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ABSTRACT BOOK

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LIST OF SELECTED PAPERS - POSTER PRESENTATION

P01	A. Mitevski	Macedonia	Rectal Prolapse in 89 Years Old Woman-Case Report
P02	A. Đikić Rom	Serbia	TME Specimen Protocolar Sectioning and Immunohistochemistry Could Improve Assessment of CRM Involvement – Our Experience
P03	A. Sekulić	Serbia	Risk Factors for the Development of Locally Recurrent Rectal Cancer
P04	D. Kostić	Serbian Republic	Analysis of the Results of Surgical Treatment of Colorectal Cancer Through Regular and Emergency Protocol
P05	B. Vekić	Serbia	Obstructive Anorectal Melanoma – Case Report
P06	B. Radovanović-Dinić	Serbia	Metachronous Colorectal Tumors
P07	B. Gudurić	Serbia	Colorectal Cancer Screening in Four Ethnical Groups in Vojvodina
P08	B. Branković	Serbia	Clinically Important Aspects of Lymphadenectomy in the Treatment of Colorectal Cancer
P09	S. Demirbas	Turkey	Chronic Constipation: What Do We Expect From the Physiologic Tests?
P10	D. Dabić	Serbia	Relationship Between Lymph Node Ratio and Learning Curve in Patients With Rectal Cancer – Single Surgeon Expirience
P11	D. Dabić	Serbia	Proctology in Day Surgery Setting – Chalenge or Standard Procedure
P12	Z. Jovanovska-Spasova	Macedonia	Different Aproach in Treatment of The Rectal Prolapse
P13	M. Ćeranić	Serbia	Ex Vivo Sentinel Lymph Node “Mapping”By Methylene Blue in Colorectal Cancer
P14	B. Đukanović	Serbia	Urinary Diversion – Important Procedure in the Treatment of Pelvic Malignancies
P15	D. Mihajlović	Serbia	Gastrointestinal Stromal Tumor of the Rectum- A Case Report
P16	D. Miljković	Serbia	Antimicrobial Prophylaxis in Colorectal Cancer Surgery
P17	F. Mitrović	Bosnia and Herzegovina	Surgery for Colorectal Cancer: A Clinical Study
P18	E. Georgescu	Romania	Diagnosis and Therapeutical Management in Colon Cancer
P19	G. Ljuboja	Serbia	Surgical Treatment of Rectal Cancer at the Department of Surgery General Hospital Kikinda in A Period 1-1-2000 – 12-31-2004
P20	I. Georgescu	Romania	Mechanical Bowel Preparation – Yes or No ?
P21	I. Dimitrijević	Serbia	The Role of Pelvic Vegetative Nerve Preservation on Postoperative Urinary Function in Patients Treated For Rectal Cancer
P22	I. Milev	Macedonia	Treatment of Complex Perianal Fistula-Case Presentation

P23	I. D. Vilcea	Romania	Particular Histologic Types of Colorectal Carcinoma
P24	I. Kostić	Serbia	The Role of Transanal Local Excision in Treatment of Anal Canal Tumors
P25	I. Balać	Serbia	CD34 Microvascular Density as a Prognostic Parameter in Colorectal Cancer Patients
P26	J. Petrović	Serbia	Megacolon With Chilaiditi Syndrome
P27	J. Petrović	Serbia	Treatment of Condylomata Acuminata of Perianal Region and Anal Canal
P28	J. Vučković	Serbia	Surgical Treatment of Rectal Cancer From 2003 to 2009
P29	D. Janjić	Serbia	Surgical Treatment of Malignant Colon Obstruction
P30	J. Orhalmi	Czech Republic	Our Experience with Colonic Self-Expandable Metal Stents As A Bridge to Surgery
P31	D. Zoričić	Serbia	Preferable Method of Treatment for Chronic Anal Fissures-Lateral Internal Sphincterotomy
P32	M. Popović	Serbia	Accuracy of Preoperative MR Staging Compared with Pato-histologigc Findings
P33	M.. Popović	Serbia	Prognostic Value of Digitorectal Examination in Comparison with MR Staging of the Rectal Carcinoma
P34	M. Šćepanović	Serbia	Symptomatic Presentation of Colorectal Cancer – The Role of Prevention
P35	M. Nestorović	Serbia	Intussusception in Adults- A Report of Four Cases
P36	M. Ristanović	Serbia	CAG Repeat Length in the Androgen Receptor Gene in Men With Colortectal Cancer in Serbia
P37	N. Čolović	Serbia	Neutropenic Enterocolitis in Acute Myeloid Leukemia
P38	N. Stojanović	Serbia	Referral Diagnosis in the Proctology Clinic of the Pancevo Hospital
P39	B. Odalović	Serbia	Volvulus Colon Sigmoidei – Surgical Treatment
P40	P. Petričević	Serbia	Radiation-damaged Rectum: Resection With Coloanal Anastomosis Using the Endoanal Technique
P41	M. Plešić	Serbia	Diffuse Large B Cell Non-Hodgkin Lymphoma of the Colon
P42	M. Sofronievska Glavinov	Macedonia	Postoperative Urinary Retention After Inguinal Hernia Repair
P43	R. Doder	Serbia	Screening for Prevention and Early Detection of Colorectal Cancer - Prospective Study of 2000 Colonoscopies
P44	S. Sečen	Serbia	Glyceryl-Trinitrate (0.2%) Ointment in the Treatment of Chronic Anal Fissure – 10 Year Results
P45	S. Sečen	Serbia	Diltiazem (2%) Ointment in The Treatment of Chronic Anal Fissure – 8 Year Results
P46	S. Antić	Serbia	Retroperitoneal Cyst of Urachus
P47	S. Demirbas	Turkey	Does the Ratio of Lymph Node Has a Notable Prognostic Factor on the Survival of Patients with Stage III Colorectal Cancer

