

# MANagement gUideLines for Low Anterior Resection Syndrome

## The MANUEL project

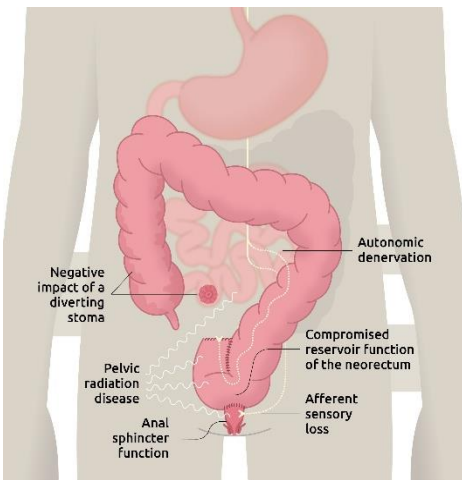
P. Christensen, C IM Baeten, E. Espin-Basany, J. Martellucci, K. Nugent, F. Zerbib, G. Pellino, H. Rosen. *Colorectal Disease* 2021;00:1-15.

### Summary

Eight colorectal surgeons and gastroenterologists with expertise in the assessment and management of low anterior resection syndrome (LARS) aimed to develop a practical guidance for healthcare professionals who manage LARS patients. The MANUEL project is an up-to-date consensus summary covering all aspects of LARS pathophysiology, assessment, and management.

### Method

The project was subdivided among working groups, each devoted to a section of MANUEL. A literature search strategy was developed and agreed on, and individual members led the writing of a respective work package for which they had expertise. Consensus was reached by roundtable discussion, utilizing published evidence and clinical experience. The manuscript was then reviewed by a LARS patient, who also contributed a section on patient perspective.



### Epidemiology and Symptoms

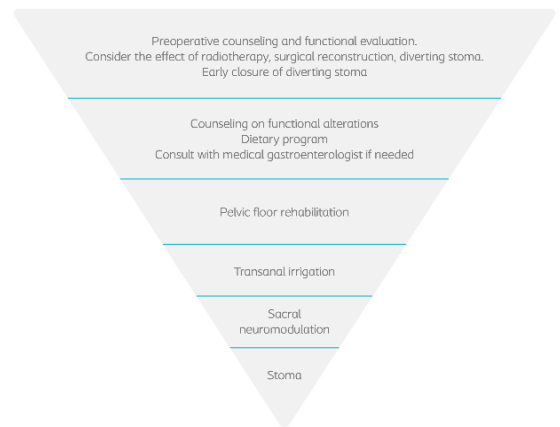
LARS shows a high prevalence (60-90%) and can last for years after surgical treatment of the rectum. It is defined as 'disordered bowel function after rectal resection, leading to a detriment in quality of life'. The most frequently reported outcomes are incontinence (97%), high stool frequency (80%), urgency (67%), evacuation dysfunction (47%), problems with gas–stool discrimination (34%), and effects on health-related quality of life (80%).

### Pathophysiology

Treatment for rectal cancer can affect the function of the internal and external anal sphincters, anorectal sensation, rectal compliance, rectal emptying, and stool consistency. Therefore, the aetiology of LARS is considered multifactorial, with a complex anatomical, neurological, physiological, and psychological background.

### Best Supportive Care

Since the focus at the beginning of treatment is on survival and cancer cure, there is minimal expectation for bowel problems after surgery. Frequently reported concerns are finding toilets when away from home, getting to the toilet in time, emitting odour in social situations, bowel accidents, and sensing a lack of bowel control and knowing what foods to eat when dining out. A multimodal approach to management should be considered using various rehabilitative techniques according to individual needs of the patient. The suggested treatment chart (right) was developed by the authors.



### Transanal irrigation (TAI) as a treatment option for LARS

Studies that have evaluated TAI as a treatment for LARS have demonstrated a significant effect. The authors state that appropriate patient selection and training are important when considering TAI as a treatment option. A multidisciplinary team, including a gastroenterologist, is recommended before, during, and after TAI. Patient selection for TAI as a treatment for LARS will depend on the severity of symptoms. Supportive care should have been initiated and shown to be insufficient, and any spontaneous improvement of the patient's situation should be ruled out.

According to the authors, it is mandatory to provide patients with the support of experienced staff who will provide assistance not only at the hospital but (more importantly) also at home, until the patient is able to perform TAI autonomously. Although perforation can be regarded as a rare complication, a rectal and endoscopic examination should be conducted to exclude any anatomical anomalies. Intensive and standardized training should be mandatory in order to keep this risk as low as possible.

The rectal catheter used with the TAI system can be cone shaped or a rectal balloon catheter. If a rectal balloon catheter is used in LARS patients, the experts advise only to inflate the balloon to a minimum to control leakage of irrigation fluid during instillation, due to the risk of inflating the balloon in the area of the anastomosis.