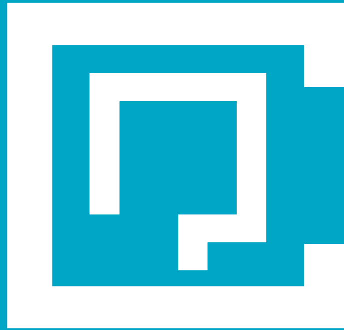

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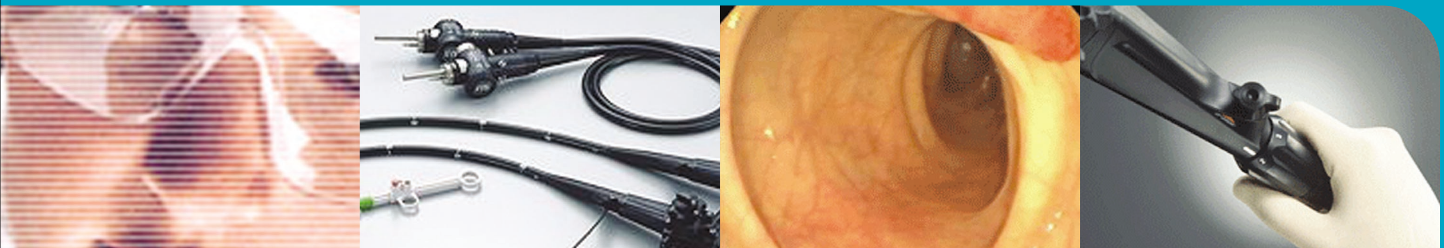

8th Annual Scientific Meeting

Old Colorectal Problems and New Anorectal Procedures

Programme Book

Grand Ballroom, 1/F.,
Harbour Plaza Hong Kong Hotel, Whampoa, Kowloon
14 January 2006 (Saturday)

CME & CNE Accreditation

CME points
Hong Kong College of Family Physicians
Hong Kong College of Physicians
The College of Surgeons of Hong Kong
MCHK CME Programme (non-specialist)

CNE points
Institute of Advanced Nursing Studies
College of Nursing, Hong Kong

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Organizing Committee

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Message from the Chairman

Dear Colleagues

It is my greatest pleasure to welcome you all to the 8th Annual Scientific Meeting of The Hong Kong Society for Coloproctology. It has always been a happy event for all our members to gather together breaking the ice between different specialties.

This year we are proud to present to you Professor G. F. BUESS from Germany who pioneered Transanal Endoscopic Microsurgery (TEM) for early rectal tumour. We are also honoured to have Dr. A. LONGO from Italy who will take us through the journey of development of Stapled Anopexy since the very start. Professor J. W. MILSOM from United States will recapitulate the surgical management of Inflammatory Bowel Disease which has become more common in our locality and our friend Dr. C. M. LEUNG will review the medical treatment and our local experience in Hong Kong.

Apart from our international faculty, we shall also have the fascinating competition of the Best Paper Award by our local institutions. Traditionally, this is the occasion where we can share innovative ideas evaluated by scientific methods. The high quality of our papers in previous meetings will definitely be met or even surpassed in this upcoming event.

You are hereby cordially invited not only to attend but to participate actively and hope to see each and every one of you in January.

William Meng

Dr. William C. S. MENG
Chairman of Organizing Committee
8th Annual Scientific Meeting
Hong Kong Society for Coloproctology

Message from the President

Dear Colleagues

As the new President of the Society, it gives me great pleasure to invite you to participate in what has become an almost a decade long tradition: on 14 January 2006, I look forward to welcoming you in person to the Society's 8th Annual Scientific Meeting (ASM) in Harbour Plaza Hong Kong Hotel. The symposium theme this year is old colorectal problems and new anorectal procedures. We have called upon the strongest international faculty to share with us some of the latest exciting innovations as well as to review some traditional treatment modalities. You can be reassured that the symposium could provide first class continuing medication education and will definitely be worthy of your time. I must take this opportunity to thank Dr. William Meng, chairman of the organizing committee; without his efforts the meeting would not have been possible.

For the young fellows, you are strongly encouraged to submit your original work for consideration for presentation in the free paper session. Remember, not only you are given a precious opportunity to present papers to your peers but it is also the most efficient way to get your work known and debated.

Once again may I cordially request your participation on the academic exchange in the ASM. Do register early!

