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healthpoints

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Message from the Chief

This special issue of Healthpoints is devoted entirely to the treatment of colorectal conditions. We are pleased to have the opportunity to shed light on topics that people are sometimes shy to discuss, because treatment for colorectal disorders can restore patients' quality of life.

The Division of Colorectal Surgery provides comprehensive care for all benign and cancerous colorectal disorders. Our program has grown rapidly over the last two years to now include five practice locations in the tri-state area, and we are often able to provide same-day appointments for patients' comfort and convenience. Our surgical repertoire, which includes nearly every

treatment option for simple and complex colorectal conditions, is available in very few other centers in the world.

We look forward to answering your questions and to working with you as part of your healthcare team.

P. Ravi Kiran, MBBS, MS, Msc, FRCS, FACS
Chief and Program Director, Division of Colorectal Surgery



Pelvic Floor Program

Non-surgical and minimally invasive therapies resolve symptoms, restore quality of life for the majority of patients.

Pelvic floor disorders affect the lives of over 28 million Americans, yet relatively few seek and receive adequate treatment for these treatable conditions. NYP/Columbia aims to reverse this trend by letting patients know that effective help is available – often without surgery – and patients need not continue to suffer with

embarrassing symptoms.

What is the pelvic floor?

Both men and women have a pelvic floor. The pelvic floor includes the muscles, ligaments, connective tissues and nerves that support the bladder, rectum and other pelvic organs.

Pelvic Floor Program ~ Continued on page 2

More from the Department of Surgery experts at:

The pelvic floor muscles stretch like a muscular trampoline from the tailbone (coccyx) to the pubic bone and from one sitting bone to the other sitting bone (side to side). These muscles are normally firm and thick.

What are pelvic floor disorders?

Pelvic floor disorders occur when the “trampoline” that supports the pelvic organs becomes weak or damaged.

Common symptoms of pelvic floor disorders include:

- ◆ Constipation
- ◆ Difficulty controlling wind or bowel motions
- ◆ Fecal leakage with coughing, sneezing, laughing or exercising (fecal incontinence)
- ◆ Rushing to the toilet for fear of fecal leaking or leaking before you can get there (fecal urgency)
- ◆ Having part or all of the wall of the rectum slide out of place, sometimes sticking out of the anus (rectal prolapse).

The Division of Colorectal Surgery is unique among medical centers in that it offers a comprehensive, multidisciplinary program to diagnose and treat pelvic floor problems with both non-surgical and surgical approaches. Directed by **Emmanouil (Manny) Pappou, MD, PhD**, the Pelvic Floor Program includes the full range of services to properly evaluate and treat patients in-house. They use non-invasive as well as novel minimally invasive and robotic surgical therapies, and these are effective in resolving the majority of people’s conditions.

According to Dr. Pappou, “Most centers send patients to other locations for testing, and it can be difficult to interpret results from external tests. We perform a full physical exam and all testing right here, ourselves, which gives us a better idea of what is going on. We have highly accurate instruments to evaluate the pelvic anatomy and muscle function, including anorectal manometry to determine how fit the pelvic muscles are, and endoanal ultrasound to tell us if the anal muscle is intact.” Because all testing, evaluation, and treatment is done by a unified team, the specialists collaborate together and communicate easily, which improves the quality of care in comparison to settings where patients must visit separate specialists for each test or consultation.



Emmanouil Pappou, MD, PhD

Fecal incontinence

Fecal incontinence is one of the most common problems treated at the Pelvic Floor Program. As Dr. Pappou explains, the incidence increases with age, obesity, and in women, in proportion to the number of times she has given birth. People often avoid reporting symptoms of incontinence even to their physicians because of feelings of shame and embarrassment, but Dr. Pappou encourages people to seek help. “Many patients and physicians are under the impression that there are no good treatments for incontinence, but that simply is not true,” says Dr. Pappou.

Fecal incontinence: nonsurgical approaches

Many patients with fecal incontinence can be helped with a step-wise approach including dietary modifications, medications to bulk up the stool, and biofeedback. Biofeedback is a non-invasive, painless, and highly effective method of using visual signals on a computer monitor to train the brain to consciously relax and contract the pelvic muscles. The signals come from a tiny electronic probe placed in the anus. The program has a dedicated biofeedback expert, who works closely with many patients in the program and is able to help over half of patients (60-80%) to resolve their problems in just six sessions of biofeedback.

