ACPGBI South Africa Travelling fellow 2017
(Dr. Meryl Oyomno)

Introduction

The South African Colorectal Society (SACRS) in collaboration with the Association of Coloproctology of Great Britain and Ireland (ACPGBI) invited colorectal trainees and consultants within 5years of qualification to apply for a 1 month observership in the UK, funded by the ACPGBI, to visit 1 or 2 units and attend the ACPGBI congress in Bournemouth on 3-5th July 2017. I was the fortunate first recipient of this award.

This report is organized into the following thematic components:

- Purpose of the visit
- The conference
- Visit to the University of Oxford colorectal surgery unit
- Visit to St Mark's Academic institute
- Social and cultural engagements
- Overall experience
- Acknowledgement and vote of thanks.

Purpose of the visit

My aims when applying for this fellowship were to get further exposure to:

- Laparoscopic surgery for colorectal malignancy
- Trans anal surgery
    - Trans anal total mesorectal excision Ta TME,
    - Trans anal endoscopic operation TEO for rectal polyps,
    - Trans anal microsurgery TEM
    - Trans anal minimally invasive surgery TAMIS
- Inflammatory bowel disease IBD management, surgery and setting up a combined Physician-surgeon outpatient clinic and multi-disciplinary team IBD MDT.
- Learn advanced endoscopy skills and attend the taTME cadaver course.
- Management of pelvic floor disorders, faecal incontinence, observe anorectal physiological studies being conducted and interpreted.
- ERAS implementation
- Setting up and encouraging research within a unit.

- Learning teaching techniques and establishing skills laboratories for training of junior surgical trainees.
- Get to do a short research project during the period that gets published and presented at an international conference and lays the foundation for a PhD research topic.
- To broaden my view of the world through international travel, learning and experience the culture in the UK.
- And in general to learn important skills and make global contacts that I can fall back on as I establish an academic colorectal unit when I return back home to South Africa.

The Conference

The 2017 ACPGBI Congress in Bournemouth 3rd-5th July was my first stop. I arrived a day earlier on 2nd July 2017 and had the opportunity to sightsee. The weather was beautiful with temperatures of up to 28°C, which was a godsend having come from the cold South African winter. I sent pictures of the great seaside weather back home and had several of my friends envious and doubting whether I was really in the UK or rather by the beach in Mombasa, Kenya.

COUNCIL DINNER: Later that evening, I attended the Council dinner. The venue, the West Beach Restaurant, was beautiful with the seaside as a backdrop and the food amazing but best of all was the opportunity to meet several council members (Ms. Nicola Fearnhead, Mr. Brendan Moran, Prof. Gina Brown and Mr. Baljit Singh) whose work I have over the years of my training, read. I was seated on a table with two leading females in the colorectal field globally, Prof Gina Brown and Ms. Asha Senapati and was able to get some astounding career advice from them. They encouraged me to visit and work in other units internationally so as to broaden my view and thinking and to help me realize that there are several different ways to get things done and after all the exposure, I could select what I felt and saw as the best way. I also had a chance to meet the other international ACPGBI travelling fellows and several council members.

ACPGBI CONGRESS: This was my first international congress to attend. It was extremely well organized and I attended multiple sessions. My highlights included:

Day 1. The BK ultrasound course. This 3hr session was one of the best I spent in the UK. They explained everything in a manner that was very simple and easy to understand, used illustrations and we had hands on time in small groups on

Ultrasound simulators and exercises in identifying male and female pelvic structures, fistulas and sphincter defects. I felt that the course really horned in the transanal ultrasound skills I had been exposed to as a trainee and gave me confidence in my interpretation and reporting.

> **Application**- this has proven to be an invaluable skill since I got back, being not only, the only colorectal surgeon but also the only person with the skill to carry out transanal ultrasound assessments in my hospital. I have since been working with the urologist and gynecologists in my institution, The Steve Biko Academic Hospital SBAH, and the adjacent Tshwane District Hospital, doing assessments for patients with Obstetric associated sphincter injuries OASIS, faecal and urinary incontinence, posterior compartment prolapse etc. prior to repair.

