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Service: **Colorectal**

Trans anal Surgery

Exceptional healthcare, personally delivered

What is trans anal surgery?

Trans anal surgery involves the removal of a rectal growth through the anus. It has been performed since the mid-1980s. For many years it has been a specialist operation only available in a few centres. More recently, there have been advances in technology to allow more surgeons to be able to use this technique.

When is trans anal surgery performed?

It is usually indicated in patients who have a benign polyp that is deemed too large to be removed in the endoscopy department. It may also be recommended for removal of a rectal polyp where the endoscopist has recommended that the polyp should be removed in one piece. This ‘one piece’ excision may not be possible endoscopically.

The benefits of removing a polyp in one piece is that when it is looked at under the microscope, the pathologists will be able to truly say whether the polyp has cancer in it or not. This evaluation is not possible when a polyp is removed in several pieces.

A small percentage of patients who are diagnosed with rectal cancer may be offered trans anal surgery. This may be in combination with radiotherapy. This would be as an alternative to major surgery which usually requires patients to have a stoma bag.

What other tests are necessary before the operation?

Usually it will be necessary to perform a flexible sigmoidoscopy or colonoscopy prior to trans anal surgery. This will allow us to gain accurate information about the growth we are trying to remove. If we are worried about the possibility of an underlying rectal cancer, we will arrange a CT and MRI scan.

Most patients are prescribed medication to cleanse the bowel on the day prior to the operation. This will involve taking 2 sachets of powder which is mixed with water. Other drinks such as orange squash and cordial can be mixed with it to improve the taste which some may find unpleasant. The reason for cleansing the bowel is to ensure that there are clear views of the growth during the operation.

What does the operation involve?

The operation is performed under general anaesthetic by keyhole surgery and takes between 1 and 2 hours.

All patients have a temporary urinary catheter inserted at the start of the procedure. A 4cm flexible port is inserted into the anal canal to allow the surgeon to use standard keyhole equipment. As with a colonoscopy, gas is used to keep the rectum widely open to allow the operation to proceed.

For benign polyps, the growth is essentially ‘skinned’ from the bowel muscle wall in one piece. For cancers, a full thickness excision is performed with a good rim of healthy tissue around. Occasionally this internal wound is stitched closed; however, sometimes we leave this wound open to heal slowly.

What is the recovery like after surgery?

It is usually a day case procedure and so you will be able to go home later that day. As with a colonoscopy procedure, your abdomen will feel bloated and gas filled when you come around from the anaesthetic. It is important to get up as soon as possible and walk around. We usually recommend a quick trip to the toilet to let off the gas.

Over the next 2-3 days you may experience some anal discomfort and pain. You may also experience some spot bleeding from the rectum. In most cases this settles within a week. If it gets worse rather than better we would recommend attending A+E or contact your healthcare provider for referral to surgical hot clinic for a review.

A small percentage of patients experience a temporary fever. we recommend taking paracetamol for a few days if this occurs.

Your bowels may take up to a week to start working. This is because of the bowel preparation taken before your operation. You can return to a normal diet straight away. You may be fit to drive after 1 week and to return to work after 2-4 weeks. You will be issued with a discharge summary and a copy will go to your GP. Pathology results from the removed growth will usually take 2 weeks.

Normal follow up after this procedure will involve a flexible sigmoidoscopy in the endoscopy department, usually by the surgeon who has performed the operation. This will happen three months after surgery. You will be given a phosphate enema to prepare your bowel for this follow up test.

What are the results like from surgery?

For patients with benign polyps, the surgery is usually curative. Patients under 75 years can expect to be invited for an endoscopy 'screening' programme as they may be at risk of developing further polyps in future.

For patients with rectal cancer, this operation can be curative for very early cancers. For more advanced rectal cancers that are still small in size, this operation is not standard. Usually major surgery would be recommended. Currently there are trials underway evaluating the safety of this technique in such cancers. Some patients with more advanced but small, rectal cancers have opted for this technique as an alternative to major surgery. In North Bristol we have treated a small percentage of patients with rectal cancer in this way. At this early stage, the risk of developing recurrent rectal cancer in patients undergoing this surgery is low.

We cannot predict which patients, if treated this way, will develop a recurrence and need further surgery. For these patients a close follow up programme is offered involving regular flexible sigmoidoscopy, MRI and CT scans.

What are the risks and long term effects of surgery?

This operation is usually well tolerated by patients, regardless of age. Patients can expect to be discharged the same day and are usually back to their normal selves within a week.

All surgery has risks and it is important to be aware of these risks before agreeing to surgery.

Specific complications

- Bleeding (usually spotting for 3-5 days then should stop)
- Pain around rectum/anus (common, should settle)
- Abdominal bloating(should settle in 24 hours)
- Infection (rare), transient temperature(more common)
- Urinary retention (increases with age, occasionally may need to be discharged with a catheter).
- Faecal urgency (this usually settles after 1 week)
- Faecal incontinence (rare).

Cancer patients

This biggest risk of choosing this operation over standard abdominal surgery is the risk of the cancer coming back either in the scar or spreading to nearby lymph nodes. For most patients with rectal cancer, this risk is low. For a small group of patients this risk may rise to 30%. All patients are offered a close follow up programme. International studies have suggested that it should be possible to still perform major surgery if a cancer returned in the rectum after undergoing trans anal surgery. This issue will be discussed with you indepth prior to undergoing this procedure.

Is anyone not suitable for surgery?

We have operated on patients ranging in age from 35 to 90 years. It is well tolerated in all age groups. Sometimes it may not be possible to perform trans anal surgery. This may be because the growth is too large to be safely removed using this technique. In a small percentage of cases we would need to perform major abdominal surgery (anterior resection) to remove your rectum instead. This operation carries significant risks – stoma formation (40%), anastomotic leak(<8%), damage to other structure in the abdomen and death (<2%).

Is there an alternative to trans anal surgery?

Yes, many centres recommend major abdominal surgery in order to remove the rectum/growth. This is standard treatment however carries significant risks with regard to recovery and longer term bowel function.

Is the operation painful?

As with all operations, you should expect some pain. Usually this is localised to the anus. Taking over the counter painkillers such as paracetamol regularly will help. Your discomfort should settle down after a week.

If you have any concerns about ongoing symptoms or you are unsure about anything after surgery, contact your healthcare professorial for advice.

PATIENT APPROVED

How to contact us:

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Tel: 0117 4143610 / 43611
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In an emergency call out of hours
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www.nbt.nhs.uk

If you or the individual you are caring for need support reading this leaflet please ask a member of staff for advice.

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