

International Collaborative “Cyber Classroom” (2023)

[10:00am – 12:30 pm, (Malaysia time: GMT+8), 1st April 2023 “Platform: UTAR Zoom Meeting”

Invited Speakers



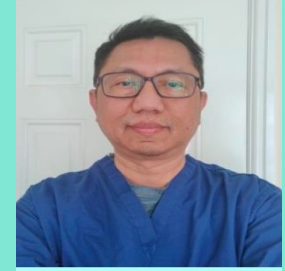
Assistant Prof Dr Faisal Elagili
(Consultant Colorectal Surgeon,
SASMEC@IIUM), IIUM, Kuantan



Prof Dr Lau Hui Ping
(Consultant Thoracic Surgeon),
CEO- UTAR Hospital, Kampar



Dr. Iskandar R Budianto, MD., Phd.,
(Consultant Pediatric Surgeon) ATMA JAYA
Catholic University of Indonesia



Dr. Kyaw Toe, (Breast Surgeon)
North Tees & Hartlepool NHS Trust
United Kingdom

ORGANISED BY:

CLINICAL DEPARTMENTS, FACULTY OF MEDICINE & HEALTH SCIENCES UTAR &
DEPARTMENT OF SURGERY, ATMA JAYA CATHOLIC UNIVERSITY OF INDONESIA
IN COLLABORATION WITH THE “UTAR SURGICAL SOCIETY”

Registration Link:

<https://forms.gle/ZA6onPQEPXwGevY5A>

“FREE
REGISTRATION”

Meeting ID & PW will be
sent upon Registration



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International Collaborative “Cyber Classroom” (2023)

”MODERATORS”



Dr. Yan Naing Soe



Dr. Lee Bee Sun,



Dr. Irene Stephanie,



Dr. Sim Lin Kiat

”Master of Ceremony”



Miss Yeak Xi Yuan



Miss Tan Hui Yin



Miss Chong Tze Ping



Miss Goh Jun Lynn

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بِآيَاتِنَا وَلِيَتَّقُوا رَبَّهُمْ
Garden of Knowledge and Virtue

UTAR
UNIVERSITI TUNKU ABDUL RAHMAN

PROGRAMME

10:00 – 10:05 am

Introduction & Opening address

Emeritus Professor Dr. Cheong Keng Soon (Dean, MK-FMHS)

10:05 – 10:30 am

Talk 1: “Updates in the Management of Perianal Diseases

Assistant Prof Dr Faisal Elagili (Consultant Colorectal Surgeon), Malaysia

10:30 – 10:55 am

Talk 2: Overview of Thoracic Trauma

Prof Dr. Lau Hui Ping (Consultant Thoracic Surgeon), Malaysia

10:55 – 11:10 am

Q & A : Discussion

11:10 – 11:15 pm

“Group Photography Session”

11:15 – 11:40 am

Talk 3: “Gastrointestinal Anomalies in Neonates”

Dr. Iskandar R Budianto, MD., Phd (Consultant Paediatric Surgeon) indonesia

11:40 – 12:05 am

Talk 4: “Updates in the Management of Breast Cancer”

Dr Kyaw Toe (Breast Surgeon) NHS Trust, UK

12:05 – 12:20 pm

Q & A : Discussion

12:20 – 12:30 pm

“Conclusion & Closing remarks”

Felicia Kurniawan MD., MPH., PhD (The Dean of FMHS) Atma Jaya Catholic University of Indonesia



Principles of Management of Perianal Disease

Asst. Prof Faisal Elagili, MD,MS,FASCRS
Consltant of Colorectal Surgery
Department of Surgery, Faculty of
Medicine
International Islamic University



Overview

- › Benign anal disease encompasses common problems including **hemorrhoids, anal fissures, pruritus ani, perianal abscesses, and fistulae.**
- › Healthcare practitioners diagnose and treat these conditions accurately about 50% to 83% of the time.
- › **A rectal examination** is key to accurate diagnosis and treatment.
- › Patients who mention anal problems during a visit may have suffered with the condition for years.