C. Chung

Dr. Cliff C. C. CHUNG
President
Hong Kong Society for Coloproctology

Programme

13:00 - 13:45 **Lunch & Registration**

13:45 - 14:00 **Opening Address:**
Dr. William C. S. MENG & Dr. Cliff C. C. CHUNG

Symposium : Old Colorectal Problems and New Anorectal Procedures

Chairpersons:
Dr. Janet F. Y. LEE & Dr. LUK Yiu Wing

14:00 - 14:15 Stapled Anopexy after Ten Years
Dr. Antonio LONGO
Consultant Chief Surgeon
Department of Coloproctology and Pelvic Diseases
St. Elisabeth Hospital, Vienna, Austria

14:15 - 14:30 Transanal Endoscopic Microsurgery (TEM) - A Review
Prof. Gerhard BUESS
Visiting Professor 2005-2006
Department of Surgery
Kwong Wah Hospital, Hong Kong

14:30 - 14:45 Treatment of Inflammatory Bowel Disease Using Laparoscopic Methods
Prof. Jeffrey MILSOM
Professor of Surgery
Weill Medical College of Cornell University, New York, USA

14:45 - 15:00 Inflammatory Bowel Disease: Local Experience and Medical Therapy
Dr. LEUNG Chi Man
Specialist Gastroenterologist
Department of Medicine
Pamela Youde Nethersole Eastern Hospital, Hong Kong

15:00 - 15:10 **Discussion**

15:10 - 15:40 **Break**

Programme

Free Paper Session

15:40 - 16:40	**Chairpersons :** *Dr. Patrick Y. Y. LAU & Dr. Kevin K. K. YAU*
15:40 - 15:50	Critical Appraisal on the Role and Outcome of Emergency Colectomy for Uncomplicated Right-sided Colonic Diverticulitis *Dr. Jennifer W. C. MOU* *Department of Surgery, The Chinese University of Hong Kong* *Prince of Wales Hospital*
15:50 - 16:00	Stapled Hemorrhoidopexy for Acute Thrombosed Hemorrhoids: A Randomized Trial *Dr. James C. H. WONG* *Department of Surgery, Pamela Youde Nethersole Eastern Hospital*
16:00 - 16:10	Factors Affecting the Quality of Life of Colorectal Cancer Patients in Hong Kong Chinese Population *Dr. Shirley Y. W. LIU* *Department of Surgery, The Chinese University of Hong Kong* *Prince of Wales Hospital*
16:10 - 16:20	'Distal-First' Technique for Laparoscopic Total Mesorectal Excision in Patients with Ultra-low Rectal Cancers *Dr. Oliver C. Y. CHAN* *Department of Surgery, Pamela Youde Nethersole Eastern Hospital*
16:20 - 16:30	Endoscopic Argon Plasma Coagulation as First-line Treatment for Chronic Radiation Proctitis *Dr. Nancy C. NG* *Department of Surgery, The Chinese University of Hong Kong* *Prince of Wales Hospital*
16:30 - 16:40	The Use of Transrectal Ultrasound in Pre-operative Assessment of Rectal Tumour *Dr. KWOK Shu Yan* *Department of Surgery, Kwong Wah Hospital*
16:40	**Prize Presentation and Closing :** *Dr. William C. S. MENG*

Keynote Lecture

Stapled Anopexy After Ten Years

Dr. Antonio LONGO
Consultant Chief Surgeon, Department of Coloproctology and Pelvic Diseases,
St. Elisabeth Hospital, Vienna, Austria

The haemorrhoids and anal mucosa improving anal fluid continence, therefore it is advantageous to preserve them.

The most theory accepted by now, is the prolapse theory.

These alterations predisposes to well-known vascular complications of the haemorrhoidal tissue: edema and thrombosis.

In addition the displacement of the rectal mucosa into the anal canal is frequently combined with continence disorders such as moist anus, soiling and leakage.

