Ano-Rectal Surgery: Clinical Assessment and Risk Management

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ABSTRACT

Background:
The perianal, anal and rectal region lend themselves to early clinical diagnosis without the need to resort to complex investigative processes. With adverse events increasing in hospitals worldwide Risk Management has become a major part of Quality Assurance.

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Procedures

The history followed by inspection, palpation, rectal examination, proctoscopy and then sigmoidoscopy are sufficient to clinically diagnose most conditions.

If a full local examination is not performed a delay in diagnosis of conditions such as carcinoma of the anal canal and rectum may occur.

Inappropriate treatment of other conditions such as pruritus ani, warts, haemorrhoids, polyps, abscesses and fistulas may result.

Functional Unit of Continence

The anus, anal canal and rectum are a functional unit responsible for the maintenance of continence of faeces and flatus as well as the co-ordinated process of defecation. Theories such as the valvular mechanism of the anorectal angle have been postulated to explain the process. Basic factors responsible for the maintenance of continence are:

1. The anorectal angle - formed by the puborectalis muscle,
2. The internal sphincter,
3. The external sphincter.

This is all controlled by a reflex interaction and integration between:

a) The sensory receptors in the pelvis,

b) The smooth muscle internal sphincter supplied by the autonomic nervous system and,

c) The striated muscle of the external sphincter - supplied by the somatic fibres of the pudendal nerve. It is postulated at rest with the faeces in the rectum that the anorectal angle acts like a valve. As pressure increases the valve is accentuated, maintaining continence. However as the bulk increases further receptive relaxation of the internal sphincter occurs. There is a sampling of the faecal material by the sensitive epithelium of the anal canal resulting in the desire to defecate and the sensation of the need to pass flatus.

This is further controlled by the voluntary external sphincter muscle.

Defecation

With straining the anorectal angle is reduced and straightened, the internal and external sphincter muscles relax and defecation occurs.

Pathological

Continence may be interfered with as a result of localised or generalised disease or following trauma or surgery.

Histological Features

The perianal skin is stratified squamous epithelium with keratinisation. Just above the anal verge the skin, hair, sebaceous glands and sweat glands there is a transitional type of epithelium for a distance of approximately 1 cm - to the pectinate line.

Above the pectinate line the glands of Lieberkuhn's and goblet cell appear a muscularis mucosa and lamina propria are found.

The pectinate line (dentate line):

a) The pectinate line is formed at the site of the fusion of the embryonic proctodermal plate and post-allantoic gut embryologically.

b) The pectinate line is a land mark not only histologically but is also the site at which there are major practical significant changes as it is a junctional zone between:

1) The somatic sensory supply to the skin, modified skin and the autonomic supply to the mucosa above the pectinate line.

2) The junction between the haemorrhoidal arterial supply derived from the mesenteric artery and the lower pudendal artery supply from the iliac.

3) Systemic circulation below the dentaline and portal venous system above.

4) The lymphatic drainage below the dentaline is to the inguinal node above the dentaline to the pelvic lymph nodes - there is some overlap with this particularly in pathological states.

c) Anal glands open at the pectinate.

History and Examination

Symptoms indicate disease but a more detailed analysis then indicates the diagnosis:

1. Bleeding,
2. Pain,
3. Protruding or prolapsing lump,
4. Discharge - starting on the underwear or associated bowel action with pus and mucous,
5. An irritation,
6. Faecal incontinence,
7. Unsatisfied defecation,
8. Changes in bowel habit and urgency with either diarrhoea or constipation,
9. "Haemorrhoids" - often patients complain of "haemorrhoids".

The diagnosis of haemorrhoids cannot be taken at face value as patients often use this term for any anorectal problem.

All the above symptoms may be associated with disease:

a) In the anorectal region,

b) From a higher level in the bowel,

c) As a result of some generalised problem.