The IBD symposium on Pouch Surgery looked at issues such as when should IRA be selected over IPAA, post-op pouch care, the relative merits of IPAA, IRA and Kock pouch were debated. The pre- and post- stapling checks in restorative proctocolectomy, pouch volume, the effects of age in pouch surgery and the 2017 ACPGBI ileoanal pouch report were discussed.

> **Application**- During my visit to St. Mark's, I went on to have further discussions with Mr. Omar Faiz in theatre and Prof Sue Clark in the polyposis clinic clarifying questions I still had on this topic. They were able to give me advice on actual cases I had back home e.g. a 16yr old female presenting with multiple pelvic and pre-sacral collections following IPAA 5years prior for FAP. We had several interesting discussions on IRA vs. IPAA, management of intra-abdominal desmoids, the data on Sulindac and Aspirin chemoprophylaxis etc. I learnt from Mr. Faiz the importance of being very meticulous when operating on these children to avoid complications because if there are complications, the parents my be reluctant to bring in the younger siblings for surgery and they could end up in the long run dying of colorectal cancer as young adults. He does not do an air leak test but rather does endoscopic review of the anastomosis line on table post anastomosis to ensure it's intact and rule out bleeding.

I also enjoyed participating in the **Supporting staff wellbeing and resilience with Schwartz rounds session** which touched on various sensitive issues including the Manchester bombing and taught me the importance of debriefing and emotional wellbeing of all staff members in a safe, neutral environment.

Day 1 ended at 7pm with drinks at the welcome reception in the exhibition area. I chose to attend the reception rather than the BDRF fun ran, as I needed to meet and be introduced to several ACPGBI senior members, unit heads and consultants. Thank you to Mr. Charles M. Amstrong for all the introductions.

Day 2. I attended the **Histopathology session** in which the ITBCC consensus statement and TNM 8 were reviewed i.e. the essentials (T4a&b, N1c, M1a-c) and additionally Tumour budding, MSI universal testing, KRAS, BRAF etc.

The BJS lecture given by Mr. Brendan Moran on **Significant polyps and early colorectal cancer SPECC**, the good, the bad, the ugly, was very insightful. He put up one phrase that has now become a mantra to me " Decisions are more important than incisions" and something that Prof Gina Brown highlighted to me during the council dinner. The session on **colorectal cancer papers** presented by young research fellows was motivating while the one on **the value of collaborative research** was an eye opener.

Application- I'm glad to note that various South African academic colorectal units are currently participating in the EuroSurg collaborative IMAGINE study, an international student lead observational study of postoperative ileus and management after elective colorectal surgery. My unit at Steve Biko Academic Hospital SBAH in Pretoria is also taking part and I am a supervising consultant.

Other than taking part in international collaborative research, I have also gotten involved in local collaborative research. We are currently in the process of creating the first local a colorectal cancer database in South Africa. Dr. Brendon Bebington of the Wits Donald Gordon Medical Centre WDGMC initiated the study. He set up the database for the Wits Academic Hospitals in Johannesburg were I trained and encouraged me to do the same when I completed my training and moved to the SBAH. I have setup a similar colorectal cancer database at the Steve Biko Academic Hospital and the surrounding University of Pretoria academic hospitals where I am now based. Hopefully in 5 years time we will have good reliable data from multiple centres in South Africa and be able to give definitive local incidence rates, outcomes and risk factors that'll be able to inform local nationwide protocols for screening, management and surveillance of colorectal cancer in South Africa and affect government funding and policies.

I also attended the BDRF lecture on **Evidence-Based Enhanced recovery,** the **parastomal hernia repair** satellite symposium, the **AIN** screening session and found **The Research Today programme and breaking trial**s very entertaining.

Day 3.

