Colon & Rectal Surgery
Associates, Ltd.
Improving Outcomes Through Education, Research and Meaningful Collaborations
It is always touching to hear stories of patients who are appreciative for the care they have received. A wedding photo of one such patient and her new husband is displayed in Dr. Ann Lowry’s office. But the reason for this young bride’s gratitude is one that few people would predict. “She had Crohn’s disease, and she needed her colon removed,” explains Dr. Lowry. “Afterwards, she was so happy and grateful. She told me that she got her life back after the surgery, and wished she had had the surgery much earlier. Before her surgery, she was usually able to work but had no energy for anything else. The inconvenience of a stoma was nothing compared to fatigue and pain she experienced before surgery. Colorectal surgery may not be glamorous, but it can be very rewarding.”

Dr. Lowry is President of Colon & Rectal Surgery Associates, Ltd. (CRSAL). The practice was founded in 1963, and has been affiliated with the University of Minnesota from its inception. Today, the expanded practice of 16 surgeons is one of the largest colorectal practices in the nation and works on the cutting edge of international medical advances. The group provides the majority of the clinical education for the University of Minnesota in colon and rectal surgery through the longest running colon rectal surgery program in the United States. The fellowship celebrated its 50-year anniversary in 2000. In addition to training colorectal fellows, CRSAL surgeons also train general surgery residents and lead international medical education programs.
We evaluate and treat disease that may be difficult for patients, and sometimes also physicians, to discuss,” acknowledges Dr. Lowry. “Most people know that they should undergo colorectal cancer screening, but patients sometimes hesitate to go to their doctor for an examination of their colon and rectum. We also treat pelvic floor issues. Fecal incontinence may not be life threatening, but it can drastically affect a patient’s quality of life. Sadly, because patients are embarrassed, they find the topic difficult to broach. Media buzz points to urinary incontinence as the last closet medical issue, but fecal incontinence remains a condition that many patients suffer in humiliated silence. We want primary care physicians to know that several new treatment options exist for these patients.”

The surgeons at CRSAL discuss their subspecialty with frank empathy and a passion to communicate medical advances. “We offer four different silos of specialty concentration,” explains Dr. Brett Gemlo, a senior partner in the practice. “We offer specialized treatment of colon and rectal cancer; inflammatory bowel disease, including Crohn’s disease and ulcerative colitis; pelvic floor problems, including fecal incontinence, constipation and prolapse; and anorectal disorders. Each of our surgeons has a primary strength in one of these four areas.”

“We work in multidisciplinary teams that evolved out of our surgeons’ clinical interests,” says Dr. Lowry. “A basic philosophy of ours from the very beginning has been to provide innovative care by working collaboratively. We encourage surgeons to develop their own individual interests. Our size means that when we develop a particular service driven by surgeon interest, we have the patient volume to allow that surgeon to cultivate depth of expertise. We see approximately 20,000 patients every year. We were among the first to offer endorectal ultrasound staging of rectal tumors and three of our surgeons are internationally recognized for their expertise in this technique. Patient volume and staging referrals from other physicians have enabled us to rapidly develop depth of clinical experience. For instance, we have developed a significant experience in less invasive techniques for rectal cancer such as transanal endoscopic microsurgery (TEM). Our size and comprehensive subspecialty concentration benefits our research efforts as well.”

“Other colorectal centers may have a predominance in one area of specialty,” notes CRSAL surgeon Dr. Amy Thorsen. “The breadth of our practice enables us to offer concentrated expertise in all areas of colon and rectal surgery.”

Colorectal cancer is one of the leading causes of cancer-related deaths among women and men in all ethnic groups. Though these tumors are more common after 60, they can appear much earlier. Colorectal cancer treatment makes up approximately one-third of CRSAL’s practice. “Guidelines recommend that everyone have a colonoscopy beginning at age 50, or in some instances earlier,” says
Dr. Anders Mellgren. “Our hope is that we can catch these cancers early as they then have a much better prognosis.”

The outcomes after treatment of colorectal cancer have advanced significantly over the last 10 to 15 years, with improvements in rectal cancer treatments outpacing advances in colon cancer treatments. The local recurrence rate for rectal cancer has decreased from almost one out of four patients to single digit rates, and the number of patients needing a permanent colostomy had decreased substantially. Thirty years ago, approximately 50% of people with rectal cancer faced a permanent colostomy as a consequence of surgery. When treated by surgeons trained in advanced techniques, only 10% to 20% of patients require a permanent colostomy. For patients treated by nonspecialist surgeons, the reported rate is significantly higher.

“In the past,” says Dr. Mellgren, “the tumor was always removed first, and we decided thereafter if additional treatment, such as radiation, was needed. Today, the treatment philosophy has completely changed. We now tailor the treatment to the individual patient. Evaluation starts, usually, with CT scans and a rectal ultrasound to assess the size and the stage of the tumor. Early rectal cancers may be treated with a local procedure, such as the TEM procedure, which is less invasive and improves quality of life compared to a major abdominal resection. If the tumor is aggressive, it is treated with chemotherapy and radiation before surgery to shrink the tumor and enable complete removal.”

The rate of rectal cancer recurrence in the pelvis has dropped from 25% to rates of 5% to 10% in European studies. “Today,” says Dr. Mellgren, “it is reasonable to expect a recurrence rate in the single digits. This is the result of better tailoring the treatments, and using changed and improved surgical techniques. Even when a colostomy is necessary, a skilled surgeon can perform the procedure so that the colostomy is easier for the patient to manage. Quality of life is an important part of a successful outcome.”

