

COLON AND RECTAL SURGICAL ASSOCIATES

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Does a Clean Colon Lead to a Clean Mind and Clean Body?

The Data (or Lack of Data) About Colon Cleansing.

(Check out page 2 of this Newsletter)

THE END

For those with a short attention span and a desire for immediate answers, here is the conclusion of this article: **CONCLUSION**— Save your time and money. Do not bother trying to clean or cleanse your colon. Your colon does not require any user intervention.

THE BEGINNING

Proponents of colon cleansing claim that cleansing is necessary to maintain a healthy colon, lose weight, prevent colon cancer, and clear the body of toxins or parasites. Ads for colon cleansing supplements warn that mankind is living with an average of 20 pounds of undigested, impacted, rotting colonic fecal matter stuck to the colonic wall. Furthermore, this “spackle” has been stagnating for years, creating an ideal environment for parasites and interfering with the absorption of nutrients. As reported in USA Today on January 11, 1999, “Most people who eat the standard American ‘goo and glue’ diet have about 5-10 pounds of matter stored in the colon. It’s said that, according to the autopsy, John Wayne had 40 pounds of impacted fecal matter in his body at death. Elvis reportedly had 60 pounds.” None of this reportage was ever confirmed.

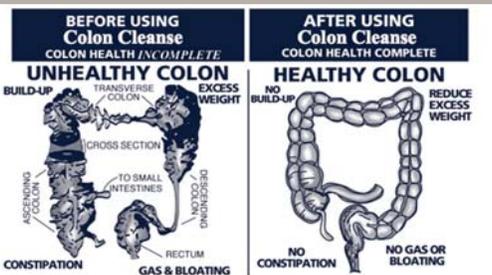
The result of this supposed build-up of poisonous fecal waste is that the toxic matter becomes absorbed through the colon wall and into the circulation, leading to a new syndrome called auto-intoxication. Auto-intoxication then causes lethargy, headaches, decreased sexual drive, acne, and body odor.

The jump to therapeutic colon cleaning seems easy and logical. Who wouldn’t want to have a better memory, clearer vision, immunity to disease, clearer skin, and a better sex life? A clean colon must lead to a clean body and an even cleaner mind. Buy the product and reap the benefits.

BEFORE THE BEGINNING

Practiced for both religious and health reasons in Egypt since 1500 B.C. and recorded in the Eber

Papyrus, hollow reeds were inserted into the rectum while bathing in the Nile, to induce water flow into the rectum. Did the Schistosomiasis trematodes get a free ride through the reed into the rectum as well? The Greeks used cleansing to enhance fitness and strength. Colonic irrigation was widely used in hospitals and doctors’ offices until the 1920’s, when it began to fall out of favor due to questions regarding its necessity and efficacy. Recently, colon cleansing has staged somewhat of a comeback due to aggressive marketing via infomercials and the internet. If it is on television or the internet, it must be true. OMG! LOL!



Who wouldn't want a "healthy colon"?

TODAY

Methods used to irrigate the colon involve colonic hydrotherapy (enemas or “high colonics”), dietary changes, and oral purgatives. According to the advertisements, there are many substances used to remove stubborn colonic wall plaque and sludge. Activated charcoal, cascara, fennel seed, turmeric, betaine HCL, magnesium oxide or green-black walnut hull are just a few of the many products used. The process may require several weeks to one year to dislodge the mucoid plaque.

During colonic irrigation, a colon hydrotherapist inserts a tube into the rectum and instills up to 20 gallons of water. Supplements such as coffee, probiotics, enzymes, even oils may be added to the irrigation fluid. The abdomen is massaged and the colon contents are evacuated through the tube. Some techniques approach downright quackery.

Psyllium may be added to the hydrotherapy fluid. When the fluid is evacuated the solid mass of psyllium may indeed look like sludge or a cast of the colon, encouraging the now cleansed, horrified and relieved victim to plunk down more cash for future relief.

Despite all of the hype and claims, there is no scientific evidence to support any of these practices. Normally, the mucosal lining of the colon constantly regenerates, sloughing old cells along with any associated particulate matter. Numerous glands secrete mucus, making it difficult for anything to truly adhere to the walls of the colon. The symptoms of lethargy, low appetite, weight gain, headache, and irritability are not caused by auto-intoxication of rotting food stuck to the colon. Many of these symptoms are explained by the normal mechanical distention of the bowel, activating the body’s autonomic nervous system. There is abundant evidence that the colon walls are superbly resistant to the movements of bacteria, viruses and toxins through the colon. Translocated bacteria and viruses are rapidly cleared by the B-cell and T-cell systems in the bloodstream and lymphatics. There is no objective evidence that cleansing the colon can relieve the vague symptoms described by colonic cleansing device manufacturers.

