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Low anterior resection syndrome

Syndrome de résection antérieure basse

1. Systematic Reviews and Meta-Analysis

1.1. Generic Acupuncture

Sharp 2025 Sharp G, Findlay N, Clark D, Hong J. Systematic review of the management options available for low anterior resection syndrome (LARS). Tech Coloproctol. 2025 Feb 4;29(1):58. https://doi.org/10.1007/s10151-024-03090-3

Backgound	Rectal cancer incidence is increasing. Low anterior resection is currently the gold standard surgical management. Postoperatively, patients may present with symptoms indicative of low anterior resection syndrome (LARS). LARS can be debilitating and is difficult to treat with low efficacy of treatment modalities. This systematic review aims to highlight the current evidence regarding LARS management.
Methods	Systematic review of Medline, Cochrane and Embase used the following terms: “low anterior resection syndrome” AND “management”, “low anterior resection syndrome” AND “treatment”. Articles that focus solely of low anterior resection syndrome management in patients > 18 years were included. Bias risk was assessed via the Newcastle-Ottawa quality assessment scale for cohort studies and the JBI critical appraisal tool for randomized controlled trials. Due to heterogeneity of methodology, no statistical analysis was performed.
Results	Thirty-eight articles with a total of 1914 patients were included in this review. Ninety-five per cent underwent surgery for malignancy. Treatment options included pharmacology, pelvic floor rehabilitation (PFR), transanal irrigation (TAI), sacral nerve modulation (SNM), **percutaneous tibial nerve stimulation (PTNS)** and “treatment programs” starting from the least invasive procedures escalating to more invasive treatments upon failure. The most common published medical therapies report Ramoestron use; however, studies are low impact. PFR showed significant improvement in LARS mostly in those with symptoms of faecal incontinence. However, long-term outcomes are inconsistent. TAI supplies pseudo-continence with its greatest benefit reported in those with incomplete evacuation. TAI has significant short-term effects on LARS but little long-term effect. TAI is also associated with a significant drop-out rate. SNM's hypothesised benefit is extrapolated from non-LARS associated FI. Results show improvements in FI but a high rate of explantation. PTNS evidence suggests little if any significant LARS improvement. A single “stepwise programme” study reported that 77 per cent did not progress further than diet and medication. Little evidence suggests benefit regarding diet or acupuncture.
Discussion	There is no consensus as to the optimal treatment strategy for LARS. LARS is multifactorial and requires sensitive discussion between patient and surgeon to address the most prominent symptom. It requires physical and psychological input. No single treatment option provides superior results. Treatment is based on symptom control and patient acceptance.

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