I attended the **pelvic floor plenary**, the keynote lecture of **sacral nerve stimulation (SNS)- it's all in the brain**, the **advanced and complex cancer symposium** that looked at individualized surgical treatment based on tumour response. I also attended the symposium on **laparoscopic colorectal resection** training and **Prof Rockall's Ethicon session** on anastomotic leaks.

Following the ACPGBI **Presidential handover session**, I remember having a conversation with Mr. Charles Amstrong in which he explained to me how the ACPGBI president is elected years in advance and is required to sit in on all sessions prior to their term of office meaning that when they finally do get into office, they're already up to speed with all ongoing and future projects thus ensuring continuity, efficiency and avoidance of time wasted and disruption to ongoing projects. I was very impressed and think this is something that we should consider back home in South Africa not just in our medical societies but also in government institutions.

The congress ended following the **anastomosis symposium** that looked at leak rates in relation to level of training and also how to prevent, mitigate and manage anastomotic leaks.

The second part of my fellowship involved an observer ship at The University of Oxford and The St. Mark's Academic institute, colorectal surgery units on 1st - 16th August and 17th - 31st August 2017 respectively.

Visit to the University of Oxford colorectal surgery unit.

During my 2 weeks at Oxford, I was able to attend ward rounds with the fellows (Dr. Sandeep, Claudia Reali and Roel Bolckmans) and consultants (Mr. Roel Hompes, and Bruce George). It was interesting to see their approach to suspected anastomotic leaks and their use of contrast enemas in the investigation. I also learnt the algorithm for management of bleeding from a rectal anastomosis i.e. stopping of anticoagulants, cold saline enemas, to endoscopic management. I saw several

interesting cases e.g. a Grade 2 rectal leiyomyosarcoma invading the obturator that required extra-levator dissection and taking the obturator fascia. The abdominal part of the surgery was done open and the rest via endoscopic transperineal approach. One patient had a Crohn's proctectomy for severe treatment resistant perianal crohn's disease, which required APR with a flap and we had a discussion on the merits of the TME vs. the close plane dissection during the ward round. We also discussed the concerns with TEM surgery in young patients with T1/2, N0 and M0 rectal cancer.

We also discussed the use of Vicryl mesh to reconstruct the pelvic floor post DXT and prevent perineal small bowel ECF post APR for anal SCC. Occasionally omentoplasty is done but noted that mobilization of lots of omentum results in gastroparesis.

The use of Daltaparin (fragmin) rather than enaxoparin (clexane) for VTE prophylaxis as the effect is equivalent but fragmin cheaper was also discussed.

In late pouch complications such as pre-sacral collections, endosponge doesn't work. Rather reserve the use of endosponge for early cases was something else I was taught.

We discussed redo pouches and anastomotic strictures with Mr. B. George and the recommendation for TME plane for crohn's proctectomy, to avoid inflammation involving the mesorectum and getting caught out with cases of missed malignancy.

For rectal GIST, we discussed the recommendation for pre-& post-op gleevac during MDT.

Management of slow transit chronic constipation when all else fails (failed medical Rx and SNS) in a 54yr female was also discussed. A laparoscopic end ileostomy with prophylactic sublay permacol doughnut mesh to prevent parastomal hernias was done. The recommendation is to not do resection and rather offer biofeedback for chronic constipation.

In theatre, I observed several interesting cases. They had 1-2 theatres running with 4-8 cases daily (Monday to Thursday), the highlights included the following:

- Laparoscopic anterior resection of a T2N0M1 (resectable Liver mets) rectosigmoid invasive adenocarcinoma in a 47yr old gentleman who presented with PR bleeding. Hook used for dissection not harmonic or ligasure.