Fecal incontinence: minimally invasive approaches

If the problem persists despite these therapies, a minimally invasive surgical approach called sacral nerve stimulation may be tried. Sacral nerve stimulation (SNS) is an extremely effective method of retraining the brain to feel the anal area. The first step in SNS is to surgically place tiny electrodes in the tissue around the anus. This is performed in the operating room. Once in place, the electrodes stimulate the nerves that enervate the muscles in the anus. “SNS helps patients to better feel the sensation of the anal muscles when they contract, and it rejuvenates the action of the nerves on the muscles so that the action of subconscious muscles becomes more active,” explains Dr. Pappou. The success rate in helping patients regain continence is very high, curing approximately 80% of patients of fecal incontinence.

The program offers other non-surgical therapies as well, including injections of botox, Solesta™, and others.



Steven Lee-Kong, MD, at the console of the surgical robot.

Other pelvic floor disorders

Other conditions treated at the pelvic floor program include pelvic pain, constipation, rectal prolapse, and internal prolapse. Just as a stepwise approach is used for fecal incontinence, non-surgical therapies are effective in the majority of patients with other pelvic floor disorders. Only if non-surgical options fail does the team then consider surgical treatment.

For patients who require surgery to correct anatomical problems or damage due to trauma or other causes, the program uses minimally invasive, laparoscopic and robotic techniques. Dr. Steven Lee-Kong, an expert in the use of the surgical robot for colorectal surgery, says, "Use of the surgical robot in pelvic surgery helps with ease of performing the surgery, flexibility, and access. It gives excellent magnification and a stable view because the camera is not hand-held as in other laparoscopic surgeries. The robotic instrumentation gives us more degrees of freedom than straight instruments, which lets us target an area more precisely." Dr. Lee-Kong and Dr. Pappou use robotic techniques routinely in their daily surgical practice.

In short, the Pelvic Floor Program uses minimally invasive methods to resolve patients' symptoms. Dr. Pappou concludes, "These therapies work, and they can completely change a person's quality of life." ■

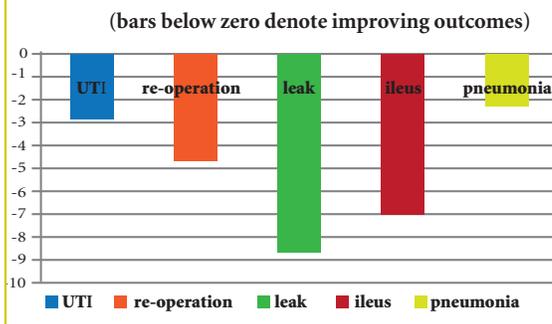
[Learn more at columbiasurgery.org/conditions-and-treatments/pelvic-floor-disorders](http://columbiasurgery.org/conditions-and-treatments/pelvic-floor-disorders)

Quality and Outcomes Research

Quality and outcomes research is instrumental in maintaining the high level of clinical care provided at the Division of Colorectal Surgery. According to **P. Ravi Kiran, MBBS, Chief and Program Director, Division of Colorectal Surgery**, quality and outcomes research continually informs and improves the division's clinical practices. "Every patient's care is monitored for measures of quality including complication rates, length of stay, short- and long-term outcomes, and overall patient experience. This information is used to improve patient care and decrease costs," says Dr. Kiran. "In addition to using the national guidelines, we constantly reevaluate how we take care of patients based on real-time information from our surgeons."

Dr. Kiran is well regarded for his expertise in outcomes research, and the Division is considered a leader in outcomes-related expertise in NY and the country. The Division is one of the few in the country that houses an institutional outcomes database that encompasses research, surgical quality and education. In addition to being presented at national and international conferences and published in major surgical journals, data from NYP/Columbia related studies have been incorporated into national guidelines for use for all patients in the country.

Percent change in various outcomes 2013-2015



Data from the Division's database show that the five common complications of colorectal surgery (urinary tract infection, need for reoperation, leakage from the anastomosis, obstruction of the intestine, and pneumonia) have significantly decreased over the last two years. This improvement is attributed to a series of quality improvement measures instituted at the Division in 2013.

One direct example of how the research program benefits patients is its recent work concerning bowel preparation before colorectal surgery. For 50 years, there has been no consensus about the best way to prepare patients before colorectal resection (removal of a portion of the colon), and so Dr. Kiran and his colleagues studied the problem. The group found that a combination of a mechanical bowel preparation and oral antibiotics reduces a patient's risk of surgical site infection or leakage by half. In addition to reporting these findings at the 2015 American Surgical Association meeting this spring, the division has incorporated them into a protocol that is already improving patients' outcomes.

