Colon, Rectum and Anus

Medical Student Lecture

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34 y.o. female

- Several year h/o constipation, on chronic laxatives. Getting worse.
- Physical exam: flat, soft abdomen, normal bowel sounds, non-tender.
- Serum studies: unremarkable
- Standard abdominal x-rays and CT-scan unremarkable
- Anything else that you want to obtain on this patient?
Constipation

Surgeon’s Perspective

- Rule out obvious “anorectal” causes of constipation that can be found on initial exam
  - Perform DRE, anoscopy +/- rigid sigmoidoscopy
  - Look for severe hemorrhoids, perianal abscess, etc.

- Rule out mechanical obstruction
  - Causes: malignancy, volvulus, rectocele, etc.
  - Studies: plain films, CT scan, gastrograffin enema, ** colonoscopy
Example of mechanical obstruction
What is this?
What do you do for this?
Constipation

Surgeon’s Perspective

- Now we’re dealing with the more “chronic type”
- Rule out pelvic floor dysfunction
  - Why is this important??
  - Approximately 2/3 of patients with chronic disease
- Tests
  - Colonic transit marker study
  - Defecography
  - Anorectal manometry
  - Anorectal electromyography
- Treatment
  - Nonsurgical
    - Biofeedback, meds, etc.
  - Surgical: rare
Constipation

Surgeon’s Perspective

“Surgical Chronic Constipation”

- Idiopathic Constipation
  - Need documented delayed transit time
  - Failed non-surgical therapy ($\Delta$ diet, exercise, laxatives, enemas)
- Surgery
  - Total colectomy + ileoproctostomy
    - NOT subtotal (doesn’t work)
  - Very effective
Constipation

Surgeon’s Perspective

“Surgical Chronic Constipation”

- Oglive’s Syndrome (a.k.a. “Intestinal Pseudo-obstruction”)
  - Etiology unknown
  - Older patient with multiple medical problems
  - Diffusely dilated colon & NO mechanical obstruction
- Treatment algorithm
  - Colonic Decompression via colonoscopy
  - Medication: neostigmine
  - Only potential surgical issue:
    - dilated cecum +/- perforation
73 y.o. male

- Demented, multiple medical problems, recently admitted, s/p colonoscopic decompression for Oglive’s syndrome and discharged 24 hours ago
- Now presents to the ER with fevers, tachypneic, tachycardic, labile blood pressure, abdominal pain, distended abdomen, peritoneal signs, What do you want to do next for this patient?
55 y.o. female

- Otherwise healthy.
- Slow onset of worsening fatigue. Complete review of systems otherwise negative.
- Primary care physician noted anemia on serum studies and occult blood on DRE.
- Her vitals and physical examination are completely normal.
- She’s in surgery clinic. She’s not sure why she’s there. Can you help her out?
55 y.o. female

- Colonoscopy shows a 3 cm in length 50% circumferential mucosal lesion in the ascending colon.
- Bx’s show dysplastic cells among adenomatous tissue, but no definitive malignancy.
- What next?
  - CEA level
  - CT scan +/- PET scan
Surgery for Colorectal Cancer

- Segmental resection with reanastomosis
  - May not be possible for very low rectal cancers
  - Can be done laparoscopically
    - Safe
    - Oncologically sound
      - *En-bloc* resection of adjacent tissue/organs if necessary
- Role for metastasectomy
  - Liver, lung, etc.
  - Must remove all evidence of metastatic disease
  - 30 – 40% 5-year survival
Colorectal Cancer

- **Adjuvant chemotherapy for colorectal cancer**
  - All stage III patients (lymph node involvement)
  - “High risk” stage II patients with colon cancer
    - e.g., T4 disease
  - All stage II patients with rectal cancer

- **Neoadjuvant chemoradiation for rectal cancer**
  - **Purpose**
    - Downsize tumor to potentially save anal sphincter
    - Downsize tumor to obtain negative radial margins
  - **Who gets it**
    - On endoscopic transrectal ultrasound (mandatory)
      - T3+ tumor
      - Nodal disease (biopsy proven)
45 y.o. male

- Very healthy, active, no medical problems, no medications, presents with 2 day history of severe left lower quadrant pain and fevers.
- Abdominal exam reveals localized LLQ tenderness, peritoneal signs, non-distended, hypoactive bowel sounds.
- Serum studies are remarkable only for an elevated WBC
- Any other investigational studies?
45 y.o. male
Diagnosis?
What next?
Diverticulitis

- When do you operate?
  - Recurrent disease in older patients
  - 1st episode in young patients (<50)
    - Very controversial
  - Complicated disease
    - Abscess
      - First drain it percutaneously
    - Fistula
    - Perforation
      - Controversy regarding type of operation
        (anastomosis versus no anastomosis)
Diverticulitis
Perforation

Hinchey Classification

- Stage 1: Pericolic or mesenteric abscess
- Stage 2: Pelvic or retroperitoneal abscess
- Stage 3: Purulent peritonitis
- Stage 4: Fecal peritonitis
19 y.o. Female with Ulcerative Colitis

- Refractory (frequent exacerbations) to medical therapy; sent to you by a gastroenterologist because patient is considering surgery. Her disease is currently in remission.

- What is the preferred *elective* operation for this patient?
How do you treat anal cancer?