Controversies within colorectal surgery

This issue gives a useful introduction to some of the controversies and current debates within colorectal surgery. By their very nature, as the articles do not represent a comprehensive review of the subject matter the authors can only hope to stimulate the reader to explore the issues at greater depth.

INVESTIGATING THE COLON

Wan and Darzi (p. 692) discuss the investigation of the newly presenting colorectal patient. Perhaps more than any other facet of surgical practice, this area is being subjected to re-evaluation and assessment. While the traditional approaches of history and clinical examination will always remain at the forefront of good surgical practice, newer paradigms of programmed investigation are being proposed ever more frequently.

Cost pressures and efficiency mean that any surgeon must think and plan carefully in order to investigate the maximum number of patients, in the shortest period of time, with the highest degree of accuracy. Thus we have arrived at a consensus that dictates that full colonic evaluation means either a full colonoscopy or a combination of sigmoidoscopy — rigid or flexible — and double contrast barium enema. The recognition that colorectal cancer mortality rates will only fall when the stage of disease at presentation falls means that more and more patients will require investigation at younger ages.

The introduction of nurse endoscopy to the UK has been a long time coming. Now well established for flexible endoscopy, several centres are developing training programmes for nurse-led colonoscopy — a change that will have a significant impact on capacity.

The future may lie in non-invasive techniques such as virtual colonoscopy. Early data suggest that this technique is easily as accurate as barium enema in the area that matters — the diagnosis of clinically relevant neoplastic lesions over 1 cm in size. How this technology fits in with national screening programmes of either flexible sigmoidoscopy or faecal blood testing will be one of the challenges of the next decade.

ULCERATIVE COLITIS

Miller and Windsor (p. 698) provide a good overview of the current status of the management — both medical and surgical — of ulcerative colitis. The dream of an effective medical therapy that significantly alters the natural history of severe colitis remains elusive but newer agents with greater efficacy and less toxicity are now available.

However, surgery still remains a significant challenge for patient and surgeon alike. Restorative pouch procedures are probably the operation of choice for the right patient but problems still exist. High complication rates even in the best hands mean that patients must still pay a significant price for the prize of good function without a stoma. Results are improving but the road remains bumpy for all but the luckiest.

COLORECTAL CANCER

Colorectal cancer remains the second biggest cause of cancer deaths in the UK. With more than 18 000 deaths annually in England and Wales alone there is little room for complacency. The two articles from Carter and colleagues (p. 703, 706) cover many of the current issues being debated.

National screening programmes are being piloted in two main areas addressing two very different approaches. The faecal occult blood trials have arisen from the Nottingham and Danish trials showing reduced mortality in screened groups. Fairly non-invasive and easy to perform, the real issues here relate to compliance rates, accuracy and additional generated workload. The newer study of 'one-time' flexible sigmoidoscopy takes a different approach with a more invasive investigation of greater specificity. Once again, however, compliance rates and impact on endoscopy workload remain the great unknown.

For patients with established disease even greater challenges remain. The introduction of the Calman–Hine report on cancer services has resulted in greater site specialization in the UK — surely not before time. Although the evidence is variable there is compelling reason to believe that patients being operated on by specialist colorectal surgeons have improved survival rates. Why this is the case remains less clear but access to additional therapies such as radiotherapy and chemotherapy is likely to be one factor. Surgical techniques will also play a part, particularly for rectal cancer where widespread use of total mesorectal excision has reduced local recurrence rates in most centres.

Sadly significant numbers of patients present with disease incurable by surgery alone. The international literature contains many studies demonstrating improved survival with chemotherapy and other surgical techniques. Far too few patients with resectable liver metastases are offered this option in the UK, although this is slowly changing. The same is true for patients suitable for adjuvant treatments such as radiotherapy and chemotherapy.

The field of colorectal surgery is moving forwards rapidly in the new millennium. This symposium provides the reader with much to consider in two of the most important areas. HM

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