Considering that haemorrhoidal symptoms are secondary to prolapse, and that the disease does not manifest itself without prolapse, it is rational to assume that the reduction of such alteration could solve all the connected disorders. On the basis of this assumption we have set up a technique that reduces the anal mucosa and haemorrhoidal prolapse by a circular stapler mucosectomy carried out above the haemorrhoidal tissue, thus saving both the haemorrhoids and the anal mucosa. The operation is easily feasible, owing to the constant presence of the mucosa rectal prolapse joined with the anal prolapse. The use of a circular stapler, has added the advantage of simplifying and speeding up the operation, and, most importantly, allows us to carry out a sterile suture in a polluted environement. The contemporaneus section and suture of the prolapse accomplished by the stapler, prevents the detachment and the bacterial infiltration of the sub-mucosa space. Moreover the technique realises an interruption of the terminal branches of the superior haemorrhoidal vessels as it is demonstrated by the histological specimen examination but at the moment, I have no argument to say if this is also a therapeutic aspect of the procedure. Up to now about 1,000,000 of this type of operations have been carried out mostly surgeons have published their own data. Prospective randomized trial comparing stapled anopexy with haemorrhoidectomy confirms sustained benefit of anopexy in the management of prolapsing haemorrhoids. The stapled procedure is superior to haemorrhoidectomy in terms of postoperative pain, stenosis, discomfort at defecation and return to normal activity.

Functional and symptomatic outcomes have been satisfactory. Moreover, my long-term follow-up outcomes was excellent and recurrences are less than 3%. The recently employment of more advanced device (PPH03), improving intra and postoperative anastomotic bleeding and operative time.

Inflammatory Bowel Disease : Local Experience and Medical Therapy

Dr. LEUNG Chi Man
Specialist Gastroenterologist, Department of Medicine,
Pamela Youde Nethersole Eastern Hospital, Hong Kong SAR, China

Inflammatory bowel diseases (IBD) are chronic inflammatory disorders of the gut of unknown aetiology and comprise two distinct entities, namely, ulcerative colitis (UC) and Crohn's disease (CD). UC is a disease affecting the colon, where inflammation may extend for a variable distance from the rectum. In CD, any part of the gastrointestinal tract from the mouth to the anus can be affected.

The incidence of IBD is higher in Western countries compared with Asian countries. Earlier reports published two decades ago showed that IBD were rare among the Chinese population in Hong Kong. We performed a retrospective review of all consecutive cases of ethnic Chinese with IBD diagnosed and treated in a regional hospital in Hong Kong from 1993 to 2005. An increased trend in the incidence of both UC and CD was observed. A total of 95 patients with UC and 46 patients with CD were diagnosed and treated. In contrast to Western countries, where familial clustering of IBD was a common occurrence, none of our Chinese patients had a family history of IBD. No gender difference was observed in UC whereas a slight male predominance (65%) was seen in CD. Diarrhoea and per-rectal bleeding were the major presenting symptoms for UC, whereas abdominal pain was the predominant presenting symptom for CD. Most of the patients with UC had distal colitis (59%), namely proctitis (35%) and proctosigmoiditis (24%). Ileocolonic disease (67%) was the commonest pattern of involvement for CD, whereas isolated small bowel disease (16%) or isolated large bowel disease (17%) was relatively less common. Extraintestinal manifestations were rare. Erythema nodusum was seen in one patient with CD at presentation. Another patient with CD had radiological evidence of sacroiliitis. ERCP was undergone in one patient with UC for deranged liver function and revealed features of sclerosing cholangitis. Majority of patients (98%) with UC responded to medical therapy alone. Colectomy was performed in two patients (2%) because of toxic magacolon in one patient and severe colitis refractory to medical treatment in another patient. Patients with CD were more likely to require surgical treatment and 19 patients (41%) had a history of least one intestinal resection.

Medical therapy of IBD should firstly to induce clinical remission and then to maintain the disease in remission. The initial therapeutic approach depends upon the extent of bowel involvement as well as the severity of disease at presentation. Traditional therapies include the use of 5-aminosalicylate (5-ASA) agents and corticosteroids. Immunosuppressive drugs have demonstrated efficacy in the setting of steroid-dependent and steroid-resistant diseases. Recent advance has led to the development of biologic treatments. The prototypical anti-TNF agent, infliximab, has showed promise in the treatment of IBD refractory to conventional medical therapy. In general, most clinicians use a stepped approach to therapy in which more potent agents are added to the regimen if less active drugs fail to achieve an adequate response.

