COLORECTAL CASES

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AUCKLAND COLORECTAL CENTRE

MercyAscot
GREENLANE + EPSOM + TAKAPUNA

CASE 1

Lower abdominal pain

- 39 yo man
- BMI 32
- 3/7 suprapubic pain
- Anorexia, no n,v, diarrhea 3 days then BNO, recurring episodes over 6 months
- Examination: well, in clinic, afebrile, minimally tender LLQ, no peritonism
- Investigations – CRP 35, WCC 14.7, Hb normal, MSU normal

Suspect diverticulitis ?

INVESTIGATIONS part 1

- Get blood tests
  - CRP - > 100/ 150 → consider acute admission
  - FBC → anemia? → further investigations (cancer/ IBD)
  - Renal → dehydration, for contrast CT

Diverticulitis

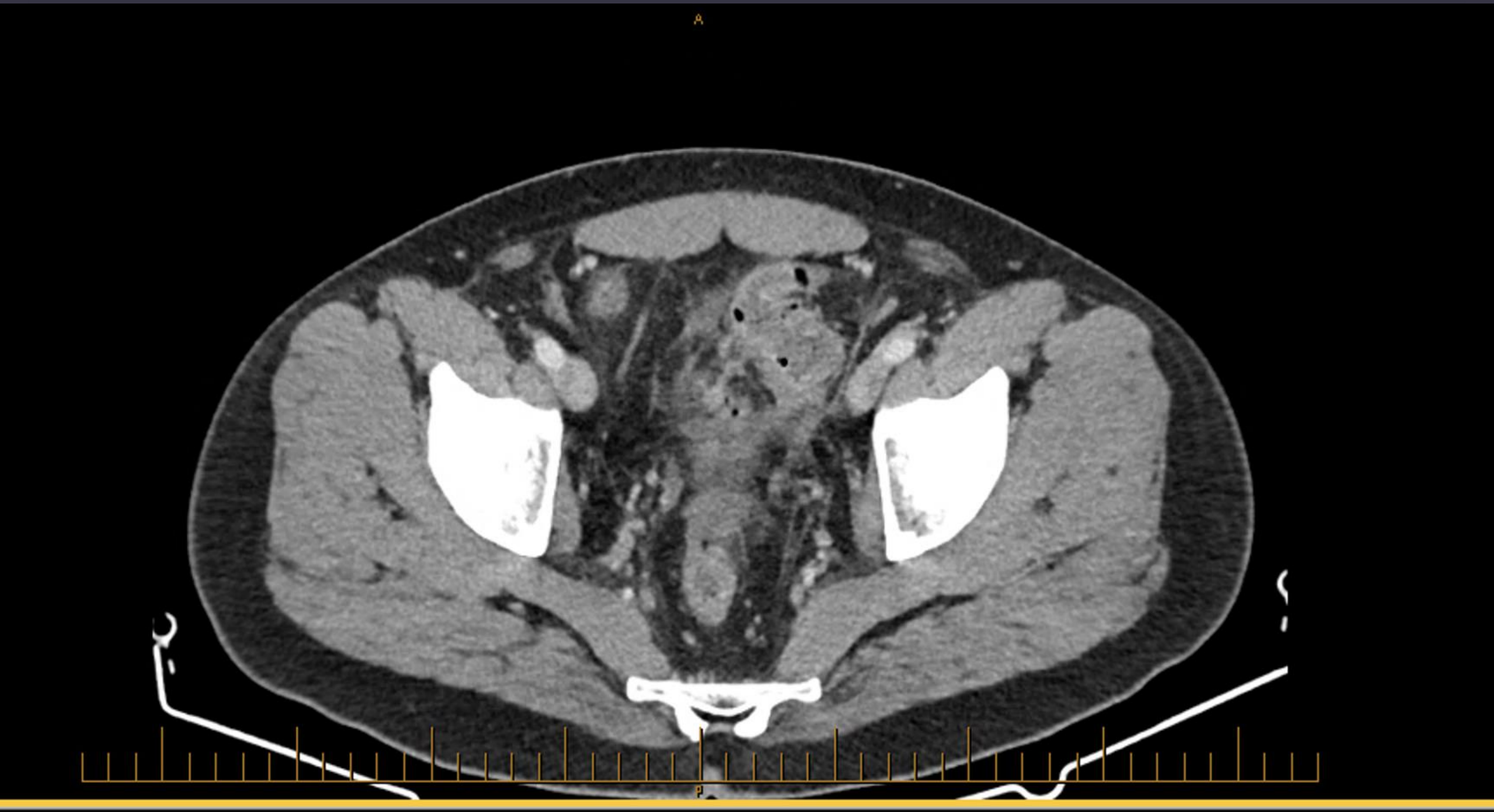
INVESTIGATIONS

part 2

- Acute
  - CT abdo/ pelvis
  - **UNCOMPLICATED + no red flags → no further investigations**
    - Routine colonoscopy or CT colonography is not required
    - Rate of underlying cancers similar to the incidence of bowel cancer in a screened population in NZ ie 3-4%
  - **COMPLICATED +/- red flags → COLONOSCOPY**
    - Risk features on index CT abdomen
      - Perforation
      - Mass
- Elective
  - CTC
  - Colonoscopy