- Loop ileostomy reversal (1yr post LAR and neoadjuvant therapy for locally advanced rectal cancer). They do an intra-operative distal limb washout with 120ml Savlon to ensure its patent and that the ileocaecal valve isn't blocked with concretions. PDS 4.0 full thickness interrupted anastomosis then change gloves before sheath and skin closure to decrease SSI.
- Parastomal hernias repairs: open procedure, incision around stoma, stoma mobilized, Permacol mesh cut into a doughnut, and placed retromascularly.
- EUA for pouch-perineal fistula
- LAR and TaTME. They do an on table pre-op savlon rectal wash out. The legs are draped with clear plastic and 2-hrly-leg cuff check for compartment syndrome and 4hrly bring down the legs from lithotomy to Lloyd Davis position done. I also got the see the TaTME registry that's managed by Mr. Hompes and Ms. Penna.
- Anal sphincter repair (OASIS) and had a discussion on whether or not to do a stoma in patients with grade 4 OASIS.
- Laparoscopic ventral mesh rectopexy
- Excision of mucosal prolapse
- Laparoscopic extended right hemicolectomy. They used the ultravision Alesi surgical system to eliminate surgical smoke and provide a continuously clear visual field.

I also attended two presentations. I really enjoyed the one on anatomy and management of hemorrhoids looking at the NICE guidelines for HAL, the eTHoS Trial (Cost effectiveness of stapled haemorroidopexy Vs. traditional excisional haemorrhoidectomy), HubBle Trial (Heamorrhoidal artery ligation Vs. RBL for symptomatic grade 2 and & hemorrhoids), radiological embolization, 5% phenol injections and the dreaded serious complications of banding that can result in APR, fistula and permanent stomas. The other presentation was on the management of entero cutaneous fistula ECF.

I attended the colorectal MDT meetings. They had interesting cases and doctors in peripheral hospitals would present their cases via Teleconferencing. I noted that they were very pro- PET scans. I was keen to attend the Liver MDT (Hepatobiliary HPB CRC colorectal cancer liver metastasis) on Friday but unfortunately it didn't take place while I was there. On Friday afternoons I attended Mr. Bruce George's Surgical IBD clinic at the John Radcliff Hospital.

Visit to St Mark's Academic institute.

During my 2 weeks at The St. Mark's academic institute I had a really lovely time. I got to see Mr. Faiz. perform several laparoscopic total colectomy and IRA operations for polyposis in teenagers. His technique was meticulous and he would talk through the procedure step by step. At the end of which he would engage me in a sit-down for about 15 minutes discussing the patient, the disease, the surgery, the critical steps, post op care, potential complications. And he would give insight not just based on what various studies had shown, but also based on what their vast experience at St. Marks had revealed. He also answered any questions regarding scenarios or patients I had dealt with back home in South Africa. At St. Mark's, they do IRA if <20 polyps in rectum, <9mm size, no high grade dysplasia or malignancy. If > 20 polyps in rectum they do IPAA. Currently their IRA: IPAA ratio is 3-4:1. They have noted a reductive effect of IRA to the number of remnant rectal polyps. They surveil the patients post IRA and should the rectal polyp number increase to >20, IPAA is done. We discussed the timing of the surgery, indications for earlier surgery e.g. protein losing enteropathy and growth retardation or significant anemia secondary to bleeding, the 15%leak rate with stapled end to end IRA and thus they now do an extra-corporeal stapled side to side IRA via a pfennesteil incision and oversew bleeding parts along the staple line and bury the staple line

I noted the same characteristic of patience and willingness to teach in Mr. Ian Jenkins who I observed doing pelvic exenteration cases, laparoscopic LAR and parastomal hernia repairs, Prof Sue Clark in her polyposis clinic, Ms. Carolynne Vaizey in theatre and also during the intestinal failure MDT and ward rounds. It seems to be the culture at the St. Marks academic institute.

