

# James Aitken

MB, BS; LRCP, MRCS; MS: FRCS (Edin); FCS(SA); FRACS  
**General and Colorectal Surgery**

Unit 4,  
77 Grand Boulevard,  
Joondalup, 6027

Suite 41  
Hollywood Medical Centre,  
85 Monash Avenue,  
Nedlands, 6009

Tel: 6389 0244

Fax: 6389 0255

[www.perthcolorectal.com.au](http://www.perthcolorectal.com.au)

email: [info@perthcolorectal.com.au](mailto:info@perthcolorectal.com.au)

**All correspondence to Hollywood**

## **TRANSANAL ENDOSCOPIC MICROSURGERY (TEMS)**

This general guide is designed to provide background information to the operation that you will shortly undergo. It aims to supplement verbal discussion, to answer common questions and to be readily available as an *aide memoir*. It cannot cover in detail every aspect of your individual operation and may not deal with some areas that are of particular concern to you. These can be dealt with individually.

You should feel free to ask about any aspect of your care. All your questions will be answered fully, honestly and in as much detail as you wish. In the heat of the moment it is easy for questions that you intended to ask to slip from your mind. You should note on paper any questions that you may have.

Further information is available at the web site above. This site also provides links to other sites that may provide additional information.

### **What is involved with TEMS.**

Most patients undergo TEMS because they have a benign, non-cancerous, polyp in the rectum. Once anaesthetised an operating sigmoidoscope is passed into the rectum. Long instruments are passed down the scope and the polyp removed. It is similar to laparoscopic (key hole) surgery, but performed through the anus.

TEMS is not normally suitable for rectal cancers. The risk of local recurrence in the bowel itself is too great and as the lymph nodes are not removed there is the potential for cancer deposits in the lymph nodes to be left behind. In a small number of patients TEMS is offered to patients with a rectal cancer as a 'compromise' procedure. This is normally because the risk of open surgery is greater than the risk of leaving cancer behind after a TEMS.

### **Before the operation.**

The polyp needs to be fully assessed. This may require either a trans-anal ultrasound or a MRI scan. You will have a number of routine blood tests and a heart trace (ECG).

You will need to have full bowel preparation, just like before a colonoscopy. Details of how to do this are available on another advice sheet.

It is important that we know every medical issue that might affect you. What may appear unimportant to you may be essential for us to know. In particular, we need to know all the drugs you are taking. You should bring them to the hospital in their original packet. Unless advised specifically to the contrary you should take all your drugs up to and including the morning of surgery. The exceptions to this are blood thinning agents, such as aspirin, plavix or warfarin, and diabetic drugs. These require special arrangements and must be discussed on an individual basis.

**Pain relief.**

You will have minimal pain after this operation. You may feel as if your bowel is full of gas (which it is). Simple Panadol will be adequate.

**Going home.**

Selected patients can go home the same day. However, if you wish to go home the same day you must have the necessary back up. Patients going home the same day of surgery must not drive, operate machinery, make important decisions or sign legal documents for at least 24 hours after the operation conclude. These restrictions also apply to patients who have had an overnight hospital stay and still within the 24 hour post-operative period.

Most patients go home the next day. You will feel no different from when you have your colonoscopy. There are no sutures (stitches) to be removed. You can return to work within 72 hours.

**What can go wrong?**

In surgical terms this is a minor to intermittent operation. Although major complications are a rare, adverse events are possible, as after any surgical procedure. These include drug reactions, post-operative bleeding, deep vein thrombosis, heart and lung complications and wound infections. This list is not exhaustive and if you have any concerns about the possible side-effects or complications you should ask about them before you sign the consent form.

There are two specific potential problems specifically related to TEMS. The first is that the bowel can be perforated at the time of surgery. Normally this can be repaired *via* the sigmoidoscope. If this was to occur, you will need to remain in hospital for at least 48 hours so we can monitor your progress. A small number of perforations cannot be managed through the sigmoidoscope and the perforation has to be repaired through an abdominal incision. This has to take place immediately under the same anaesthetic. This makes the operation a major procedure. Patients are in hospital for at least a week and full recovery takes three months.

**Follow-up**

TEMS is ideal for benign, non-cancerous, polyps.

If the pre-operative biopsies show the polyp is a cancer it is likely that TEMS will only be suitable for a small number of highly selected rectal cancers. Even small cancers are often best treated by abdominal surgery, usually an anterior resection.

Once the polyp has been removed it will be fully assessed by the histopathologist. Despite taking multiple biopsies prior to the TEMS some polyps, when fully studied, are found to be cancer. Depending on the histology it may not be necessary to undertake further surgery. In other patients a formal resection of the bowel (an anterior resection) may be required. Careful consideration has to be given to each of these polyps on an individual basis.

You will need to have the site of the polyp inspected by rigid sigmoidoscopy in the rooms at three, six and twelve months. Thereafter you will be followed by colonoscopy.