# COMMON SURGICAL CONDITIONS: TIPS FROM THE GENERAL SURGEON

BAMP CME CONFERENCE

NOVEMBER 17, 2018

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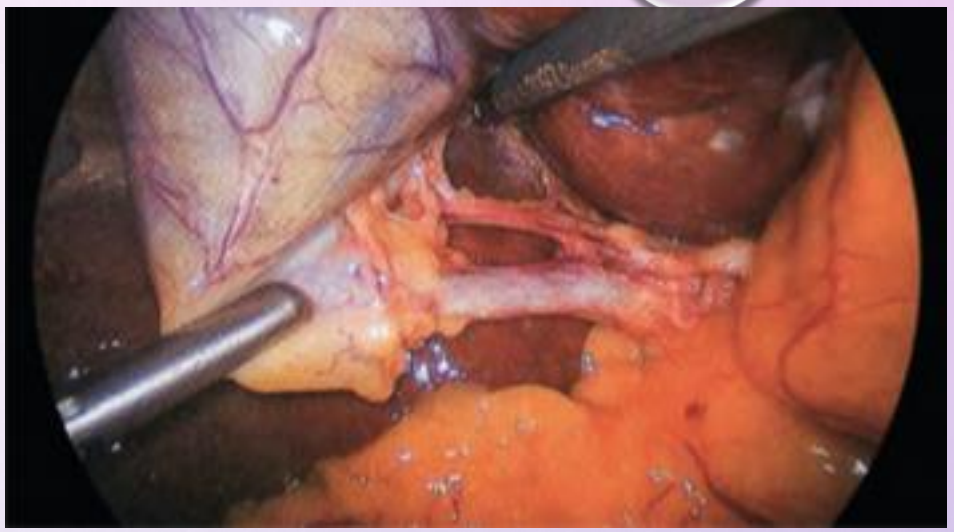
# DISCLOSURES

- NONE

# CASE 1

- 35 YEAR OLD FEMALE, WITH 6/12 HISTORY OF DYSPEPSIA, EPIGASTRIC PAIN ASSOCIATED WITH NAUSEA AND OCCASIONAL VOMITING
- DX: ?GERD
- COMMENCED ON PPI
- REVIEW 3/12 LATER, NO IMPROVEMENT IN SYMPTOMS

# CASE 1



- ASSOCIATION WITH FATTY MEALS
- ULTRASOUND TO RULE OUT GALLSTONES
- INCIDENCE – NO PUBLISHED LOCAL DATA BUT AT LEAST TWO-FOUR CHOLECYSTECTOMIES ARE PERFORMED WEEKLY AT THE QEH AND FOUR NEW SOPD REFERRALS
- MANY INDIVIDUALS REMAIN SYMPTOM-FREE WITH 10 TO 18% DEVELOPING SYMPTOMS AND BETWEEN 1 AND 3 % PER YEAR DEVELOPING COMPLICATIONS SUCH AS ACUTE CHOLECYSTITIS (AC), PANCREATITIS OR CHOLEDOCHOLITHIASIS

# WHEN IS CHOLECYSTECTOMY INDICATED?

- ALL SYMPTOMATIC PATIENTS – FATTY FOOD INTOLERANCE
- BILIARY COLIC, ACUTE CHOLECYSTITIS , EMPYEMA
- GALLSTONE PANCREATITIS (ASSOCIATED WITH STONES <5MM IN SIZE)
- HEMOLYTIC ANEMIA

