Colon and Rectal Surgery

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• Overview of CRS services at PPMC
• Anorectal Pain/Bleeding
• Surgery for Diverticular Disease
• Guidelines for Colorectal Cancer Screening
CRS Services at PPMC

• Benign anorectal disease
  – Hemorrhoids
  – Fissure
  – Abscess/fistula
  – Pruritis ani/anal itching
  – HPV/anal condyloma
  – Fecal incontinence
  – Pre-malignant skin conditions – Bowen’s/Paget’s
CRS Services at PPMC

• Benign colorectal disease
  – Diverticular disease
    • Laparoscopy
  – Inflammatory Bowel Disease
    • Ulcerative Colitis
    • Crohn’s Disease
  – Management of Stomas & Complications
  – Volvulus
  – Rectal prolapse
CRS Services at PPMC

- Malignant disease
  - Anal cancer
  - Colon cancer
  - Rectal cancer
- Most surgery is performed with laparoscopy/robotics
CRS Services at PPMC

• Colonoscopy
  – Screening
  – Diagnostic
  – Surveillance
Strengths of CRS at PPMC

- High volume of complex IBD and cancer
- Advanced laparoscopy
- Robotic surgery for pelvic procedures
- Treatment/surveillance of anal HPV
Anal Pain/Bleeding

- External Hemorrhoids
  - Itching, irritation, difficulty with hygiene
    - Symptomatic treatment
    - Topical anti-inflammatory agents
  - Thrombosis
    - Acute (1-2 days) – local excision, not clot evacuation
    - Beyond 1-2 days – reassurance, topical anti-inflammatory agents, analgesics, stool softeners
Anal Pain/Bleeding

• Internal hemorrhoids
  – Painless bleeding/prolapse
    • Increased fiber/fluid intake, topical anti-inflammatory agents
    • Elastic band ligation (EBL) – office procedure
      – Hold anti-platelet agents 1 week prior, Coumadin 5 days prior
    • Excisional hemorrhoidectomy
      – Significant post-operative pain – up to 3-4 weeks
Anal Pain/Bleeding

• Anal fissure
  – Sharp, stabbing, “knife-like” pain during defecation, following by dull aching/throbbing pain for hours afterward
    • Fiber/fluid-soaks/topical anti-inflammatory agents
    • Topical nitrates/calcium channel blockers
    • Lateral internal anal sphincterotomy
Anal Pain/Bleeding

- Abscess/fistula
  - Pain, swelling, drainage, fever
  - Cryptoglandular vs. Crohn’s vs. HIV
  - Drainage +/- antibiotics
  - Staged management of fistula – seton drainage followed by definitive procedure
    - Preserve continence
    - Fistulotomy, advancement flap, LIFT
Elective Colectomy for Diverticular Disease

- Old guidelines:
  - Elective sigmoid colectomy for:
    - 2+ episodes of simple diverticulitis requiring hospitalization
      - Age < 50 at 1st attack, consider after 1 attack
    - 1 episode of complicated diverticulitis
      - Contained perforation
      - Abscess (>3-4 cm)
      - Colovesicle/colovaginal fistula
Elective Colectomy for Diverticular Disease

• 2014 ASCRS Practice Parameters:
  – Decision to recommend elective sigmoid colectomy after resolved uncomplicated diverticulitis should be individualized
    • Special situations - Immunocompromise, pre-transplant
  – Elective colectomy should typically be considered after recovery from an episode of complicated diverticulitis
  – Routine elective resection in young (< age 50) patients no longer recommended
Colorectal Cancer Screening

• Average risk patient >50 years old
  – FOBT, FIT, fecal DNA
  – Colonoscopy – every 10 years
  – Flex sig +/- DCBE – every 5 years
    • If + polyp(s) → colonoscopy
  – CT colonography ("virtual colonoscopy") – every 5 years
    • Any abnormal finding → colonoscopy
    • Polyps >10 mm – sensitivity 85-93%, specificity 97%
    • Polyps 6-9 mm – sensitivity 70-86%, specificity 86-93%
    • Flat polyps – sensitivity 65-80%
Colorectal Cancer Screening

• Family History of CRC
  – 1st Degree relative diagnosed age >60 – normal screening
  – 1st Degree relative diagnosed age <60 – 10 yrs before age at diagnosis
Colorectal Cancer Screening

- Personal history of polyps, average baseline risk
  - Small hyperplastic rectosigmoid polyps – 10 years
  - 1-2 small (<10 mm) tubular adenomas – 5-10 years
  - 3-10 small (<10 mm) tubular adenomas – 3 years
  - >10 small (<10 mm) tubular adenomas - < 3 years
  - 1+ large (>10 mm) tubular adenomas – 3 years
  - 1+ villous adenomas – 3 years
  - Adenoma with high grade dysplasia – 3 years
  - Sessile serrated adenomas (<10 mm) without dysplasia – 5 years
  - Sessile serrated polyp (>10 mm) or any size with dysplasia – 3 years
  - Serrated polyposis syndrome – 1 year
Colorectal Cancer Screening

- Average risk, < age 50, with symptoms
  - Change in bowel habits
  - Bleeding unexplained by hemorrhoids
  - Change in caliber of stool
  - Abdominal pain
  - Anemia
  - Unexplained weight loss
CRS at PPMC

• Appts within:
  – 1-2 weeks for non-urgent issues
  – 1 week for new cancer patients
  – 24-48 hours for urgent issues

• Call
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Questions

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