

## Tips for GP trainees working in colorectal surgery

As a GP trainee covering a colorectal team, you will encounter a variety of pathologies, and patients. This can range from a younger population with inflammatory bowel disease (IBD), older patients with bowel cancers, and those of any age with anorectal complaints.

Colorectal cancer is common but it is very treatable; survival rates are increasing all the time, partly thanks to the help of screening programmes using faecal occult blood. Your attachment will give you a huge insight into the investigation, operations, and complications that your patients in primary care could have. This understanding will help enormously when counselling patients and following them up in primary care.

### THE BASICS

1. Colorectal surgery requires a rounded approach to patient care, as well as a multidisciplinary approach including gastroenterologists, radiologists, stoma nurses, and dieticians.
2. Attending outpatients will give you a clear picture of what represents a high-risk pattern of symptoms in bowel cancer.
3. Be aware of the different type of stomas and what they produce.
4. Use a chaperone for invasive examinations. It is reassuring for the patients and covers your back.

### THE PATIENT

5. Bowel problems are embarrassing. We may be used to dealing with them but most patients find it very odd talking to a stranger about their poo.
6. Every 2-week rule referral will be concerned about cancer. This is not the only diagnosis that can cause a change in bowel habit but it is important to exclude it, or diagnose it early and treat accordingly. The outcomes from bowel cancer are better the earlier it is diagnosed.

7. Patients are individuals. What is best for one, is not necessarily best for the next. Think about the whole patient and not just their disease. This is easier said than done.

### STOMAS

8. Ileostomies are (generally) right sided, spouted, and produce a watery effluent.
9. Colostomies are (generally) left sided, flat to abdominal wall, and produce more solid stool.
10. Ileostomies are formed because:
  - a. They divert bowel contents to allow a more distal anastomosis to heal.
  - b. The distal bowel has been resected, that is, an end ileostomy.
11. Colostomies are formed because:
  - a. They protect a distal anastomosis (rarely).
  - b. It is deemed that a primary anastomosis is likely to fail. This is usually an emergency operation with peritoneal contamination.
  - c. The distal bowel has been resected, that is, after an abdomino-peroneal resection for low rectal cancer.
  - d. To defunction a diseased segment, for example, an obstructing tumour.

### RESECTIONS

12. Resections are determined by colonic blood supply.
13. Right hemicolectomy: caecum→first third of the transverse colon. Primary ileocolonic anastomosis.
14. Left hemicolectomy: last third of the transverse colon→rectum. Primary anastomosis, usually avoiding a stoma.
15. Sigmoid colectomy: the diseased area of the sigmoid is removed. Primary anastomosis, usually avoiding a stoma.
16. Hartmann's procedure: is a sigmoid

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colectomy without primary anastomosis and is usually an emergency operation. The proximal bowel becomes an end colostomy. The distal bowel, (rectal stump) is either oversewn or brought to the surface as a mucous fistula.

17. Anterior resection: sigmoid colon→rectum. Covering ileostomy is normally needed.
18. Abdominoperoneal excision of the rectum (APER): sigmoid→anus. The proximal colon becomes a permanent end colostomy.
19. Laparoscopic resections are increasing in number, and hence recovery times and hospital stays are being reduced.
20. Some of the above operations require bowel preparation, but it is very consultant specific, so find your local protocol.
21. Anastomotic leaks are the most feared complication with any primary anastomosis. Classically they occur from 7–10 days. Any signs of sepsis in this window are due to an anastomotic leak until proven otherwise.

## CANCER

22. Treatment is stepwise:
  - a. Diagnose (endoscopy and histology).
  - b. Stage (computed tomography of chest/abdomen/pelvis, and in rectal cancers, magnetic resonance imaging of rectum).
  - c. Treat, according to multidisciplinary team decisions (surgery, chemotherapy, and in rectal tumours, radiotherapy).
23. Most colorectal cancers have a natural history starting from polyps. If detected, these can be removed at colonoscopy so they will never develop into cancer. This is the basis of screening.
24. Colonoscopy is invasive, with risks of bleeding and perforation. Bowel preparation can cause significant dehydration and acute kidney injury, especially in older people. Consent is taken with this in mind.
25. Right-sided bowel cancers present late with symptoms of obstruction, or earlier with iron deficiency anaemia.
26. Left-sided tumours present earlier with change in bowel habit (to looser) ±blood per rectum (PR) ±tenesmus.
27. Even with metastasis colorectal cancer is treatable, patients with liver metastasis are often now undergoing liver resections.

## RECTAL BLEEDS

28. We know that blood loss is deceptive. This doesn't make it any less scary for the patient having a PR bleed, especially when you say there is nothing you can do to stop it.
29. PR bleeds are generally managed conservatively, and investigated once it has stopped, (flexible sigmoidoscopy or colonoscopy). The exception is a massive bleed in an unstable patient, and here angiography can provide a diagnosis and potential intervention. If this fails, a laparotomy is last resort.

## INFLAMMATORY BOWEL DISEASE

30. Beware of masked abdominal clinical signs in those patients on steroid therapy.
31. Postoperative complications such as sepsis and fistulas are much more common in Crohn's disease than ulcerative colitis (UC). In general, surgery in Crohn's disease is avoided if at all possible.
32. Radical surgery in UC is often undertaken since disease is limited to the large bowel. Resection of the colon is therefore curative, eliminating the increased risk for colorectal cancer conferred by the disease.
33. Fistulas can respond to medical management, that is, reducing bowel throughput with total parenteral nutrition, but may require surgical excision.

## ANAL AND PERI-ANAL COMPLAINTS

34. Haemorrhoids are frequently found at 3, 7, and 11 o'clock positions, and are classified according to degree of prolapse. First degree never prolapsing, fourth degree are irreducible.
35. Anal fissures are longitudinal tears in the lower half of the anal canal. They usually lie in the midline. Fissures not in the midline should be suspected to be due to other pathology, for example, malignant disease or infection such as syphilis.
36. Anorectal abscesses are dealt with acutely by incision and drainage. If they are related to a fistula formal investigation (MRI is useful) and treatment is required, which has to wait until the acute infection has settled.
37. Pilonidal sinus is unusual in the over 40s.

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