Progress

- Within a month had colonoscopy, tolerated prep
  - Scattered diverticulosis in sigmoid colon with mild inflammation and luminal narroring but complete scope to terminal ileum
- Month after colonoscopy, pain, fevers
  - CRP 170
  - Oral antibiotics
  - CT – sigmoid diverticulitis with extraluminal air consistent with localized perforation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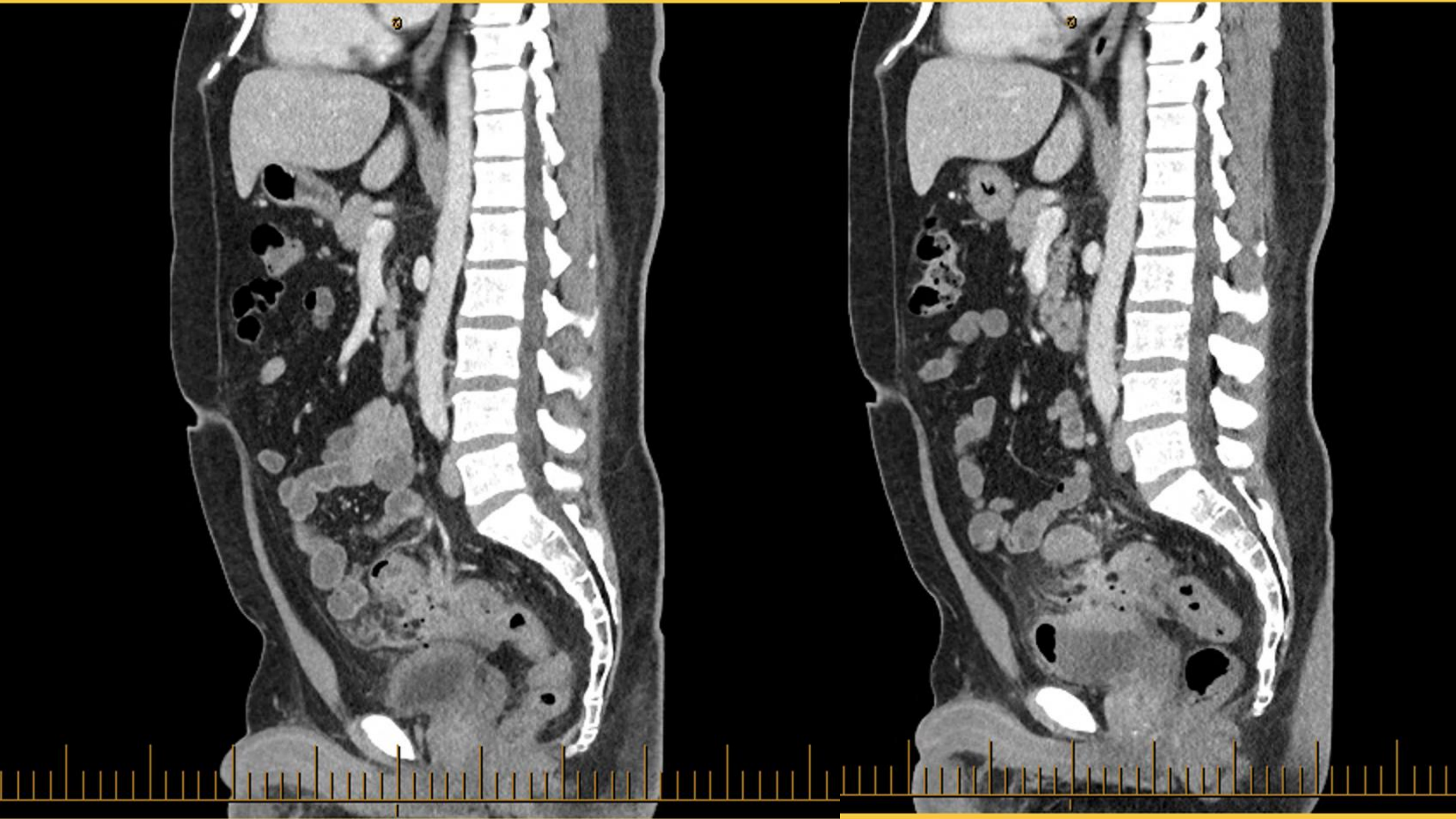
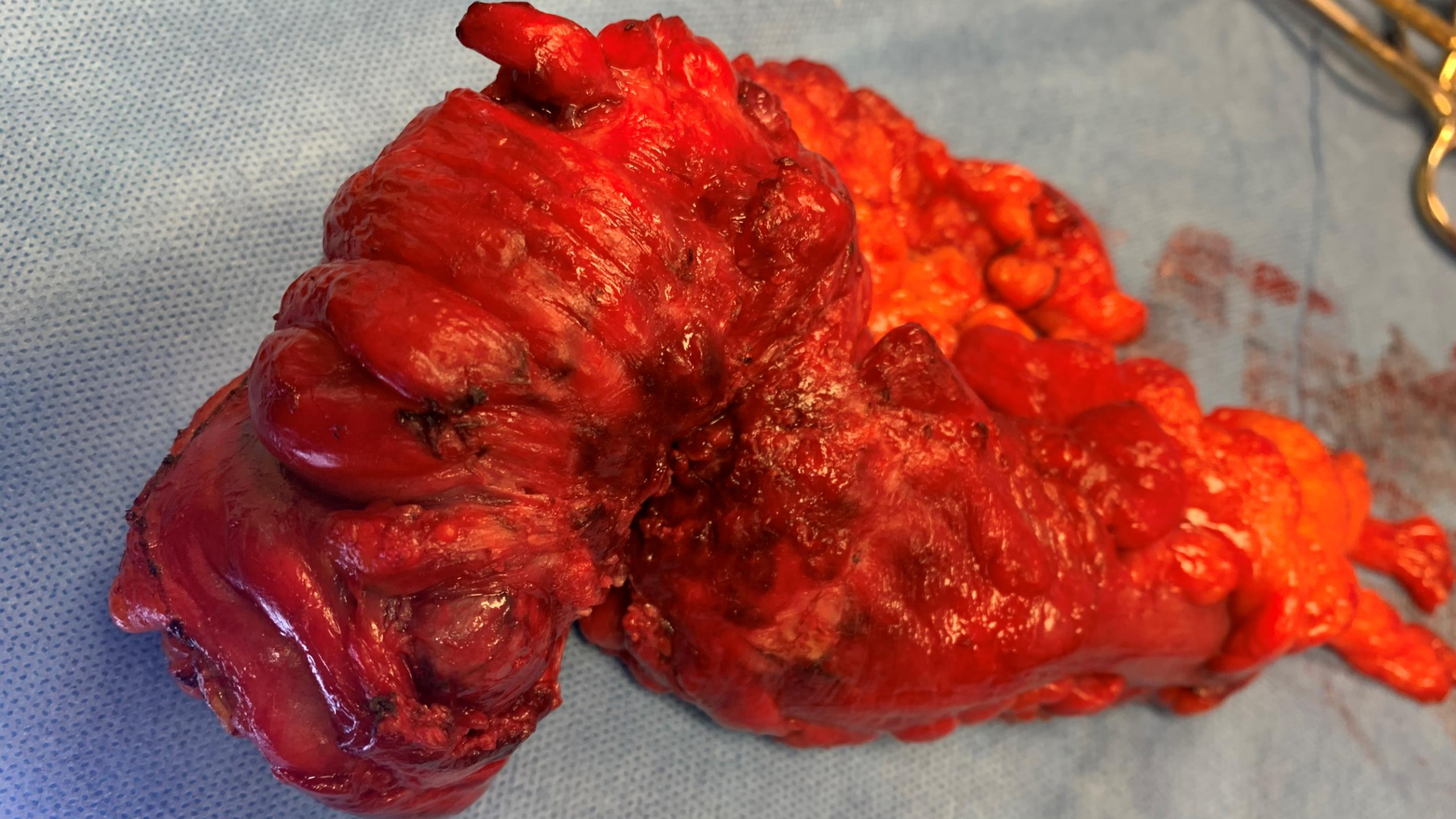
More progress