“One of the advantages of our group’s size is that we are able to offer a range of available advanced treatments,” explains Dr. Thorsen. “We take the time to evaluate patients thoroughly. We offer new techniques, including TEM and laparoscopic surgery. We also counsel patients when not to operate. In some situations where cancer is beyond the reach of a curative surgical procedure, our comprehensive evaluation can sometimes point out treatment options not familiar to other physicians.” Data indicates that comprehensive evaluation of colorectal cancer is critical to optimal outcomes.

“We have many tools available to us today to treat rectal cancer,” says Dr. Gemlo. “But the fact remains that no two rectal cancers are the same. The most important thing is to individualize the treatment for each patient. After diagnosing rectal cancer, we use...”

While rectal pain and bleeding are often attributed to hemorrhoids, there are multiple causes. As demonstrated by Dr. Sharon Dykes, careful examination in the office usually reveals the diagnosis.
endorectal ultrasonography and additional steps that might include an MRI or colonoscopy to stage the cancer before we determine the appropriate approach. When patients learn that they have cancer, they understandably want us to cut it out right away. I have to tell them that it’s far more important to get all the specific information than to go directly to the operating room for what might not be the best operation for their circumstances.”

CRSAL’s approach is designed to provide state-of-the-art care from patient screening through diagnosis, staging, treatment and follow-up. “We are surgical oncologists for colorectal cancer,” explains Dr. Thorsen, “but we do more than just surgery. Patient follow-up is a vital step in treatment, and is dictated by the patient’s staging. Because rectal cancers do have a higher rate of local recurrence, we follow up with ultrasounds for up to five years afterwards and sometimes even longer. Patient follow-up procedures may include colonoscopies, office visits or consultation with a medical oncologist, depending on the kind of cancer we are treating. We do our own local surveillance, monitoring the location of the cancer, to make sure it doesn’t recur. Our practice is structured around an ongoing relationship with our patients.”

CRSAL is currently piloting a colorectal nurse navigator in the southwest metro to facilitate each patient’s journey through the individually tailored diagnostic, treatment and follow-up steps. CRSAL is also working in community hospitals to make access to care easier, and to keep primary care physicians involved in patient care.

CRSAL physicians provide innovative work for patients suffering from bowel dysfunction and pelvic floor problems. The Pelvic Floor Center at CRSAL evaluates and treats approximately 2,500 patients annually. As the largest pelvic floor center in the country, it draws patients from Minnesota, the five-state region and from even further away. The center offers cutting-edge evaluation and treatment options for patients suffering from fecal incontinence, severe constipation, bowel dysfunction and prolapse. Although not life threatening, these health issues affect a broad range of patients and can have a devastating effect on quality of life.

“They have terrible problems for years and years because they are too mortified to discuss them with anybody,” says Dr. Gemlo. “Regrettably, in some cases, patients have been told that nothing can be done for them. When they get to us, we ask the right questions, and the floodgates open. I think that more tears are shed over incontinence in my office than over any other condition. Despite what some patients have been told, there are, in fact, many things we can do to help. Our center is a leader in researching new treatments for these conditions. Ninety to 95% of patients affected by fecal incontinence are women. Endorectal ultrasound is a very useful technique to detect leakage problems after childbirth.

Dr. Anders Mellgren performs a rectal ultrasound. This well-tolerated procedure is utilized for staging of rectal cancer. Treatment of rectal cancer is quite complex today and may include preoperative radiation and chemotherapy. Careful evaluation is necessary to determine the optimal treatment of each patient. The technique is also utilized in the evaluation of anal fistulas and fecal incontinence.
Dr. Mellgren and our other ultrasound specialists are internationally recognized. We were one of the first centers to implant artificial bowel sphincters and we are involved in several studies for developing new treatment options. We were the largest participating center in a national study evaluating the use of sacral nerve stimulation for fecal incontinence. This technology will hopefully be approved for this indication later this spring.

“We are committed to providing the latest evaluation techniques and treatment modalities for these patients,” says Dr. Mellgren. “If patients have a combination of urinary and rectal problems, we cooperate with other specialties to offer a multidisciplinary approach to manage these disorders.”

The partners at CRSAL are frequently asked why they chose their specialty. “When I did my surgical training,” remembers Dr. Gemlo, “I was so impressed by the humanity of the colorectal surgeons. They were the people I wanted to work with.”

Dr. Thorsen agrees. “I think you choose surgery because you are an interventional person and you like to see results,” she says. “I have a patient who is six years out of metastatic rectal cancer with a 5% survival rate. He’s disease free. That’s my guy. I’m a very matter of fact person. I don’t like to cover things up. Patients want to know the numbers, and I tell them. But when I have a patient with a bad prognosis, I also tell them about patients like this man who is doing well after six years. There’s no reason why I can’t try to make today’s patient just like him. You have to concentrate on the outcomes. Go for the gusto. You have to go for that.”

“It is a real privilege to be part of our patients’ journey,” concludes Dr. Gemlo. “We treat very sensitive, private and serious health issues. The way our patients conduct themselves makes me feel honored to be in their presence. They are an inspiration.”

PhOTO BY DAVID GINSBERG

Dr. Sharon Dykes discusses the alternative treatment options with a patient. For many colorectal conditions, a variety of treatment options and surgical approaches, including minimally invasive techniques, exist. The selection of the optimal treatment for a patient involves careful evaluation and discussion with the patient. The full spectrum of treatment options — including laparoscopy, robotic surgery and transanal endoscopic microsurgery (TEM) — is available through CRSAL.

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