PURPOSE: Endoscopic management for colorectal lesions is very common, but early cancers are sometimes included in the resected specimens. The aim of this paper is to determine the indication and the limit of endoscopic management for colorectal cancer.

METHODS: The recurrent lesions after endoscopic management for early colorectal cancer performed during January 1980 and December 2002 were studied clinicopathologically.

RESULTS: There were 1792 lesions of endoscopic management for colorectal lesions including 887 adenomas with mild atypia, 455 adenomas with moderate atypia, 185 intramucosal carcinomas, 37 carcinomas with submucosal invasion, 133 hyperplastic polyps and 95 others. Out of 37 carcinomas with submucosal invasion, four (10.8%) had recurred. Three out of those had showed a component of poorly differentiated adenocarcinoma. Distinct invasion of lymph vessels was revealed in one lesion. All of them had massive submucosal invasion with a remarkable desmoplastic response (1). Two patients had rejected an additional surgery. Others two cases had surgery approximately a month after endoscopic resection, but they had recurred 17 months and 68 months later, respectively. Finally, all patients died of recurrence.

CONCLUSION: The lesions which have a desmoplastic response in the cancer stroma seem to need an additional surgical intervention with lymph node dissection performed immediately after endoscopic resection, or these lesions should be avoided to resect endoscopically.

DENERVATED NEORECTUM AS A POSSIBLE CAUSE OF DEFECATORY MALFUNCTION AFTER ANTERIOR RESECTION FOR RECTAL CANCER
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PURPOSE: At the ordinary procedure of low anterior resection for rectal cancer, the neorectum is constructed with “denervated” sigmoid colon because extrinsic autonomic nerves are sacrificed in a various degree. At the current study, we evaluated the motor activity of neorectum and compared it with the postoperative defecatory status in patients who underwent low anterior resection for rectal cancer.

METHODS: Sixty patients who underwent anterior resection were examined. The motility of the neorectum was examined with 4-sensor intraluminal pressure monitoring, and the segmental colonic transit time was determined with radiopaque markers. In addition, changes in colonic motility after extrinsic autonomic denervation at distal colon were studied in rats using strain gage transducers.

RESULTS: 28 patients experienced loss of propagated contraction waves down to the neorectum. In the non-propagated cases, transit time through the neorectum segment significantly prolonged in comparison with the propagated cases. Minor spastic waves at the neorectum were observed in 26 patients, which closely correlated with inferior mesenteric artery transaction and defecatory disorders. In rats undergoing autonomic denervation, motility index, average amplitude and number of cycle at distal colon were significantly increased in early phase of postoperative period.

CONCLUSIONS: The motility of denervated neorectum is a possible mechanism for postoperative defecatory disorder in patients who underwent anterior resection for rectal cancer.

CLINICAL AND PATHOLOGIC STUDY OF PERIANAL HIDRADENITIS SUPPURATIVA
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PURPOSE: Cases of perianal hidradenitis suppurativa (PHS) are extremely rare in Japan. Pathogenesis and various treatments for PHS are evaluated by clinical and pathohistological analysis in my cases, emphasizing difference from western patients.

METHODS: Twenty four cases of PHS in my 30 years experience were classified by bowel habit including anal hygiene, vocation, obesity, smoking, DM, history of symptoms, initial diagnosis and bacteriology. Each surgical procedure was evaluated by size of the lesion, duration of symptoms, postoperative management and healing duration. The excised specimen was examined histopathologically to find the causes.