The history and examination are directed at differentiating these possible signs:

1. The type of bleeding is critical and needs further description; the blood may be dark or bright, mixed with the stool, on the paper or dripping in the bowl. The bleeding may be associated with pain or painless.

2. Blood mixed with the stool can suggest a cause of bleeding higher up in the bowel.

3. Bright red blood on the toilet paper suggests haemorrhoids.

4. Black stools may indicate bleeding from higher in the stomach.

5. A few drops of blood associated with severe pain on and after defecation could suggest a fissure.

6. The presence of pus or mucous might suggest an inflammatory condition.

7. A sexual history may be necessary to diagnose HIV or AIDS or gonococcal disease. Infected proctitis can occur in either. This needs to be differentiated from non-specific proctitis.

These inflammatory conditions can present with an abscess or fistula, an atypical fissure, which is of an opportunistic infection such as amoebiasis or cryptos porous.

The Examination

1. A general inspection. The general appearance of the patient may suggest a cause of bleeding and its severity. It may be signs of pallor with excessive bleeding due to anaemia or jaundice for example where there are liver problems. There may even be signs of cachexia.

2. The examination of the abdomen is carried out first to detect masses or other features such as an enlarged liver e.g. cirrhosis of the liver may be associated with portal hypertension and bleeding haemorrhoids.

3. The left lateral position may be used for the examination.

4. The rectal examination may be difficult in the apprehensive, sensitive, overweight patient with severe pain. An examination under anaesthesia is required in some circumstances:

a) The anal verge is inspected.

b) The anal skin has ridges which irradiate peripherally. The anal orifice is usually closed but a gaping sphincter may be present.

c) The surrounding area is examined.

d) There may be signs of ulceration, irritation, excoriation, swelling or the external opening of a sinus or fistula with a discharge. Skin tags are often present and may point to underlying haemorrhoids or fissures.
e) Scars from obstetric injuries or trauma or previous surgery can be important in the assessment - particularly of incontinence.
f) A protruding lump may be present. The commonest cause of this would be haemorrhoids.
g) Several different types of polyps may be present - particularly if the patient is asked to strain or they may be prolapsed down from the rectum by the examining finger on rectal examination.

1) A pedunculated fibro epithelial polyp,
2) A pedunculated tubular adenoma,
3) A sessile villous tumour,
4) A myeloma or other connected tissue tumour such as a lipoma,
5) Even a malignancy can be protruding.

There may be skin lesions such as, rarely, melanoma, but occasionally conditions such as squamous cell carcinoma in situ.

Haemorrhoids, polyps or a rectal prolapse may appear with straining.

Abnormal laxity or descent of the perineum may occur in disorders of the pelvic floor, which can be associated with incontinence.

The anal verge can then be gently parted to demonstrate any protruding lesion or the presence of an anal fissure. Parting the anal verge may be painful with an anal fissure and the sphincter can be seen to contract with the pain.

Rectal Examination
Rectal examination is part of the routine examination for any abdominal or rectal problem. The glove must be well lubricated first. An explanation is given regarding the examination and the patient reassured. Gentle pressure is applied over the anus and this tends to overcome spasm and resistance and allows the gloved finger into the anal canal without pain. The finger is introduced posteriorly along the anal canal and the tone of the sphincter is assessed. The walls of the anal canal are palpated. Four to five centimetres into the anal canal is the upper level of the surgical anal canal. The ridge of the anorectal ring can be palpated. The finger then enters the rectum.

The finger palpates the mucosa thoroughly and then two specific structures are sought:

a) Anterior - the prostate in males. The cervix and uterus in females,
b) Posteriorly - the hollow of the sacrum and,
c) Laterally - the lateral ligaments and pelvic lymph nodes,
d) The tip of the finger palpates the Pouch of Douglas looking for a mass - for example, secondary deposits or pelvic abscess.

Palpation of the mucosa may detect lesions such as:

1) Benign polyps - pedunculated tubular adenomas or sessile villous adenomas,
2) Malignant lesions such as carcinoma of the anus or rectum - ulcerated or nodular,
3) Anal papillae,
4) The internal opening of a fistula.

