Tech Coloproctol (2009) 13:331–332
DOI 10.1007/s10151-009-0528-9

ETHICAL ISSUES

Innovations in coloproctology

Andrew P. Zbar

Published online: 28 August 2009

Sir,

It is hard to add to the eloquent and well-researched remarks already made independently by Kodner [1], Boffi [2], and Amato [3] regarding the ethical imperatives of new technologies within our field, but with respect to the PPH and STARR controversies, we are all missing the point a little. As trained coloproctologists, our duty with the introduction of 'new' technologies lies in their translation to 'old' situations. Here, the lessons learned from the institution of laparoscopic techniques should inform our practice. Are the indications for the utilization of the new procedure the same, are the contraindications similar, are the complications comparative and is there no 'neo-symptomatology' induced which is difficult to treat or even life-threatening? I must confess, on all these grounds that both PPH and STARR fail these tests. In this regard, the arguments Dr. Herold makes recently in our own journal as to whether a post-PPH syndrome exists are moot [4]. The task for colorectal surgeons is the preoperative definition of subgroups of patients likely to functionally fare badly after anorectal and colorectal surgeries and this can only be achieved by adequate case randomization and trial design. Because some clinicians do not see a problem clearly does not mean that it does not exist. I don't routinely counsel my office patients with large or circumferential haemorrhoids about the potential for a colostomy or of intractable proctalgia when I see them to discuss elective haemorrhoidectomy and there is very little in the available literature at the moment that is likely to make me change my mind to incorporate treatments where such counselling will be necessary.

Coloproctological associations must respond proactively to the 'demand' for untried and improperly represented techniques and we should apply the same stringent guidelines to data interpretation and utility that we would normally apply to any peer-reviewed process or activity. The problem here is not our linkage to industry; that is part and parcel of any scientific meeting. The problem is our acceptance as serious and influential societies of data that is uninterpretable and relatively poorly planned. In this respect, particularly in the eclectic group of patients presenting with functional bowel disorders, the search for the 'holy grail' of a 'one-operation-fits-all' approach where over 90% of patients present with a multiplicity of pelvic floor and perineal soft-tissue pathology places us in a uniquely vulnerable situation. Historically, the interpretation of data as it applied to the UK Large Bowel Project [5] in the 1980s, that of the PROSPER rectal prolapse trial [6] and now the operative outcome data of the European STARR registry [7] are always going to be difficult (if not impossible) to interpret and use in any practical sense for individual patient decision-making. All these data will do is provide us with representative standards for morbidity and mortality of the different procedures; something we already know without patient randomization.

If this is accepted we have to use our own powerful societies as accrediting bodies for data acquisition and trialling. In Australia, Professor Guy Maddern's passionate introduction of the Australian Safety and Efficacy Register of New Interventional Procedures-Surgical (ASERNIP-S) section of the Royal Australasian College of Surgeons has been a case in point; [8] designed to monitor and regulate the introduction and accrediting of new surgical techniques into old working places as it were. I would propose that our

A. P. Zbar (✉)
The Universities of New England and Newcastle, Tamworth, NSW, Australia
e-mail: apzbar@yahoo.com

societies unite to establish an international regulatory body designed to specifically oversee and sanction trialling in order to ascertain the value of these innovations in an effort to combat substandard data informing practice; a result compounded rather than clandestinely generated by our industry associations. A case in point would be the ability finally to define subgroups of patients undergoing surgery for chronic anal fissure where there is a wealth of non-sphincterotomy alternatives [9], a profusion of data on a well-defined condition, but still little to guide us regarding operative management practice [10]. That which is not sanctioned and supported will no longer have pride of place in our meetings which are rightly renowned for their honesty and professionalism.

References

1. Kodner IJ (2009) Innovations in colorectal surgery. Tech Coloproctol 13:167–169
2. Boffi F (2008) "Sutureless" PPH and STARR. Tech Coloproctol 12:352
3. Amato A (2009) Ethical issues and innovations in colorectal surgery. Tech Coloproctol 13:83–84
4. Herold A (2009) Invited commentary to Khubchandani I, Fealk MH, Reed JF (2009). Is there a post-PPH syndrome? Tech Coloproctol 13:144
5. Fielding L, Phillips RK, Fry JS, Hittinger R (1986) Prediction of outcome after curative resection for large bowel cancer. Lancet 2(8512):904–907
6. Phillips RKS (2004) Rectal prolapse—update on the PROSPER Trial. Royal Australasian College of Surgeons Annual Scientific Congress: CR 33
7. Schwandner O, Stuto A, Jayne D, Lenisa L, Pigot F, Tuech J-J, Schere R, Nugent K, Corbisier F, Basany EE, Hetzer FH (2008) Decision-making algorithm for the STARR procedure in obstructed defecation syndrome: position statement of the group of STARR pioneers. Surg Innov 15:105–109
8. Maddern G, Boult M, Ahern E, Babidge W (2008) ASERNIP-S: international trend setting. ANZ J Surg 78:853–858
9. Zbar A (2008) Sphincter-sparing surgical alternatives for chronic anal fissure: the place of fissurotomy. Dis Colon Rectum 51:1299
10. Cross KLR, Massey EJD, Fowler AL, Monson JRT (2008) The management of anal fissure: ACGBI statement. Colorectal Dis 10(S3):1–7