Some of the cases seen at St. Mark's include:

- Laparoscopic total colectomy and IRA (more than 4 cases) for polyposis
- Pelvic exenteration: high subcortical sacral resection of the L5, S1 presacral fascia and shaving of the vertebral body plus enbloc TME with an end to side pouch anastomosis and defunctioning loop ileostomy in a 63 yr. old gentleman with a locally advanced rectosigmoid adenocarcinoma with liver metastasis.
- Total Pelvic exenteration with S1/2 sacrectomy, as part of beyond TME and perineal reconstruction with left SGAP and right buttock rotation flap and right

gracilis flap in a 32yr old gentleman with a locally advanced low rectal adenocarcinoma T4,N2,M0 that perforated posteriorly post neoadjuvant chemotherapy.

We discussed the pre-operative check lists and assessments done for these patients, the prolonged post operative hospital (average 1-2months due to pelvic sepsis) and the survival benefit they seem to be seeing with the beyond TME trial patients. Omentum and Colletamp (Collagen impregnated with gentamicin) is placed pre-sacrally between the sacrum and the anastomosis.

- Laparoscopic high anterior resection
- Laparotomy and restoration of ileal continuity with abdominal wall reconstruction
- Laparoscopic anterior resection, excision of vaginal vault and defunctioning ileostomy
- EUA of IPAA and stoma reversal
- Mesh repair of incisional hernia
- EUA & laparoscopic fixation posterior rectopexy
- EUA and VAAFT
- EUA and FILAC
- Delorme mucosectomy for rectal prolapse
- EUA and pouchoscopy

I learnt about their 100,000 genomes project and the tissue collection process, attended the Colorectal cancer MDT, the IBD MDT, the complex cancer MDT, Polyposis MDT and Prof Clark's polyposis clinic where I saw several patients with FAP, MAP and other polyposis syndromes. I got to discuss with the nursing staff the genetic counseling process and the polyposis registry. I thoroughly enjoyed observing Prof Sue Clark obtain history from the patients, examine and counsel them. She would then explain the various polyposis syndromes and the decision making process for each patient. She taught about the pocket/ region in India Gujarat with a high incidence of polyposis, the effect of laparoscopic surgery on desmoids , the pathogenesis and progression of desmoids based on the different genetic mutations,. Her opinion on chemoprophylaxis and surveillance in FAP, which organs does she surveil e.g. colon and which ones she doesn't e.g. liver for hepatoblastoma. She also mentioned the fact that they offer patients with FAP IVF, pre-diagnostic embryo screening and implantation of the ones free of the genetic mutation meaning

that we may end up being the last generation of surgeons to operate on colorectal cancer due to FAP.

It was interesting to see the scrubEx scrubs exchange system at Oxford while at St Marks they had the London North West Health care hospital patient self-check in system.

Social and cultural engagements

Day 2 of the ACPGBI congress ended with a **4th of July cowboy themed dinner** that involved mechanical bull rides, enjoying classical American food such as corndogs, letting loose and learning how to line dance. I had a blast, I'm sure there are several photos taken of me and my three feet dancing that I hope will never see the light of day. It was a great cultural experience.

On Thursday 6th July following the congress end, I checked out of the hotel early and took the National express to Heathrow. I checked my bags into the storage facility and took the train to Wimbledon. As an avid tennis lover since the age of 6years, this was a dream come true. I had found out the previous night online that being week one of **the championships, Wimbledon 2017**, I could queue and for £25, get grounds admission and access to unreserved seating and standing areas for courts 3-18. I therefore got to watch the doubles matches. But just the fact that I got to go to Wimbledon will forever be a highlight in my life.

On this month long visit; I carried my tennis racquets, as I knew I couldn't go that long without playing. During my time in Oxford, I found out about **Park tennis**, an initiative by the lawn tennis association, local authorities and passionate teams of tennis coaches to not only encourage people to learn and play tennis for fun, exercise but also to ensure that local parks and tennis courts are maintained and used. So for just £6 per session, I was able to join the advance tennis classes at the Bury Knowles Park thrice a week from 8-9pm. This worked out perfectly for me because I would leave the hospital at 6pm, have dinner then at 7.30pm, jog to the park and get to have a lot of fun playing tennis and meeting new people.