- 2 months later → acute pain, pneumaturia, fevers, sweats
  - CRP 230
  - More oral antibiotics
  - Surgical review within a week
    - Discussed surgery
    - Recheck bloods
    - Repeat CT
      - Collection -→ ? Perc drain
      - Worsening perforation/ phlegmon → surgery → hartmann's/ anterior resection +/- loop





Diverticulitis TREATMENT

- New evidence antibiotics are not required in acute uncomplicated diverticulitis
  - Antibiotics do not decrease treatment failure, recurrence, complications, hospital readmissions, and need for surgery
  - CT diagnosis and CRP < 150

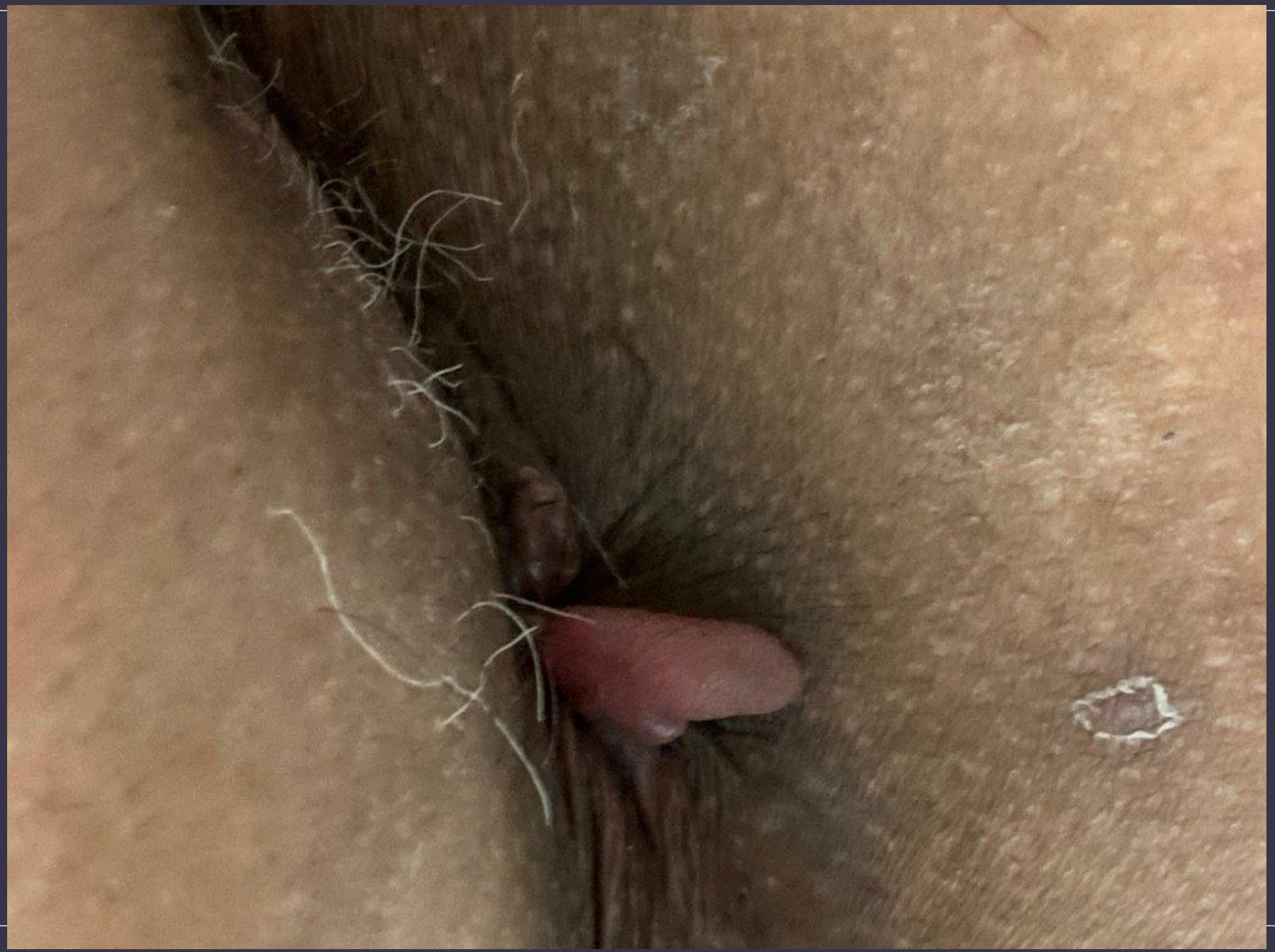
Tech Coloproctol. 2018 Jul;22(7):499-509