1. ***5-ASA agents***

   Sulphasalazine is the prototypic 5-ASA compound composed of mesalazine, the active moiety, linked to a sulfapyradine ring by an azo bond which is split by bacterial azo-reductase in the colon. Sulphasalazine is indicated for induction and maintenance therapy of mild to moderate UC. Newer 5-ASA formulations have been developed, which lack a sulfa moiety and are better tolerated. The newer 5-ASA compounds also have different delivery mechanisms, such as pH-dependent enteric coated preparation (Salofalk®, Asacol®) or slow-release preparation (Pentasa®), which are designed to deliver the active drug topically to the diseased part of the intestine. The newer 5-ASA agent is effective for induction of remission of mild to moderate CD and in maintaining remission in patients with CD after surgical resection.

2. ***Corticosteroids***

   Corticosteroids are the first medication to be evaluated systematically in patients with IBD and have been well established as being efficacious for active UC and CD. Corticosteroids are indicated when 5-ASA agents are inadequate for induction of remission. Budesonide is a novel glucocorticoid that has a high affinity for the glucocorticoid receptor but low systemic activity due to extensive first-pass metabolism in the liver, and hence a better adverse event profile. There is no evidence to recommend the use of corticosteroids as maintenance therapy for UC and CD. Corticosteroids should be tapered and stopped once remission is achieved.

3. ***Antibiotics***

   Antibiotics have been evaluated as primary therapy for IBD with the rationale of altering the composition of the intestinal microflora. The published literature suggests a modest benefit of metronidazole or ciprofloxacin for primary or adjunctive therapy of colonic CD but not for isolated small intestinal disease. Controlled trials of antibiotics in UC have not demonstrated a consistent benefit.

4. ***Immunomodulators***

   Azathioprine or its active metabolite 6-mercaptopurine (6-MP) is an immunosuppressive agent. Efficacy has been demonstrated in both active and quiescent UC and CD. Azathioprine is indicated in steroid-dependent or steroid- resistant disease. The onset of benefit typically takes several weeks and may require up to six months.

   Methotrexate is an alternative for patients who cannot tolerate or are unresponsive to azathioprine. It is effective in the treatment of steroid-dependent active CD and in maintaining remission. To guarantee bioavailability, the drug should be administered as a weekly intramuscular injection, and the response usually becomes evident over a period of several weeks. There is no role of methotrexate in the treatment of UC.

   Cyclosporine may be particularly suitable in steroid-resistant patients with new onset UC presenting as severe or fulminant disease, who are hospitalized and otherwise in need of urgent colectomy. Cyclosporine is usually given as a continuous infusion to a patient with severe colitis that is steroid-resistant after 7 to 10 days of therapy. Cyclosporine is, however, not effective for the induction of remission in CD.

5. ***Anti-TNF therapy***

   The availability of the anti-TNF agent, infliximab, has offered an important advance in therapy for IBD. Infliximab is a mouse-human chimeric monoclonal antibody that neutralizes the biologic activity of TNF-alpha. Clinical trials have demonstrated significant benefits of infliximab for induction of remission in moderately active, steroid refractory CD and maintenance of remission in these patients by repeated infusions of infliximab, given at 8 weeks intervals. Emerging evidences have suggested that infliximab is also of benefit in UC.

Critical Appraisal on the Role and Outcome of Emergency Colectomy for Uncomplicated Right-sided Colonic Diverticulitis

J.W.C. Mou, W.W. Leung, S.S.M. Ng, J.C.M. Li, J.F.Y. Lee
Department of Surgery, The Chinese University of Hong Kong, Prince of Wales Hospital, Shatin, Hong Kong SAR, China

Background
The operative approach has always been the topic of dispute for uncomplicated right-sided colonic diverticulitis and the dilemma is often met during surgery. The aim of this study is to evaluate the short-term and long-term surgical outcome of uncomplicated right-sided colonic diverticulitis in our locality.

Patients and Methods
Hospital records with an operative diagnosis of right-sided colonic diverticulitis were reviewed retrospectively. Between the period Dec 1984 to Dec 2003, 93 patients were identified. The clinical presentation, operative findings & procedures and clinical outcome were recorded. An updated telephone interview was conducted to look for any recurrent symptoms or hospitalization.

Results
There were 44 females and 49 males, with a mean age of 45 (range 18 - 81, SD±15.2). Right-sided abdominal pain is the presenting symptom in 86 (92.5%) patients. Thirty-four (36.6%) patients were febrile and 22 (23.7%) patients got a palpable right iliac fossa mass on admission. Thirty-six patients suffered from complicated diverticulitis with either abscess formation or bowel perforation and the others (57 patients) suffered from uncomplicated diverticulitis. Colectomy was performed in 59 (63.4%) patients and the others received appendectomy ± diverticulectomy. For patients with uncomplicated diverticulitis, the post-op complication rate was higher in the colectomy group but not reaching statistical significance (20% vs 6.3%, p=0.221). Though the non-colectomy group reported significantly higher rate of recurrent symptoms (28.1% vs 4%, p=0.03), the re-hospitalization rate was comparable between the two groups (15.6% vs 12%, p=1.0). The main reason for further hospitalization in the colectomy group was intestinal obstruction and that for the non-colectomy group was recurrent abdominal pain.