Haemorrhoids may be palpated as a soft cushion but are not readily palpable unless very large or thrombosed. If a painful condition such as an abscess or fissure is present, resistance to examination by the patient will be obvious and should not be pursued.

On withdrawal of the glove this is inspected for the presence of blood or mucous and the colour of the faecal material.

The rectal examination should be performed before any instrumentation

Proctoscopy and Sigmoidoscopy

Proctoscopy
The mucosa is visualised and this is particularly useful in the diagnosis of haemorrhoids. The haemorrhoids will bulge into the lumen of the proctoscope as it is withdrawn and the patient is straining.

Procedures such as injection of haemorrhoids or rubber band ligation can be performed through a proctoscope.

Sigmoidoscopy
Sigmoidoscopy can be performed in the left lateral position. It is usually a little uncomfortable particularly when the area is inflated but is usually readily tolerated. The area is inflated to allow visualisation of the mucosa or lumen or when attempting to negotiate the rectosigmoid junction which is at the level of 15 - 18 cms.

It may not be possible in about 50% of patients to pass the rectosigmoid junction which is at about 15 cms due to discomfort because of the angulation to the site.

Sigmoidoscopy shows mucosal changes - signs of inflammation, melanosis coli (patchy dark pigmentation) attributable to excessive use of laxatives, and lesions arising from the mucosa such as polyps or malignancies. These may be biopsied as necessary.

A high percentage of bowel tumours occur within reach of the sigmoidoscope. Sigmoidoscopy is one of the most cost effective ways of detecting the presence of any carcinoma. It should be used more frequently especially as bowel cancer is the second most common cancer in males and females.

Up to 50% of polyps and carcinomas of the colon are within reach of the sigmoidoscope.

Further investigation of the region may include flexible sigmoidoscopy, sigmoidoscopy and barium anaemia.

Management of Ano-rectal conditions

Some of the conditions may be treated with conservative or appropriate ointments or creams.

Many of the conditions can be treated in the office - such as haemorrhoids. Injection sclerotherapy and rubber band ligation are effective ways of treating haemorrhoids. Perianal haematomas may be incised or excised under Local Anaesthetic. A small perianal abscess can be drained. Skin tags can be removed.

Experienced Surgeons may treat the more complex conditions in the office. Anal fissures can be treated with sphincterotomy under Local Anaesthetic. A variety of degrees of haemorrhoids may be excised under Local Anaesthetic in the office as appropriate.

Even polyps may be pulled down and ligated.

The same techniques can be used in hospital with the addition of light sedation. Many cases can be treated as a day case.

Thus after a comprehensive examination of the history and examination which includes the abdomen, inspection of the perianal region, palpation of the perianal region, rectal examination, proctoscopy and sigmoidoscopy, a plan of action can be carried out.

This may involve further investigative procedures or surgery in hospital. However in many cases a definitive diagnosis can be made and a treatment carried out at that time or arranged for the near future.

Other serious problems must not be overlooked and must be taken into account before instituting a plan of action.

It must be remembered when treating the anorectal region that patients are apprehensive, may fear the presence of a possible cancer and may find the examination embarrassing and uncomfortable. This needs to be assessed thoroughly before attempting any procedures. There must be some explanation of the possibility of pain in the post-operative period.

Of course it is part of a risk management plan. The advantages and disadvantages of having a procedure are discussed and the alternative methods of treatment available also discussed.

The option may be to do nothing or to wait and see. A further review may be judicious.

It is however helpful to have literature available for the patient to read which will explain their condition in detail.

Rectal Prolapse

Normally, the rectum is securely attached to the pelvis with the help of ligaments and muscles. This attachment firmly holds the rectum in place.

Various factors, such as age, long-term constipation, and the stress of childbirth, may cause these ligaments and muscles to weaken, which means that the rectum's attachment to the body also weakens. This causes the rectum to prolapse, meaning it slips or falls out of place.