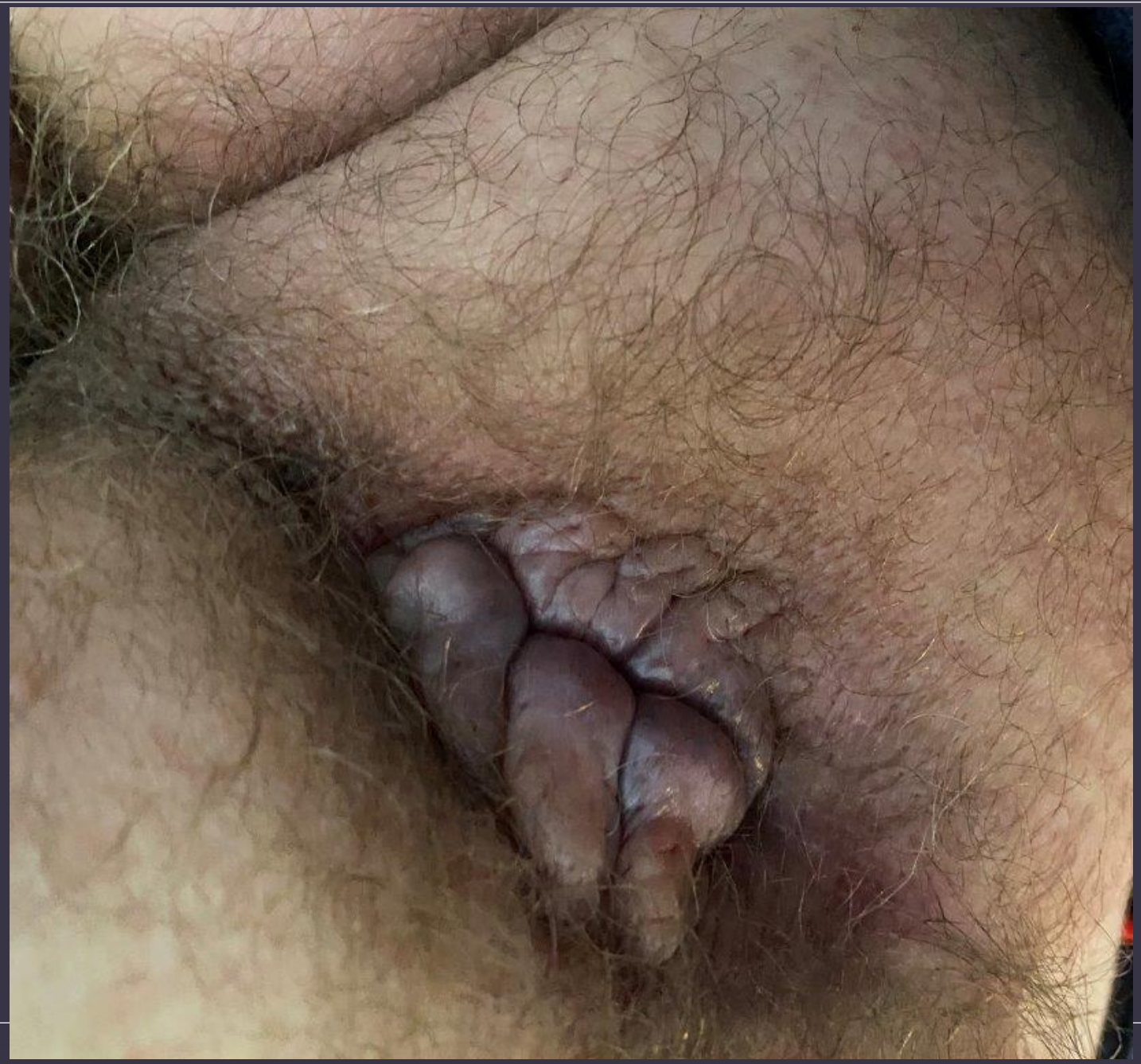
- Initial attack is usually the worse attack, often a smouldering attack is mistaken as multiple episodes
  - Risk of recurrent attack about 30%
- Surgery reserved for cases with complications or persisting phlegmon (CRP and CT evidence)
  - HARTMANN's
  - Anterior resection +/- loop ileostomy
  - Complicated diverticulitis often technically challenging surgery – often more fibrosis than cancer