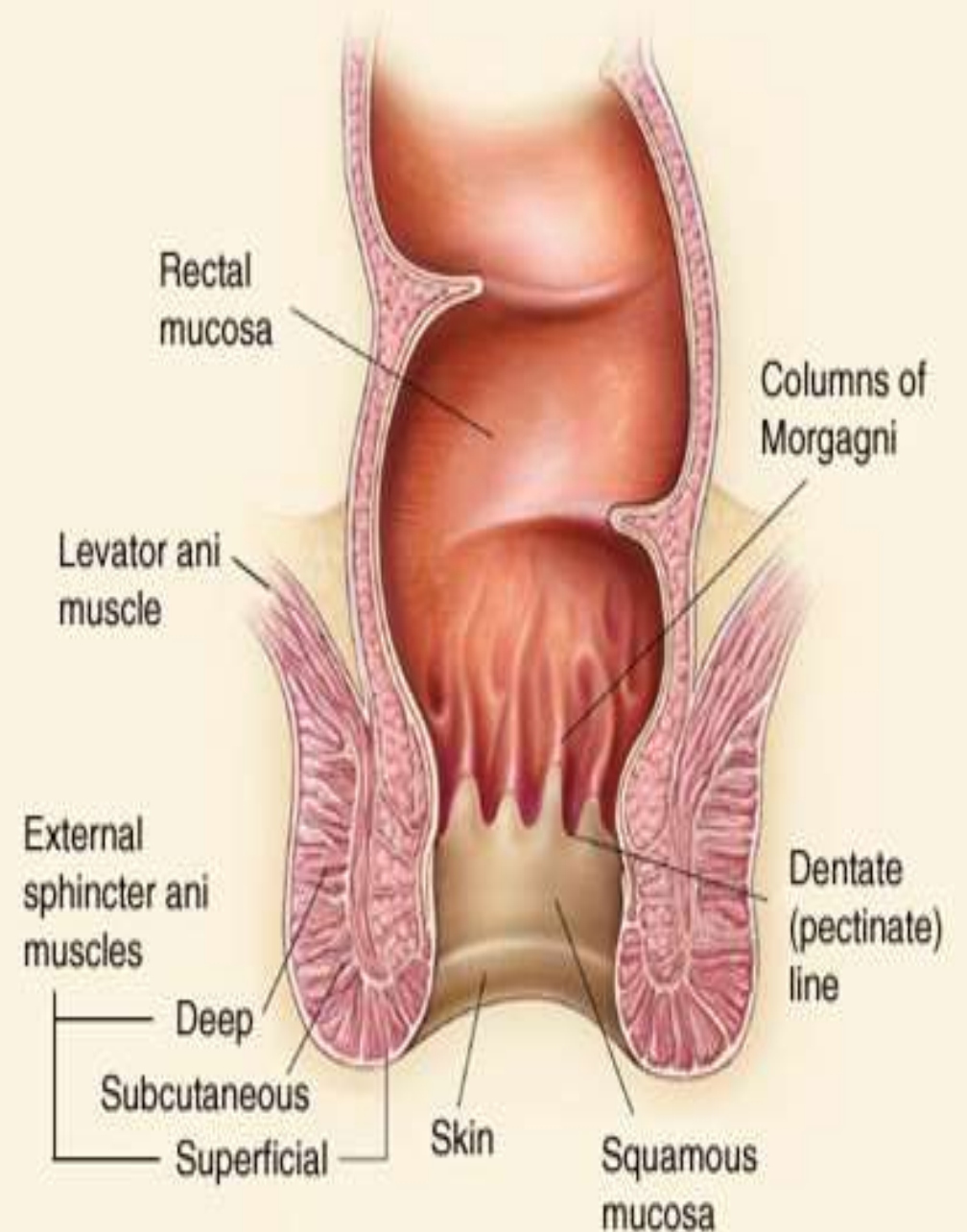


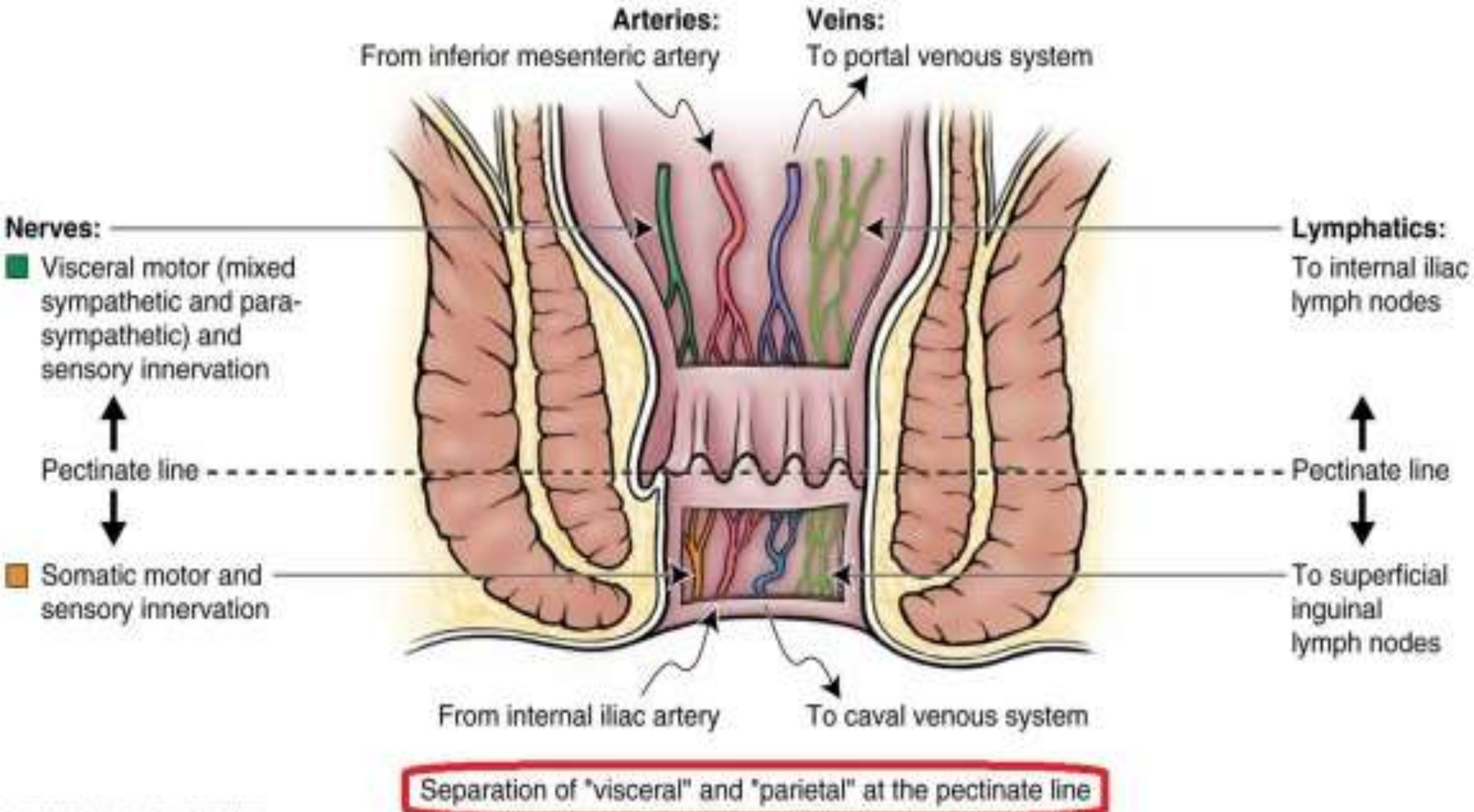
Common symptoms

- › Anal pain
- › Bleeding per rectum
- › Pus discharge from and around anus
- › Anal pruritus
- › Presence of swelling or lumps in or around anus