Dr. Kiran's study is one of the largest to date to examine bowel preparation, and provides the best evidence available to date on the topic. Six colorectal fellows are currently performing other research on topics including diverticulitis, colon cancer, ulcerative colitis, Crohn's disease and surgical outcomes following colon and rectal resection procedures. ■

Colorectal Surgery: Ostomy and Ostomy Reversal

When the Division of Colorectal Surgery prepares for surgery resulting in an ostomy, they also plan for its reversal.

Matt's Story

In early 2014, Matt Teichman was at his prime, a healthy, single young man (age 27) working at an investment firm in New York and committed to his daily fitness routine. That spring he started feeling unwell and began having symptoms of low energy, weight loss, and occasional pain. Matt put off the colonoscopy his doctor recommended, afraid of what it might reveal. By June, his pain and lethargy had worsened considerably to the point that Matt barely left his house. He had dropped 60 lbs.

At that point, Matt said, "The pain was blinding. It was so overwhelming I couldn't think clearly."

Having not seen his son for some time, Matt's father was shocked when he came for a visit. He wasted no time in getting Matt to NYP/Columbia, where the doctors found his colon to be severely inflamed due to Crohn's disease. He would need surgery to remove a diseased section of his colon.

When he woke from surgery, Matt was both frightened to see an ileostomy bag attached to his body, but simultaneously relieved that he was "no longer in an insane amount of pain, about to explode."

After his initial repulsion and fear, Matt began learning about his ileostomy bag with the help of Erin Testerman, the colorectal division's certified wound, ostomy, and continence nurse. With her support, Matt says he "became a pro" at caring for – and living with – his ostomy. It wasn't always easy; he says he went through a process of losing, and then regaining, his dignity.

About four months after his ostomy surgery, Matt's surgeon, **Daniel Feingold, MD**, performed a second surgery to reverse the ostomy. Matt has recovered well since then. But going through the challenges associated with having an ostomy changed Matt. He says that once he accepted the ostomy as part of himself, taking care of it became second nature. Initially he didn't think he'd get to that point of acceptance, but he did. He was able to go out and socialize while he



Matt Teichman and his surgeon, Daniel Feingold, MD, relaxing at the piano after his surgery.

had the ostomy, finding ways to cover the appliance so it was unnoticeable. As he described it, "I learned there are much more important things than appearances."

Having overcome the challenges of an ostomy himself, he feels very strongly about encouraging and supporting others who may be afraid or discouraged by the prospect. He has helped other patients to learn to care for their ostomies, and he offers this perspective: "It is a process. Once you go through it,

things can get back to where they were at. There are worse things in life – I think bad breath is worse than an ostomy. With the right guidance, you can live comfortably. It is not the end of the world."

Planning for Ostomy Reversal from Day 1

Just as Matt's surgeon was able to reverse his ostomy, many other patients are able to have theirs reversed as well. According to **Dr. P. Ravi Kiran**, *Chief of the Division of Colorectal Surgery*, the colorectal team avoids creating an ostomy if possible, but when it is unavoidable, they

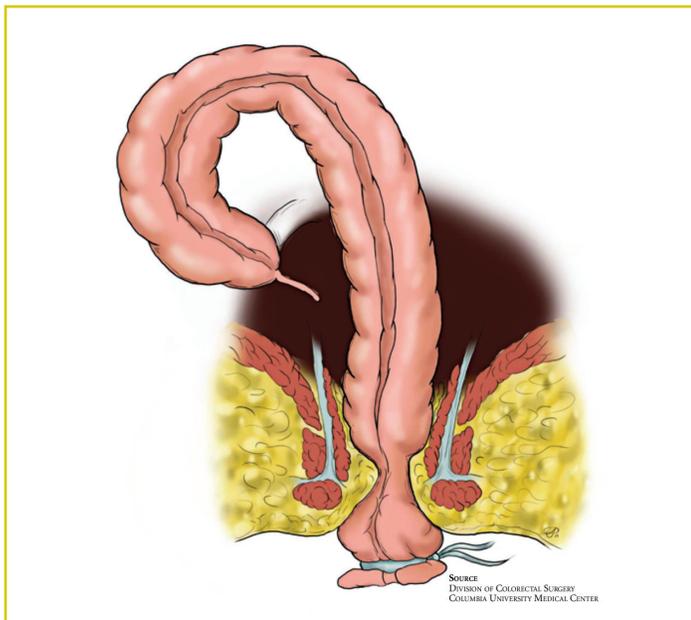
Ostomy and Ostomy reversal ~ Continued on page 5



