



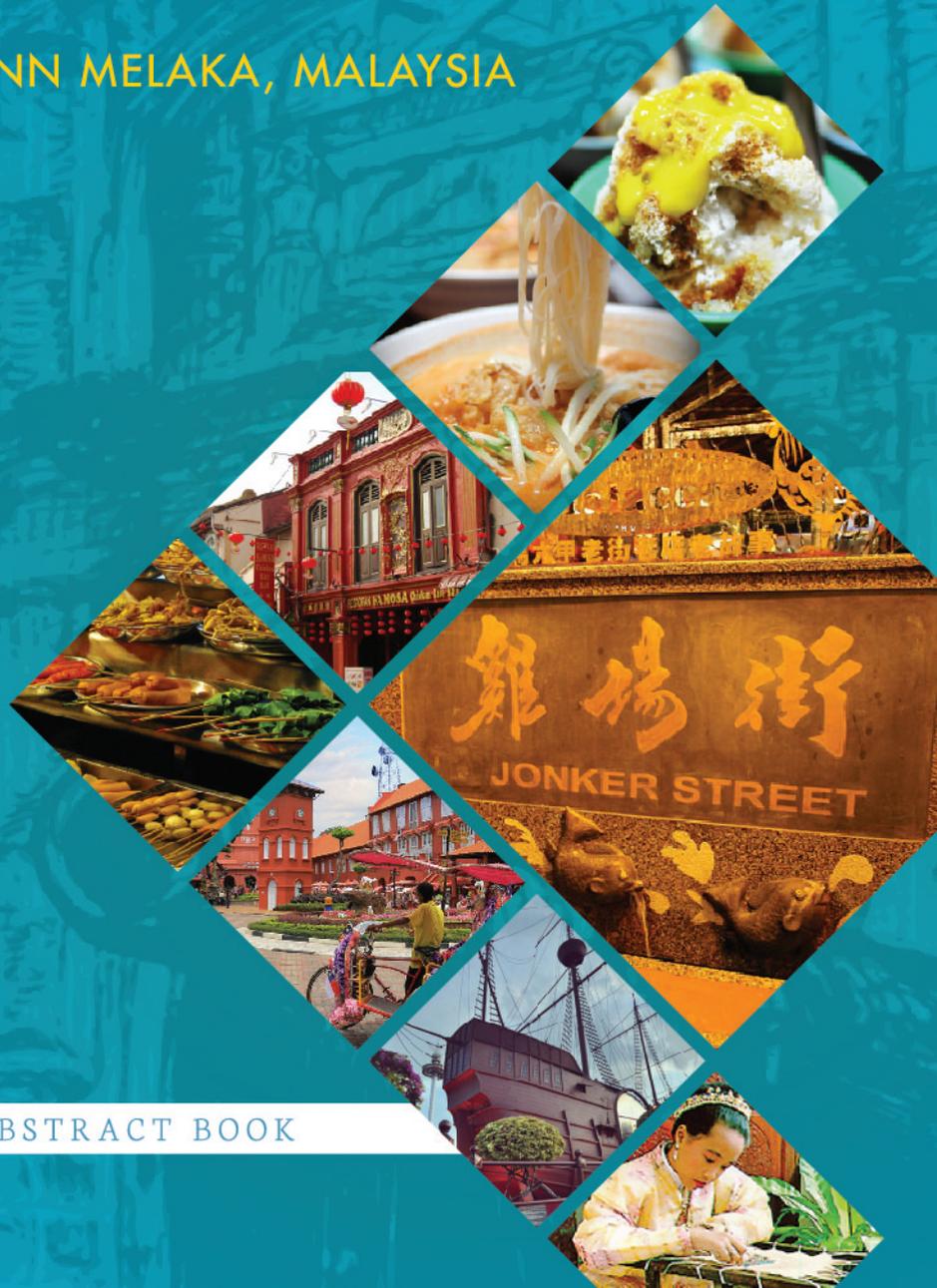
Malaysian Society of Colorectal Surgeons