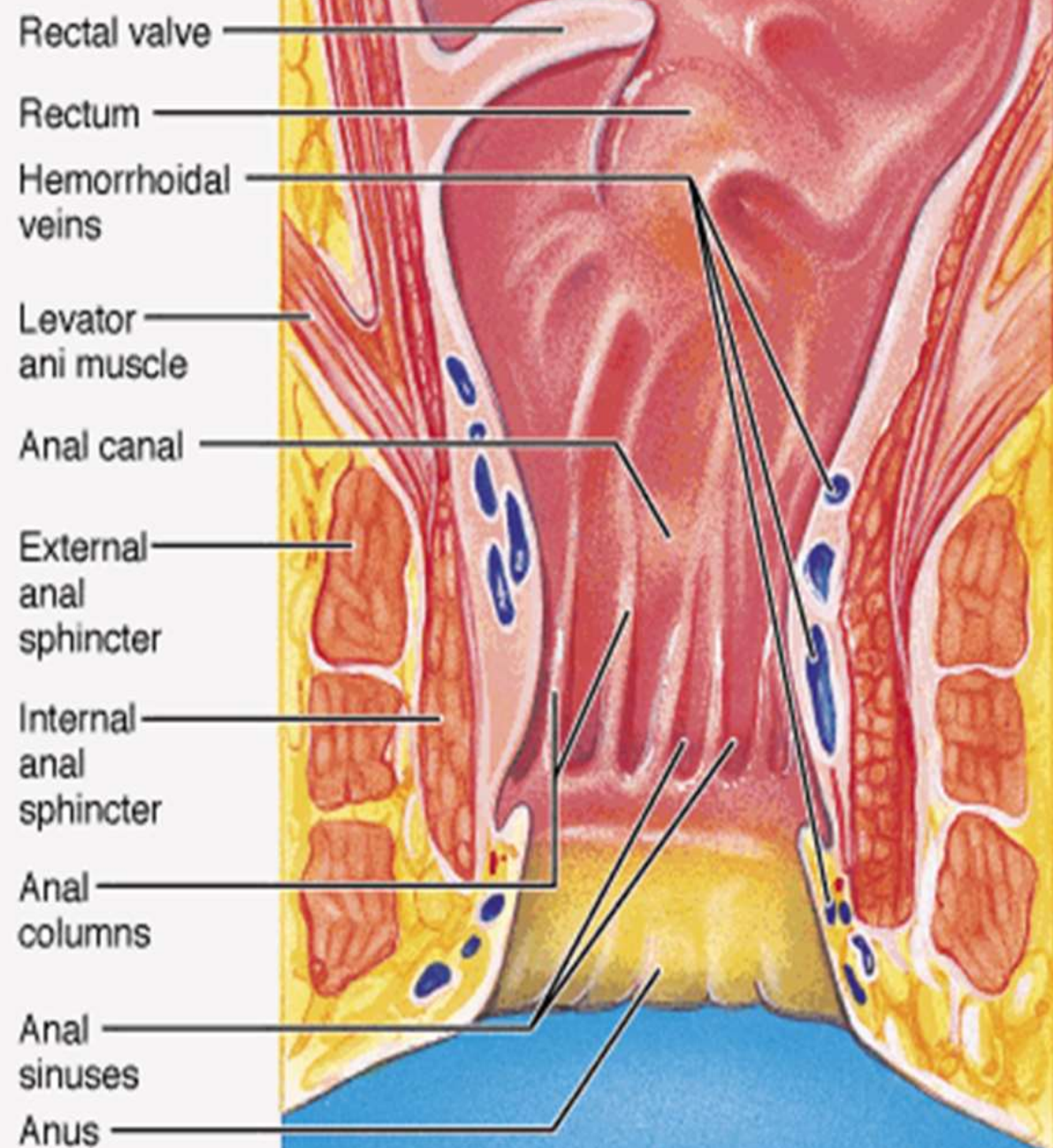
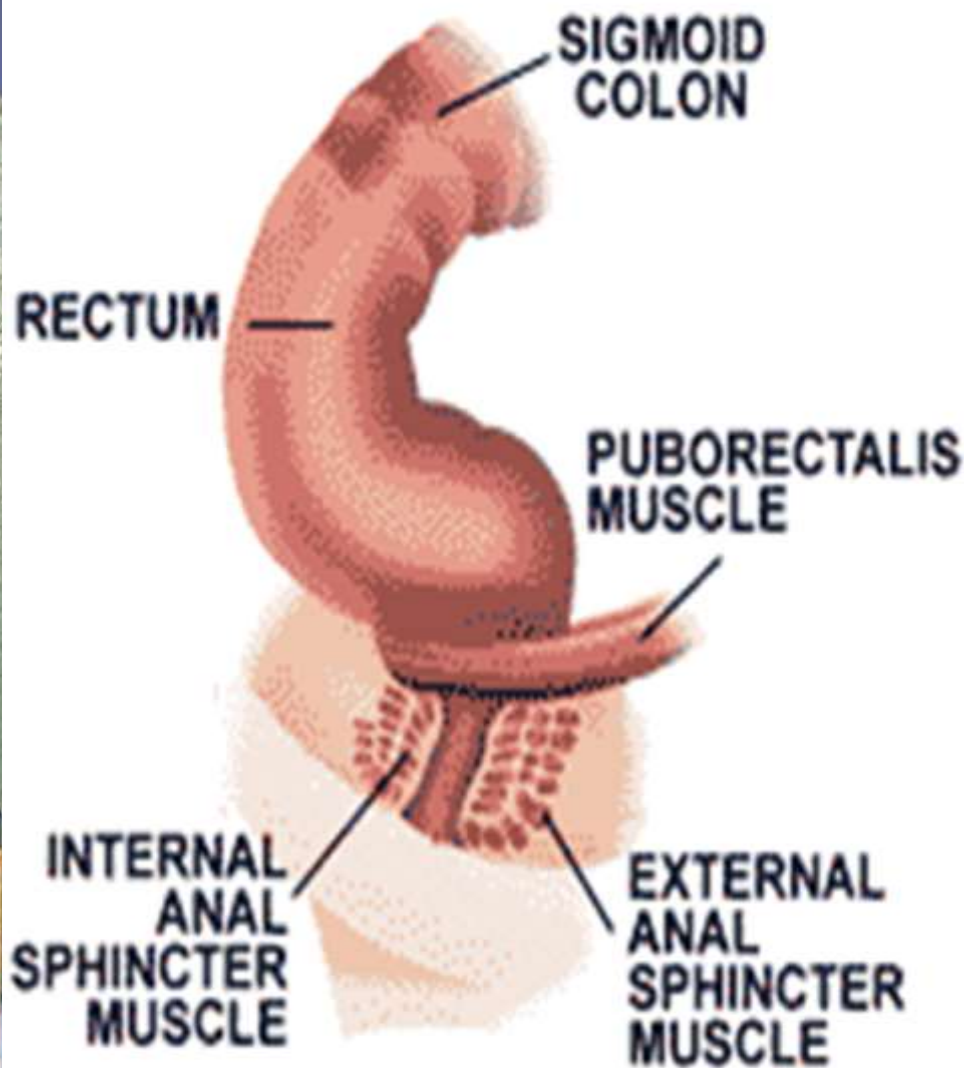
Surgical Anatomy

- › The anal canal starts at the **anorectal junction** and ends **at the anal verge**.
- › The average length of the anal canal is **4 cm**.
- › The midpoint of the anal canal is called the **dentate line**.
- › This dentate or pectinate line divides the **squamous epithelium** from the **mucosal or columnar epithelium**.