In the early stages of rectal prolapse, the rectum becomes poorly attached but stays within the body most of the time. This stage of rectal prolapse is called mucosal prolapse, or partial prolapse, meaning that only the inner lining of the rectum (rectal mucosa) protrudes from the anus.

As the rectum becomes more prolapsed, the ligaments and muscles may weaken to the point that a large portion of the rectum protrudes from the body through the anus. This stage is called complete prolapse, or full-thickness rectal prolapse, and is the most commonly recognized stage of the condition.

Rectal prolapse is an uncommon disease and primarily affects elderly people. In people older than 65 years, the prevalence is 1%.

Surgical Treatment

Various operations have been used to treat this disease. The choice of operation is tailored to suit the patient and their comorbidities.

Younger patients who have rectal prolapse without major medical problems, may be offered an abdominal rectopexy. This involves an abdominal incision and rectal dissection with suture fixation of the rectum to the vertebra. The bowel is not resected.

A resection rectopexy removes the sigmoid colon and joins the bowel together (anastomosis).

For more frail elderly patients a Delorme's operation is offered. This is a mucosal sleeve resection that is performed trans anally. The lining of the bowel is resected and the muscle wall is bunched up with sutures and placed above the muscle sphincters.

The risk of recurrent rectal prolapse is higher in Delorme's operation compared to resection rectopexy, but the Delormes operation has lower risks for patients with medical comorbidities.

n the clinical assessment of the ano-rectal region the following general principles of history, examination and patient management need to be applied.

History

For every clinical case a thorough history is taken. There are particular questions that should be asked.

First presentation

"*Why has the patient attended the Doctor*?"

- How did the lesion occur?
- When did it happen or when was it first noticed?

- What were the associated circumstances?

- What changes have occurred, for example: in size, shape, colour, discharge and when did the changes occur?

- Has there been any pain or discomfort?

- What are the features of the discomfort or pain?

- Has there been any change in the quality or the intensity of the pain or discomfort? When did this happen?

- Has there been any associated features such as fever, loss of weight, swelling, lymph gland enlargement or jaundice?

Present situation

"What is happening now?"

- When, where, how and why did the condition develop?

- What are the associated features of other symptoms, which can aid in diagnosis of the lesion?

- Are there any family or other contacts who have a similar problem?

The General History of the Patient

General Assessment

Are there any factors which may affect (positively or negatively) The presenting complaint, its treatment or the patient's recovery?

"What are present effects of past activities?"

"What are present effects of his/her present lifestyle?"

Are there any factors in the past or present social, economic, educational, religious, occupational, family history, or involvement with sporting clubs or to her social networks or people in the patient's life, which may affect (positively or negatively) the cause, treatment or outcome of the presenting problem?

"What predictions are present which will influence future management and health of the patient?"

Are there any factors in the past medical (including surgical and anaesthetic) history, socio-economic or belief systems of the patient which may influence the intended therapy? Is the intended treatment the most appropriate in the circumstances?

The Ethical Issues

What does the patient want, understand and expect?

Is the intended treatment necessary and affordable by the patient or patient's family; is it best performed by the attending doctor at this or a later time?

What is the best, and the most appropriate surgical procedure and method or anaesthesia for this patient at this time by his surgeon, in these circumstances?

What can be done? What should be done? And who should do it? Where should it be done? And who else should be present, if anyone? Can or should the treatment be delayed or deferred?

Will the optimal result be achieved (immediately or later) by not doing anything, or by undertaking a definitive procedure?

Written or verbal, consent must be given by the patient to the doctor, before any procedure is performed.

Aspects of Every Problem

A definitive or provisional diagnosis decision should be made in every case. Systematic methods of analysis are then applied to each aspect of every case presenting

Anatomical

Including histological, surgical and imaging techniques where indicated.

