeding
• Pain, burning
• Itching, soreness
• Change in bowel habit
• Pressure symptoms
• Lump
• Prolapse
• Discharge
• Fever, malaise
• Abdominal Pain
Yet More Presentations!

- Family History
- Nil
  - Screening
    - Anaemia
    - Scan
      - Polyp
    - Colonoscopy
      - Polyp / Cancer
      - Colitis
51 F - Other symptoms

- Urgency
- Rectal bleeding
- Saw GP Sept – Diagnosed haemorrhoids
Next steps

• PR – Normal
• Rigid Sigmoidoscopy – Tumour 7cm
- CEA – 25
- CT – Liver and small lung mets
- MRI
  - CRM –ve, T3 N1 M1
  - EMVI +ve
PLAN

• Histol – High grade dysplasia – await further biopsy

• KRAS, MSI requested

• Chemo – rescan – ? SCR + Primary plus Liver then RFA Lungs vs Response
Rectal Bleeding

- Common
- Potentially significant pathology
  - 90% benign disease
  - 10% malignant disease
- Recognise malignant pathology
Colorectal Cancer

• High Incidence
  • 30 000 cases per annum in UK

• Poor Outcome
  • >15 000 deaths per annum in UK
  • Second commonest cause of cancer death

• Late Treatment
  • Overall 40% 5 year survival
Age Distribution

- <65yrs: 28%
- 65-74yrs: 32%
- 75yrs+: 40%
Cancers / Adenoma Distribution

- Transverse colon 5.5%
- Splenic flexure 3%
- Descending colon 4%
- Rectosigmoid junction 7%
- Sigmoid colon 21%
- Rectum 38%
- Anus 2%
- Caecum 12%
- Appendix 0.5%
- Ascending colon 5%
- Hepatic flexure 2%
Polyp Cancer Sequence

Chromosome:
Alteration: 5q Mutation and Loss
Gene: APC

Alteration: 12q Mutation
Gene: K-ras

Alteration: 18q Loss
Gene: DCC

Alteration: 17p Mutation and Loss
Gene: p53

Normal Epithelium
Hyper-proliferation
Early Adenoma
Intermediate Adenoma
Late Adenoma
Carcinoma
Metastasis
New Cancer Diagnosis

- MDT - potentially curative
  » CT / MRI / Colonoscopy / MDT
- Fitness for surgery
- Determine surgery
  » Local
  » Radical
  » Multivisceral
- Determine need for neoadjuvant Rx
Improving Outcome In Colorectal Cancer
A Triple Approach

Early Diagnosis: High risk features

Screening: High risk asymptomatic

Screening: Low risk asymptomatic
High Risk Features

• Rectal bleeding / Change in bowel habit
• Rectal bleeding without anal symptoms
• Persistent Change in bowel habit (6/52)
• Iron deficient anaemia
• Palpable abdominal or rectal mass
Rectal Bleeding
Predicting Site and Source

• General Practitioners
  • Cancer as source = PPV 21%
  • Colon/rectum as site = PPV 35%
  • Missed 4 of 16 cancers

• Gastroenterologists
  • Cancer as source = PPV 34%
  • Colon/rectum as site = PPV 78%
  • Missed 2 of 16 cancers

Goulston KJ. 1986, Lancet
Early Diagnosis
Types Of Bleeding

• Outlet Bleeding
  • Bright red, at defaecation, on paper / in the bowl, in the absence of FH or change in bowel habit

• Suspicious Bleeding
  • Dark blood, and/or mixed with or streaked on stool. Any bleeding associated with family history or CBH

• Haemorrhage
  • Large volume bleed requiring admission / transfusion
Early Diagnosis
Predictive Value of Bleeding Type

<table>
<thead>
<tr>
<th>Outlet</th>
<th>Suspicious</th>
<th>Haemorrhage</th>
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</thead>
<tbody>
<tr>
<td>Colitis</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Diverticular Dis</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Adenomas</td>
<td>35</td>
<td>16</td>
</tr>
<tr>
<td>Carcinoma</td>
<td>5</td>
<td>13</td>
</tr>
</tbody>
</table>

- Outlet bleeding
  - PPV for left sided cancer = 34%
  - PPV for right sided cancer = 0.9%

*Church JM. 1991, Dis Colon Rectum*
High Risk Asymptomatic

- **Age**
  - > 45 years
- **Associated Disease**
  - Inflammatory Bowel
  - Polyposis
- **Past History**
  - Colorectal cancer, adenomatous polyps
  - Female reproductive / breast cancer
- **Family History**
  - Polyps / Colorectal cancer
  - **Colonoscopy interval dictated by condition**
Lifetime Risk
Colorectal Cancer

- General population 1 in 50
- General population > 50yrs 1 in 25
- One 1º relative > 45yrs 1 in 17
- One 1º and one 2º relative 1 in 12
- One 1º relative < 45yrs 1 in 10
- Two 1º relatives 1 in 6
- More than two 1º relatives 1 in 3
Screening