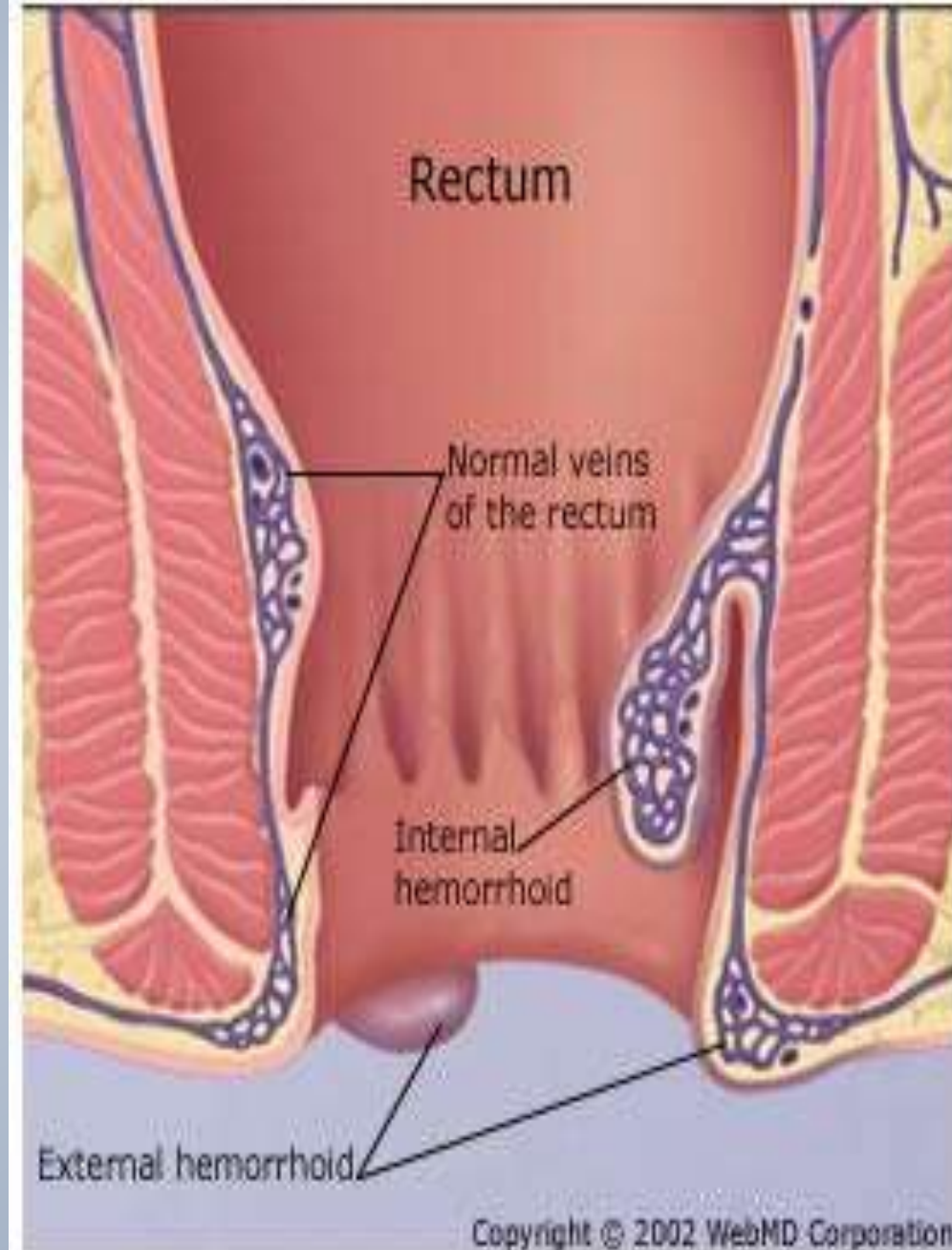
Anatomy of the Rectum and Anal Canal









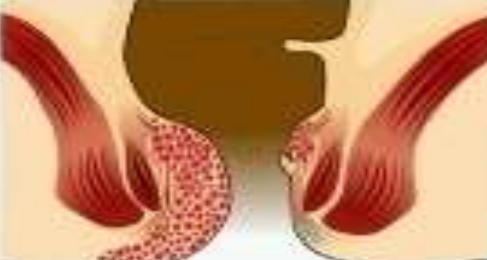

Hemorrhoids

- Hemorrhoids are an extremely common condition, affecting approximately 10 million persons per year.
- Hemorrhoids represent normal, submucosal, venous structures in the lower rectum and anal canal that may be **internal or external depending on their relationship to the dentate line.**
- Internal hemorrhoids are located above the dentate line, and external hemorrhoids originate below the dentate line.

Hemorrhoids



Internal Hemorrhoid Grades

Grade	Diagram	Picture	
1	 A cross-sectional diagram of the rectum showing a small, red, swollen internal hemorrhoid located inside the rectum, not protruding.	 An endoscopic view of the rectum showing a small, red, swollen internal hemorrhoid protruding slightly from the mucosal surface.	<p>➔ No prolapse, just prominent blood vessels</p>
2	 A cross-sectional diagram of the rectum showing a larger, red, swollen internal hemorrhoid that protrudes through the anal canal during defecation but returns to its normal position.	 An external view of the anus showing a red, swollen internal hemorrhoid that has prolapsed through the anal canal.	<p>➔ Prolapse upon bearing down, but spontaneous reduction</p>
3	 A cross-sectional diagram of the rectum showing a large, red, swollen internal hemorrhoid that prolapses through the anal canal and remains outside the rectum.	 An external view of the anus showing a large, red, swollen internal hemorrhoid that has prolapsed through the anal canal and remains outside the rectum.	<p>➔ Prolapse upon bearing down requiring manual reduction</p>
4	 A cross-sectional diagram of the rectum showing a very large, red, swollen internal hemorrhoid that prolapses through the anal canal and remains outside the rectum, often causing significant discomfort.	 An external view of the anus showing a very large, red, swollen internal hemorrhoid that has prolapsed through the anal canal and remains outside the rectum.	<p>➔ Prolapse with inability to be manually reduced</p>

Epidemiology

- › Worldwide, the prevalence of symptomatic hemorrhoids is estimated at 4.4% in the general population.
- › External hemorrhoids occur more commonly in young and middle-aged adults than in older adults.
- › The prevalence of hemorrhoids increases with age, with a peak in persons aged 45-65 years.





Risk factors

- Straining (most common cause in men)
- Constipation
- Chronic diarrhea
- Poor diet (Low-fiber diet)
- Prolonged sitting
- Colorectal malignancy
- Pregnancy
- Hereditary (weakness of the vein walls)
- Obesity
- Spinal cord injury
- Anal intercourse
- Inflammatory bowel disease, including ulcerative colitis, and Crohn disease

Clinical presentations

- › **Painless rectal bleeding:** Bright red bleeding with bowel movements is the most common presenting symptom of problematic internal hemorrhoids
- › **Pruritus(External hemorrhoids)**
- › **Perianal irritation(Internal and external hemorrhoids)**
- › **Mucus discharge(Internal hemorrhoids)**
- › **Prolapsed(Internal hemorrhoid can cause pain)**
- › **Fecal soilage(Internal hemorrhoids)**
- › **Thrombosed or engorged external hemorrhoids may present as pain without bleeding.**



On examination

- › Prolapsed internal hemorrhoid will be a **pink, endoderm-covered lump protruding from the anus.**
- › An external hemorrhoid will be the color of the patient's skin
- › A thrombosed hemorrhoid will be covered in epidermis, **usually bluish in color, very tender, and located on the lateral margins of the anus, sometimes with a dark clot eroding through the medial aspect.**



Evaluation and Diagnosis

- › History
- › Physical examination
 - › Abdominal
 - › Per rectal: Visual inspection of the anus, digital examination, and anoscopy and/or proctoscopy
- › In patients over the **age of 50 years or with a suggestive family history**, this may be the occasion for evaluation of the entire colon, usually **by colonoscopy**

Proctoscope:



Obturator



Proctoscope Sheath



Treatment

› Treatment of hemorrhoids can be divided into **operative** and **nonoperative therapies**