Daniel Feingold, MD and P. Ravi Kiran, MBBS

plan right from the beginning how they will be able to reverse it within the next six to 12 months. They achieve this goal through careful planning and innovative surgical procedures that require a high level of skill and training. While this approach is not the norm elsewhere, NYP/Columbia is able to reverse ostomies even in some patients who may not be offered such options in other centers. The division offers “end of the road” procedures such as the *Turnbull Cutait* operation, redo colorectal anastomoses, and sleeve resection for Crohn’s disease that are available at very few centers in the world.

Although surgeons at NYP/Columbia reverse many ostomies after patients recover from surgery, not every patient feels compelled to take advantage of that option. Tannette Brown, a 32-year-old mother of three from the Bronx, gained an ostomy when she had to have a cancerous section of her



The Turnbull-Cutait procedure may be performed to avoid a permanent ostomy in certain extenuating circumstances.

colon removed in 2014. After surgery and chemotherapy, she grew accustomed to her ostomy bag and moved on with her busy life. Her doctors offered to reverse the ostomy, but her approach was, “Why bother? Why would I want to go through another surgery?” It was only after thinking about swimming at the beach that Tannette changed her mind and decided to go through with the procedure. But like Matt, Tannette grew used to having an appliance and now encourages others to realize they, too, can get along just fine with it. ■

Visit columbiasurgery.org/colorectal to learn more about ostomy and ostomy reversal

WHAT IS AN OSTOMY

In some cases, the treatment of cancer, Crohn’s disease, and other serious colorectal conditions requires that patients have portions of their bowel or rectum removed. This may entail creation of an ostomy, a surgically created opening in the abdomen that allows urine or feces (or both) to pass through the body into a bag attached to the abdomen.

Sometimes people may refer to an ostomy as a stoma; a stoma is actually the end of the large or small intestine or ureter that is visible at the abdominal wall.

Different types of ostomies may be created, depending on which segment of the bowel or rectum may need to be removed.

For instance, a colostomy refers to an ostomy created by removing a portion of the colon (large intestine) or rectum, and connecting the colon directly to the abdominal wall. A colostomy may be temporary or permanent, and there are various types of colostomies that may be created. An ileostomy refers to an opening created by connecting the small intestine to the abdominal wall.

Preserving continence

In many cases, a person with an ostomy can retain continence through creation of a valve in the stoma. For example, in a continent ileostomy, surgeons use part of the intestine to create a pouch inside the abdomen, and then construct a valve in the pouch. Patients can insert a catheter into the pouch several times a day to drain waste from the pouch. This option allows patients to control the timing of his or her elimination, and prevents the need for an external appliance (waste bag). ■

Advanced Colorectal Surgical Options

Surgeons at the Division of Colorectal Surgery are able to perform procedures that maintain continence, reverse ostomies, and provide other treatment options not available elsewhere.

Each year, thousands of patients from the United States and around the world travel to NewYork-Presbyterian/Columbia University Medical Center to seek care for complex colorectal conditions. The Division of Colorectal Surgery's world renowned team offers advanced surgical options including laparoscopic and robotic surgery; continence preservation procedures; procedures to repair previously created pouches; treatment for recurrent or advanced colon and rectal cancer; advanced procedures for complex IBD; intraoperative radiation therapy; transanal endoscopic microsurgery (TEMS) and more.

