

Change in bowel habit-Is it irritable bowel?

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Objectives

- Irritable bowel syndrome- an overview
- Role of screening
- 2WW clinics
- Role of Specialist Surgeon
- Recent advances: Laparoscopic
Colorectal cancer surgery
Stapled haemorrhoidopexy

Incidence of IBS

- 40-60% of referrals –IBS/Functional dyspepsia
- 9-12% IBS incidence in population
- Female > male

Aetiology

- *Psychological morbidity*
- *Role of stress-50%.*
- *Consulting behaviour-anxiety/depression*
- *Abnormal illness behaviour-somatic complaints.*
- *Visceral hypersensitivity*
- *Post-infective bowel dysfunction-10-20%*
- *Diet-coffee/dairy/potatoes/corn/onions.*

Symptoms

- Gastro-
abd pain
bloating
diarrhoea alt with constipation
- Non-gastro-
lethargy/sleep disturbance

Criteria

- *Manning criteria*
 - (1) Abdominal pain relieved by defecation
 - (2) Looser stools with onset of pain
 - (3) More frequent stools with onset of pain
 - (4) Abdominal distension
 - (5) Passage of mucus in stools
 - (6) Sensation of incomplete evacuation

Criteria

- *Rome II criteria*
- 12 weeks or more in the last 12 months of abdominal discomfort or pain that has two of the
- following three features:
 - (1) Relieved by defecation
 - (2) Associated with a change in frequency of stool
 - (3) Associated with a change in consistency of stool

When to refer

Presence of sinister symptoms-rectal bleeding

Wt loss/appetite loss

- Age > 45
- Short history
- Non-fluctuating symptoms

BSG guidelines

- x Young patients (<45 years) typical functional symptoms, no alarm symptoms or family history of colonic cancer- IBS /no tests. (Recommendation grade B.)
- Those referred to hospital with more severe symptoms usually require further investigation including at least sigmoidoscopy, FBC, and ESR. (Recommendation grade B.)

BSG guidelines

- Diarrhoea- serum B12, red cell folate, ferritin, thyroid function, antiendomysial antibodies, calcium, albumin, and microscopy of the stool , rectal biopsy barium follow through.
- Severe diarrhoea -full colonoscopy to exclude microscopic colitis. (Recommendation grade C.)
- x Older patients with recent onset of symptoms or younger subjects with a family history of colon cancer usually justify imaging of their colon. Progressive symptoms in any age group should prompt re-evaluation of the need for further imaging. (Recommendation grade C.)

What happens then?

- Sigmoidoscopy
- Lactose intolerance
- Thyroid function
- Celiac test
- Colonoscopy/barium enema

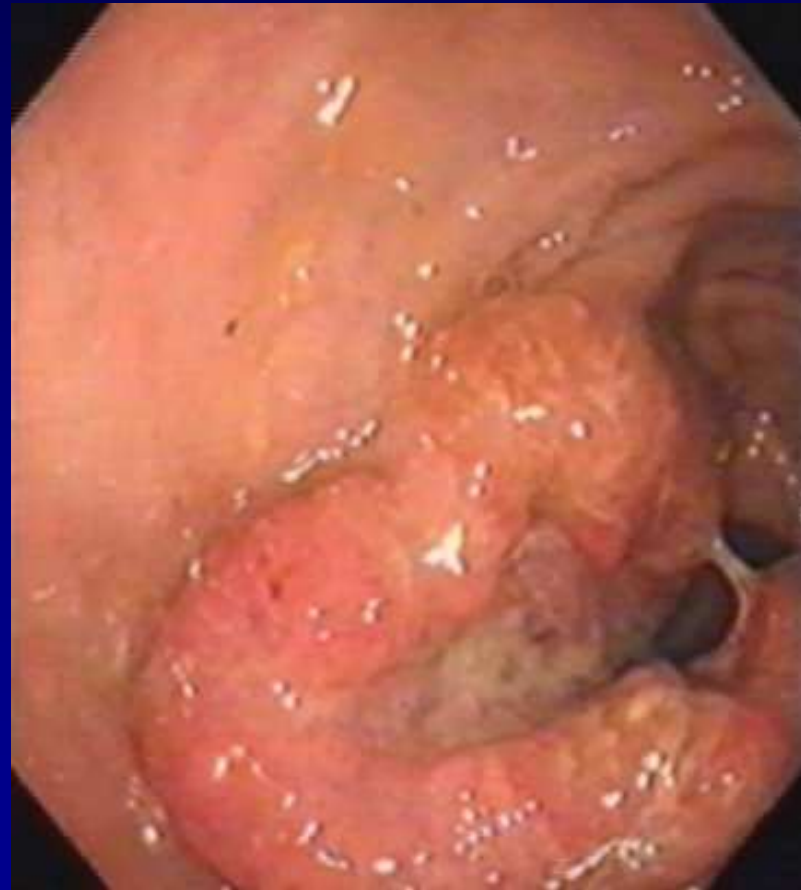
Management

- *Positive diagnosis and reassurance*
- *Listening to the patient's concerns*
- *Lifestyle advice-stress*
- *Exclusion diets-food diary*
- *Psychological therapies-counseling/
behavioural therapy/antidepressants*
- *Pharmacological treatments-
codeine/loperamide*