Functional

Including genetic or chromosomal abnormalities. Including normal and pathological physiology, biochemical, function and predicted response to the surgical intervention itself, as well as to the anaesthetic drugs and processes used.

Psychological

Including normal responses to illness and recovery, psychological reactions to health and disease, in those with emotional or psychiatric disorders.

Social

Including family history of abnormal healing or unusual drug responses. Also including the socio-cultural expression of illness in the patient's particular tribal or racial group, in the patient's socio-economic status, past and present, expected or real, occupational, sport, recreational and artistic activities, ethnicity, nationality and background of the family etc., educational level aspired to, reached or expected, refugee status if any, diet and food requirements, and what can be afforded, obtained and understood.

Spiritual

Spiritual or belief structures of the society, the patient and the doctor, will influence the presentation, the illness, the treatment and the recovery, probably more than any other single factor.

All these factors constantly influence each of the others.

Each of these factors varies in importance and effect from patient to patient, from day to day, and sometimes from minute to minute.

The following are related to specific areas of ano-rectal conditions:

Colorectal Cancer

All adult patients should be screened regularly for colorectal cancer.

The GP needs to be able to recognise the wide variation in clinical presentations.

Any patient over age 40 with even minimal rectal bleeding, should be considered for colonoscopy. High risk symptoms are:

Bleeding which is not bright in colour

Change in bowel habits

Unexplained weight loss

Abdominal pain

Mucous discharge

The technique of history taking, combined with the art and skill involved in the physical examination, still remains the basis of diagnosis, despite continuing advances in medical technology.

The diagnostic process requires correlation and interpretation of the patient's history, symptoms and signs. The skill arises in placing all these factors in a proper perspective.

After arriving at a provisional clinical diagnosis, a decision is then made regarding the need for further investigation or for surgical intervention.

Many factors must be taken into account before deciding to operate. The most important of these is to have arrived at a precise clinical diagnosis.

This is becoming increasingly important in terms of medical economics, hospital priorities, patient convenience and safety.

Topics which form the basis of all surgery:

1. Clinical diagnosis

2. Method of anaesthesia, analgesia and pain control; and

3. Surgical technique and postoperative care.

Surgery should only be undertaken by those who have had appropriate training and whose skills have been developed under the supervision of acknowledged teachers and experts in each field, as well as by practice under supervision.

Any surgical condition requires a thorough preoperative and postoperative assessment in addition to evaluation of progress during the operation.

The reasons for the decision to operate, the result expected by the patient, the family and by the treating doctors, depend on thorough assessment and detailed explanation.

A method is presented which in most cases allows for such evaluation.

It involves:

1. The history of the presenting problem;

2. A general history of the patient

3. An analysis of factors which may affect the problem; and

4. The clinical examination

Risk Assessment

Risk Area - Adverse event management

Risk - Reoccurring adverse events may be undetected resulting in unexpected adverse patient outcomes

Quality Assurance Self Assessment

- Adverse events (including sentinel events and 'near misses') occurring within the practice are documented in a designated register or database.

- Remedial action/changes to practices can be demonstrated where appropriate as a result of reviewing adverse events.

- Changes made with the intention to prevent adverse event occurence are communicated with colleagues in order to ensure a similar event does not occur elsewhere (e.g. publication in College newsletter with de-identification of practice/patient particulars).

- Risk Area - Clinical audit

- Risk - Variations in clinical practice resulting in adverse patient outcomes

- Quality Assurance Self Assessment

There is regular participation in clinical audit/peer review.

The audit covers:

- Patient diagnosis/condition
- Legibility
- Practitioner sign off

The audit:

- reviews specific cases, e.g. unexpected patient death, unexpected development of infection, etc.

- includes a multidisciplinary patient record review. i.e case is discussed in a multidisciplinary setting.

- involves review of clinical incidents reported within the practice.

Risk Area - Continuing education and training

Risk - Insufficient skills or knowledge to ensure best practice medicine is practised

Haemorrhoids

The risk management here is to:

a) Establish a diagnosis,

b) Recommend treatment.

