Quality of rectal cancer care in the United States is highly variable. Non-specialists in low-volume hospitals perform the vast majority of surgery for rectal cancer. Rates of permanent colostomy are frequently higher than expected. There is suboptimal adherence to evidence-based guidelines and an excessive rate of poor oncologic outcomes. Rectal cancer surgical outcomes in high-volume hospitals result in fewer permanent colostomies, shorter length of hospital stay, decreased surgical mortality, and better five year survival.\(^1\)

In 2011, an independent, geographically-diverse consortium of academic centers, community hospitals, private clinics, and medical societies came together to create the OSTRiCh (Optimizing Surgical Treatment of Rectal Cancer) Consortium with the mission to improve quality and uniformity of rectal cancer care in the United States. The Oregon Clinic and Providence Cancer Center were among the 14 founding institutions of the OSTRiCh Consortium, a number that now approaches 150 centers.

OSTRiCh proposes to create a Center of Excellence system based on the successful international models. The process includes mandatory skills education and verification for surgical technique, pathology assessment, and MRI protocol and reporting, as well as evaluation of multidisciplinary conferences and program administration. The American College of Surgeons Commission on Cancer will be soon implementing the OSTRiCh program in the United States.

Pelvic Floor Disorders: Physical Therapy or Surgery?

Colecrcal surgeons are an essential part of the multidisciplinary team that provides care for patients with pelvic floor problems, which may include chronic constipation, rectal prolapse, obstetric injury, pelvic floor dysfunction, or fecal incontinence. The Oregon Clinic’s Pelvic Health Collaborative includes urogynecologists, gynecologists, gastroenterologists, and urologists to best address these concerns in an integrated, patient-centered way. Although some conditions do require surgical repair, many can be well-managed with a bowel regimen and physical therapy.

What is Pelvic Floor Physical Therapy?
Pelvic floor physical therapy involves more than just kegel exercises. Pelvic floor physical therapists have specific and specialized training, including pelvic floor “down training” and biofeedback. Biofeedback is a non-surgical treatment option to help patients strengthen or relax their pelvic floor muscles in order to improve bowel or bladder function and to decrease pelvic floor pain. These interventions are highly effective for people suffering with bowel dysfunction: studies in adults suggest that biofeedback shows improvement for approximately 70% of patients who have not responded to other treatment measures.

When is Surgery Indicated?
This depends on the condition and the functional status of the patient. Rectal prolapse requires surgical repair and can be approached via a laparoscopic, robotic, or perineal approach. Concomitant vaginal or bladder prolapse can be repaired at the same time. There has also been an explosion of available treatment options for fecal incontinence, including submucosal injections, sacral neuromodulation (which consists of the implantation of a nerve stimulator), and newer, just approved technologies, such as the Fenix. Our providers and staff strive to make a consultation for frequently embarrassing and underrecognized problems a comfortable, reassuring experience.

References:
Archampong et al, Cochrane Database 2012.
A cutane anal pain is a common problem facing patients. It is important to arrive at the underlying cause quickly, as often the blanket diagnosis of hemorrhoids is applied and the patient continues to suffer. Almost always, the cause can be determined by a careful history and physical exam. There are four common causes of the acute anus.

1. Thrombosed external hemorrhoid

The patient often exhibits a sudden onset of anal pain, commonly after straining, coughing or exercise. On exam, an obviously swollen, purplish hemorrhoid is seen. It is very tender, but has no signs of infection, such as pus or redness. If caught immediately, a clot extraction can be performed under local anesthetic, but over the next days to weeks, the clot will slough off and swelling will eventually resolve, leaving a benign skin tag that does not require removal. Of note, as external hemorrhoids are covered with skin, they cannot be rubber banded or sclerosed. Only the insensitive area above the dentate line is amenable to these procedures.

2. Anal fissure

These patients, who frequently have a history of constipation, complain of a “knife-like” pain, or sharp tearing sensation during all bowel movements. Fissures can also be associated with bleeding. On examination, the external appearance of the anus is entirely normal, or there may be a small skin tag, frequently in the posterior midline, pointing to the internal location of the fissure. Management consists of a bowel regimen (stool softeners, fiber powder, and improved water intake), as well as a compounded cream, usually diltiazem. Surgical management (internal sphincterotomy) or Botox injection is reserved for the 20-30% of non-responders. These patients should be followed up by a surgeon if they do not respond within a few weeks.

3. Ischiorectal Abscess

This is another common anal crisis which the patient or provider may attribute to “hemorrhoids.” The pain gradually escalates, starting off as a blurred feeling and progressing over a few days to a severe, throbbing or aching pain which prevents the patient from sleeping. Often, there is no relationship to BMs. There may be accompanying low grade fever and malaise. On examination, there may be a diffuse, poorly localized area of swelling at the anal verge with overlying erythema. The management of ischiorectal abscesses is to undertake incision and drainage as soon as possible. Generally, antibiotics are not appropriate, unless the patient cannot be drained in an expeditious fashion. All patients with ischiorectal abscesses should be followed up after drainage by a surgeon. About 50% will have an associated fistula, which will require surgical management at a later stage.

4. Prolapsed internal hemorrhoids

The patient may have a long history of hemorrhoidal protrusion with bowel movements or even physical activity. There may be accompanying rectal bleeding. They may report that the protrusion became suddenly irreducible and acutely painful. The pain will worsen as the hemorrhoids first become edematous and then thrombose. On examination, there will be dramatic swelling of dark purple tissue at the anal verge. Commonly, this area is very tender, though responds to the application of topical anesthetic. If there is no throbbing, the pain improves with pressure and reduction of the prolapsed tissue. Management should be conservative in almost all cases. A minority of patients will need surgical hemorrhoidectomy to relieve their complaints.

Less than 10% of all patients we see with symptomatic hemorrhoids will require surgical treatment. stapled hemorrhoidectomy. There were no significant complications from our treatment. This treatment may help expedite discharge from the hospital, decrease the need for blood transfusion, and significantly decrease the morbidity and expense of an emergent operation, particularly in the medically frail. Our experience is that this is also true for outpatients with symptomatic hemorrhoids who in most cases, can avoid the significant discharge and expense of an operative hemorrhoidectomy by using sclerotherapy in the office.

Hemorrhoids 101

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Transanal Endoscopic Microsurgery (TEM)

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Top Doctor, Portland Monthly Magazine, 2015

Q: I have a lesion in the rectum. Should I pursue TEM resection or standard transanal excision?

A: The choice of procedure is based on tumor characteristics and patient preferences. Although not all patients with rectal polyps and cancers are appropriate for the TEM procedure, this technique offers a great alternative to traditional more invasive options. As always, treatment must be individualized based on tumor characteristics and patient preferences.