A colorectal surgeon's tale

Robin Phillips* speaks to Ruth Williamson, Commissioning Editor:

Professor Robin Phillips qualified at the Royal Free Hospital School of Medicine, London, UK, with higher surgical training completed in association with St Mary's Hospital Medical School, London, UK. Professor Phillips became a Consultant Surgeon at St Mark's Hospital in 1987 and has continued the appointment since. In addition, since 1993 Professor Phillips has been supported by the Imperial Cancer Research Fund (now CRUK) and is the Director of the St Mark's Polyposis Registry. In November 1999, Professor

Phillips was appointed Civilian Consultant in Colorectal Surgery to the Royal Navy. Professor Phillips's research has predominantly been colorectal, mostly cancer, although with a maintained research interest in inflammatory bowel disease, anal fistulas and hemorrhoids. Here, Professor Phillips discusses his career to date, challenges in colorectal surgery and what we can look ahead to in the near future.

Q What led you to specialize in the field of colorectal surgery?

Chance. As a young surgeon in training I needed to spend time in research to gain a higher degree. Opportunities that never quite came off included vascular surgery (I learnt a new radioimmunoassay for prostacyclin in the late 1970s to early 1980s at the Hammersmith Hospital, London, UK), melanoma, metabolic water and pain. Almost falling off the end of the career ladder, an opportunity came to take over what was called the Large Bowel Cancer Project, founded by Peter Fielding who had left to take a post in America. This was an audit of 4500 patients in the 1970s and established firsts relating to surgeon-related variables (anastomotic leak rate, local recurrence and so on). The data were on a main frame computer, talked to with punch cards. We did early Bayesian [1] and logrank [2] analyses.

At the same time, the experimental part of my thesis looked at anastomotic

carcinogenesis in a rodent model and showed that suture materials were important [3]. At the time anastomotic stapling guns were being introduced that had stainless steel wire staples. They rapidly changed to tungsten and other metals.

I was hooked. I completed my higher surgical training, rounding it off with a year as a Resident Surgical Officer at St Mark's Hospital, London, UK, with a short clinical fellowship in Toronto, Canada. Both transformed my clinical and operating theatre approach.

In 1987, aged 34 years, I was appointed Consultant Surgeon to St Mark's Hospital and Senior Lecturer at St Bartholomew's Hospital, London, UK.

Q You are now the Clinical Director at St Mark's Hospital. Throughout your career, what has been your greatest achievement to date?

Maintaining a strong clinical and research presence. Too often my experience has been

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that universities are concerned almost exclusively with money and citations, with a little teaching for seasoning, and have little or no interest in clinical activity. Nonacademic clinicians, on the other hand, are put off by this, and so they find other outlets for their interests. However, only surgeons know where the surgical frontiers are, and only surgeons can lead and inspire other surgeons or take forward surgical research. There is a danger that future surgical clinical leaders, not coming from the universities who have shown no interest, may succumb to the dark side of administration, targets and money, and fail to see and develop the surgical frontiers that need developing.

Q Since becoming Clinical Director in 2004, what has been your greatest challenge?

We had a period of great uncertainty when six consultants joined University College, London, UK. We needed to appoint talented surgeons, gastroenterologists and radiologists, and were very successful. Other than that, managing and inspiring people is probably the toughest part. Trying to play to strengths and not pick away at weaknesses, maintaining humor, a useful tool that will turn many an edge, and remembering inheritance; give sunlight to others and watch them grow.

Q You are a specialist in cases that have 'gone wrong' elsewhere. Do you have an example of such a case within colorectal cancer that has been particularly rewarding to work on?

Most of my examples relate to patients confronted by a future with a stoma, usually a consequence of anastomotic failure deep in the pelvis where reconstruction is hard. I remember clearly a man in his early fifties who had surgery and radiation therapy for a rectal cancer and a very bad reaction to them both. He arrived with a permanent epidural for his pain, a stooped skeleton of a man. Investigation showed a cavity behind the bladder containing feces and urine, a consequence of radiation necrosis of his colon and bladder. A total of 8 h of surgery cleared out the cavity, plugged the hole in the bladder with omentum, and restored intestinal continuity with a pull-through anastomosed transanally and acting as its own vascularized graft. He was transformed. Now 10 years later I see him once a year, tanned, upright and striding in from the golf course.

Q What are the most important things to consider when working on such cases in colorectal cancer?

