Colorectal cases

Dr Sze-Lin PENG

FRACS, FCSSANZ

Middlemore Hospital Auckland Colorectal Centre

Greenlane Medical Specialists Allevia Hospital (Mercy)

Aims of session

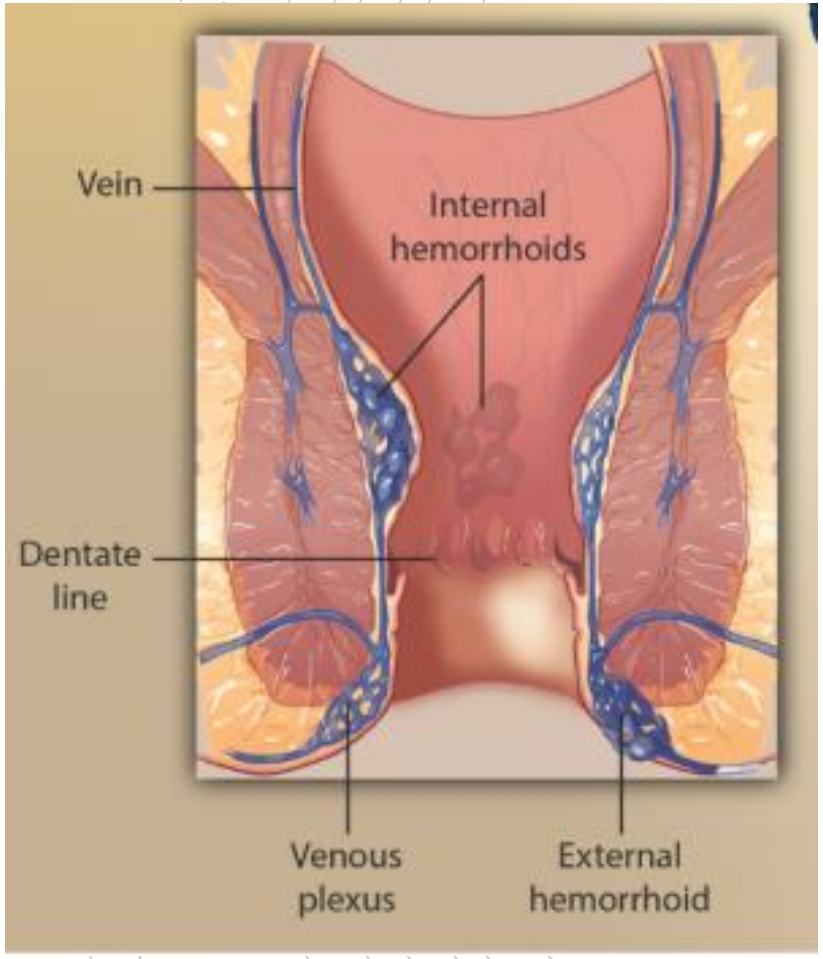
- Recognise skin vs mucosa
- Recognise haemorrhoid vs anal fissure phenotype
- Recognise which patients may benefit from banding
- Understand principles of banding
- Consider what is the risk and features of early onset bowel cancer (<50yrs)
- Reminder regarding medical management of anal fissure

Case 1

- 35 yr old man
- Fresh PR bleeding
- Painless
- Had bands a few years ago but it didn't work - reports bands fell out early
- No previous colonoscopy
- No FH
- Bloods normal

- What is shown on the photo? - haemorrhoid or fissure phenotype?
- Any protruding mucosa?
- Tolerated a PR – no masses
- Proctoscopy – grade 2 haemorrhoids, nothing else prolapses out
- What are the options? – surgery? Banding? Injection? Laser?
- What is his risk of cancer?

Banding



- For internal haemorrhoids / minor mucosal prolapse only – rarely any external effect
- **Does not work for external disease**
- Silicon bands are place well above the dentate line
- Often at the most superior part of the haemorrhoid
- A 29-31mm proctoscope is required for best views and to insert the banding equipment
- Some patients need sedation or even a GA
- 2 main complications: - severe tenesmus (sometimes with urinary retention!) and delayed bleeding at 1-2 weeks
  - Why does that happen?
  - Is it predictable?
  - Should anticoagulation be stopped for banding?

Why does that happen?