Conclusion
Emergency colectomy is not advisable for uncomplicated right-sided colonic diverticulitis because the associated short-term and long-term morbidities out-weighted its benefit.

Stapled Hemorrhoidopexy for Acute Thrombosed Hemorrhoids: A Randomized Trial

J.C.H. Wong, C.C. Chung, H.Y.S. Cheung, O.C.Y. Chan, K.K.K. Yau, M.K.W. Li
Department of Surgery, Pamela Youde Nethersole Eastern Hospital, Hong Kong SAR, China

Purpose
A randomized controlled trial to evaluate and compare the safety and efficacy of stapled hemorrhoidopexy with conventional hemorrhoidectomy for patients with acute thrombosed hemorrhoids.

Method
Patient admitted with acute thrombosed hemorrhoids were recruited and randomized into two groups: 1) Stapled hemorrhoidopexy group and 2) excision hemorrhoidectomy group. Surgery was performed within 24 hours after admission. Demographic, peri-operative data and complications were recorded. Patients were followed up using a structured proforma to evaluate pain, symptoms, continence function and overall satisfaction at regular intervals.

Results
Twenty-two patients, aged 24 to 82, were randomized, including 9 females and 13 males. There were 11 patients in each group. The median follow up was 13 weeks. The age and sex of the two groups were matched. No significant difference was identified between the two groups in terms of operative time and blood loss. There was no unscheduled readmission in the stapled group, as opposed to two in the excision group. In the stapled group, two patients (18%) were complicated by transient urinary retention. In the excision group, four patients (36%) developed complications. Three of them suffered from urinary retention and one developed secondary hemorrhage. Although there was no significant difference between the two groups in terms of post-operative maximal pain score, average pain score as well as the analgesic requirement, patients in the stapled group recovered faster with respect to decrease in pain ($p=0.02$) and wound healing ($p=0.005$). None of the patients in the stapled group required a second intervention, whereas two patients in the excision group required additional procedures. In the stapled group, smooth muscle incorporation in the doughnuts was found in 54%, but this was not associated with any change in post-operative continence function. Patients in the stapled group has a significantly better overall improvement ($p=0.035$) as well as satisfaction score ($p=0.004$).

Conclusion
Stapled hemorrhoidopexy for patients with acute thrombosed hemorrhoids is safe. Its effectiveness in relieving symptoms is at least equivalent to conventional surgery, with comparable complication rate and continence function. Most importantly, our data suggest the stapled technique is superior because it results in faster recovery and is associated with better overall improvement and patient’s satisfaction.

Factors Affecting the Quality of Life of Colorectal Cancer Patients in Hong Kong Chinese Population

S.Y.W. Liu, W.W. Leung, S.S.M. Ng, J.F.Y. Lee
Department of Surgery, The Chinese University of Hong Kong, Prince of Wales Hospital, Shatin, Hong Kong SAR, China

Background
Changes in quality of life, bladder and sexual dysfunction were recognized complications after colorectal resection for cancers. Current literature results were simply representing the Western population. Few trials were available for investigating such changes in Chinese.

Objective
To evaluate the potential factors affecting the quality of life (QOL) of colorectal cancer patients in Hong Kong Chinese population.

Method
QOL was assessed in patients who had undergone curative rectal or colonic resection for at least more than 1 year by either open or laparoscopic approach for carcinomas of sigmoid, rectum or anal canal. Disease-free patients were invited for questionnaire study. The European Organization for Research and Treatment of Cancer (EORTC) QOL-C30 & CR38 (Chinese version) questionnaires were adopted for analyzing the QOL and investigating the impact on QOL by age, gender, location of tumor, surgical approach, sphincter preservation and presence of stoma.