# COLOPROCTOLOGY 2015

INTERNATIONAL SCIENTIFIC MEETING

12<sup>TH</sup> TO 15<sup>TH</sup> MARCH 2015

HOLIDAY INN MELAKA, MALAYSIA



SOUVENIR PROGRAMME & ABSTRACT BOOK



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## Malaysian Society of Colorectal Surgeons Office Bearers 2013 – 2015

<b>President</b>	Dr Lu Ping Yan
<b>Immediate Past President</b>	Dato' Dr Wan Khamizar Wan Khazim
<b>Vice President</b>	Prof Dr Azmi Md Nor
<b>Hon Secretary</b>	Assoc Prof Datuk Dr Ismail Sagap
<b>Hon Treasurer</b>	Prof Dr April Camilla Roslani
<b>Council Members</b>	Dr Jasiah Zakaria Dato' Dr Meheshinder Singh

## Coloproctology 2015 Organising Committee

<b>Chairman</b>	Dr Lu Ping Yan
<b>Scientific Chairman</b>	Dr M Sarkunna Thas
<b>Scientific Committee Members</b>	Prof Dr April Camilla Roslani Assoc Prof Datuk Dr Ismail Sagap Prof Dr Azmi Md Nor Dr Samuel Tay Dr Mohd Akhtar Qureshi
<b>Allied Health Professional Programme</b>	Dato' Dr Meheshinder Singh Matron Mariam Mohd Nasir
<b>CORUM Programme</b>	Dato' Dr Meheshinder Singh
<b>Social</b>	Dr Manohar Padmanathan
<b>Publicity / Publications</b>	Dr Chong Hoong Yin Dr Tharmaraj T Renganathan
<b>Committee Members</b>	Dato' Dr Wan Khamizar Wan Khazim Datuk Dr Yunus Gul Dr Paul Selvindoss Dr Ahmad Shanwani Dr Jasiah Zakaria



## Message



Welcome to Coloproctology 2015, and to the historic state of Malacca!

The Organising Committee has worked hard to come up with a very interesting programme. From the outset, we planned a programme which would cover common conditions and situations faced by general and colorectal surgeons when managing patients with colorectal conditions.

The programme this year includes topics on how to manage complications which may occur following colorectal surgery, managing functional colorectal problems such as rectal prolapse and incontinence, managing obstetric and non-obstetric perineal and anal sphincter injury. In addition, there will be updates on the current status of the National Colorectal Cancer Registry and Colorectal Cancer Screening in Malaysia. Coloproctology 2015 will also address important ethical and medico-legal issues in colorectal surgery.

We hope all of you will find Coloproctology 2015 to be interesting, beneficial and relevant to your clinical practice.