Take a good history and understand very clearly what it is that the patient most wants. Then hold up a mirror so they can see what they want and what risks and perils there might be in getting there. In my practice I am rarely dealing with more attacks on the cancer; I am trying to put right what has gone wrong and do not want to make matters worse or use up a large aliquot of what little remaining time there may be in someone whose prognosis is limited.

Q As an esteemed researcher in colorectal surgery, what do you consider the most exciting recent research within your field?

I think personalization is very exciting. Whether in cancer, inflammatory bowel disease or surgical training, honing the treatment/education to the individual and their particular needs will surely be the way forward. Crohn's disease is not one disease, and when it is, the patients are not all the same. Cancer is not one disease and likewise patients vary. Current blunderbuss research will make way for the tailored – new analytical methods will replace the randomized controlled trial and systematic review.

Q What emerging research are you currently working on at St Marks Hospital?

I am very much involved with research in familial adenomatous polyposis, a dominant inherited colorectal cancer syndrome, and in anal fistulas, both Crohn's and idiopathic. I have worked on both of these fields my entire consultant career. Probably the most exciting current area is the demonstration that fistulas are not driven by infection; indeed, infection cannot be demonstrated even with advanced molecular techniques. Probing this as well as the familial adenomatous polyposis frontier will continue to be my life's work.

Q Will this be the major focus of your work over the next few years?

My research in familial adenomatous polyposis will continue to be patient orientated: what problems do they have (large bowel, upper GI tract and desmoid disease), and how do we address these issues and make their lot easier? There is much yet to do. In fistulas the relation with wound healing in general and the potential for scaffolds primed with biological agents, such as

anti-TNF or stem cells/other growth factors, allied to advances in imaging expose a wide open terrain of increasingly individualized therapy.

Q Is there a particular area of research you are interested in working on that you currently are not?

I do not really have time to take on another area of research; however, if I were to have my life again, there are numerous possibilities. In particular in colorectal surgery, there is a muscle in the anal sphincter known as the longitudinal muscle that nobody knows what it does. If its function could be deduced and tested in the clinical laboratory, then I envisage light potentially being thrown on a number of areas – from fistulas through to constipation – and I have some ideas how it might be done!

Q Considering all the experience you have gained, what would you say are the major obstacles in advancing colorectal surgical techniques?

Time at the coal face. Only by constant practice and exposure to nuance can real excellence be gained. The European Working Time Directive allied to young men and women ‘wanting a life’ reduce time at the coalface and thereby conspire against excellence. Great sportsmen, writers, actors, and experts in any field are not great through lack of commitment, time and practice. It is understandable that the next generation look at their fathers and mothers and decide “I am not following in their footsteps”. It is admirable that balance in life can be achieved so much more easily. Benefits accrue to spouse, family and individual, and yet my own view is that true excellence will never be achieved in this way. Therefore, I believe that advancing colorectal surgery technique needs constant practice; as such, lifestyle choices and legal constraints to working hours can be the biggest obstacles.

Q How do you feel that these obstacles are to be overcome, in order to ensure advances are made in research?

As far as research is concerned, surgeons want to be surgeons. They want to drink, breathe, eat and sleep surgery – and some of them want to push at the frontier. The universities only have an interest in the latter sentence; none in the first two. In my view, this disconnection between the universities and surgery is the biggest obstacle to advances in surgical research in the future.

Q What words of advice would you give a young researcher entering the field of colorectal surgery?

First and foremost, you are a surgeon. Hone your clinical skills as you develop your research ideas, never let them fall by the wayside. Be wary of lazy thinking; research and writing are hard tasks and clinical work a demanding and alluring mistress. It is easy to have good intentions that are never fulfilled and, although hard, it is very fulfilling to go that extra mile.

Q Overall, how would you summarize the current status of colorectal cancer surgery & where do you think major advances will be made?

Colorectal cancer is common and its surgery needs to be commonplace. Straightforward cases increasingly will be performed by minimal means, earlier cases identified through screening permit even more limited approaches to be considered, adjuvants will become more powerful and imaging more sure. Then there are the bad ones, they will need centralization. Whereas laparoscopic surgery will be the norm, the failures and the disasters will need difficult open surgery. Where will be the training ground for that? As for the major advance, Henry Ford said “If I had asked people what they wanted, they would have said faster horses.” So don’t ask me!

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