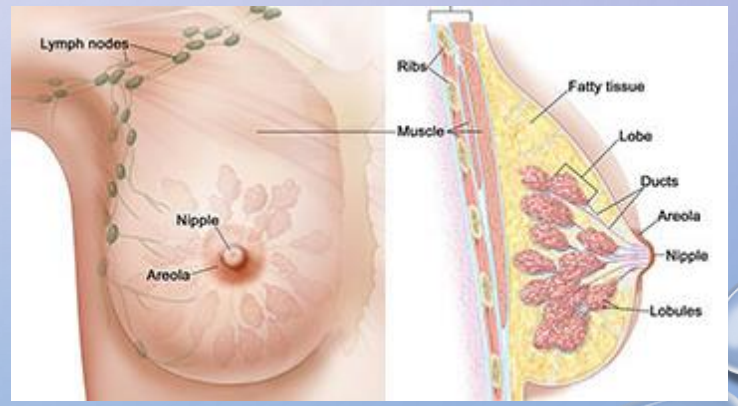
# ACUTE CHOLECYSTITIS

- EARLY LAPAROSCOPIC (EMERGENCY) CHOLECYSTECTOMY IF PATIENTS PRESENT WITHIN 10 DAYS OF SYMPTOMS HAS SIMILAR OUTCOMES AS IF ELECTIVE CHOLECYSTECTOMY PERFORMED
- OUTCOMES INCLUDING CONVERSION TO OPEN AND BILE DUCT INJURY RATES
- ADVANTAGES IN SHORTER DURATION OF HOSPITALIZATION, AVOIDS RECURRENT ATTACKS, INTERIM PANCREATITIS, SICK DAYS FROM WORK
- HOWEVER, AT THE QUEEN ELIZABETH HOSPITAL, ACCESS TO EMERGENCY OPERATING THEATRE NOT ALWAYS AVAILABLE IN TIMELY FASHION

# CASE 2

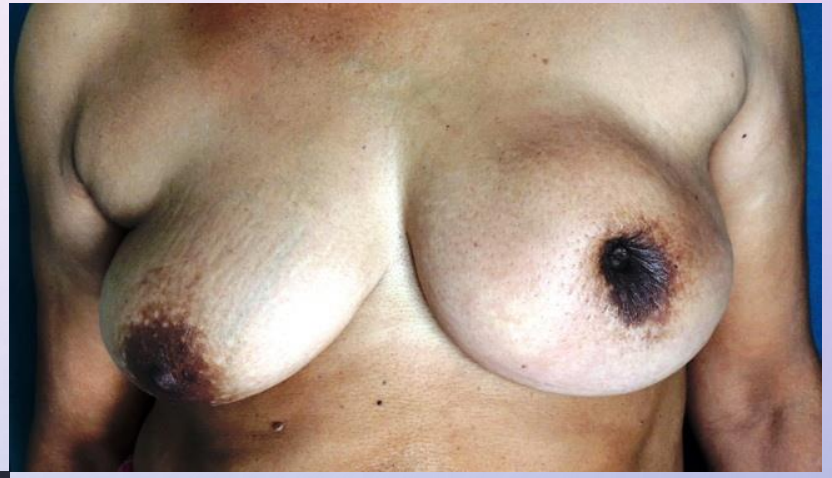
- 47 YEAR OLD FEMALE WITH PAINLESS BREAST LUMP, NO FAMILY HISTORY OF BREAST CANCER
- MOBILE  3 CM LUMP WITH NO NIPPLE OR SKIN CHANGES, NO AXILLARY NODES

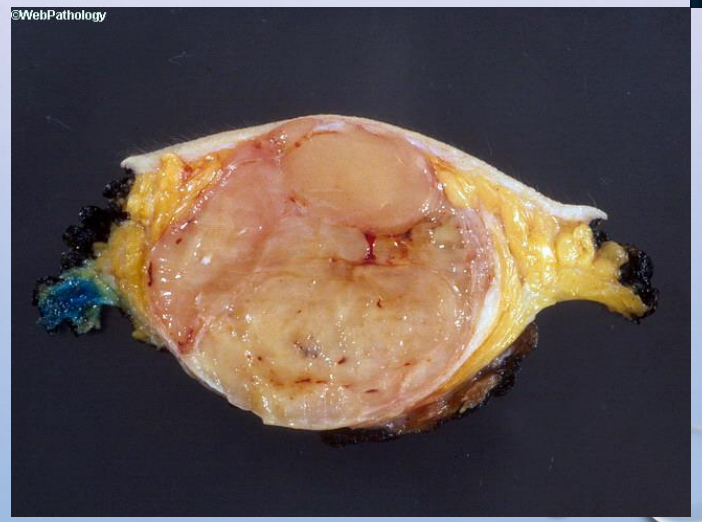
- NEXT BEST STEP:
- OBTAIN MAMMOGRAM AND REVIEW IN ONE MONTH
- OBTAIN ULTRASOUND AND REVIEW IN ONE MONTH
- REQUEST IMAGING AND TIMELY REFERRAL TO A SPECIALIST