1. Nonoperative

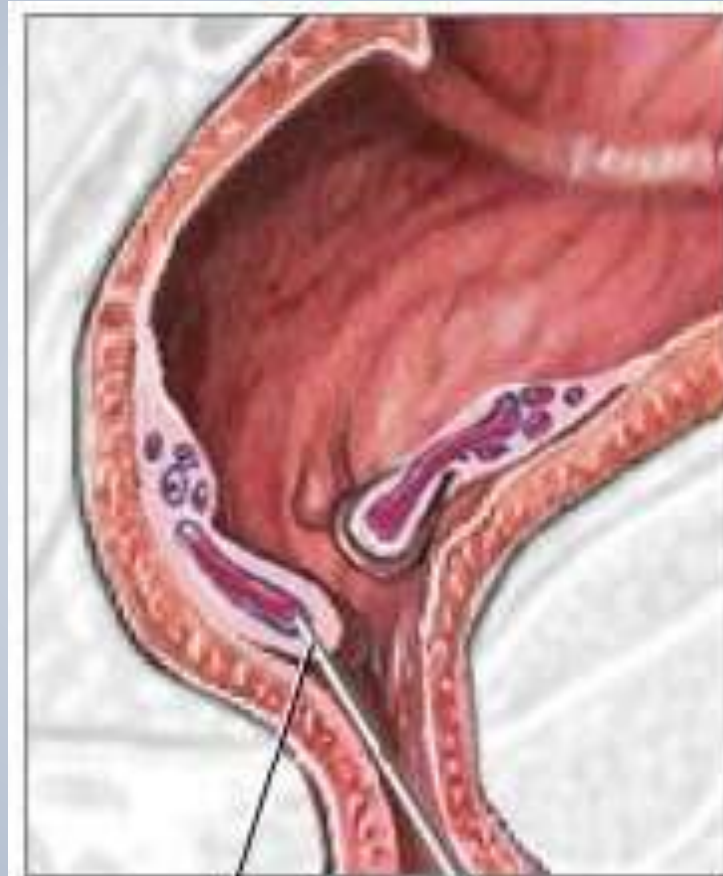
- The treatment of internal hemorrhoids depends on the degree of disease.
- Typically, patients with grades **I, II, and III** internal hemorrhoids can be treated nonoperatively,
- Whereas **grade IV** disease or symptoms that do not respond to in-office management should be referred for surgical intervention.
- Increased **fiber intake and adequate fluids**
- Patients should be counseled to **avoid straining and limit their time spent on the commode**



Treatment

2. Operative

- Most patients with **grade I, II, and III** hemorrhoid disease in whom medical treatment fails may be effectively treated with office-based procedures such as
 - Banding
 - Sclerotherapy
 - Infrared coagulation



Sclerosing agent is injected





Treatment

› Surgical hemorrhoidectomy

1. Refractory to office procedures
2. Unable to tolerate office procedures
3. Have large external hemorrhoid
4. Have combined internal and external hemorrhoids with significant prolapse (grades III to IV).

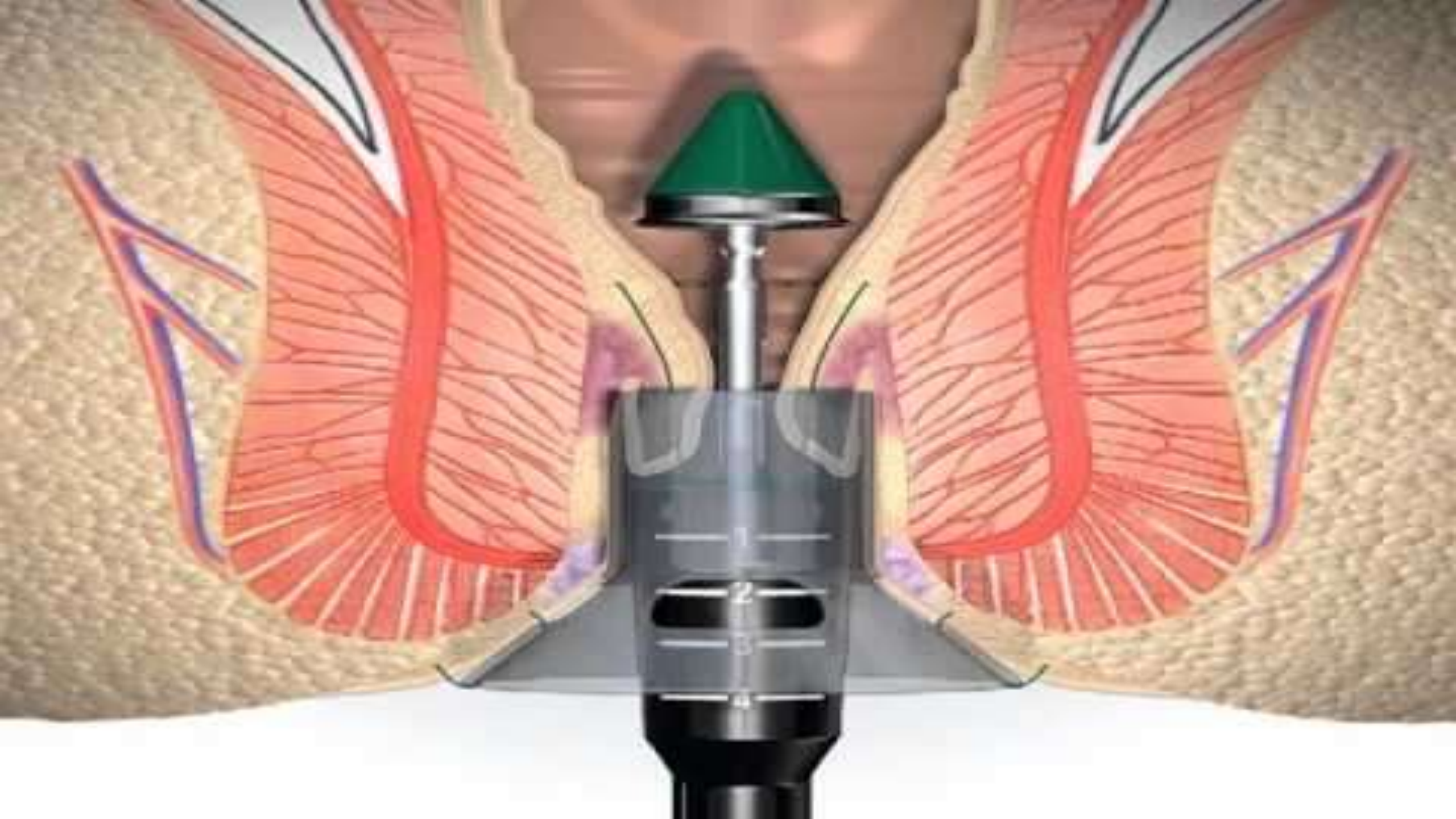
➤ Surgical operations

2. Hemorrhoidectomy
 - Milligane Morgan (open haemorrhoidectomy)
 - Ferguson (closed haemorrhoidectomy)
3. Stapled hemorrhoidopexy
4. Doppler-assisted hemorrhoidal artery ligation