Results
One hundred and twenty-nine patients, who had been operated from July 2001 to Dec 2004, completed the questionnaires. Statistical analysis revealed that postoperative QOL and bladder dysfunction were independent of age, gender, location of tumor, surgical approach and the presence of stoma. With regard to age, younger patients (age<65) had better role functioning ($p=0.032$) and emotional functioning ($p=0.028$) than older age groups despite poorer sexual functioning ($p<0.001$). For gender, male patients in younger age group (age<65) had significantly higher sexual dysfunction compared to female groups ($p=0.005$).

Conclusion
In Chinese population, young age and male gender did not affect the QOL of postoperative colorectal cancer patients although sexual dysfunction was significantly higher in these patient groups.

'Distal–First' Technique for Laparoscopic Total Mesorectal Excision in Patients with Ultra-low Rectal Cancers

O.C.Y. Chan, J.C.H. Wong, K.K.K. Yau, C.C.C. Chung, M.K.W. Li
Department of Surgery, Pamela Youde Nethersole Eastern Hospital, Hong Kong SAR, China

Background

Sphincter preserving surgery with coloanal anastomosis for very low rectal cancer has been shown to have sound oncological clearance and prevent patient from having permanent stoma. It is always a major challenge however, for surgeons to achieve a clear distal margin to prevent local recurrence. Herein, we describe a technique which helps to ensure a clear distal margin during laparoscopic resection for ultra-low rectal cancers.

Method

Three patients with rectal cancer at 4cm from anal verge with preoperative imaging showing T2 tumor were included. Transanal division of rectum distal to the tumor with adequate resection margin was first performed. Rectal tube was detached from sphincter and was closed to prevent tumor spillage. Subsequent laparoscopic dissection was facilitated. Specimen was then delivered via anus. Transanal coloanal anastomosis was subsequently carried out using interrupted sutures. Covering loop ilesotomy was performed in all cases.

Results

The average operation time was 140min. No major complication occurred and the average hospital stay was 7 days. Histology confirmed clear distal margin in all three cases.

Conclusion

This 'distal-first' technique helps to achieve clear distal resection margin in patients with early rectal cancer close to the anal verge. It is safe, technically feasible and aids subsequent pelvic dissection. Longer follow up and more patients are required to assess its oncological and functional outcome.

Endoscopic Argon Plasma Coagulation as First-line Treatment for Chronic Radiation Proctitis

N.C. Ng, S.S.M. Ng, J.F.Y. Lee, R.Y.C. Yiu, J.C.M. Li, K.L. Leung
Department of Surgery, The Chinese University of Hong Kong, Prince of Wales Hospital, Shatin, Hong Kong SAR, China

Background
Chronic radiation proctitis is a serious complication of radiotherapy for pelvic malignancies, which can be very difficult to treat. This prospective study aimed to evaluate the efficacy and safety of endoscopic argon plasma coagulation (APC) as first-line treatment for chronic radiation proctitis that did not respond to regular steroid enemas.

Methods
From January 2001 to December 2004, twenty consecutive patients with chronic radiation proctitis received APC as first-line treatment. Main outcome measures were control of bleeding, hospitalization and blood transfusion requirements, and complications. Patients who did not respond to APC were subjected to formalin dab as salvage treatment.

Results
The median duration of rectal bleeding before APC was 6.3 (range, 1-32.6) months. Eight patients required repeated admissions to hospital for blood transfusions (median 3.5 units, range 2-15 units) before APC. The median number of sessions of APC was 1.5 (range, 1-3). APC was only effective in twelve patients (60%). Eight patients had persistent bleeding despite repeated APC. Among them, six patients were subjected to salvage formalin dab, while two patients died before further treatment could be given. Complete cessation of bleeding was achieved in four patients after formalin dab; the other two patients died shortly after formalin dab due to progression of malignancy. For patients who responded to APC, the median number of hospital admissions was significantly reduced after treatment ($P = 0.001$). The APC responders had significantly higher pre-treatment haemoglobin level (11.9 vs. 7.9, $P = 0.018$) and a lower pre-treatment blood transfusion requirements (25% vs. 62.5%, $P = 0.167$) when compared with non-responders. At a median follow-up of 17.7 months, there was no recurrent bleeding in the sixteen surviving patients. No patients developed complications after APC or formalin dab.

Conclusion
APC is an effective and safe first-line treatment modality for chronic radiation proctitis. However, for patients with more severe bleeding as indicated by low haemoglobin level and high blood transfusion requirements, APC is less effective, and formalin dab may be a better treatment alternative.