# BREAST LUMPS

- FIBROADENOMA
- PHYLLODES
- DUCTAL CARCINOMA IN SITU
- BREAST CANCER





# CASE 3A

- 43 YEAR OLD MALE WITH 3 MONTH HISTORY OF PAINLESS BRIGHT RED BLOOD PER RECTUM. OCCASIONALLY AFTER PASSING STOOL
- NO FAMILY HISTORY OF CANCER
- DRE: 2ND DEGREE HEMORRHOIDS

# NEXT STEP?

- REASSURE HEMORRHOIDS – ADVISE INCREASE FLUID AND FIBER INTAKE
- BARIUM ENEMA
- FOBT

# CASE 3B

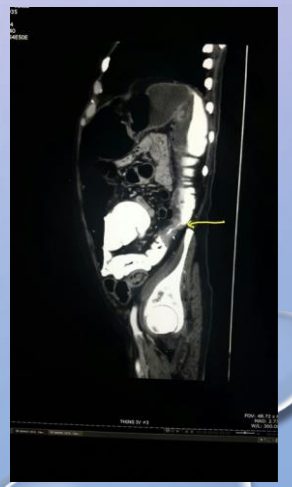
- 67 YEAR OLD FEMALE WITH SYMPTOMS OF ANEMIA,  FBC HB 6.7, MCV 65.5
- FOBT ORDERED AND POSITIVE

# CASE 3

- INCIDENCE OF CANCER IN PATIENTS OVER 40 YEARS WITH BLEEDING PR: 4-16%, POLYPS 7.6% IN ONE STUDY
- LOCAL DATA - 12% OF PATIENTS DIAGNOSED WITH CRC IN BARBADOS IN 2014 WERE YOUNGER THAN 50 YEARS OLD – BELOW AVERAGE RISK SCREENING GUIDELINES
- 45% OF PATIENTS DIAGNOSED IN 2014 PRESENTED WITH PR BLEEDING AND APPROXIMATELY 25% PRESENTED WITH ANEMIA
- REMEMBER DON'T ORDER A SCREENING TEST SUCH AS FOBT OR FIT IF THE PATIENT HAS SYMPTOMS.  THE PATIENT NEEDS A COLONOSCOPY

# CRC

- WORLD HEALTH ORGANIZATION LISTED CRC AS THE FOURTH LEADING CAUSE OF CANCER DEATHS WORLDWIDE IN THE YEAR 2012
- CRC WAS THE 3RD LEADING CAUSE OF CANCER DEATHS IN BOTH MEN AND WOMEN IN BARBADOS IN THE YEAR 2008; SECOND AFTER PROSTATE CANCER IN MEN AND BREAST CANCER IN WOMEN



