Polypoid Lesions of the Rectum

Polypoid lesions that occur within the limits of observation of a 25-cm sigmoidoscope include adenomatous (tubular) polyps, villoglandular polyps, villous adenomas, polypoid carcinomas, and a variety of other small polypoid lesions such as hyperplastic polyps, inflammatory polyps, sessile papillations, and mucosal excrescences. The very small lesions of less than 0.5 cm are essentially of no practical importance, but the larger polypoid lesions pose very important and difficult problems in many instances. In general, all polypoid lesions are removed. One exception is the inflammatory polyp, which may be an early sign of ulcerative colitis and will recur after excision. Gilbertsen and Nelms' data indicate that polypectomy will help to prevent cancer of the rectum.4 The risk of the recurrence of polyps has been studied by Henry et al.5

The surgeon has a choice of many methods for the removal of polyps. Lesions less than 1 cm in diameter can be removed with biopsy forceps or a curette, and the base can be treated with the electrodesiccating unit. These small lesions will not be considered further. Various methods for the removal of larger polyps will be described in this chapter. The choice of method must be based upon the location, histologic type, and size of the polyp, as well as general considerations such as the patient's age and other diseases.

Excision Through the Dilated Anal Canal

Under satisfactory general or regional anesthesia, the patient is placed in the lithotomy position and the anal canal is dilated widely. Retractors are then introduced (Fig. 7.1). If the mucosa is somewhat redundant, polypoid lesions as high as 8–10 cm may be intussuscepted down close to the anus and removed from this position. The polyp is grasped with Allis forceps above and below, and mucous membrane above and below is grasped in a similar fashion. A 0 chromic suture is then placed above the lesion and one is placed below it. They serve as guy ligatures to maintain traction as the tumor is removed. An incision is then made through the mucous membrane in such a fashion as to surround all of the polyp. The incision is begun from...
Excision Through the Dilated Anal Canal

above and additional interrupted 0 chromic catgut sutures are placed as soon as a cut is made. Submucous infiltration of normal saline will show whether or not the mucosa is attached to underlying muscle. If it is attached, the lesion probably is cancer and the incision must extend through the rectal wall. Usually when the lesion is soft and apparently benign, the dissection only extends down to the muscle. The entire polypoid lesion is removed by means of this cut-suture technique. If hemostasis is not complete, a second continuous suture may be used to reinforce the interrupted sutures. The wound should be entirely dry at the conclusion because continuing bleeding may form a large hematoma that will dissect between the mucosa and muscularis.

The pathologist's examination can be based on a fixed specimen, since diagnosis by frozen section of cancer in polyps is difficult. If the polyp is found to be entirely benign, no further procedures are carried out. If the lesion is shown to be cancer with definite invasion below the submucosa and into the muscle, we believe that the lesion should be treated as an invasive cancer and some type of radical resection should be performed (see Chapter 5). This decision may be modified on other bases, e.g., the age of the patient, histologic type of the cancer, and location of the tumor (i.e., whether or not a permanent colostomy would be necessary).

If the polypoid lesion was low in the rectum and the final specimen shows carcinoma confined to the tip of the polyp with invasion through the muscularis mucosae but minimal involvement of the stroma, an adequate local excision such as that described above is recommended. There is some possibility of metastasis, but this must be weighed against the additional mortality and morbidity and the quality of life that would follow a combined abdominoperineal resection in this location. After local excision the base of the polyp can be examined very easily either by palpation or through the sigmoidoscope and recurrence in that area could be detected; a further operation could be carried out at a later date if necessary.