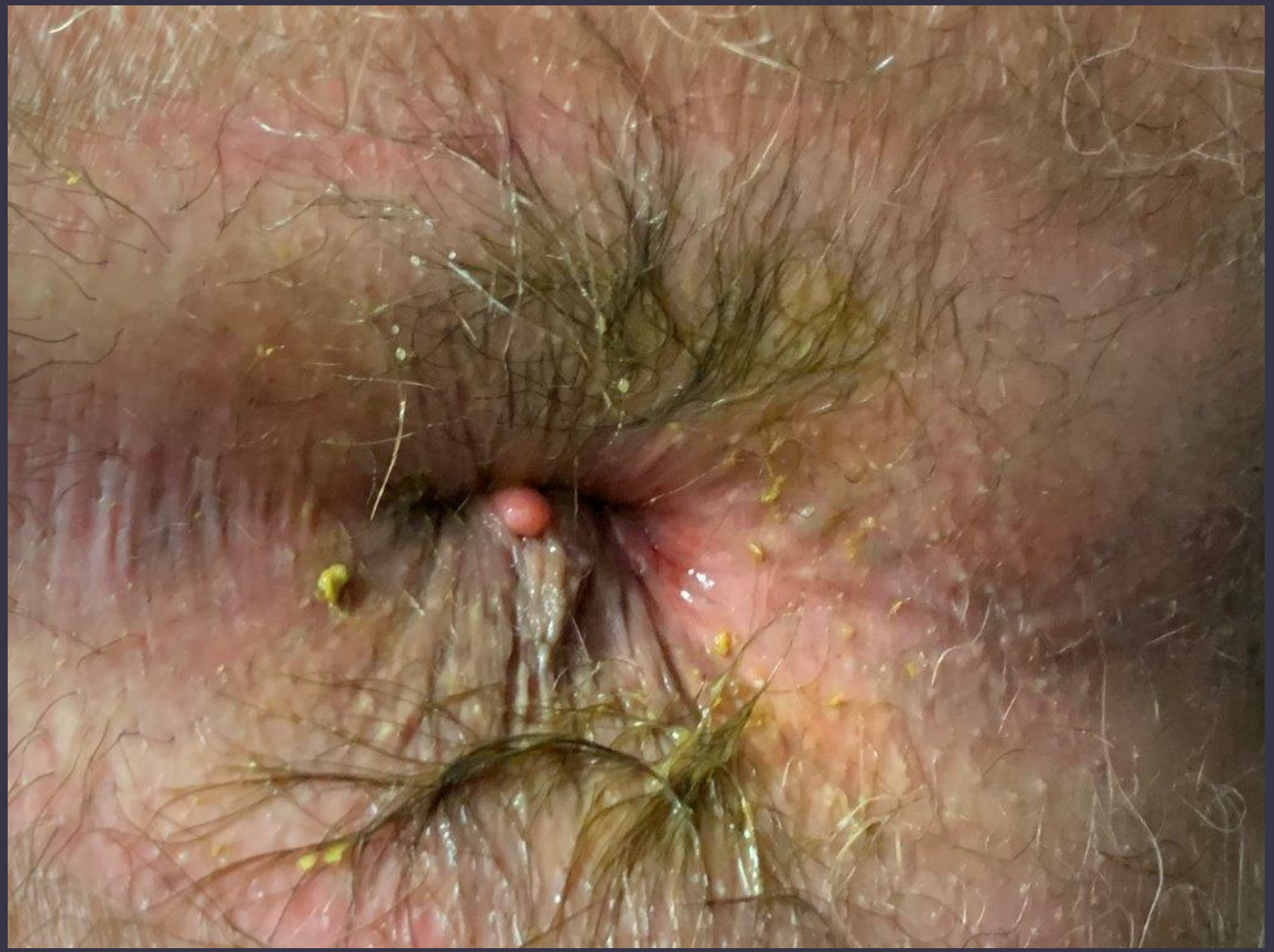
CASES 2

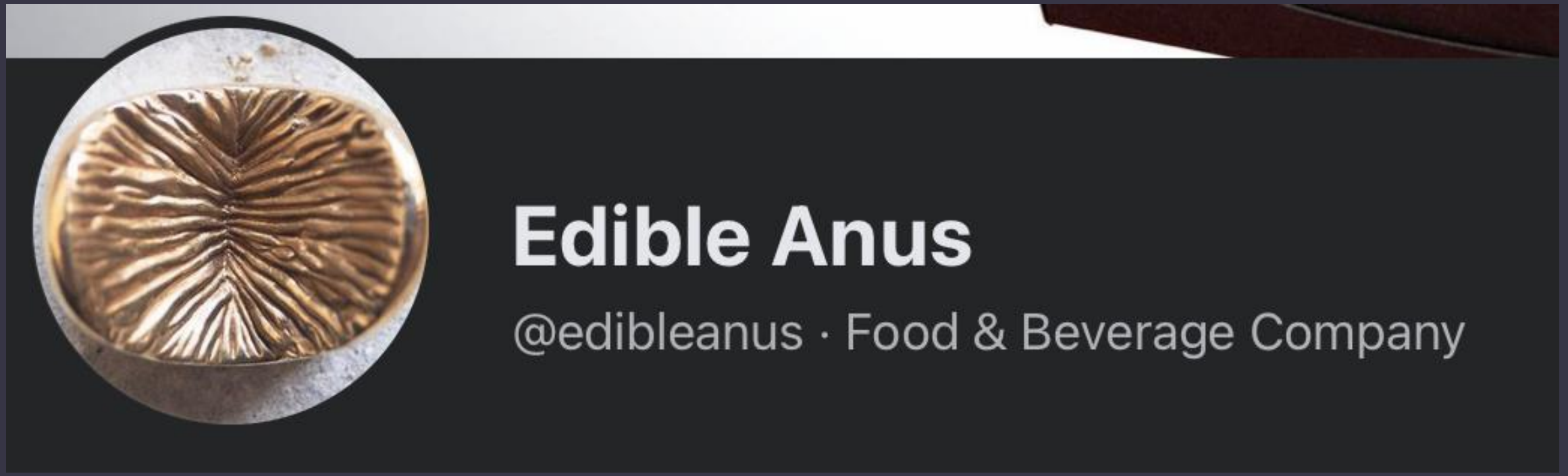
pls review this pt for consideration of banding of external haemorrhoids…

Painful PR bleeding with ‘piles’





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ANAL FISSURE

RUBBER BAND LIGATION indication

- Painless frequent bleeding haemorrhoids, no significant external disease
- Usually no sedation required if tolerates PR and 23mm proctoscopy

- Immediate risk → discomfort, tenesmus → urinary retention