**Dr Lu Ping Yan**

President, MSCRS &  
Organising Chairman, Coloproctology 2015



## Programme Summary

DATE TIME	13 <sup>TH</sup> MARCH 2015 FRIDAY		14 <sup>TH</sup> MARCH 2015 SATURDAY		
0830 – 0900	> Straits Ballroom East <b>SYMPOSIUM 1</b> Colorectal Cancer Updates	> Meeting Room 3, Level 1 <b>SYMPOSIUM 2</b> Allied Health Professionals Session (1)	> Straits Ballroom East <b>SYMPOSIUM 7</b> Managing Complications in Colorectal Surgery	> Meeting Room 3, Level 1 CASE STUDY PRESENTATION	
0900 – 0930				> Meeting Room 3, Level 1 <b>SYMPOSIUM 8</b> Allied Health Professionals Session (4)	> Meeting Room 2, Level 1 <b>SYMPOSIUM 9</b> CORUM (1)
0930 – 1000	> Straits Ballroom East <b>PLENARY 1</b>				
1000 – 1030	Coffee / Official Poster Round		> Straits Ballroom East <b>PLENARY 3</b>	Coffee	
1030 – 1100	> Straits Ballroom East <b>SYMPOSIUM 3</b> Issues in Laparoscopic	> Meeting Room 3, Level 1 <b>SYMPOSIUM 4</b> Allied Health Professionals Session (2)	Coffee	> Meeting Room 3, Level 1 <b>WORKSHOP 3</b> Allied Health Professionals	Coffee
1100 – 1130					> Meeting Room 2, Level 1
1130 – 1200	> Straits Ballroom East <b>PLENARY 2</b>		> Straits Ballroom East <b>SYMPOSIUM 10</b> Non-Healing and Recurrent Fistulas-in-Ano	> Meeting Room 3, Level 1 <b>WORKSHOP 4</b> Allied Health Professionals	> Meeting Room 2, Level 1 <b>SYMPOSIUM 11</b> CORUM (2)
1200 – 1230	> Straits Ballroom East <b>Lunch Satellite Symposium</b> (Johnson & Johnson)		> Meeting Room 3, Level 1 <b>WORKSHOP 5</b> Allied Health Professionals		
1230 – 1300			> Meeting Room 3, Level 1 LECTURE		
1300 – 1330	Lunch Friday Prayers		Lunch		
1400 – 1430		> Meeting Room 3, Level 1 <b>WORKSHOP 1</b> Allied Health Professionals	• Presentation of Best Poster Awards • Introduction of New Members • Introduction of MSCRS Council for 2015-2017 > Straits Ballroom East <b>PLENARY 4</b>	> Meeting Room 3, Level 1 VIDEO PRESENTATION	> Meeting Room 2, Level 1
1430 – 1500	> Straits Ballroom East <b>SYMPOSIUM 5</b> Trauma	> Meeting Room 3, Level 1 <b>WORKSHOP 2</b> Allied Health Professionals		> Meeting Room 3, Level 1	> Meeting Room 2, Level 1 <b>ROUND TABLE DISCUSSION</b> CORUM
1500 – 1530		> Meeting Room 3, Level 1 <b>SYMPOSIUM 6</b> Allied Health Professionals Session (3)	> Straits Ballroom East <b>SYMPOSIUM 12</b> Medico-Legal Issues in Colorectal Surgery	<b>SYMPOSIUM 13</b> Allied Health Professionals Session (5)	
1530 – 1700	> Straits Ballroom East HOW I DO IT		> Straits Ballroom East PROFESSORS' CORNER		
1700 – 1730					
1730 – 1900	> Straits Ballroom East <b>MSCRS AGM</b>				
1930 – 2200	> Seri Nyonya Peranakan Restaurant, Equatorial Hotel, Melaka <b>FACULTY DINNER</b> (by invitation only)				

<b>12<sup>TH</sup> MARCH 2015</b>	<b>PRE-CONGRESS OPERATIVE WORKSHOP</b>	> Clinical Auditorium, University Malaya Medical Centre, Kuala Lumpur
<b>15<sup>TH</sup> MARCH 2015</b>	<b>POSTGRADUATE ROUND</b>	> Meeting Room 3, Level 1, Holiday Inn Melaka



Pre-Congress Workshop  
12<sup>th</sup> March 2015 (Thursday)

**PRE-CONGRESS OPERATIVE WORKSHOP**

**Venue** Clinical Auditorium, University Malaya Medical Centre, Kuala Lumpur

**Faculty** Paul-Antoine Lehur, Giulio Santoro, Chucheeep Sahakitrungruang,  
Gerald Fitzjerald Henry, Lee Kil Yeon

**Programme**

- 0800 – 0830 Registration  
0830 – 0840 Welcoming Remarks & Opening Ceremony  
0840 – 0850 Official photograph  
0850 – 0920 **Lecture:** Interpretation of endorectal ultrasound – Fistulas / Abscesses  
*Giulio Santoro*

0920 – 1300 Live Surgery  
*Lee Kil Yeon, Paul-Antoine Lehur, Chucheeep Sahakitrungruang*

**OT 2**

Open mesh rectopexy  
Sphincter repair/Fenix implant  
Rectovaginal fistula repair  
STARR & spinofixation for rectocoele  
Laparoscopic resection rectopexy OR  
Panproctocolectomy for ulcerative colitis

