



COLON & RECTAL SURGERY

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GASTROINTESTINAL & MINIMALLY INVASIVE SURGEONS NEWSLETTER | SUMMER 2016 | ISSUE 4



L-R: Dr. Rehan Ahmad, Dr. David O'Brien, Dr. Amanda Hayman, Dr. Roy Breen, and Dr. Mark Whiteford.

LEADERS IN COLON & RECTAL SURGERY

The Colon & Rectal Surgery division of The Oregon Clinic is part of a group of subspecialty gastrointestinal, general, and endocrine surgeons. We believe that true mastery of practice requires a dedication and focus on a defined field of surgery. We use sophisticated, minimally invasive surgical techniques, including robotic assisted surgery, to treat a wide range of colorectal problems from removing cancerous growths to treating inflammatory bowel disease.

This summer, we proudly welcomed **Dr. Jonathan Chun** to The Oregon Clinic Colon & Rectal Surgery division. Dr. Chun is a fellowship trained colorectal surgeon with over 10 years of experience. Dr. Chun's experience in laparoscopic and minimally invasive approaches will complement our group.



AREAS OF EXPERTISE

- Anal, Rectal & Colon Cancer
- Anorectal Abscesses & Fistulas
- Anal Fissures
- Fecal Incontinence
- Hemorrhoids
- Laparoscopic & Robotic Surgery
- Pelvic Floor Dysfunction & Disorders
- Rectal Prolapse
- Transanal Endoscopic Microsurgery
- Ulcerative Colitis & Crohn's Disease



The Oregon Clinic: Leaders in Quality Rectal Cancer Care

Mark Whiteford, MD, FACS, FASCRS
Director, Colon & Rectal Surgery, The Oregon Clinic
Director, Colorectal Surgery, Providence Cancer Center
Top Doctor, Portland Monthly Magazine, 2005-2016

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.

Quality rectal cancer care is based on proper surgical technique (total mesorectal excision), evidence-based use of neoadjuvant and adjuvant therapy, and a multidisciplinary team approach by specialist providers, including surgeons, medical oncologists, radiation oncologists, radiologists, and pathologists with gastrointestinal expertise. The creation of similar specialized and standardized centers in Scandinavia resulted in marked reduction of local recurrence of rectal cancer and improved survival.

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.

“As the highest volume rectal cancer center in Oregon, Providence Cancer Center is prepared to be one of the first OSTRiCh Commission on Cancer Program approved centers in the Northwest.”

Two years ago, The Oregon Clinic, in collaboration with Providence Cancer Center and Compass Oncology, began incorporating the OSTRiCh standards for rectal cancer care into our daily practice. Through a weekly multidisciplinary conference, complex rectal cancer patient care is thoroughly discussed, images and pathology reviewed, and a modern, guideline-based care plan is devised to optimize patient outcomes. As the highest volume rectal cancer center in Oregon, Providence Cancer Center is prepared to be one of the first OSTRiCh Commission on Cancer Program approved centers in the Northwest.

References:
Baek et al. Int J Colorectal Dis 2012.
Archampong et al. Cochrane Database 2012.



Pelvic Floor Disorders: Physical Therapy or Surgery?

Amanda Hayman, MD, MPH
Co-Director, Enhanced Recovery After Surgery, Providence Health Systems
Quality Assessment & Safety Committee Member & Instructor, American Society of Colon & Rectal Surgeons
Top Doctor, Portland Monthly Magazine, 2016

Colorectal 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.

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The Four Common Causes of Acute Anal Pain

Dr. Rehan Ahmad, MD, FRCS
Fellow, Royal College of Surgeons
Top Doctor, Portland Monthly Magazine, 2016

Acute 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 insensate 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 bruised 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 abscess

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 hemorrhoid 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 thrombosis, 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 discomfort and expense of an operative hemorrhoidectomy by using sclerotherapy in the office.