RESULTS: All patients used to take a bath tub almost everyday as a Japanese custom. Larger body surface, obesity and vocation were not related to PHS in this series. DM, smoking and immunologic deficiency were related significantly. Bacteriology showed a variety of microorganisms; streptococcus milleri 33%, staphylococcus epidermis 21% and so on without any special preference. Initial diagnosis was fistula-in-ano/abscess in 58% of all cases in spite of no existence of
fistula. Others were pyoderma, furuncles, atheloma cutis, Crohn’s disease, squamous cell carcinoma and so on. Multiple sinus was observed in 88% and fistula developed only 2 cases. Initial wide excision was effective resulting in only 2 recurrence in 14 cases. One case must have a temporary colostomy and local unloofing. All unloofed or wide-excised wounds were laid open without skin graft nor suturing. Healing duration was depend on size of the lesions, related to the excision size. It took 2.3 months for 50 cm² and 5.8 months for 300 cm². As dressing materials, alginate was useful for wozing and exudates, and hydrocolloid was good for maintaining stable wounds. There were several ointments used but prostaglandin was rational to make healing of PHS. Histological exam showed a chronic purulent disorder of the apocrine area with decapitation or disintegration of the inner zone cells surrounded by plasma cells and eosinophils in a half case.

CONCLUSIONS: Overreaction of the apocrine gland and immunological deficiency may be causative of PHS rather than anal hygiene, obesity and vocation. Complete wide excision or unroofing showed good results, and hydrocolloid or hydrogel dressings promoted healing of skin defects. Prostaglandin ointment may be effective for PHS.

A NEW ULTIMATE ANUS-PRESERVING OPERATION FOR AN EXTREMELY LOWERRECTAL CANCER OR FOR AN ANAL CANAL CANCER
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PURPOSE: To avoid permanent colostomy, we perform a new ultimate anus preserving operation for an extremely lower rectal cancer or for an anal canal cancer. According to our pathological study of surgical specimens having received APR for a lower rectal cancer or an anal canal cancer (excluding anal cancer), neither direct invasion nor skip metastasis was observed both in the subcutaneous external sphincter muscle and in the ischiorectal fossa’s fatty tissue. However, these kinds of cancer spreads to the deep-superficial external sphincter muscles or puborectal muscle were observed in 14 %. Therefore, two different removal methods of anal canal were theoretically considered.

OPERATION METHODS: If the depth of invasion is within muscle layer, the radical operation can be accomplished by the internal sphincter muscle resection (ISR method). When the tumor invasion exceeds the internal sphincter muscle, safety surgical resection margin can be kept only by resection of deep-superficial external sphincter muscles (ESR method). Both subcutaneous external sphincter muscle and ischiorectal fossa’s fatty tissue are preserved. So, anus preserving operation can be accomplished by preserving subcutaneous external sphincter muscle.

RESULTS: Six patients received ISR and twelve patients, ESR. The severe intraoperative complications never occurred and the postoperative course was uneventful. All patients having received ISR had an excellent anal function without soiling. Some patients having received ESR sometimes complained of night soiling but satisfied the anus preservation.

CONCLUSION: ISR and ESR are excellent procedures for anus preservation. With keeping subcutaneous external sphincter muscle, the ultimate anus preserving operation is possible by the lowest handsewn coloanal anastomosis.

QUALITY OF LIFE FOLLOWING SURGICAL INTERVENTIONS IN CROHN’ DISEASE
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PURPOSE: To determine the exact place of surgery in the treatment of Crohn disease. Furthermore to build up the strategy of the treatment and to realize and possibly prevent the difficulties of the surgical treatment and follow up the changes of quality of life after surgical interventions.

METHOD: Between 1st January 1993 and 31st December 2003 74 Crohn patients were operated on because of Crohn disease in our department. All together 100 interventions were carried out. As a part of our analysis we studied the distribution of patients according to age and sex, the location and type of Crohn disease, the preciseness of preoperative diagnostic methods, the indications of operation, the morbidity and mortality of patients.

RESULTS: The preoperative diagnosis matched with the intraoperative findings in 82% of the cases. Among the operations carried out in our department we performed several types of operations from the stomach to the anorectum. In 13 cases emergency and in 87 cases elective interventions were carried out. The mortality of emergency operations was 7.5%, complications requiring re-operations occurred in 23% of the cases. The mortality of elective interventions was 1.1%, while the morbidity of complications reached the value of 3.4%.

CONCLUSIONS: Surgery plays its most important role in the treatment of complications in case of Crohn disease. It is the common task of a surgeon and a gastroenterologist to determine the indication and the optimal time of the operations so that the patient should undergo an elective intervention with less morbidity and mortality risk. As a result of the nature of Crohn