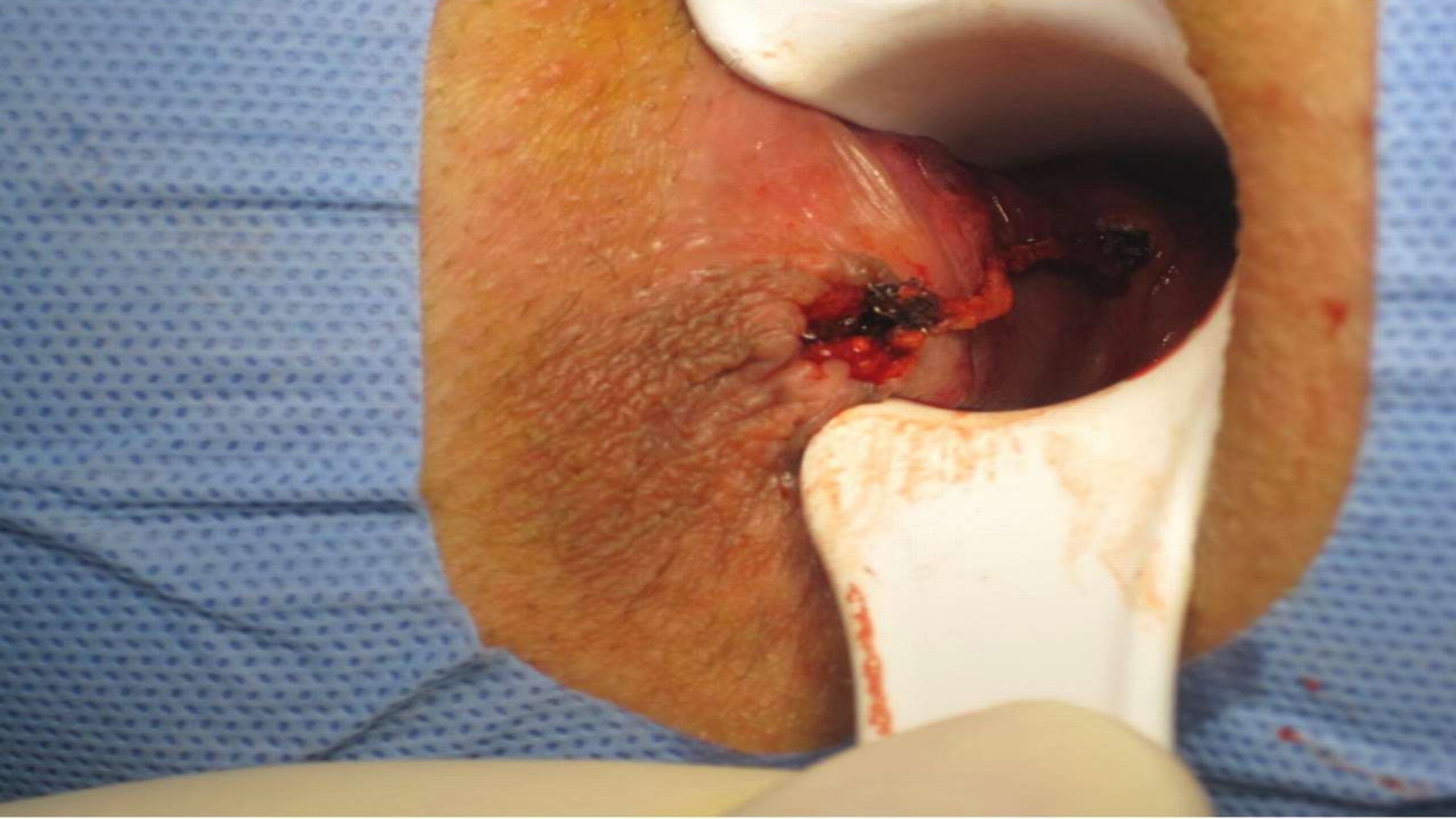
Treatment

- › Patients with painful external thrombosed hemorrhoids can be offered medical treatment or complete excision
- › Excision should be offered only to patients with an external thrombosed hemorrhoid less than 48 to 72 hours old



Open Hemorrhoidectomy





Anal Fissure

- › Anal fissure is an **ulcer-like, longitudinal tear in the midline of the anal canal, distal to the dentate line.**
- › The underlying aetiology of the anal fissure is **anal sphincter spasm**, resulting in high anal pressure which constricts the blood supply, which results in an ischaemic ulcer





Anal Fissure

- › The pathogenesis of anal fissures includes
 - Trauma
 - Elevated anal pressure
 - Ischemia
- › In the posterior midline, which is the site of most fissures, the blood flow is less than half of that seen in other quadrants of the anal canal, and this, in turn, likely contributes to a decreased ability to heal.
- › Typically, there is elevated anal canal pressure in patients with an anal fissure, which is thought to be due to increased internal anal sphincter tone as well as spasm of the muscle beneath the tear, which, in turn, is due to pain from the initial trauma.



Anal Fissure

- › The cumulative lifetime incidence is estimated at **11%**.
- › In almost 90 % of cases, an idiopathic fissure is located in the **posterior midline**, but it can also occur in the **anterior midline**.
- › Fissures in lateral positions should raise suspicion for disease processes such as
 - **Crohn ' s disease**
 - **Tuberculosis, syphilis**
 - **HIV / AIDS**
 - **Dermatologic conditions (e.g., psoriasis),**
 - **Anal carcinoma**

Anal Fissure

› Can be **acute or chronic**

1. **Acute fissure**

- Look like a simple laceration
- Present less than 2 to 3 months
- Associated with bleeding during bowel movements
- Heal with local management.



Anal Fissure

2. Chronic

- Lasting more than 2 to 3 months
- Characterized by edema and fibrosis
- Fibers of the internal anal sphincter may be visible at the fissure base
- Sentinel pile ' (skin tag) at the distal fissure margin, and a hypertrophied anal papilla in the anal canal proximal to the fissure

Chronic anal fissure





Clinical presentation

- › Pain during and after passage of stool
 - Described as sharp, tearing, “like passing knives,” or “shards of glass
- › Rectal bleeding: Usually limited to minimal bright red blood on toilet tissue, is frequent.
- › On digital examination, a chronic fissure feels rough, raised, or fibrotic in the mid-distal anal canal

Treatment

› Nonoperative treatment of acute anal fissures

- Continues to be safe
- Has few side effects
- Should typically be the **first-line treatment**
- Nonoperative measures such as
 - **Sitz baths**
 - **Psyllium fiber or other bulking agents**
 - **With or without the addition of topical anesthetics or topical steroids**





Treatment

- › The chronic anal fissure can be treated with topical pharmacologic agents such as a **calcium channel blockers or nitrates**
- › Injections of botulinum toxin
- › Lateral internal sphincterotomy

Perianal Abscess

- › Most perirectal abscesses originate from an **infected anal gland**
- › Anorectal abscess occurs more often in **males** than **females**
- › May occur at any age, with peak incidence among **20 to 40 year olds**