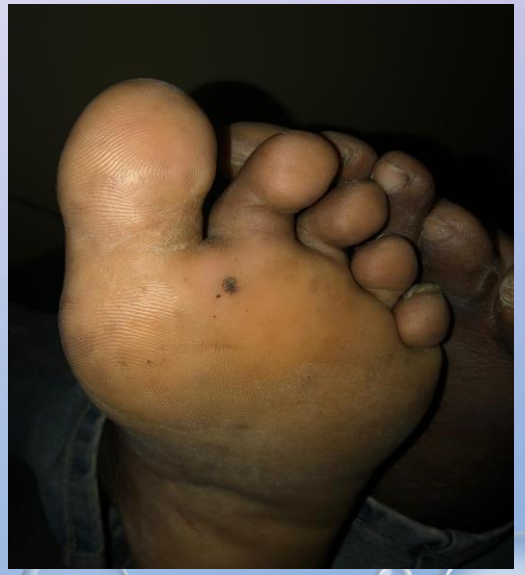
# CRC SCREENING RECOMMENDATIONS -

# CRC SCREENING

- COLONOSCOPY – FROM AGE 45 YEARS FOR AFRICAN AMERICANS. ONLY COMPLETE PREVENTATIVE SCREENING TEST. EVERY 10 YEARS IF NORMAL. REDUCTION IN INCIDENCE AND MORTALITY OF 80% IN DISTAL COLON AND 40-60% IN PROXIMAL COLON CANCERS
- FECAL IMMUNOCHEMICAL TESTING – ANNUALLY IN PATIENTS WHO REFUSE COLONOSCOPY IN SEQUENTIAL TESTING. ONE TIME SENSITIVITY OF 79% FOR CANCER DETECTION
- CT COLONOGRAPHY – EVERY FIVE YEARS. REPLACED DOUBLE CONTRAST BARIUM ENEMA AS A SCREENING TEST. AVAILABLE AT THE QEH
- COLOGUARD – COMBINATION OF FECAL DNA TESTING AND FIT, NEWER SCREENING TEST. EVERY 3 YEARS. ONE TIME SENSITIVITY OF 92% AND 40% FOR CRC AND SESSILE SERRATED POLYPS >1CM IN SIZE. SENSITIVITY OF 82-92% FOR ADENOMAS >1 CM IN SIZE. AVAILABLE IN PRIVATE SECTOR
- FLEXIBLE SIGMOIDOSCOPY EVERY 5 YEAR TO 10 YEARS ( REDUCES INCIDENCE BY 33% AND MORTALITY BY 43%)[8]
- CAPSULE COLONOSCOPY – 88% SENSITIVITY FOR DETECTING ADENOMAS ≥6MM

# CASE 4

- 65 YEAR OLD LONG STANDING DIABETIC WITH PUNCTURE WOUND 6/7 PRIOR WITH PAIN AND SWELLING, NO SYSTEMIC SYMPTOMS, AFEBRILE WITH NORMAL HEART RATE AND BLOOD PRESSURE, RBS OF 10
- PUNCTURE SITE SEEN WITH YELLOW RIM AROUND IT



# DIABETIC FOOT INFECTIONS GRADING - IWGDF

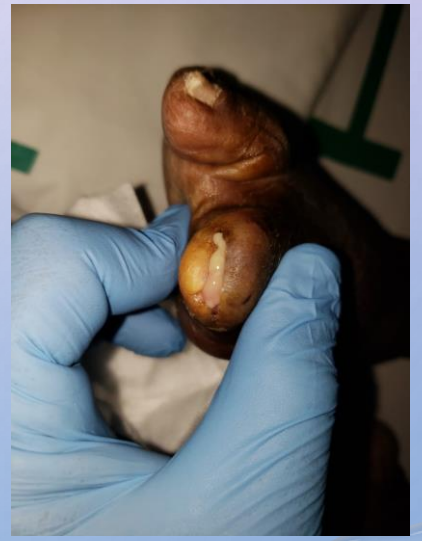
- 1. UNINFECTED
- 2. MILD INFECTION – LOCAL SWELLING, PAIN/TENDERNESS OR PUS,, ERYTHEMA 0.5-2 CM, ONLY SKIN OR SUBCUTANEOUS TISSUE INVOLVED
- 3. MODERATE INFECTION – ERYTHEMA 2 CM OR INFECTION INVOLVING MUSCLE, TENDON, BONE OR JOINT
- 4. SEVERE INFECTION – SYSTEMIC SIGNS PRESENT – 2 OR MORE SIRS

# DIABETIC FOOT CARE

- APPROPRIATE FOOTWEAR THAT FITS AND PROTECTS FEET, WITH SOCKS
- INSPECT SHOES DAILY TO ENSURE NO FOREIGN BODY PRESENT – WITH NEUROPATHY MAY BE MISSED OTHERWISE
- INSPECT FEET DAILY, SHOES INDOORS AND OUTDOORS
- SEEK MEDICAL ATTENTION SAME DAY IF PUNCTURE OCCURS
- ENSURE TETANUS STATUS UP TO DATE
- APPROPRIATE OFF-LOADING IN PRESENCE OF DIABETIC FOOT ULCER