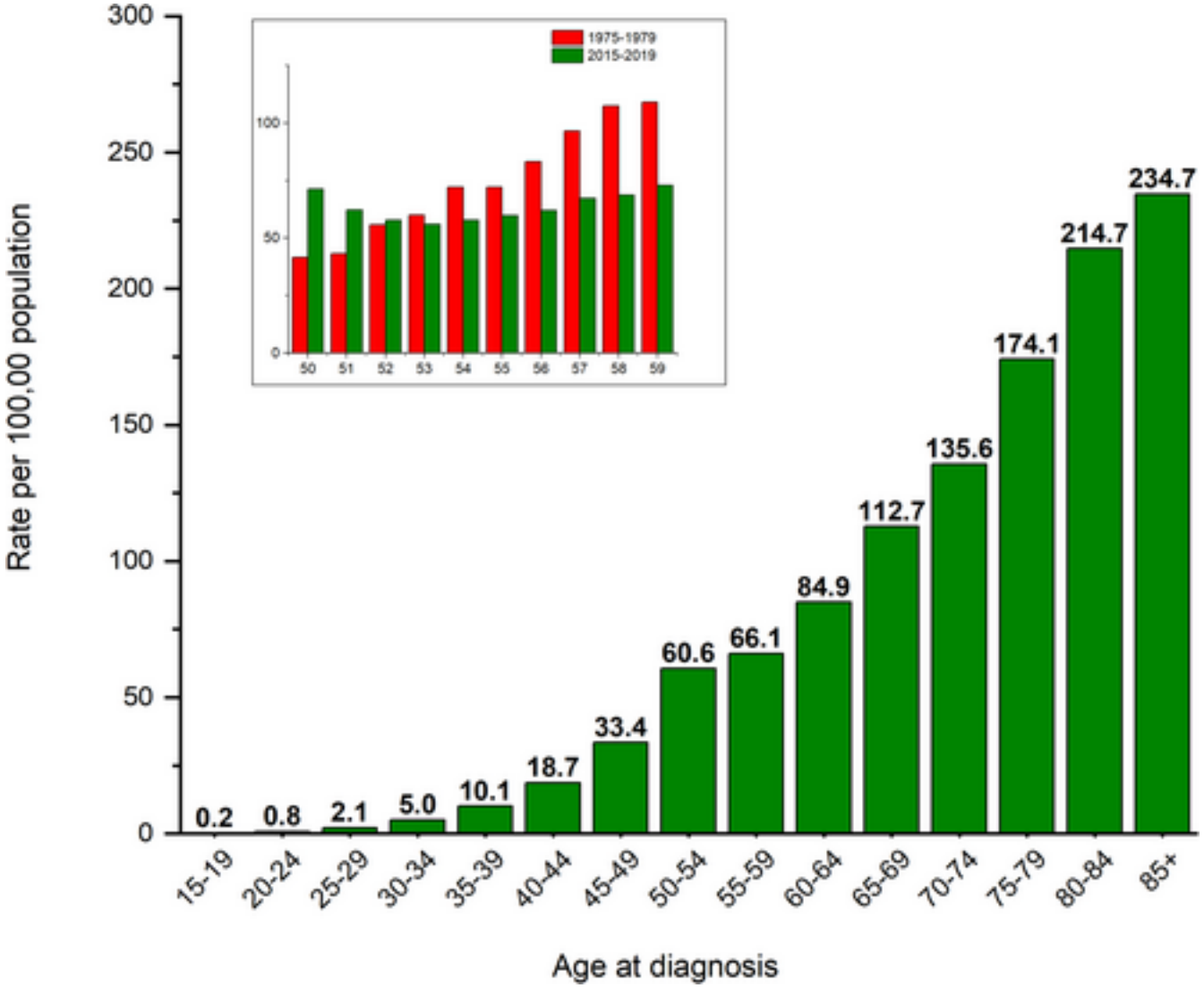
Tenesmus – muscular/ tense patients esp male, ? Too many bands,? Too much suction pressure

Delayed bleeding – granulation tissue occurs for all excisional procedures at 10-14 days

Is it predictable? – clinical!

Should anticoagulation be stopped for banding? – discuss with haematology/ cardiology but consider from day of band since bleeding is delayed

Early onset bowel cancer <50years



Features of early onset bowel cancer

- 10% of all colorectal cancers diagnosed
- <10% hereditary
- ¾ are left sided cancers
- Of which 40-50% are rectal
- No one symptom with good predictive value but common combination = change in bowel habit (hardly ever constipation) + bleeding

So what can we do to ensure case 1 does not have bowel cancer

- PR + lifestyle advice (take a good history?)
- Rigid sigmoidoscopy
- Treat haemorrhoids
- REASSESS 2-3 months
- Escalate to colonoscopy/ flexible sigmoidoscopy
- Fecal calprotectin
  - Rule out IBD
  - Mildly elevated associated with cancer/ significant polyp

Case 2

- 35 yo woman
- Issues with painful swollen anus since childbirth 8months ago, every bowel motion leads to perianal swelling
- Constipation
- Fresh PR bleeds on tissue paper only
- No family history

- Are the lumps' surface covered by skin or mucosa?
- Is banding possible?
- Are these reducible?