Not all haemorrhoids require surgical intervention and alternative treatments for each problem should be offered.

It should be remembered for any anal procedure that the postoperative recovery can be very painful particularly if a complication occurs. Thus the patient needs to be adequately warned about the possibility of pain and the possibility of fainting with pain or due to psychological responses.

The patient often comes for reassurance that they have not got a cancer. If cancer cannot be completely ruled out as a local cause of the problem then further examination with sigmoidoscopy and colonoscopy will be required.

For haemorrhoids, the treatment may consist of diet alone and review may be required. Other alternative treatments are local applications, which may sting, injection sclerotherapy, rubber band ligation and surgical intervention.

Haemorrhoids may be treated with injection or rubber band ligation but it should be remembered that either technique can be painful and complications such as infection or bleeding may occur - in particular secondary haemorrhage eight to ten days later or even reactionary haemorrhage within 24 - 48 hours of the procedure.

There needs to be adequate explanation for the procedure. If an office procedure is to be carried out the patient needs to be fully informed about the extent of the procedure and the aftercare. In particular risks of fainting and causing damage to oneself. The appropriate supervision afterwards is required.

Rectal prolapse

It should be explained to patients and relatives particularly with elderly frail patients that surgery is not always successful because:

a) it may fail to correct the problem permanently

b) it may not alleviate some of the symptoms such as excessive constipation or diarrhoea

The pros and cons need to be evaluated with the patient and relatives prior to surgery. How disabling is the problem to the patient and carers. The precise risks of each specific operation should be explained including the risks of any surgery or anaesthesia.

Anal fissure

Anal fissure can be a persistent problem or an acute problem, which resolves. This needs to be considered in the treatment.

There are a variety of local treatments available, which do not involve cutting the sphincters - sphincterotomy. These include use of local application and injections. There is a debate as to how effective these are but patients may prefer to try these such as Botulinum toxin injections. Anal stretch has been widely discredited.

The surgical treatment is usually a subcutaneous lateral sphincterotomy with or without excision of tag and the fissure itself. The patient should be warned that the operation does not actually remove the fissure but allows it to heal up or removes the pain. The fissure in itself may not always heal but the pain should be relieved.

The risk of incontinence should be discussed but it is rarely a factor in experienced hands.

The procedure can be done in the office in the appropriate setting but it can also be carried out under Local Anaesthetic with light sedation as a day case.

Possible risks of the procedure are excessive bleeding, infection or development of a fistula, but the incidence of complications is low.

One of the other risks would be not cutting sufficient sphincter to relieve the spasm. The sphincter can be difficult to find if not experienced so care is taken in carrying out the procedure to ensure the correct muscle is divided.

Anal polyps

There are a variety of different types of polyps in the anorectal region. Some are benign and never become malignant, such as anal tags and hyperplastic polyps. There are others however, which have a high potential to become malignant. These may be a single or multiple polyps. There are the tubular adenoma type or the villous adenoma type. The tubular adenoma type often has a stalk whereas the villous adenoma type is flat and velvety.

The Risk Management here is that an incomplete rectal examination or failure to do a rectal examination can miss these potentially malignant conditions. Other aspects of the Risk Management are in the treatment of which there are a variety of techniques, which can be used.

The important thing with all of these of course is to remove a benign lesion completely and also to remove a malignant lesion completely. However it is important to recognise that there are risks in operating in this area even though it is below the puborectalis level such as perforation of the full thickness and developing infection. Bleeding is also one of the severe complications in this area.

Abscesses and Fistula

At the age of 80, particularly in females there is a high risk of developing faecal incontinence — to flatus and solid, when performing these procedures. A subcutaneous sphincterotomy can lead to incontinence if excessively plied. In a similar way fistulotomy has a high risk of developing anal incontinence in the aged. An increasingly popular method of treating these fistulas is to use a Seaton whereby the sphincter is only gradually divided over time and replaced by scar tissue. Many feel that this is less likely to cause incontinence. Thus one must be judicious when recommending sphincterotomy or fistulotomy in the aged. Other factors may play a part in the elderly such as patients who have neuromuscular discoordination.