# IWGDF

- RISK ASSESSMENT GUIDES SCREENING INTERVAL  FOR DIABETIC FOOT ULCERATION
- BASED ON NEUROPATHY, FOOT DEFORMITY, PAD AND PREVIOUS ULCERATION/AMPUTATION



| Risk category 0 | Risk category 1 | Risk category 2 | Risk category 3 |
|---|---|---|---|
| Normal Plantar Sensation | Loss of Protective Sensation (LOPS) | LOPS with either High Pressure or Poor Circulation (PAD*) or Structural Foot Deformities or Onychomycosis | History of Ulceration, Amputation or Neuropathic Fracture |
| LOW RISK | MODERATE RISK | HIGH RISK | VERY HIGH RISK |

*Peripheral Arterial Disease

## Patient history

- Is there any numbness and tingling in the feet? Is the numbness and tingling worse at night or at rest? (This is a sign of Advanced Neuropathy).
- Is there a sensation of bugs crawling on the feet?
- Is there any burning?
- Is there any sharp shooting pain down the legs?
- Are there any leg or foot symptoms on walking relieved immediately with sitting or bending forward? (Possible Spinal Stenosis – prevalent in our aging population).
- What is the patient's activity level?
- Is there a presence or history of open wounds on the feet?
- Is there any swelling in the legs or feet?
- Are the feet cold or hot to touch?

## FOLLOW-UP BASED ON RISK CATEGORIES

| Risk category 0 | Risk category 1 | Risk category 2 | Risk category 3 |
|---|---|---|---|
| LOW RISK | MODERATE RISK | HIGH RISK | VERY HIGH RISK |
| Re-check in 12 months | Re-check in 6 months | Re-check in 3 months | Immediate referral if active ulcer or Charcot foot.<br>Re-check in 1 month if history of ulcer or Charcot foot. |

## TREATMENT PLAN

| Risk category 0 | Risk category 1 | Risk category 2 | Risk category 3 |
|---|---|---|---|
| Patient education, daily inspection, proper footwear, routine foot care as needed, yearly follow-up. Tight glycemic control necessary to maintain this risk category. | Patient education, proper footwear, soft molded insoles, routine foot care as needed, daily self-inspection, 6 month follow-up | Patient education, proper footwear with possible modifications, custom molded insoles fitted into footwear with possible modification to relieve areas of pressure, scheduled routine foot care, daily self-inspection, 3 month follow-up | Patient education, extra depth footwear with custom modification, custom molded insoles with modifications to relieve pressure, offload with cast as necessary, scheduled routine foot care, daily self-inspection, monthly follow-up |

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# Diabetic Foot Screening Pocket Chart

**IDF urges all health care practitioners to identify, assess and treat the patients earlier in the "WINDOW OF PRESENTATION" between when neuropathy is diagnosed and prior to developing an ulcer**

# COMBINED WITH OVERALL DIABETES CARE

- GLYCEMIC CONTROL
- HBA1C Q 3-6 MONTHLY
- SMOKING CESSATION
- DIETARY ADVICE, EXERCISE
- BLOOD PRESSURE CONTROL
- RENAL/CARDIAC/OPHTHAL

# INGUINAL HERNIAS

- REFER ALL INGUINAL HERNIAS TO A GENERAL SURGEON EVEN IF THE PATIENT IS ASYMPTOMATIC
- TWO RANDOMIZED TRIALS SHOWED WATCHFUL WAITING I.E. NOT OPERATING IMMEDIATELY AFTER DIAGNOSIS IS SAFE, HOWEVER 23-35% CROSSED OVER TO BECOMING SYMPTOMATIC AT TWO YEARS AND 2/3 IN ONE STUDY AT 10 YEARS.
- EMERGENCY PRESENTATION IN WATCHFUL WAITING GROUP REMAINED RARE
- CAN REDUCE EMERGENCY PRESENTATION WITH INCARCERATION AND STRANGULATION

# SEBACEOUS CYSTS

- SIMILARLY REFER ALL TO A GENERAL SURGEON
- SMALL ELLIPTICAL EXCSION ELECTIVELY WHEN THE CYST IS SMALL
- AVOIDS LARGER SCAR OR EMERGENCY INCISION AND DRAINAGE FOLLOWED BY REPEAT SURGERY AND CYST EXCISION AT A LATER DATE IF THE CYST BECOMES INFECTED

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# THANK YOU

# QUESTIONS/COMMENTS ?