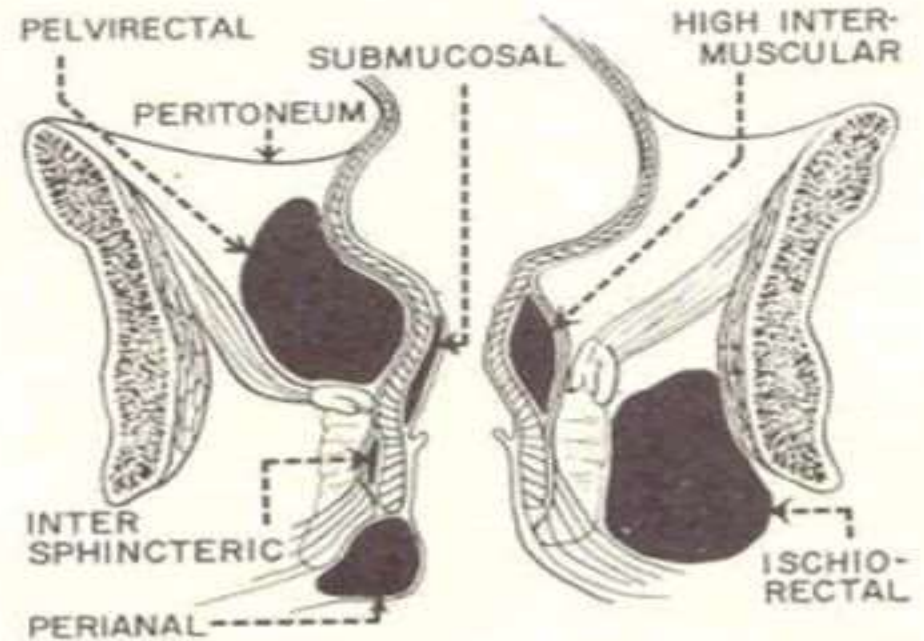


Perianal Abscess



Classification of anal abscesses:

- Perianal (60%)
- Ischiorectal (20%)
- Intersphincteric (5%)
- Supralelevator (pelvirectal) (4%) (is very difficult to diagnose clinically and is very rare and caused by inflammation or a disease in the pelvis)
- Submucosal (1%)



The sites of abscess formation in the region of the anus and rectum.



Clinical Presentation

- › The diagnosis of anorectal abscess is usually based on the patient's **history and physical examination.**
- › **Superficial abscesses**
 - Perianal pain and swelling are common
 - Drainage and fever occur less often
- › **Deeper abscesses(supralelevator)**
 - May also present with pain that is referred to the perineum, low back, or buttocks.



Clinical Presentation

- › Inspection of the anoperineum may reveal
 - Superficial erythema and fluctuance with
 - Tenderness to palpation
 - May be unrevealing in patients with intersphincteric or deeper abscesses
- › Digital rectal examination and anoproctoscopy are occasionally needed to clarify the diagnosis.
- › Sedation or anesthesia may be needed when an awake examination is limited by pain or tenderness.
- › CT scan, ultrasound, MRI should be considered in patients with occult anorectal abscess,

Treatment

- › Immediate **incision and drainage**, either in the office or in the OR, is recommended over the site of fluctuance closest to the anal verge.
- › Unless the patient has **diabetes**, is **immunocompromised**, or presents with **cellulitis**, antibiotics need not be prescribed after a successful incision and drainage.



Fistula-in-ano

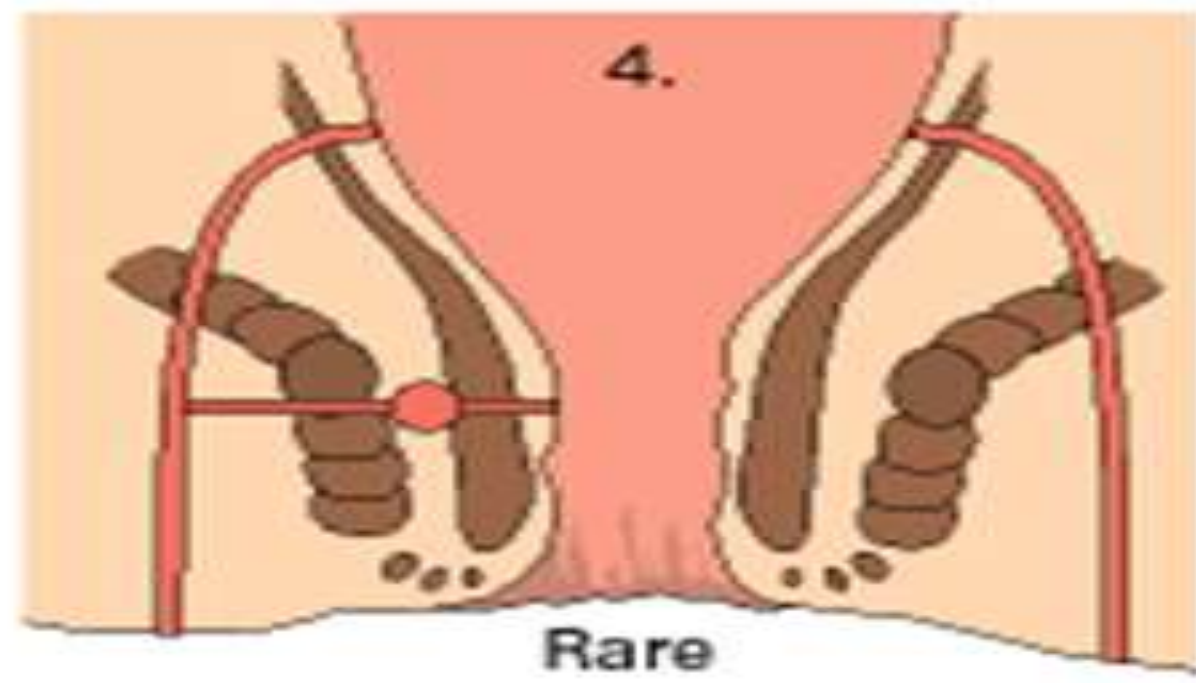
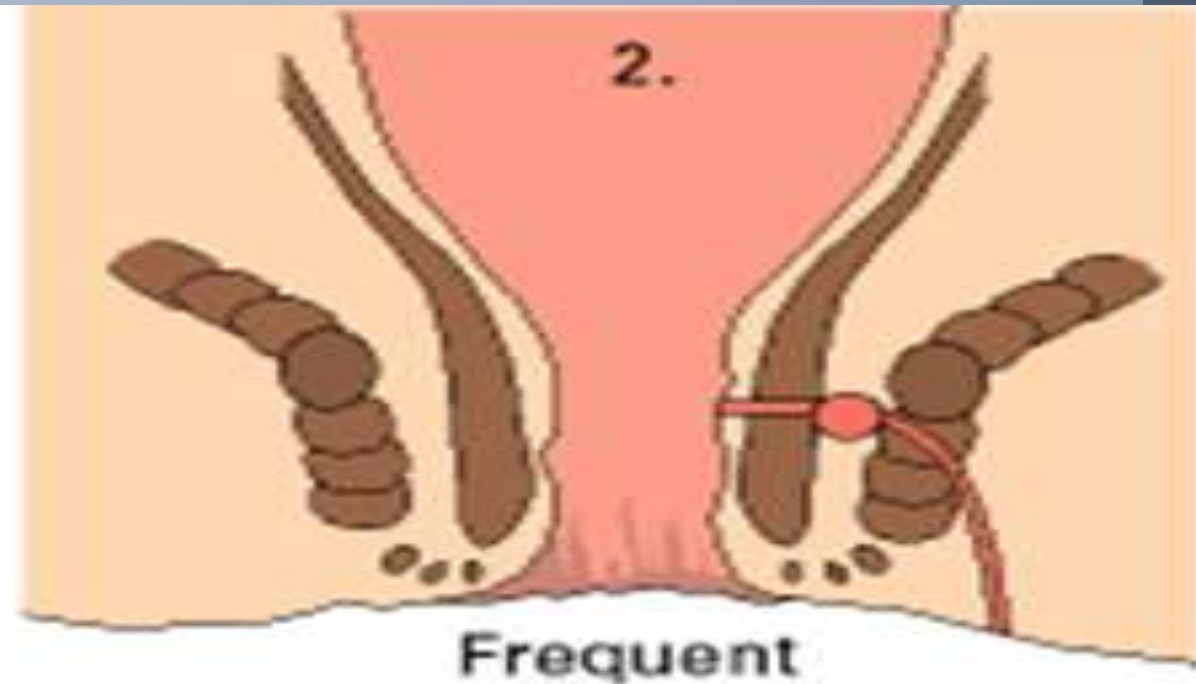
- › Is epithelialized track tract that connects the **perineal skin to the anal canal**.
- › Although the most common etiology for perianal fistula is **an anorectal abscess**, other etiologies include **Crohn's disease, radiation proctitis, foreign body, prior anal surgery, infections (such as HIV, tuberculosis, or actinomycosis), and malignancy**