- Delayed risk → bleeding in 7-14 days –rarely need admission

- Anticoagulation
  - If important indication (stent, cva, etc) → if not anemic, may be safer to accept some bleeding
  - If not – careful discussion re risk of delayed bleeding with ANY haemorrhoid intervention, consider stopping anticoagulation for the RISK PERIOD ie 1-2 wks after banding

Painless PR bleeding

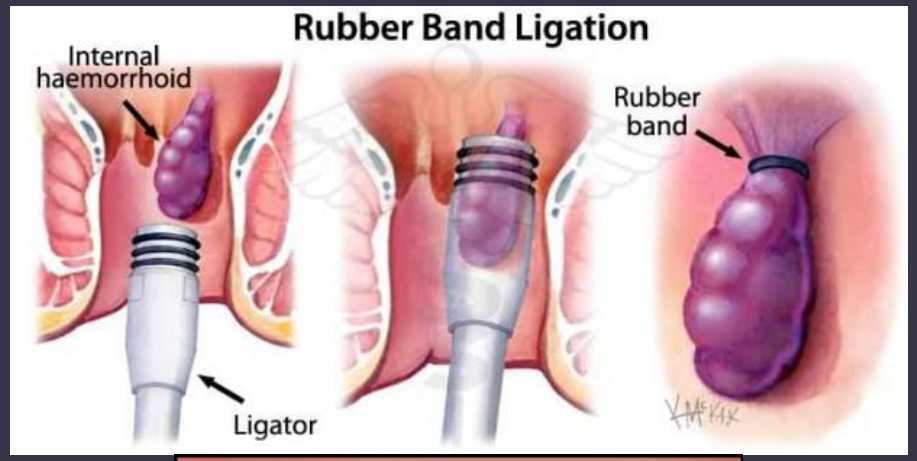
DON'T forget to consider colonic exoneration in anyone > 45yrs

