



Progress of Colonoscopy Surgery for Colorectal Cancer Testing Antigen in Carcinoma

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ABOUT THE STUDY

Colorectal carcinoma is a cancer of the large intestine, or malignant tumor, which can affect the colon or rectum. The colon (also known as the big intestine) is divided into several anatomic segments and connects to the small intestine. The cecum/ascending colon (on the right side of your body), the transverse colon (in the middle of our body), the descending colon (on the left side of our body), and the sigmoid colon (on the right side of our body) make up the colon (in your pelvis area). The sigmoid colon links to the rectum, the lowest section of the large intestine just above the anal canal. If indeed the tumor is found early enough, it can be removed using one of several procedures during a colonoscopy, including endoscopic mucosal resection or endoscopic sub mucosal dissection. Complete surgical removal with acceptable margins is the preferred treatment for persons with localized cancer. A partial colectomy (or proctocolectomy for rectal lesions) is an operation in which the afflicted area of the colon or rectum, as well as parts of the mesocolon and blood supply, is removed to allow for the removal of draining lymph nodes. Depending on the individual and lesion circumstances, this can be done through an open laparotomy or a laparoscopic procedure. The colon may then be rejoined, or a person may experience a colonoscopy.

Colorectal cancer is widespread, with a lifetime risk of about 5% in several countries, where it is the primary cause of cancer death, with around 4000 patients dying each year. The majority of individuals with colorectal cancer can have potentially curative surgery, but more than a third will relapse, however recurrence may be effectively palliated or even cured with additional treatment. Patients who have had primary colorectal cancer may acquire metachronous colorectal lesions as a result of their treatment (polyps or new cancers). Patients are frequently placed on a surveillance programme after a curative surgical resection to detect metachronous colorectal lesions or local or distant tumor recurrence. However, the best surveillance schedule and modalities are not yet evident, although the overall effect has been shown to improve survival.

The first stage in colorectal surgery is to determine the location and degree of the disease. Preoperative colonoscopy or CT scans are used to determine the location of tumors in the vast majority of instances. However, investigations have indicated that these approaches for detecting tumor location have a significant probability of error. Endoscopic colon cancer localization was erroneous in 29% of cases (32/110), with this proportion being substantially higher (43.8%) in right-sided colonic tumors. In another study, error was observed to be higher when the operating surgeons did not do a preoperative colonoscopy. Furthermore, it was discovered that an inadequate colonoscopy can result in incorrect lesion location. Preoperative CT at colonoscopy has also been shown to have low accuracy in lesion localization in studies. Intraoperative Colonoscopy (IOC) is a good alternative for colonic malignancies that cannot be precisely located during laparoscopy. IOC allows surgeons to see colonic malignancies intraluminally, and when combined with a laparoscopic examination, it allows them to precisely identify the extent of colorectal resection. This is critical for lower rectal cancers, where the distal resection border must be identified precisely.

Understanding colonic architecture and mesenteric attachments is necessary to comprehend why colonoscopy may be so difficult and why it is beneficial to be able to visualize the shaft arrangement during insertion. The length of the human colon varies greatly between 68 and 159 cm, as measured at laparotomy. On mesocolon, the sigmoid and transverse colons are usually free, therefore they can considerably increase or reduce in length and movement depending on the colonoscopies' operation. These portions show the most looping during colonoscopy insertion. Female patients, who appear to have a longer transverse segment than men, may have more transverse colon looping deep into the pelvis. The descending and ascending colons seem to be generally in a relatively stable point along the left and right paravertebral gutters; however, in 8% of European patient populations, the descending colon remains mobile on a persisting descending mesocolon, and the splenic flexure is also particularly mobile in 20%, predisposing

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to atypical (counterclockwise) colonoscopy looping in the left colon. Around 17% of patients who have a colonoscopy will have adhesions in their sigmoid colon, resulting in a permanent pelvic loop. Diverticular disease or pelvic surgery can cause adhesions, which can be hereditary or acquired.

A colonoscopy is a frequent, essential, and relatively safe screening procedure used to look for symptoms of colorectal cancer and investigate gastrointestinal disorders. Colonoscopies may be required on a frequent basis for people at a higher risk of

colorectal cancer and older persons to monitor their intestinal health. Colonoscopy surgery in the form of Scope-guide provides essential information to the endoscopist that, if correctly understood, has the potential to improve procedure performance substantially. Magnetic imaging would appear to be a vital tool in guaranteeing excellent practice and precise documentation of the process as we progress towards widespread population screening by colonoscopy to avoid colorectal cancer. It's a big step toward the ultimate aim of a colonoscopy that's safe, and painless.