Park's Classification

1. **Inter sphincteric (70%)**
 2. **Trans-sphincteric (23%)**
 3. **Supra sphincteric fistulae (5%).**
-
1. **Extra sphincteric (2%)** rare type include the tract passes outside all sphincter muscles to open in the rectum.







Classification

› Anal fistulas may also be classified as “**simple**” or “**complex**”

› **Complex**

1. Transsphincteric fistulas that involve greater than 30% of the external sphincter
2. Suprasphincteric, extrasphincteric, or horseshoe fistulas
3. Anal fistulas associated with **IBD, radiation, malignancy, preexisting fecal incontinence, or chronic diarrhea.**

➤ **Simple**

- intersphincteric and low transsphincteric fistulas that involve less than 30% of complex



Evaluation and Treatment

› Symptoms

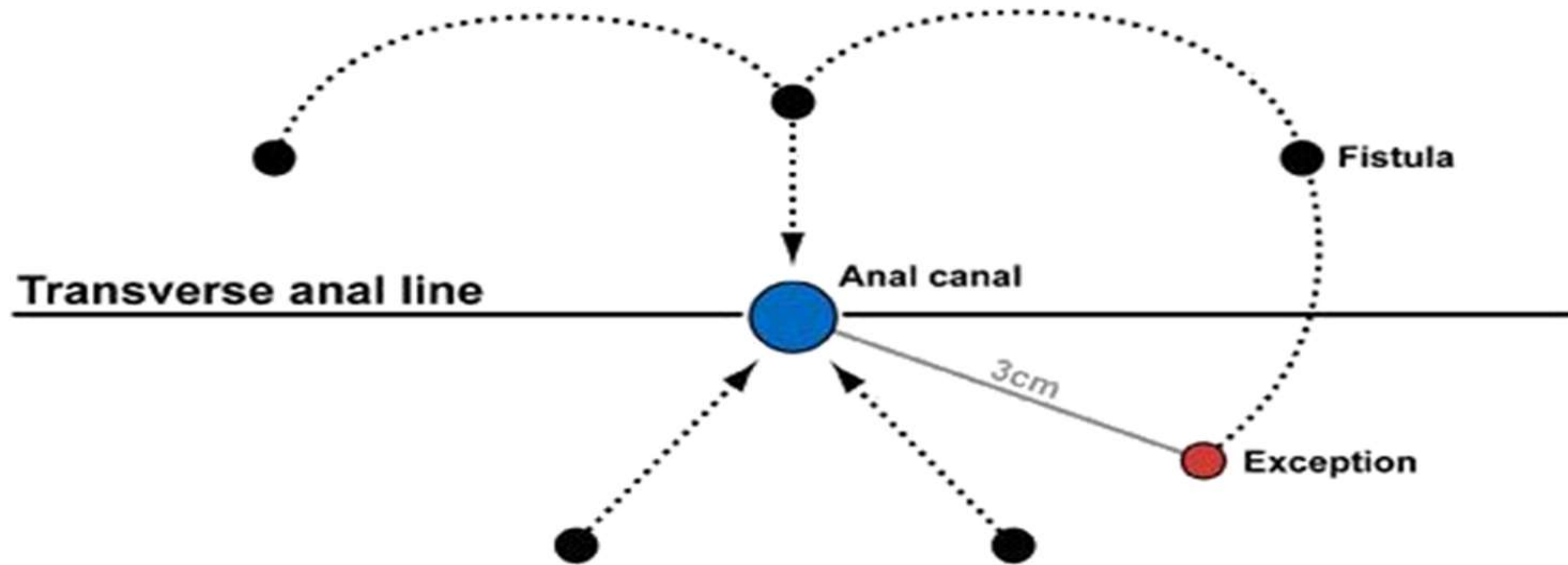
- A patient with a fistula-in-ano often recounts a history of an abscess that has been drained either surgically or spontaneously.
- Drainage, pain with defecation, bleeding due to the presence of granulation tissue at the internal opening and swelling

› Physical Examination

- The external opening may be seen as an elevation
- In most cases, the internal or primary opening is not apparent.
- Internal openings may be felt as indurated nodules or pits leading to an indurated tract

Goodsall's Rule

Posterior: curved tracts



Anterior: straight tracts



Investigations

- › **Anoscopy** should be done prior to operation in an attempt to identify the primary opening.
- › **Sigmoidoscopy** should be performed to locate a proximal internal opening and to exclude underlying pathology, such as proctitis or neoplasia.
- › **Colonoscopy or barium enema** and a small bowel series are indicated in patients who have symptoms suggestive of **inflammatory bowel disease** and in patients with **multiple or recurrent fistulas**.
- › Imaging with **CT, ultrasound, MRI, or fistulography**, has proven useful in the assessment of **occult anorectal abscess, recurrent fistula-in-ano, and perianal Crohn's disease**.



Treatment

- › Lay open
- › Loose seton
- › Cutting seton
- › Advancement flap/ligation of the intersphincteric fistula tract (LIFT)
- › Fistula plug
- › Fibrin glue



Fistulotomy





Thank you