F.O.B
Flexible Sigmoidoscopy
Virtual Colonscopy
CT Colography
Colonoscopy

- Perforation rates: 1 in 5000
- Caecal intubation rate > 90%
- Missed polyps
Imaging efficiency
CT colonography - Safety

• No deaths

• NEJM 2007
## SIGGAR data
>5000 patients overall

<table>
<thead>
<tr>
<th></th>
<th>CTC</th>
<th>versus</th>
<th>C’S SCPY</th>
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<tbody>
<tr>
<td>Inadequate</td>
<td>4%</td>
<td></td>
<td>7%</td>
</tr>
<tr>
<td>Cancer/LP (ns)</td>
<td>10%</td>
<td></td>
<td>11%</td>
</tr>
<tr>
<td>Cancers missed</td>
<td>0</td>
<td></td>
<td>0</td>
</tr>
</tbody>
</table>
Low risk - Screening
FOB - Nottingham

- Randomised clinical trial
  - 152,850 participants
  - Compliance - 53%
- Disease stage (screened vs control)
  - Stage A: 20% vs 11%, \( p<0.001 \)
  - Stage C,D: 46% vs 52%, \( p<0.01 \)
- Mortality
  - Disease specific - 40% vs 49%, \( p<0.05 \)

*Hardcastle J. - Lancet, 1996*
Screening – present / future

- USA – Colonoscopy at 50 – ↓cancer
- UK
  - NHS FOB 60-69
  - If positive – colonoscopy
- Polyps begin in low risk at 35-40
- Screening ALL at 40-45 eradicate cancer
85 F - Professor

- Rectal bleeding
- Family History
- Symptoms prolapse
- Previous failed colonoscopy - Pain
Virtual colonoscopy

- Right colon polyps
- Attempt at colonoscopy – Expert
  - Withdrew Consent
PLAN

• Delormes Procedure

• On table Colonoscopy GA

  – Poor Prep right colon not seen ........ one polyp removed transverse colon – low grade dysplasia
Rectal Prolapse

Delorme
What role for endoscopy?
Outpatient Treatments

- Sclerotherapy
- Infrared coagulation
- Rubber band ligation
- Cryotherapy
Traditional excisional surgery

Minimally invasive surgery

Stapled anopexy (PPH)

Transanal Haemorrhoidal Dearterialisation
THD / HALO

Trend to minimally invasive surgery

MORE INVASIVE

LESS INVASIVE
Technique

http://www.bbc.co.uk/news/health-10808311
Personal Outcomes

- 10 months >150 cases
- Daycase 80%
- Normal activity Day 4 > 50%
- Complication Nil
- Recurrence 2.5%
• Tender lump anal verge
• Evacuation (LA)
Simple, low

Complex ? High Crohn’s
Complex - setons
New techniques – Fistula plug

Fibrin Glue
> 3/12

- Feature of chronicity
  - Fibrosis of edges
  - Visible IAS
  - Sentinel Tag

Chronic Anal Fissure
Manual Anal Dilatation

The consensus

- Incontinence reported 0-50%
- Uncontrolled disruption of sphincters
Normal anal sphincter
Anal stretch
Sphincter Fragmentation
Modern Practice in UK
Lateral sphincterotomy
Modern Approach

- Women
  - Cream
  - Botox
  - ? LAS
- Men
  - Cream → Botox
  - LAS
<table>
<thead>
<tr>
<th>Tailored Treatment</th>
<th>Healing %</th>
<th>Incontinence %</th>
</tr>
</thead>
<tbody>
<tr>
<td>GTN 0.2% (^{(1)})</td>
<td>50-70</td>
<td>≈ 0</td>
</tr>
<tr>
<td>Diltiazem 2% (^{(2)})</td>
<td>65-70</td>
<td>≈ 0</td>
</tr>
<tr>
<td>Botox</td>
<td>70 – 90</td>
<td>&lt; 1</td>
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<tr>
<td>Internal sphincterotomy</td>
<td>93-100</td>
<td>0-37</td>
</tr>
</tbody>
</table>

\(^{(1)}\) Carapeti et al Gut 2000
\(^{(2)}\) Carapeti et al DCR 2000
PILOMIDAL SINUS
Primary closure Failure

One week after the op. There's virtually no visible progress, except for the pinky red granulation tissue around the wound.  
http://pilonidal.totopic.net  14 May 2003 08:22
Limberg Flap
Limberg Result

Two weeks: R/O sutures

3 – 4 weeks

6 weeks
PRURITIS ANI

- Itching
- Burning
- Pain

• Primary pruritis with no obvious cause usually reflects faecal soiling irritating the perianal skin
ANAL WARTS
(condylomata acuminata)

- HPV
- STD
- Topical podophyllin.
- Laser excision
- Cryotherapy.
- Surgery
- AIN - Histology
Q and A