Warts

Anal Warts, Perianal Warts, Low Anal Warts:

Often the area is infected multifocally. Thus obliteration of one set of warts may still not eradicate the rest.

There are a variety of treatments, which include use of Podophyllin paint as an application, liquid Nitrogen and freezing. Other techniques are diathermy and surgical excision.

Some procedures can be carried out in the office whilst others require Anaesthesia and inpatient or Day Surgery treatment.

Sometimes further investigation is required for example HIV status etc. Anal warts may be associated with other perianal conditions such as haemorrhoids because of their frequency.

Pilonidal sinus

Pilonidal disease may present in two main ways. There is the acute abscess or the discharging sinus.

With the abscess in the early stage there is swelling and discomfort and this is followed by increasing pain, swelling and erythema until eventually an abscess presents and may even spontaneously discharge. Following this a sinus may persist particularly when there are underlying hair follicles deep in the natal cleft. Multiple sinuses may occur.

Thus the abscess is dealt with by drainage. Once the abscess has formed it does not respond to antibiotics. Local applications are not effective.

With the discharging sinus it may be blood and pus and acute exacerbations. The treatment is complete excision. The wound is treated either with primary closure in the less infected cases, or by healing under second intention where the wound is allowed to heal.

It is important in treating these patients to explain the process, which is going to occur — the risk of further infection with primary closure, and severe pain, which might occur as a result or the long time that the healing process takes when attempting to close by second intention.

The other risk with pilonidal sinus is the type of Anaesthesia. Many Surgeons have the patient placed in the prone position, which increases the Anaesthetic risk. Positioning can be important.

Anal tags SCC

Anal tags may signify internal disease such as a fissure.

Patients often have difficulty cleaning their anal area and may present with discomfort, itch, a bad odour and a mucous discharge.

They will consequently be embarrassed to present and discuss their condition

Pruritis ani may be an associated condition.

Treatment

Treatment can be symptomatic e.g. with use of creams.

Treatment can be carried out under local anaesthesia, in the office. It may require suturing.

There may be some swelling after surgery as the perianal region expands and contracts.

Colorectal Cancer Guidelines

2015 Colorectal Cancer Guidelines have been made available from the MEJIM November 2018 menu or visit:

www.me-jim.com/November2018/colorectal_cancer_guidelines_short_form.pdf

Summary of Contents:

EVIDENCE-BASED RECOMMENDATION GRADES

- Primary prevention
- Dietary and lifestyle strategies
- The use of aspirin for prevention of colorectal cancer
- Population screening for colorectal cancer (with Evidence Based Recommendations)
- Signs & symptoms predictive of colorectal cancer
- Optimal maximum time from referral to diagnosis and treatment (diagnostic interval)
- Strength of association between family history and colorectal cancer risk
- High-risk familial syndromes
- Familial adenomatous polyposis (FAP)
- MUTYH-associated Polyposis
- Lynch syndrome
- Juvenile polyposis syndrome
- Serrated polyposis syndrome

- Imaging a patient with a diagnosis of colon/rectal adenocarcinoma
- Pathology and staging
- Preparation for surgery and peri-operative optimisation
- Elective and emergency surgery for colon and rectal cancer
- Neoadjuvant and adjuvant therapy for rectal cancer
- Recommendations – Management of resectable locally recurrent disease and metastatic disease
- Management of resectable locally recurrent disease and metastatic disease
- Recommendations – Management of non-resectable locally recurrent disease and metastatic disease
- Management of non-resectable locally recurrent disease and metastatic disease
- Recommendations – The role of systemic therapies in non-resectable metastatic disease
- The role of systemic therapies in non-resectable metastatic disease