There are risks associated with colon cleansing. Mechanical colonic irrigation tubes can perforate the rectum and the large volume of cleansing fluid may cause electrolyte imbalances and cardiac arrest. Unclean equipment used to irrigate the colon may lead to infections. Oral colon cathartics lead to psychological or physiological dependence and may interfere with the absorption of certain prescription medications.

A daily diet containing 25-35 grams of fiber and adequate hydration will help maintain adequate colonic throughput.

Save your time and money. Your colon will take care of itself. No user intervention is required.

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How to Remove a Rectal Foreign Body in ONE Easy Step. (Rare is the Patient who Experiences this Problem Twice.)

(Check out page 2 of this Newsletter)

THE END

For those with a short attention span and a desire for immediate answers, here is the conclusion of this article: **CONCLUSION**— From a safety standpoint, the anal opening is best used for outgoing mail only. Insertion of a foreign body into the anus holds the potential for a painful and embarrassing injury.

WHY DO OBJECTS BECOME STUCK IN THE RECTUM?

Not uncommonly, a call is placed from the emergency room physician to the surgeon, requesting help extracting a rectal foreign body. In most cases, the uncomfortable and embarrassed patient has tried for hours or days to remove the offending object himself or herself. Why did the foreign object become stuck in the first place?

The rectum is a muscular tube measuring 12-15 cm in length, with the sigmoid colon located proximal to the rectum and the anus located distal to it. To enter the rectum, an object must pass through the internal and external anal sphincters. Once inside the rectum, if the object travels beyond the coccyx, manual retrieval is difficult not only because it is out of reach, but because the object will be lodged proximal to the anterior curvature of the coccyx. The coccyx will now act as a check point, preventing egress of the solid foreign body. Even if the foreign body can be removed, repeated dilatation of the sphincteric complex holds the potential to damage the sphincteric muscle fibers, causing permanent difficulty with anal continence.

WHAT SORTS OF OBJECTS ARE INSERTED INTO THE RECTUM?

Objects can be inserted for a variety of reasons, including medical reasons such as enemas for disimpaction, for sexual pleasure, or during sexual assault. Bottles, light bulbs, dildos, vibrators, fruits or vegetables are just a few of the objects extracted from the colon or rectum (figure 1). Other, more unusual items include old radio vacuum tubes, coat hangers and enema installa-

tion kits filled with red wine instead of the standard enema fluid.

HOW TO REMOVE A RECTAL FOREIGN BODY. STEP ONE... CALL SOMEONE WITH EXPERIENCE.

In an asymptomatic, stable patient, after a thorough abdominal and anal exam, a careful and gentle proctosigmoidoscopy may be performed to both evaluate the colorectal lining and possibly visualize the foreign body. If there is no evidence of rectal perforation, an attempt to remove the object in the emergency department is appropriate.

If there are symptoms of rectal perforation, such as abdominal or pelvic pain or a rigid abdomen, urgent operative treatment is required. An elevated white blood cell count or free intraperitoneal air seen on plain x-ray also may lead to operative intervention.



Figure 1. The Foreign Body of Interest is NOT the hip prosthesis.

Intravenous pain medication or conscious sedation at the bedside is usually needed to help the patient relax while an attempt is made to remove the object in the emergency room. The best position to extract the object is with the patient in the supine position and with the legs elevated in stirrups (lithotomy). If the object is proximal to the rectosigmoid junction, it may not be palpable

during a digital exam. With the operator's well-lubricated gloved fingers placed slowly, gently and carefully into the rectum, abdominal pressure with the left hand is used to guide the object towards the rectum. If lucky, the surgeon may be able to grasp and extract the object. A Foley catheter inserted past the object can be used to release the negative pressure that has created a vacuum above the object. Ring forceps may be used if the object is visible through an anoscope, taking care not to pinch the rectal mucosa. Vacuum extraction can also be used if available. Extraction of the object with a sharp tenaculum should be avoided due to the possibility of rectal perforation. If extraction in the E.R. is successful, close follow-up is needed as there is always a risk of delayed sigmoid or rectal perforation secondary to pressure necrosis. The patient should be admitted for observation, or discharged home and seen in the office the next day for follow-up.

Overly aggressive extraction attempts should be avoided in the E.R. If all gentle attempts are unsuccessful, then the patient is brought to the operating room. Under general anesthesia, manual transanal extraction is attempted. If unsuccessful, exploratory laparotomy is needed.

With the abdomen open, the object is palpated in the sigmoid colon and is gently pushed or milked toward the rectum and extracted. In some stubborn cases, the colon must be opened to extract the object. Judgment is used to determine whether or not a temporary colostomy is required. In patients with rectal or sigmoid perforation and gross spillage of stool, a sigmoid resection and end colostomy is performed (Hartmann's procedure). The colostomy can be reversed at a later date.

Rare is the patient who experiences a second retained foreign body. However, it is prudent to advise patients that situations giving rise to a retained colorectal foreign body are best avoided in the future.