Foreword

Approaches to Anorectal DiseaseH. Randolph Bailey, MD, FACS, FASCRS¹¹ Department of Surgery, University of Texas-Houston, Smith Tower, Houston, Texas

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The management of anorectal disease distinguishes the colon and rectal surgeon from other physicians who manage patients, both medically and surgically. While considered “trivial” by the casual observer, disorders of the anorectum can be life-altering for the patient. From “simple” problems such as pruritus ani and hemorrhoids to complex issues such as anal fistula and rectal polyps, understanding of the pathophysiology and anatomy is critical to success in management. We now have a large body of data on which to base our treatment of these conditions.

Most anorectal operations were performed on an in-patient basis as recently as 20 to 25 years ago. In 1974, when I was a resident at the Ferguson Clinic, the routine length of stay following surgical hemorrhoidectomy was 5 days! Today, due to improved perioperative care and pressure from third-party payers, most of these procedures are performed in the ambulatory setting. The biggest beneficiary of this change has been the patients who, in my opinion, do much better when spared from the hospital environment.

Complications after anorectal surgery have decreased significantly in recent years. We now know that restriction of fluids in the perioperative period dramatically reduces the incidence of urinary retention. Carefully and skillfully performed anorectal operations also lead to decreased risks for anal stenosis and disturbances of continence. We want to be “plastic surgeons of the anus”!

Since most patients describe any abnormality of the anal area as “hemorrhoids,” our understanding of these conditions is important, and we must have a number of techniques in our armamentarium, from simple to complex. Appropriate care often requires a tailored approach to achieve an optimal result. Every new technique must be measured against surgical hemorrhoidectomy with regard to durability and long-term patient satisfaction.

Anal fissure is likely the most common problem seen by the colorectal specialist, with many treatment options available. When patients fail nonoperative therapy, many surgeons have been frightened by reports of alterations of

continence and therefore reluctant to suggest sphincterotomy. That procedure, when performed appropriately, will result in the highest rate of cure with minimal risk. Many of the happiest patients in my practice are those who have benefited from sphincterotomy.

Pruritus ani, often misspelled, is a condition which makes many patients miserable. Usually, minor alterations in diet and perianal hygiene can give the patient a new lease on life. Refractory pruritus or situations when the perianal skin “looks funny” are an indication for biopsy to diagnose rare but treatable benign or malignant conditions such as Bowen’s, Paget’s, or lichen sclerosis.

There have probably been more advances in the treatment of anal fistula in the last 15 years than any other aspects of anorectal disease. Many promising techniques are available, and the skilled colorectal surgeon must be familiar with multiple approaches in order to provide safe and appropriate care. Recto-vaginal fistula can also be very challenging to treat successfully. Timing of surgery and evaluation of continence and sphincter anatomy are critical to achieving good results. Several of the new approaches to fistula-in-ano are applicable to rectovaginal fistulae as well. These include advancement flaps and a trans-perineal variation on the ligation intersphincteric fistula tract (LIFT) procedure.

There are two divergent approaches to the evaluation of patients at risk for anal intra-epithelial neoplasia. Some surgeons are very aggressive in screening for these changes with anal Pap tests and high-resolution anoscopy. Others wait for visible or palpable disease and treat it by ablation or excision. The jury is still out on which approach is the best. The authors of the relevant chapter have described both approaches and their advantages.

The trans-anal approach to large rectal polyps and early cancers is technically challenging, and can be likened to “building ships in bottles.” Conventional local excision of these tumors is limited by the level of the lesion and the skill of the operating surgeon. Trans-anal endoscopic microsurgery requires expensive equipment, and is not available in all centers. More recently, trans-anal minimally invasive surgery

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has been described and popularized. It has the advantage of using more readily available laparoscopic equipment with similar results.

Dr. Langenfeld and the chapter authors are to be congratulated on the publication of an excellent resource

for surgeons treating anorectal disease. They have emphasized data and formulated evidence-based recommendations in the treatment of these problems. Our patients are the real beneficiaries of the knowledge which we glean from this volume of *Clinics in Colon and Rectal Surgery*.