Colorectal Cancer

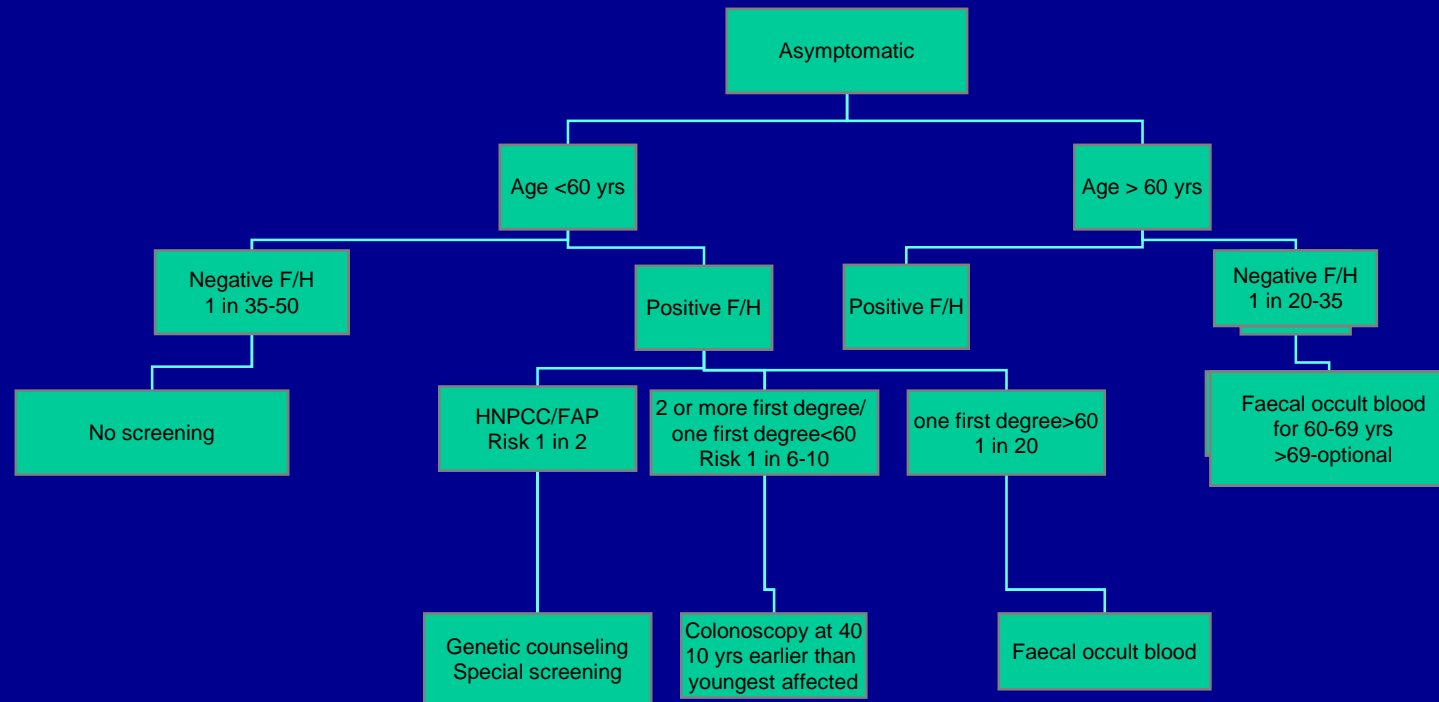
- Second most common cancer
- 30,000 new cases/year England and Wales
- 45% five year survival



Prevention

- Prevention- Primary/ Secondary
- Screening- Faecal occult blood/ Flexible sigmoidoscopy/Barium enema /Colonoscopy/Virtual Colonoscopy/ DNA in stools

Algorithm for screening Colorectal cancer



Referral guidelines-2WW

- Rectal bleeding with loose stools-6 weeks
- Palpable right side abd mass/rectal mass
- Rectal bleeding without anal symptoms >60 yrs
- Loose stools without bleeding >40 yrs
- Iron def Anaemia

Diagnosis & Staging

- Barium enema / Colonoscopy-Caecal intubation-90%
 - Pre-op CT for all
 - MRI for rectal cancer
-
- *Heald et al. MRI in predicting curative resection of rectal cancer: new dilemma in multidisciplinary team management. BMJ. 2006 Oct 14;333(7572):808.*