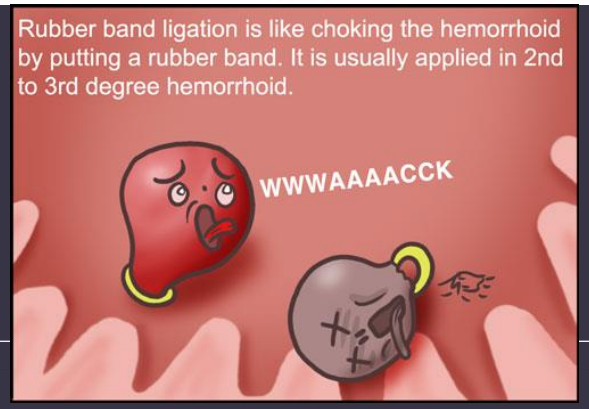
Consider alternative diagnosis in the repeat presenter

Consider fecal calprotectin to help triage need for referral

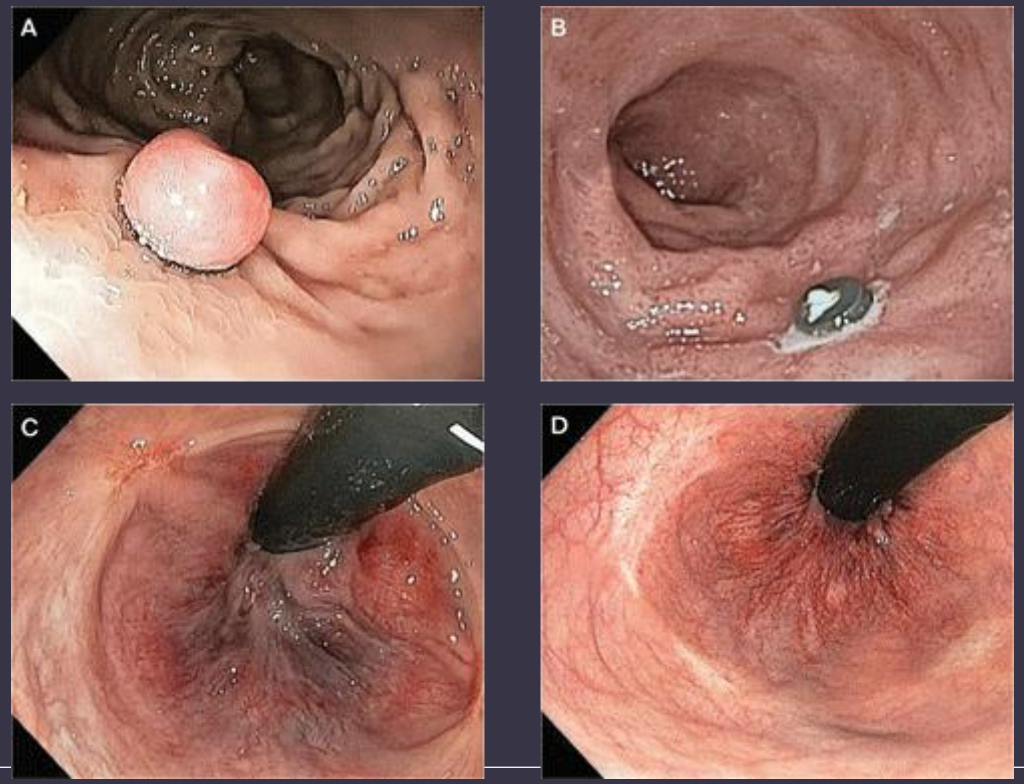
Bands are placed above the haemorrhoid, delayed bleeding is from the ulcer formed

WRONG ✕





CORRECT ✓




HAPPY NEW YEAR!
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