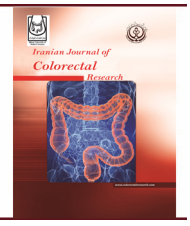
Letter to Editor

Iran J Colorectal Res 2021;9(4):176.

Iranian Journal of Colorectal Research



Low Anterior Resection Syndrome

***Seyed Vahid Hosseini*[1]*, MD**

[1]*Colorectal Research Center, Shiraz University of Medical Sciences, Shiraz, Iran*

Corresponding authors:
Seyed Vahid Hosseini,
Colorectal Research Center, Faghihi Hospital, Zand Ave, Postal Code: 71348-44119, Shiraz, Iran. **Tel:** +98 9171175582
Email: hoseiniv@sums.ac.ir

Received: 02-05-2021
Revised: 02-05-2021
Accepted: 11-12-2021

Please cite this paper as:
Hosseini SV. Low Anterior Resection Syndrome. *Iran J Colorectal Res*. 2021;9(4):176. doi: 10.30476/ACRR.2021.91000.1096.

Dear Editor

In the recent two decades, the rate of sphincter-saving procedures following rectal resections has increased with improving pelvic dissection techniques, and this has significantly reduced the number of patients with a permanent ostomy. Reconstruction following rectal resection includes a colonic pouch after low anterior resection or a small bowel pouch following total proctocolectomy in cases of ulcerative colitis or polyposis. Maintaining gastrointestinal continuity is not necessarily associated with a good functional result as up to 60% of patients undergoing sphincter-saving procedures report some degrees of frequency, urgency, and uncontrolled passage of feces or gas (1). These symptoms are collectively considered as low anterior resection syndrome, the pathophysiology of which is related to internal anal sphincter denervation or injury to the extrinsic nerves from the spinal cord that mediate the rectoanal inhibitory reflex. Poor compliance of neorectum and rectal volume loss are other explanations for this pathology (2). Surgical attempts to reduce the burden of this pathology fail to maintain long-term patient satisfaction, with studies showing the same level of patient satisfaction one year after surgery (3). The first-line therapy for this syndrome is dietary modifications such as an increased intake of fiber-containing foods and decreased consumption of caffeine, citrus, spicy foods, and alcohol. Pelvic floor rehabilitation is the second line of therapy, especially if symptoms last for more than six months. If no response to the first and second-line therapies is achieved and the symptoms last for more than one year, the patient may benefit from sacral nerve stimulation (2). The main dark spot in our understanding of low anterior resection syndrome is the lack of long-term studies about the outcomes of different treatment modalities.

Conflicts of interest: None declared.

References

1. Temple LK, Bacik J, Savatta SG, Gottesman L, Paty PB, Weiser MR, et al. The Development of a Validated Instrument to Evaluate Bowel Function After Sphincter-Preserving Surgery for Rectal Cancer. Dis Colon Rectum. 2005;48(7):1353-65.
2. Nguyen TH, Chokshi RV. Low Anterior Resection Syndrome. Curr Gastroenterol Rep. 2020; 22(10):48.
3. Hüttner FJ, Tenckhoff S, Jensen K, Uhlmann L, Kulu Y, Büchler MW, et al. Meta-analysis of reconstruction techniques after low anterior resection for rectal cancer. Br J Surg. 2015;102(7):735-45.