Over the weekends, I took long walks around Oxford; sightseeing with some of the friends I had made who were also visiting fellows from Italy (Dr. Elena Schembari). I visited the **Ashmolean museum** in Oxford, saw the view from **the Shard** and visited **the National Gallery** in London which gave me the opportunity to see in person all the beautiful paintings I had learnt about in high school art.

I attended the **Notting Hill Carnival** in London and Sunday church services at the Hillsong Oxford and London church.

Overall experience

The visit was absolutely worth it. I'm glad to note that I managed to achieve most of what I stated to be my aims for the fellowship and have been able to put it into use since my return to South Africa. What stood out for me was the TaTME at Oxford and at St. Marks the total colectomy and IRA and pelvic exenteration surgical cases and polyposis clinic. I was fascinated by what Prof Sue Clark has managed to set up with years of hard work and dedication. I'm sure one day; she'll be receiving a Nobel Prize.

There weren't many constraints and limitations. I think by visiting two centers I got to observe a lot and see how different units are run. I would definitely recommend visiting 2 units rather that 1. The 1month duration was also ideal for me, as I didn't have to be away from my post back in South Africa for too long and was able to get leave authorized by my Head of department.

What should be done to improve the experience? Not much, being the first recipient of the award in South Africa meant that the process needed to be streamlined. I'm sure it'll be easier for subsequent recipients to get responses earlier to ensure they can book flights earlier, get cheaper rates and apply for cheaper accommodation at the respective hospitals.

Acknowledgement and vote of thanks.

I would like to extend my gratitude to both the SACRS and ACPGBI for this once in a lifetime educational and cultural opportunity. Thank you ACPGBI for the generous funding.

I would especially like to thank from the SACRS; Mr. Tim Forgan, from the ACPGBI; Mr. Charles Maxwell Amstrong, Mr. James Wheeler, Ann O'Mara (Administrative manager), Mr. Peter Dawson (President), from the Oxford University Hospitals; Emma Worthington-Chapman (Colorectal department administrator for Janus and Occtopus Colon Cancer Charity), Mr. Chris Cunningham and Mr. Bruce George, from the St. Marks Academic institute; Mr. Omar Faiz, Prof. Janice Ferrari (Course manager), Mr. Ian Jenkins, Prof Sue Clark and Ms. Carolynne Vaizey for not only helping me with the administrative requirements for the congress and visit (thanks Ann), hotel and accommodation suggestions (thanks Janice), visa application letters (thanks Emma) but also for not just allowing me to visit their units, attend ward

rounds, sit in on MDT and various other meetings, but for taking the time after theatre to sit and discuss in details the decision making around the various theatre cases (e.g. Mr. Omar Faiz – IPAA vs. IRA in pediatrics, and the intra-operative post IRA anastomotic check etc.) and answer my numerous questions.

I also want to thank Prof John Northover whom I met at the council dinner. He encouraged me to visit the St. Marks academic institute and put me in contact with Mr. Omar Faiz. I thoroughly enjoyed my visit to St. Marks and learnt so much. I am forever indebted to the St. Marks and Oxford teams.

I very grateful to Prof Janice Ferrari who helped not just to organize the visit and accommodation on very short notice, but also personally took me for orientation around the hospital and introduced me to all relevant parties. She was also very organized and made suggestions and notified me daily of all the clinics, theatre, and meetings available for me to attend. And where necessary would contact the relevant parties in advance so that they knew I was coming. She also organized all the fellows in such a way that we didn't overcrowd any clinic and as such were able to get individualized teaching and time.

It is said that time is the most valuable gift that anyone can give. I'd like to express my deep gratitude and appreciation to the entire staff at St. Marks. I was humbled by the amount of time they each spent teaching me, educating me and answering my numerous questions.

Finally, I'd like to thank my colleagues and Head of Department, Prof. T. Mokoena for allowing me to take leave for the month and covering my unit while I took up this fellowship opportunity.