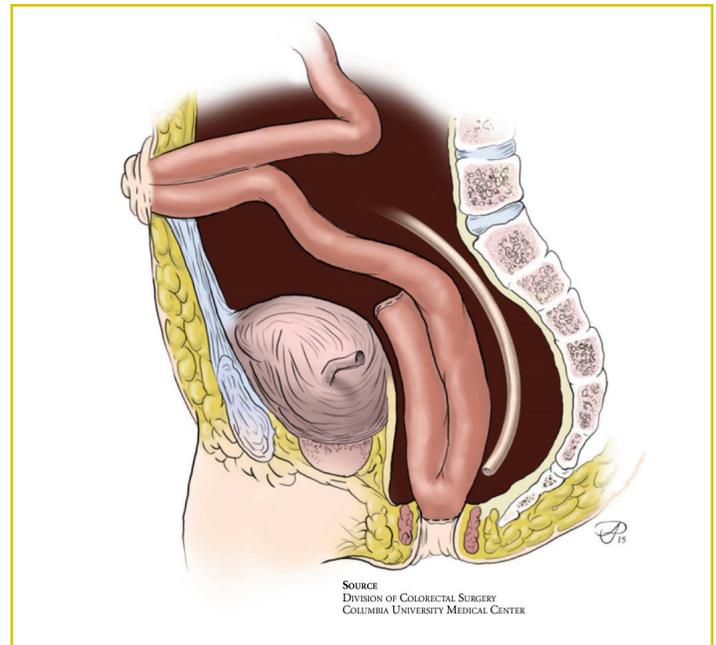
The following are descriptions of several of the procedures commonly performed by the Division:

J-pouch: The 'J-pouch' is an alternative to traditional ileostomy that may be used to treat patients with ulcerative colitis or familial polyposis who need to have the colon and most of the rectum surgically removed. If the anal sphincter is intact, the surgeon can use a part of the ileum (part of the small intestine) to create an internal pouch. The pouch is then connected to the anus just above the sphincter, which is preserved for continence. J-pouch may also be called ileoanal reservoir, ileoanal anastomosis, pull-thru, endorectal pullthrough, pelvic pouch, or ileal pouch anal anastomosis (IPAA).

K-pouch: Also called Koch pouch or continent ileostomy, this is a variation of ileostomy in which the surgeon creates a reservoir pouch inside the abdomen using a portion of the small intestine. A one-way valve that prevents escape of waste is created inside the pouch, and a stoma is connected to the abdominal wall. The valve prevents the opening on the abdomen from leaking any contents, thus avoiding the need for an external appliance (bag). Instead, the patient can insert a catheter into the pouch to drain waste at his or her convenience. Candidates for K-pouch surgery include patients with poor anal sphincter function, and those who have had their sphincters previously removed and have a traditional ostomy but wish to avoid the encumbrance of an external appliance.

Ostomy Reversal: Surgeons at NYP/Columbia are often able to reverse ostomies after patients recover from colorectal resection. *Please see our article on p. 4 for a full description of this special expertise.*

Pouch repair operations: When pouch failure occurs, surgical options may include pouch revision, creation of a redo pouch, or neo-pouch creation. In some circumstances,



J-pouch procedure. An alternative to traditional ileostomy

the conversion of a J-pouch into a continent ileostomy (K-pouch) may be considered to preserve continence and improve patients' quality of life. NYP/Columbia's experience and expertise often allows for preservation of the sphincter.

Continence Preservation: Surgeons at the center can often devise surgical solutions to avoid a permanent ostomy. They are able to do this even in adverse circumstances such as multiple previous operations, complicated or severe inflammatory bowel disease, and advanced colon and rectal cancer. The continent ileostomy reservoir is also an option for some patients with poor sphincter function, when restorative surgery is not feasible or desired, and for those with a permanent conventional ostomy seeking continence.

Enterocutaneous fistula: The Division of Colorectal Surgery provides advanced care to patients with intestinal fistulae and other abdominal conditions secondary to inflammatory bowel disease, benign and malignant colorectal disease. In collaboration with specialists in plastic surgery, urology and gynecology, division surgeons are able to repair the involved organs, restore intestinal continuity, and reconstruct associated tissue including the abdominal wall. Surgeons at the center collaborate with specialists in gastroenterology, nutrition, enterostomal therapy, oncology and radiology, as these challenging conditions require a multidisciplinary approach.

Complex reoperative surgery: For complicated benign and malignant colorectal conditions, the division performs the full scope of complex procedures such as:

- ◆ Ileoanal pouch creation
- ◆ Revisional pouch surgery
- ◆ Continent ileostomy
- ◆ Repair of complex enterocutaneous and intestinal fistulae
- ◆ Management of locally advanced and recurrent colon and rectal cancer
- ◆ Turnbull Cutait procedure
- ◆ Salvage of ileoanal pouches (for patients who develop dysfunction after a previous ileoanal pouch procedure or when pouch failure occurs)
- ◆ Specialized perineal and abdominal techniques for pouch-perineal or pouch-vaginal fistulae, pouch sinus, pelvic sepsis related to the pouch, pouch and anastomotic strictures, Crohn's disease complicating the pouch, and pouch prolapse.