The Use of Transrectal Ultrasound in Pre-operative Assessment of Rectal Tumour

S.Y. Kwok, P.Y.Y. Lau, W.C.S. Meng, A.W.C. Yip
Department of Surgery, Kwong Wah Hospital, Hong Kong SAR, China

Objective
Transrectal ultrasound has improved the ability to delineate the layers of the rectal wall and to identify enlarged lymph nodes, thereby improving treatment and predict the prognosis of the patient with rectal tumour. This prospective study is to examine the accuracy of transrectal ultrasound in pre-operative staging of rectal tumour by assessing the depth of tumour infiltration (T staging).

Methods
From December 2001 to August 2005, there were fifty three patients with rectal tumour was studied prospectively. They were submitted to preoperative evaluation by transrectal ultrasound and the results of imaging were compared with the histological findings of the resected specimen.

Results
The histological diagnoses were: non-invasive tumour (n=16, 10 villous or tubulovillous adenoma, 6 carcinoma in situ); invasive tumour (n=37, 11 pT1, 11 pT2, 15 pT3). The overall accuracy of transrectal ultrasound for depth of tumour infiltration (T staging) was 81% (43/53). Overstaging occurred in 5.7% (3/53) of patients, whereas understaging occurred in 13.2% (7/53). The accuracy for pT0/pTis tumour was 100% (16/16), 91% (10/11) for pT1, 27% (3/11) for pT2 and 93% (14/15) for pT3.

Conclusion
Transrectal ultrasound accurately assessed the depth of infiltration of rectal tumour. This method may aid the selection of treatment for patients with rectal tumour.

A Case Report : Faecal Peritonitis Complicating Pregnancy

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The reported incidence of colorectal cancer in pregnant women is between 0.001 to 0.1%. Delay in diagnosis and treatment is often the cause of poor prognosis.

A 28 year-old lady (gravida 1, para 0) was admitted for abdominal pain and bloody diarrhoea at 18 weeks gestation. Her past health was unremarkable except that she experienced a few episodes of per rectal bleeding prior to pregnancy and at 16 weeks gestation, which were all treated as dysentery with antibiotics. However, as her symptoms failed to improve, she was referred to us.

On admission, the patient was septic and developed generalized peritonism. Digital rectal examination revealed a rectal tumour at 7cm above anal verge. Laparotomy was performed and found 400ml faeculent material in the peritoneal cavity. Due to the presence of the gravid uterus, the rectum could not be adequately assessed. Therefore, after adequate lavage, the transverse colon was brought out as end colostomy and mucous fistula.

Lengthy discussion and counselling was made by obstetrician, clinical psychologist, general surgeon and the couple. The patient finally agreed for medical termination of pregnancy. Then abdominal computed tomography was arranged for staging and low anterior resection with total mesorectal excision was performed 4 weeks after the initial laparotomy. Primary anastomosis was not attempted because of the suspected residual disease in the pelvic side wall. She recovered smoothly after the second operation. Pathology confirmed T3N1 tumour with clear resection margins and postoperative chemo-irradiation was given.

The clinical outcome of this patient highlights the importance of detailed physical examination and proper investigations in handling patients with lower gastrointestinal symptoms. Without clinical suspicion, per rectal examination and change in bowel habit during pregnancy is often assumed to be related to haemorrhoids and hormonal change. As a result, even a low lying rectal tumour could easily escaped detection throughout the antenatal period.

The Efficacy of Multidisciplinary Approach on the Management of Constipation

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Background
Standard measures for the management of constipation includes adequate dietary fiber and fluid intake, regular exercise, and biofeedback training. However, there is no documentation on the effect of the above in Hong Kong.

Aim
To evaluate a rehabilitative program for the treatment of constipation in Hong Kong.

Methods
Patients diagnosed with chronic constipation using the Rome II criteria were recruited. Clinician, dietitian and physiotherapist assessed the patients. Anorectal physiology investigations and defaecation proctography were performed prior to and after the treatment program. The treatment program involved consultation by the dietitian, postural re-education, and pelvic floor re-education on proper defaecation pattern. Patients were followed up in alternate week for the first three months and monthly for another three months. As there was no significant difference in anorectal physiology finding in the previous pilot study, a new method of anorectal manometry to observe the dyssnergic defecation was introduced. By investigating the relationship of the external anal sphincter pressure and rectal pressure during straining and squeezing, the coordinated response of anorectum during the attempted defecation was assessed.