P48	S. Maksimović	Serbian Republic	Implications of Extracapsular Extension of Nodal Metastases for Prognosis in Patients with Colorectal Cancer
P49	S. Aranđelović	Serbia	Ruptura Colonis Rectosygmoidei Et Prolapsus Intestini Tenui Transrectoanalis-Case Reports
P50	S. Sekulić	Serbia	Colectomy of Acute Colon Cancer Obstruction
P51	T. Milaćević	Serbia	Perforated Colorectal Cancer-A Surgical Emergency With Poor Prognosis Case Report
P52	L. Vasile	Romania	Colon Cancer - Trends 2004-2009
P53	I. Spirovski	Macedonia	Venter Pendulum – Case Report
P54	R. Živić	Serbia	Large Benign Cystic Teratoma of The Mesosigmoid Causing Intestinal Obstruction – Case Report
P55	Z. Milićević	Serbia	Expression Analysis of Hsp90 That Predictively Identifies Metastatic Colorectal Cancers

P-22

TREATMENT OF COMPLEX PERIANAL FISTULA-CASE PRESENTATION

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A perianal fistula is a pathological canal outlined with granulation tissue and lined with epitilium from anal glands that connects internal opening in the anal canal with external opening or openings at the perianal skin. We are presenting a 51 years old patient with 15 years old history of perianal fistula. On preoperative evaluation by passing a probe trough the fistulous canal and entering the internal opening at the posterior midline it was concluded that the patient has a high posterior transsphincteric fistula with high blind tract. Additionally on DRE excellent resting and squeeze anal pressure were concluded. The operation was done with spinal anesthesia in a lithotomy position. Initially fistulectomy around the probe till the external sphincter was done. Then proceeded fistulotomy of the whole tissue above the probe by cutting through the whole external sphincter after it was concluded that the pressure at the anorectal ring is sufficient. The granulation tissue around the internal opening was thoroughly excised and the additional incision was made toward the coccyx for wide opening of the deep postanal space. Endotracheal tube was put in the rectum and the wound was pack with pe troleum gaze. On the 1th postoperative day the patient was aloud to eat and the tube was removed the second day when 3-4 sitz baths per day were started. On the 5th postoperative day the patient was discharged with advice for weekly visits. Approximately 5 months after the operation the wound is completely sealed and the patient has no trouble with continence for gas, liquid or solid stool. In conclusion if the pressure in the anal canal on the preoperative evaluation is sufficient it is safe to cut through the whole external sphincter posteriorly in order to make a radical operation for complex posterior perianal fistula as long as m. puborectalis is intact.
Keywords: complex perianal fistula, fistulotomy, anal pressure

TREATMENT OF COMPLEX PERIANAL FISTULA- CASE PRESENTATION

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INTRODUCTION

A perianal fistula is a pathological canal outlined with granulation tissue and lined with epitilium from anal glands that connects internal opening in the anal canal with external opening or openings at the perianal skin. Almost always it develops as a chronic form of the cryptoglandular disease which starts as an infection of the anal glands in the intersphincteric plane. In the rest of the cases it can develops from trauma, surgical procedure, IBD, anal fissure, carcinoma, radiation therapy, actinomycosis, tuberculosis, chlamydial infection etc. A number of classifications of the disease have been proposed from which the Park's classification is most widely used. It is based on the relationship of the fistulous tract to the external sphincter basically dividing the fistulas into intersphincteric, transsphincteric, suprasphincteric and extrasphincteric. The term "complex" fistula originates from this classification and describes fistulas whose treatment poses a higher risk of impairment of continence like: high transsphincteric (the tract crosses above the lower 30-50 % of the external sphincter), suprasphincteric, extrasphincteric, anterior fistula in a female, multiple tracts, recurrent fistula, or the patient has a preexisting incontinence, local irradiation or Crohn's disease [1, 2]. There are several forms of treatment of perianal fistulas which are basically a surgical procedures such as fistulotomy, fistulectomy, loose or cutting seton use, endorectal advancement flap procedure, or some of the recent more conservative procedures like fibrin glue installation and using of anal fistula plug [7, 8, 9].