**OT 3**

Laser haemorrhoidoplasty  
FiLAC  
Lap anterior resection using automated  
stapling device  
Transanal resection/TAMIS

1300 – 1620 Lunch / **Lecture:** Interpretation of endorectal ultrasound – Cancers / Prolapse /  
Incontinence  
*Giulio Santoro*

(continued live surgery)

1620 – 1630 Closing remarks

1630 Tea



## Daily Programme 13<sup>th</sup> March 2015 (Friday)

0830 – 0930 > Straits Ballroom East

### **SYMPOSIUM 1** – Colorectal Cancer Updates

**Chairpersons:** Ahmad Shanwani, Wan Khamizar Wan Khazim

An update on National Colorectal Cancer Patient Registry [pg 13]

*Muhammad Radzi Abu Hassan*

Advances in genetic testing and counselling [pg 13]

*Abdul Rahman Jamal*

Current status of colorectal cancer screening in Malaysia [pg 14]

*Nor Saleha Ibrahim Tamin*

0930 – 1015 > Straits Ballroom East

### **PLENARY 1**

**Chairperson:** April Roslani

Fecal Incontinence Management: Trends over the 25 last years [pg 15]

*Paul-Antoine Lehur*

1015 – 1030  
COFFEE / OFFICIAL POSTER ROUND

1030 – 1130 > Straits Ballroom East

### **SYMPOSIUM 3** – Issues in Laparoscopic Colorectal Surgery

**Chairpersons:** Ismail Sagap, Jasiah Zakaria

Bowel preparation

*Yunus Gul*

The finer points

*Paul Selvindoss*

Containing costs [pg 17–18]

*Chucheep Sahakitrungruang*

1130 – 1215 > Straits Ballroom East

### **PLENARY 2**

**Chairperson:** Azmi Md Nor

Role of ultrasound in anorectal surgery [pg 19]

*Giulio Santoro*

0815 – 1000 > Meeting Room 3, Level 1

### **SYMPOSIUM 2** – Allied Health Professionals Session (1)

Welcome Remarks

*Meheshinder Singh, Mariam Mohd Nasir*

Montage presentation:

Stoma care and tribute to the late Mr Peter Chua Past-President of Malaysian Ostomy Association (MOsA)

*Mohd Rahime Ab Wahab, Mohamad Amiruddin Jaafar*

**Chairperson:** Mariam Mohd Nasir

Enterostomal therapist: Where will your journey take you? [pg 15]

*Rohani Arshad*

**Chairperson:** Rozita Mohamad

Enterostomal therapy nursing services in Malaysia: Challenges and the way forward [pg 16]

*Mariam Mohd Nasir*

1000 – 1030  
COFFEE

1030 – 1300 > Meeting Room 3, Level 1

### **SYMPOSIUM 4** – Allied Health Professionals Session (2)

**Chairperson:** Mariam Mohd Nasir

Indonesian perspective: Quality of life of an ostomate [pg 20]

*Widasari Sri Gitraja*

**Chairperson:** Mohd Amiruddin Jaafar

International ostomy guidelines

*Rusinahayati Moktarudin*

**Chairperson:** Ikram Bauk

Stomacare: How competent are you? [pg 20]

*Rohani Arshad*

**Chairperson:** Norsehha Ahmad

Prevention is better than cure: Recognising, managing and treating peristomal and stomal complications [pg 20]

*Rozita Mohamad*

**Chairperson:** Mohd Amiruddin Jaafar

Home care for stoma patients in Indonesia [pg 21]

*Edy Mulyadi*

1215 – 1300 > Straits Ballroom East

### **Lunch Satellite Symposium** (Johnson & Johnson)

Science of Tissue Management Energy for Colorectal Surgery

*Shastri Satyanand*



Daily Programme  
13<sup>th</sup> March 2015 (Friday)