Crohn's disease: For Crohn's disease of the small intestine, the division offers extensive experience with bowel resection, stricturoplasty, treatment of enterocutaneous and other fistulae, and the use of reconstructive procedures. When Crohn's disease involves the large intestine, division surgeons have in-depth understanding of Crohn's colitis and continence preservation techniques, which allows for the control of disease and prevention of complications while maintaining quality of life. Intestinal continuity frequently can be maintained without a permanent ostomy, even in complex circumstances. For anorectal Crohn's disease, the surgeons' expertise in surgical techniques facilitates prompt and effective treatment of abscesses, fissure, incontinence, and simple and complex fistulae while preserving continence.

Robotic surgery: NYP/Columbia is one of the few centers in New York to offer robotic surgery for the management of benign and malignant diseases of the colon and rectum. This technology provides visualization and maneuverability, and facilitates a minimally invasive surgical approach even in difficult circumstances, such as within the confines of the pelvis.

Operations for pelvic floor dysfunction: NYP/Columbia offers the full spectrum of surgical techniques for patients whose fecal incontinence is caused by damage to the pelvic floor or anal sphincter. Surgery is also appropriate for many patients with internal rectal prolapse. Surgeons at the center regularly use robotic technology that allows them to see inside the pelvis and perform very delicate procedures, including ventral mesh rectopexy. As with laparoscopic surgery, use of the surgical robot reduces scarring, the risk of complications, and post-operative recovery time. ■

Visit columbiasurgery.org/colorectal.org to learn more about complex colorectal surgery

ANAL FISSURE PROTOCOL

In addition to its surgical capabilities, the division offers innovative non-surgical therapies such as its muscle-sparing procedure for anal fissures.

Anal fissures are small cuts or tears at the skin of the anal opening. They typically cause pain when a person has a bowel movement, and pain can be severe for hours afterwards. Although some anal fissures heal without treatment, some do not, and these go on to cause chronic pain problems. Medical therapy, primarily a muscle relaxant cream applied around the anus, is effective in healing about 70% of anal fissures.

For the 30% of patients who continue to have problems, the colorectal surgery program offers a unique protocol developed by **Daniel Feingold, MD**, who pioneered the approach based on his observations of effective wound care protocols. Proven to be highly effective, the procedure is performed in the operating room under sedation and includes four steps:

- ◆ Gently dilate the anus with special retractors
- ◆ Clean out the fissure with curettage to stimulate healing
- ◆ Cauterize the wound with electrocautery to seal the wound
- ◆ Inject triamcinolone (generic Kenalog), a steroid, into the fissure.

The majority of patients are pain-free within ten days of this procedure. The Kenalog protocol represents an important non-surgical, low-risk alternative to the standard treatment for anal fissures, sphincterectomy. Although considered the gold standard for many years, sphincterectomy entails cutting the sphincter muscle, which can cause undesirable function-related problems such as incontinence. ■

Learn more about Columbia's anal fissures protocol at <http://columbiasurgery.org/news/2014/04/01/new-protocol-treat-anal-fissures>

Expanded Locations

Please call the Division of Colorectal Surgery at **212.342.1155** to make an appointment to see our surgeons at any of our five convenient locations.

Columbia University Medical Center

Herbert Irving Pavilion
161 Fort Washington Avenue, 8th Floor
New York, NY 10032-3784

Columbia Doctors Midtown

51 West 51st Street, Suite #380
New York, NY 10019

Columbia Doctors Riverdale

3050 Corlear Avenue, Suite #204
Bronx, NY 10463

Lawrence Medical Associates

685 White Plains Road
Eastchester, NY 10709

Hudson Valley Hospital

Medical Office Building
1978 Crompond Road, Suite #101
Cortlandt Manor, NY 10567

Same Day Appointments

Our main office routinely accommodates patients for same-day visits. This “no-wait” policy is especially helpful for patients with acute pain or newly diagnosed colorectal cancer.

To make an appointment, please call: **212.342.1155**

Save the Dates



Lung Health Awareness Day

Saturday, April 9, 2016

The Faculty Club
630 West 168th Street 4th Floor
New York, NY 10032

Registration and information: Call 212-304-7817
or e-mail: jas2134@cumc.columbia.edu

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