CASE PRESENTATION

We are presenting a 51 years old patient with 15 years old history of perianal fistula (Fig. 1). On preoperative evaluation by passing a probe trough the fistulous canal and entering the internal opening at the posterior midline it was concluded that the patient has a high posterior transsphincteric fistula with high blind tract [7, 8]. Additionally on DRE excellent resting and squeeze anal pressure were concluded. The operation was done with spinal anesthesia in a lithotomy position. Initially fistulectomy (Fig. 2) around the probe till the external sphincter was done [3]. Then proceeded fistulotomy of the whole tissue above the probe by cutting through the whole external sphincter after it was concluded that the pressure at the anorectal ring is sufficient [7, 9]. The granulation tissue around the internal opening was thoroughly excised and the additional incision was made toward the coccyx for wide opening of the deep postanal space (Fig. 3). Endotracheal tube was put in the rectum and the wound was pack with petroleum gaze. On the 1st postoperative day the patient was allowed to eat and the tube was removed the second day when 3-4 sitz baths per day were started. On the 5th postoperative day the patient was discharged with advice for weekly visits (Fig. 4). Approximately 5 months after the operation the wound is completely sealed and the patient has no trouble with continence for solid, liquid stool or gas. (Fig. 5).

DISCUSSION

Simple low transsphincteric fistulas are best treated only by fistulotomy with worldwide reported recurrence rate from 2% to 9 % and rate of any form of incontinence from 0% to 17% [2]. The treatment of complex transsphincteric fistulas is more of a surgical challenge. A number of procedures are mentioned as first line forms of treatment in this cases. However all of them are caring big reported rates of recurrence and any form of incontinence rates. Endorectal advancement flap procedure has reported recurrence rate from 0% to 66% and incontinence rate of any form of up to 31%.[2, 5] Use of a seton in this cases even though it has low recurrence rate from 2%-8% has high reported incontinence rate of any form of up to 60% [6]. More recent forms of treatment with fibrin glue and anal fistula plug probably need more trials to evaluate [4, 5]. When fistulotomy is in question as a form of surgical treatment of high transsphincteric fistula in the literature there are different standings of what can be cut of the external sphincter. The most radical approach is that you can cut the whole of the external sphincter and not causing incontinence disorder as long as m. puborectalis is intact. The less radical approach is that anteriorly where m. puborectalis is absent it is necessary to save the deep portion of the external sphincter. And the least radical approach says that we should always save the deep portion when performing a fistulotomy for high transsphincteric fistula especially in a female where fistulotomy is not the choice of treatment for anterior perianal fistula [7, 8, 9]. The incidence of continence disorders after fistulotomy for high transphincteric fistula is up to 34% which is by the way much less than for Seton use for example where probably the excessive endoanal fibrotic scar has its role [6].

CONCLUSION

Our case is an example that the when properly indicated and performed fistulotomy can be a successful procedure in the treatment of high transsphincteric fistula and that when the pressure in the anal canal on the preoperative evaluation is sufficient it is safe to cut through the whole external sphincter posteriorly in order to make a radical operation for complex posterior perianal fistula as long as m. puborectalis is intact.