Results
Ten patients completed the program using the new method of anorectal manometry for assessment. The mean age was 51.9 from 40 to 67 years old. On completion of the program, there was significant improvement in fibre intake (pre : 12.919 +/- 1.06; post : 20.266 +/- 1.064; p=0.001), average straining effort (pre : 6.36 +/- 0.391; post : 3.72 +/- 0.391; p=0.001), average straining time (pre : 17.61 +/- 2.172; post : 6.00 +/- 2.172; p=0.004). There is no significant difference in the result with sex as a covariate. There was no significant difference in all anorectal physiology finding although 70% of these patients achieved a decrease at the external anal sphincter pressure on straining but statistically non-significant (pre : 26.09 +/- 4.014mmHg; post : 24.15 +/- 4.014mmHg); 100 % of patient reported >50% improvement in their symptoms. There was 60% of patient suffering from urinary incontinence as well.

Conclusion
This trial demonstrates that such rehabilitative program for constipation can significantly improve the symptom of constipation. The new method of anorectal manometry was launched to assess the paradoxical response of anorectum during attempted defecation. Larger number of patients would be conducted to verify these results. This modified version of anorectal manometry is expected to document the severity and progression of constipation in a more sensitive way.

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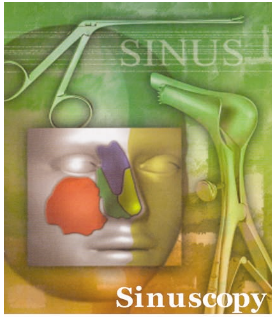

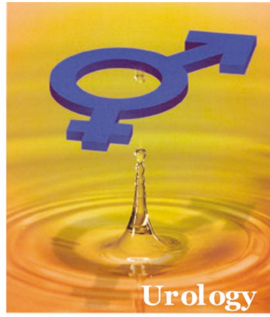

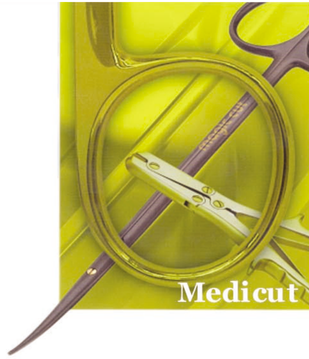

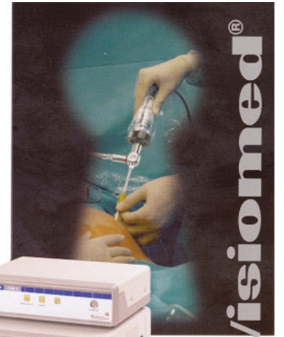

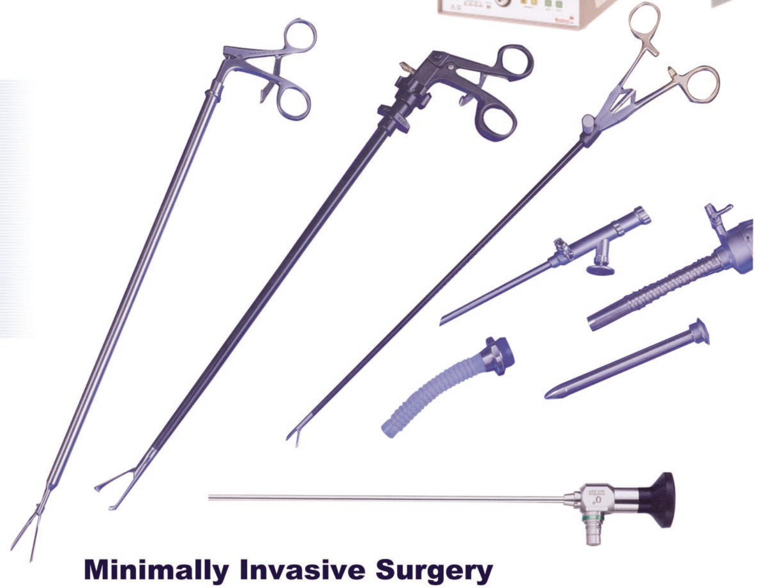

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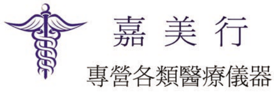

香 港 肛 腸 科 學 會

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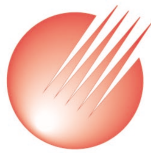

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