Hemorrhoids 101

Roy Breen, MD, FACS
Fellow, American Society of Colon and Rectal Surgeons
Top Doctor, Portland Monthly Magazine, 2008-2009 & 2016

Less than 10% of all patients we see with symptomatic hemorrhoids will require surgical treatment. Most patients respond to nonoperative measures. Treatment options that we offer patients with symptomatic internal hemorrhoids include rubber band ligation, infrared coagulation, or sclerotherapy.

In view of infrequent, but sometimes serious complications that may occur with rubber band ligation (such as bleeding, pain and infection), we have increasingly utilized sclerotherapy in our practice. This involves the injection of chemical irritants into the hemorrhoids and/or prolapsing mucosa to

cause shrinkage of tissue. We have been using phenol in oil, which is safe even in patients taking blood thinners such as warfarin or Plavix.

At this year's meeting of the American Society of Colon and Rectal Surgeons in Los Angeles, we will be presenting our results of phenol sclerotherapy for acute inpatient hemorrhoidal bleeding. This involved patients who were admitted to the hospital with acute gastrointestinal hemorrhage requiring transfusions. Our average population was generally elderly with a high prevalence of comorbidities. Only one patient out of 19 required post-sclerotherapy blood transfusion and this patient required a

About the Gastrointestinal & Minimally Invasive Surgeons

Innovation

Our group has 20 years of history in program, procedure, and instrument development.

Focused Areas of Expertise

We are dedicated to providing high-quality care using the latest technology. Our surgeons focus on the following fields of surgery:

- Endocrine Surgery
- Colon & Rectal Surgery
- Gastric & Esophageal Surgery
- General Surgery
- Liver, Biliary & Pancreas Surgery
- Vein Treatment

Research

- Active clinical and basic science research program
- Participation in multi-institutional research efforts
- Internal quality assessment and improvement
- Publications include:
 - Three current textbooks
 - More than fifty book chapters
 - Over 300 peer reviewed papers



Back: Drs. Newell, Hayman, Hammill, Breen, Ahmad, O'Brien, Zelko, Swanstrom, Wolf
Front: Drs. Hansen, Jamison, Aliabadi-Wahle, Dunst, Whiteford, Reavis

Active Participation in the Medical Community

Our doctors hold leadership roles in the most well-respected hospital systems in the Portland metropolitan area and in regional and national specialty societies.

Education

We train surgical and resident fellows accredited by The Fellowship Council and/or ACGME in:

- Foregut Surgery
- Colorectal Surgery
- Liver and Pancreas Surgery
- Minimally Invasive Surgery



Transanal Endoscopic Microsurgery (TEM)

David O'Brien, MD, FACS
Fellow, American Society of Colon and Rectal Surgeons
Top Doctor, Portland Monthly Magazine, 2011

Transanal endoscopic microsurgery (TEM) is a minimally invasive technique developed in Germany in the 1980s to treat complex rectal polyps and early rectal cancers not amenable to removal by endoscopic or traditional transanal methods. Lesions in the middle and upper rectum are often amenable to TEM resection, allowing many patients avoid the need for a radical abdominal operation and its sequelae.

The device contains a large operating proctoscope, laparoscope, special insufflators, and multiple working ports. Key to its success is the markedly improved visualization, when compared to standard transanal techniques. This is accomplished by carbon dioxide insufflation of the rectum, and smoke evacuation during cauterization. Additionally, the laparoscope and specialized instruments help simplify lesion excision in this narrow working environment.

Studies comparing TEM to standard transanal excision have demonstrated that TEM resection of rectal polyps and cancers is associated with a higher negative margin rate and a lower rate of lesion recurrence. Complication rates are extremely low and are much less significant when compared to radical resection of the rectum.

The steep learning curve, along with the higher cost of this equipment, has kept this technique from more widespread usage. We are very fortunate to be able to offer this technology to our patients. Over the last five years, our group has performed 161 TEM procedures for polyps, cancers and other rectum pathologies. Our experience and reputation in this technology have allowed us to teach this procedure to other colon and rectal surgeons across the US and at international surgical conferences.

Studies comparing TEM to standard transanal excision have demonstrated that TEM resection of rectal polyps and cancers is associated with a higher negative margin rate and a lower rate of lesion recurrence.

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.

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