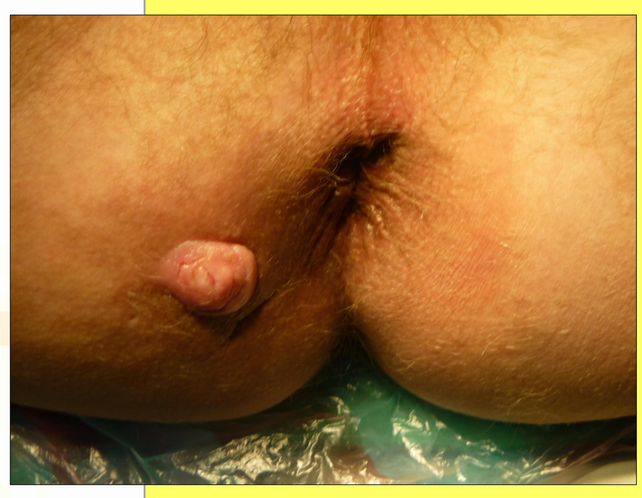

Fig. 1 *Preoperative condition*

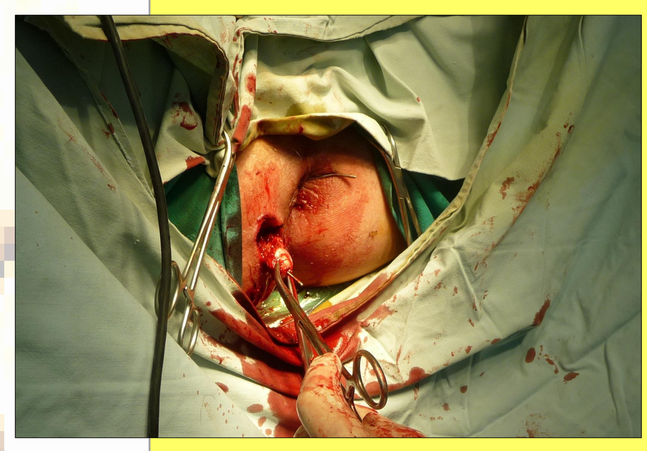

Fig. 2 *Initial fistulectomy*

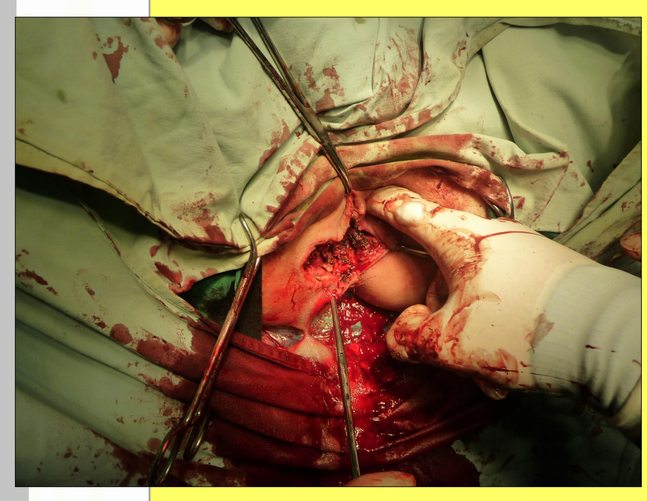

Fig. 3 *Fistulotomy with unroofing the deep postanal space*

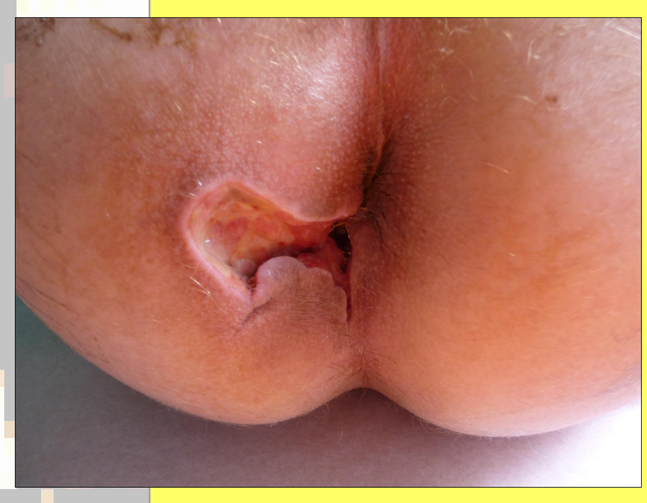

Fig. 4 *Two weeks after the operation*

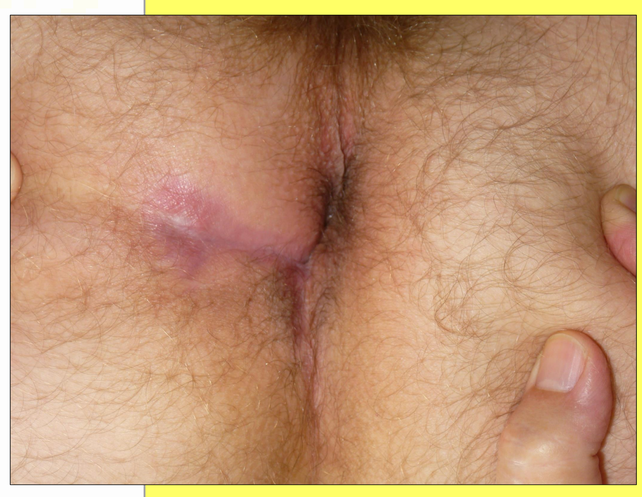

Fig. 5 *Current condition*

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