1300 – 1415 LUNCH / FRIDAY PRAYERS	1300 – 1400 LUNCH
<p>1415 – 1545 <span style="float: right;">&gt; Straits Ballroom East</span></p> <p><b>SYMPOSIUM 5 – Trauma</b> <i>Chairpersons: Gerald Fitzgerald Henry, Mohd Ismail Ali</i></p> <p>Non obstetric perineal and anorectal trauma: Guidelines for emergency and long-term management <a href="#">[pg 21]</a> <i>Paul-Antoine Lehur</i></p> <p>Obstetric trauma <i>Charles Tsang</i></p> <p>Colonic trauma <a href="#">[pg 22]</a> <i>Rattaplee Pak-art</i></p>	<p>1400 – 1445 <span style="float: right;">&gt; Meeting Room 3, Level 1</span></p> <p><b>WORKSHOP 1 – Allied Health Professionals (Convatec Malaysia Sdn Bhd)</b> <i>Mohd Rahime Ab Wahab</i> <i>Mohamad Amiruddin Jaafar</i> <i>Norsehha Ahmad</i></p> <p>1445 – 1530 <span style="float: right;">&gt; Meeting Room 3, Level 1</span></p> <p><b>Workshop 2 – Allied Health Professionals (Coloplast)</b> <i>Mohd Rahime Ab Wahab</i> <i>Mohamad Amiruddin Jaafar</i> <i>Ikram Bauk</i></p>
<p>1545 – 1730 <span style="float: right;">&gt; Straits Ballroom East</span></p> <p><b>HOW I DO IT</b> <i>Moderators: M Sarkunathas, Tharmaraj T Renganathan</i></p> <p>Magnetic anal sphincter: An option to treat fecal incontinence <a href="#">[pg 23]</a> <i>Paul-Antoine Lehur</i></p> <p>Pelvic floor US in incontinence and obstructed defecation <i>Giulio Santoro</i></p> <p>Obstetric perineal injury repair <i>Chucheep Sahakitrungruang</i></p> <p>Laparoscopic rectal surgery: Intersphincter resection <i>Chucheep Sahakitrungruang</i></p> <p>Surgical treatment of anal abscess <a href="#">[pg 24]</a> <i>Arun Rojanasakul</i></p>	<p>1530 – 1700 <span style="float: right;">&gt; Meeting Room 3, Level 1</span></p> <p><b>SYMPOSIUM 6 – Allied Health Professionals Session (3)</b> <i>Chairperson: Rozita Mohamad</i></p> <p>Stoma care: Bedside stories <i>Norlizah Turiman [pg 24]</i> <i>Alimuddin Ali Padu [pg 25]</i> <i>Noorfariza Hussin</i> <i>Azniwani Yusoff [pg 25]</i> <i>Hamka [pg 26]</i></p> <p><i>Chairperson: Mohd Rahime Ab Wahab</i></p> <p>Learning to live with a stoma. How did I do it? <a href="#">[pg 26]</a> <i>Sri Tharan</i></p> <p><i>Chairperson: Norlizah Turiman</i></p> <p>Remembering the pioneer in ETN: Norma N Gill Day Celebration <a href="#">[pg 27]</a> <i>Mariam Mohd Nasir</i></p>
1730 – 1900 <b>MSCRS AGM</b>	<span style="float: right;">&gt; Straits Ballroom East</span>
1930 – 2200 Faculty Dinner (by invitation only)	> Seri Nyonya Peranakan Restaurant, Equatorial Hotel, Melaka



## Daily Programme 14<sup>th</sup> March 2015 (Saturday)

0830 – 1000 > Straits Ballroom East

**SYMPOSIUM 7 – Managing Complications in Colorectal Surgery**  
*Chairpersons: Manohar Padmanathan, Ong Kee Thiam*

Incomplete doughnut after double stapling in low rectal anastomosis  
*[pg 27]*

*Ismail Sagap*

How to get the bowel to reach the pelvic floor for a low colo-anal / pouch anal anastomosis

*Charles Tsang*

Managing complications in colorectal surgery *[pg 28]*

*Francis Seow-Choen*

Incontinence following surgery for fistulas-in-ano and lateral internal sphincterotomy *[pg 29]*

