ACPGBI Travelling Fellow Report

Mr Gregory Thomas MBBS BSc MD FRCS

# Nantes

## Background

Nantes university hospital is a large teaching hospital in the centre of Nantes. It has a medical school and acts as a tertiary referral unit for many specialties, including complex pelvic floor pathology. It has over 900 beds. Professor Paul Lehur is the senior colorectal surgeon at this hospital. He has an interest in the management of pelvic floor and functional bowel disorders. He is an international authority on these problems. He has published and lectured widely on this topic. He did a lot of early work on the use of artificial bowel sphincters. Currently, he has published much of the first work on the magnetic anal sphincter. His junior colleague, Professor Guillaime Meurette, also has an interest in pelvic floor surgery. He is a laparoscopic surgeon and has performed a significant number of rectopexy procedures, many with the Da Vinci robotic system.

I am a colorectal trainee with an interest in pelvic floor surgery. I undertook an MD at St Mark's Hospital into the use of different neuromodulatory treatments for pelvic floor disorders. I have continued to maintain a research interest in this field. I am keen to pursue this as a consultant.

I flew out from Gatwick airport on the afternoon of Sunday 17th April. I arrived in my hotel in Nantes that evening.

## Monday 18th April

This day started with a meeting with Prof Lehur and an introduction to the rest of the department. There was a departmental meeting. During this, all of the weekend's admissions were discussed, and the activities for the week ahead are planned. It is worth pointing out at this point that I am not fluent in French. I can understand written French to an extent, and even spoken French when kept simple. However, the doctors were keen to explain things to me in English at every opportunity. This meant that I was able to make the most of my visit.

On Monday morning there was an outpatient clinic with Prof Lehur.
Here is a brief summary of notable patients from this clinic.

1. 60yr old female. Tertiary referral. Mesh erosion post mesh rectopexy. Treated with proctectomy and primary anastomosis. Follow up.
2. 60 year old female. Evacuatory dysfunction. Treated with biofeedback and rectal irrigation.
3. 50 year old female. Previous CVA. Presents with a full thickness rectal prolapse. For laparoscopic ventral mesh rectopexy.
4. 60 year old female. Previously underwent placement of a magnetic anal sphincter. For follow up.
5. Follow up of a patient with an artificial anal sphincter (ABS device).

In the afternoon there was an operating list with both Prof Lehur and Prof Meurette. Here is a brief summary of each of the cases.

1. Recurrent Crohn's anal fistula. Treated with fistula glue.
2. Delorme's operation for full thickness rectal prolapse.
3. Placement of a permanent SNS for faecal incontinence
4. Replacement of SNS battery.

The day concluded with another departmental meeting.

Tuesday 19th April

The entire day was spent in the operating theatre with Prof Lehur. Here is a brief summary of each of the cases.

1. Female patient with anismus. Botox injection.
2. Resection of rectal mucosal prolapse in a patient with a previous rectopexy for external rectal prolapse.
3. Magnetic anal sphincter placement.
4. Colonoscopy under GA (procedure performed by two clinicians).
5. High transphincteric fistula- staged fistulotomy and comfort drain placement.
6. Open ventral mesh rectopexy for rectocele and enterocele. Previous artificial anal sphincter (ABS) in situ.

Wednesday 20th April

The morning was spent in the outpatient clinic with Prof Lehur.

Here is a brief summary of notable patients from this clinic.

1. Follow up of PTNS at 7 years. Still maintaining a good result.
2. Post haemorrhoidectomy with faecal incontinence
3. Anal fistula in a patient who had previously undergone a coloanal pull through following a rectal resection after DXT.
4. Magnetic sphincter follow up.
5. Rectal prolapse in patient with an anal gatekeeper bulking agent in situ.
6. Recurrent rectal prolapse with bladder prolapse post lap VMR. For redo open mesh rectopexy.
7. Complex fistula in pouch patient post vaginal delivery.

The afternoon was spent at another hospital. Once a month, a tertiary pelvic floor clinic takes place. Prof Lehur took me along to this clinic. There was a urologist, a gynaecologist and a specialist in pelvic pain. Six patients were assessed. All attending doctors were given the chance to question and examine the patient. A decision on their management was made at the same time.

Thursday 21st April

The morning was spent in the operating theatre with Prof Lehur.

1. Anal sphincter repair. Overlapping technique.
2. Perineal repair of full thickness rectal prolapse. Previous rectopexy and STARR.
3. Endoscopic ACE (antegrade colonic enema) procedure.

At lunchtime there was a neurogastroenterology meeting with Prof Lehur and Prof Meurette. This concerned the discussion of difficult cases. Most of these had constipation and various evacuation difficulties. There was also a review of current research projects.

There was an operating list in the afternoon with Prof Meurette

1. Robotic redo ventral mesh rectopexy (polyester mesh). For a patient with a recurrent rectal prolapse with concurrent enterocele and cystocele.

Dinner with Prof Lehur and Prof Meurette.

Friday 22nd April

Friday morning was spent in the outpatient clinic with Professor Meurette.
This was a general colorectal and proctology clinic.

I travelled home that afternoon.

Reflections

This placement allowed me to have broad exposure to complex pelvic floor cases in a short period of time. Such a case mix would be difficult to find in the UK. Prof Lehur was very welcoming and was happy to translate anything into English at every opportunity. He has also asked me to write a chapter for a text book with him, which I am currently undertaking.

I have listed below some specific clinic matters which I found of interest. Some of these I will endeavour to use in my own practice as a consultant

They had a wide experience of the magnetic anal sphincter. They have achieved good results, and apparently have had few complications. The technique appears to be straight forward. Meticulous attention to asepsis is essential during placement. It is possibly better for passive incontinence. I understand that they have had trouble recruiting large enough numbers for a national multicenter study into this device. If these good results are maintained in larger randomised studies, then this presents a potentially useful treatment option.

The ABS procedure is no longer performed there, and indeed in many other countries. This appears to be due to the emergence of other less invasive treatments, and the significant complications reported from its use. However in some patients, good results were seen and follow up at longer than 15 years was seen in several patients.

For sacral nerve stimulation, a permanent lead was used for the test stage. This was performed under GA. If successful, the second operation is performed under LA. Meticulous attention to asepsis was noted. They reported a 70% success rate of test stage. They have a large experience of this procedure, and this is probably a more honest result, than many of those seen in the published reports.

The ACE procedure may be performed using endoscopic placement. This is in a manner similar ot the PEC procedure. A device called the chait is used. This can be applied, in carefully selected cases, to those with both faecal incontinence and constipation.

They have begun to use group biofeedback sessions to good effect. This is likely due to the reassurance that the patient gets when they see that others are troubled by the same condition. It is also a more effective use of resources.

They seemed happy to apply the STARR procedure, although did this infrequently. This is in contrast to many of the units I have worked in.

They are keen to offer a ventral mesh rectopexy. A polyester mesh is used. Prof Lehur has seen few mesh erosion complications. They feel that the polyester mesh reduces the risk of this complication. This interesting, and is not something I have come across in UK practice. They accepted that there was no real benefit in using the Da Vinci robotic system for rectopexy. However, given that this device was freely available at the hospital its use continued.

The French people, in general, are more adverse to the idea of a stoma than those in the UK. This has a significant bearing on many aspects of colorectal practice.

I had a very enjoyable week, and learnt a great deal. I would like to thank the ACPGBI for their generosity in giving me this opportunity.

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