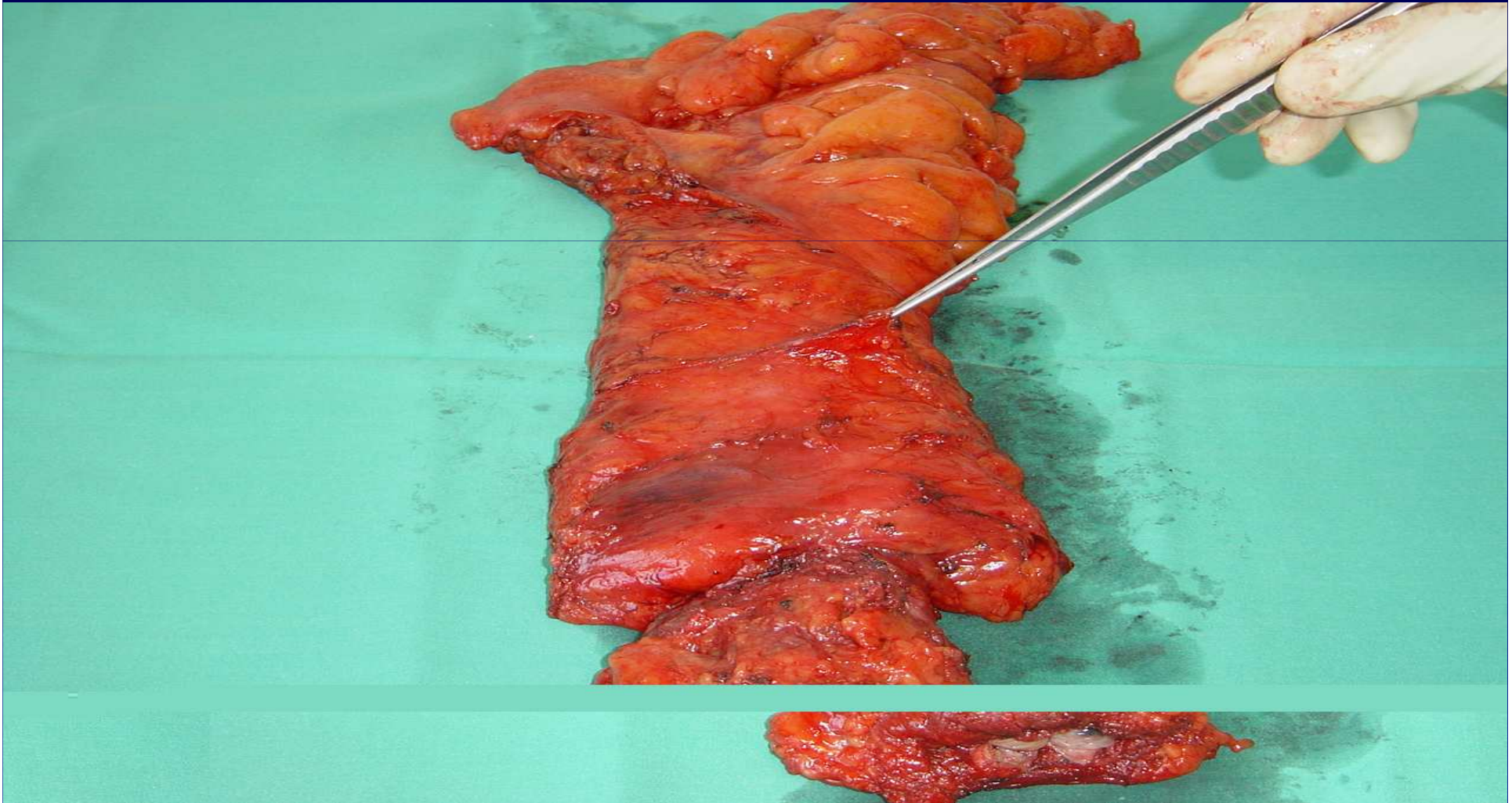
Risk factors in Rectal Ca

- CRM positive
- Vascular invasion
- Nodal spread

Heald RJ. Rectal cancer: the Basingstoke experience of total mesorectal excision, 1978-1997.

Arch Surg. 1998 Aug;133(8):894-9.

TME –Rectal cancer



Surgery- specialist role for Rectal Ca

- TME for lower 2/3 rectal cancers
- APR rate lower than 40%
- Overall curative resection rate of 60%
- Emergency surgery during daytime/experienced staff- stenting

Laparoscopic Colorectal cancer surgery

- Minimal surgical stress/Early Recovery
- Cancer clearance?/ Nodal harvest?
- Port Site mets
- Injury to adjacent organs
- CRM- Local recurrence
- Longer operating time/ learning curve!

Evidence

- *Smith A et al. Lap colon surgery expert panel and programme in evidence based bowel care. Toronto (ON): cancer care Ontario(CCO): 2005 Sep*
- RCT 1071 patients
- Survival 85% (lap) vs 83%(open)
- Recurrence 17% vs 21%
- Operating time 163 min vs 111 min
- Hospital stay 5.1 days vs 7.3 days

Outcome (NICE)

- 15-25% mortality for emergency surgery and 4-7% for elective surgery acceptable
- Wound infection rates 10%
- Anastomotic leak rates 8% for anterior resection and 4% for other resections
- Local recurrence rate 10% within 2 years

Daniels IR et al. Accurate staging, selective preoperative therapy and optimal surgery improves outcome in rectal cancer: a review of the recent evidence. Colorectal Dis. 2007 May;9(4):290-301. Review.

Summary

Thank You for
your patience!