- Are the lumps' surface covered by skin or mucosa?
- Is banding possible? – yes, but wouldn't help the external skin issues, also the patient is bothered by swelling rather than bleeding
- Are these reducible? – if yes – may be a discussion between haemorrhoidal ligation vs excision
  - If no – excision only
  - Excision is the gold standard – pain ++ for the 1st 1-2 weeks but least chance of recurrence
  - All other techniques – laser, ligation = short term less pain but long term more recurrence

Case 2

- 29 yr old woman with painful defecation, feels like paper cut
- Tissue paper bleeding mostly
- Told has IBS – diarrhoea mostly
- Also has ‘haemorrhoids for years’
- Now less bleeding but has itch, bottom feels a bit sweaty

- Fissure or haemorrhoid phenotype?
- What are the 2 lumps covered by? – skin or mucosa
- Where is/ was the fissures in this photo?

- Fissure or haemorrhoid phenotype?
  - fissure
- What are the 2 lumps covered by? – skin or mucosa
  - Skin – classic midline skin tags ie sentinel tags associated w fissures
- Where is/ was the fissures in this photo?
  - Anterior and posterior midline but the posterior midline one is complicated by a superficial fistula

Treatment for case 2

- Told does not have haemorrhoids – skin tags
- IBS – bloods, calprotectin → refer to gastro if needed
- RECTOGESIC/ topical diltiazem asap – we don't see patients who have < 4 weeks symptoms anymore as waitlist to see ANY doctor is very long
- REASSESS – symptoms gone with topicals, normal calprotectin → reassure, if skin tags don't have a skinny stalk/ < 1.5cm – avoid surgery. Anal cosmesis not guaranteed. Risk the fissure is reactivated, BIGGER skin tags post excision.
  - Persisent issue → refer

- Fissure or haemorrhoid phenotype?
- Is the external opening close to the anal verge?
- Where is the fissure in this photo?
- Infected fissure? – what sequelae?
  - Fistula – likely superficial – NOT cryptoglandular type so can usually lay open/ fistulotomy

Case 3

- 75 yr woman
- Fecal incontinence – but actually mucous, blood on underwear
- Hard to keep clean, using lots of tissues
- Had a normal colonoscopy a year ago

- Are the protruding lumps mucosal or skin?
- What are the pale areas on the lumps?

- Are the protruding lumps mucosal or skin?
  - Mucosal
- What are the pale areas on the lumps?
  - Fibroepithelisation associated with mucosal prolapse
- Treatment options
  - Banding?
  - Haemorrhoidectomy?
  - Is this a full thickness rectal prolapse?

Treatment for case 3

- Good sphincter tone
- Not full thickness rectal prolapse
- Given degree of prolapse and fibroepithelisation only excision likely to be definitive if fit for surgery
- Pelvic floor physiotherapy unlikely to help

Case 4

- 40 yr old man
- Painful perianal lump
- After a week, it ruptured and bled
- There was a dark spot/ head with bleeding
- So painful – wants ‘surgery’

- Lump covered by skin or mucosa?
- Perianal hematoma
  - Incise and drain in the 1st 48hrs – but once can palpate it/ no tension in the clot no difference to pain resolution
  - Always settle in 10-14 days – black head → reduced size → pea/rice sized
  - No role for prophylactic surgery
  - No role for banding as external issue
  - Rarely surgery
    - clot chronic - months
    - clot forms in same place
    - Ie see something excision can target that is not just a skin tag

Case 5

- 38 yr old woman
- PR bleeding fresh 1-2 TBSP , haemorrhoid pops out
- Bowel frequency – thinks its IBS, stress
- Some mucous, sometimes just blood and flatus
- Had banding in her 20s
- Considering another pregnancy next year

What are the concerns in the history?

What initial tests could be useful?

- What are lumps surface covered by - skin or mucosa?
  - What is the anorectal pathology?
  - Banding?
- A year later whilst pregnant – hb 90, calprotectin 3000
- Ulcerative colitis

- Point = sometimes the anus is just the symptom not the pathology