*Paul-Antoine Lehur*

1000 – 1045 > Straits Ballroom East

### PLENARY 3

*Chairperson: Yunus Gul*

Surgical approaches to rectal prolapse: Towards a consensus in 2015? *[pg 34]*

*Paul-Antoine Lehur*

1045 – 1115

COFFEE

1115 – 1300 > Straits Ballroom East

**SYMPOSIUM 10 – Non-Healing and Recurrent Fistulas-in-Ano**

*Chairpersons: Retna Rasa, Gooi Boon Hui*

Causes and prevention *[pg 35]*

*Arun Rojanasakul*

Role of ultrasound in difficult fistulas *[pg 36]*

*Giulio Santoro*

MRI in the assessment of complex fistula in ano

*Hamzaini Abdul Hamid*

Management

*Charles Tsang*

0830 – 0900 > Meeting Room 3, Level 1

*Chairperson: Azniwani Yusoff*

Case Study Presentations

*Norlizah Turiman [pg 30]*

*Edy Mulyadi [pg 30]*

*Norsehha Ahmad*

*Ikram Bauk*

*Noorfariza Hussin*

0900 – 1000 > Meeting Room 3, Level 1

**SYMPOSIUM 8 – Allied Health Professionals Session (4)**

*Chairperson: Mohd Rahime Ab Wahab*

Setting up Enterostomal Therapist (E.T.) private practice in Indonesia *[pg 31]*

*Ikram Bauk*

*Chairperson: Noorfariza Hussin*

Counselling: Are we doing it right? How should we do it? *[pg 32]*

*Widasari Sri Gitraja*

1000 – 1030

COFFEE

1030 – 1115 > Meeting Room 3, Level 1

**Workshop 3 – Allied Health Professionals**

• Video show

• Stoma Siting *[pg 37]*

*Person in-charge:*

*Mohd Rahime Ab Wahab, Mohamad Amiruddin Jaafar, Noorfariza Hussin*

1115 – 1200 > Meeting Room 3, Level 1

**WORKSHOP 4 – Allied Health Professionals**

Counselling pre-operatively *[pg 38]*

*Person in-charge: ET Team*

1200 – 1230 > Meeting Room 3, Level 1

**WORKSHOP 5 – Allied Health Professionals**

Assessment and classifying peristomal skin excoriation using SACS instrument *[pg 39]*

*Person in-charge: ET Team*

1230 – 1300 > Meeting Room 3, Level 1

### LECTURE

*Chairperson: Rozita Mohamad*

Sexuality: When is the right time to talk about it? *[pg 41]*

*Mariam Mohd Nasir*

0800 – 0900

REGISTRATION

0900 – 1030 > Meeting Room 2, Level 1

**SYMPOSIUM 9 – CORUM (1)**

*Chairpersons: Meheshinder Singh, Cynthia Chu*

The value of peer support in colorectal cancer management

*[pg 32]*

*Sri Tharan*

Understanding radiation therapy in rectal cancer *[pg 33]*

*Daniel Wong*

Tests to detect colonic polyps and cancer *[pg 33]*

*Buwanesarvan Tachina Moorthi*

Q & A

1030 – 1100

COFFEE

1100 – 1230 > Meeting Room 2, Level 1

**SYMPOSIUM 11 – CORUM (2)**

*Chairpersons: Sri Tharan, Bunny Tan*

Supportive and palliative care in advanced cancer

*Loh Ee Chin*

Body changes and intimacy in colorectal cancer

*Stephen Jambunathan*

Clinical hypnotherapy: An adjunct in the management of colorectal cancer *[pg 40]*

*Alan Soh*

Q & A



Daily Programme  
14<sup>th</sup> March 2015 (Saturday)

1300 – 1400

LUNCH

1400 – 1415

> Straits Ballroom East

- Presentation of Best Poster Awards
- Introduction of New Members
- Introduction of MSCRS Council for 2015-2017

1415 – 1500

> Straits Ballroom East

**PLENARY 4**

**Chairperson: Meheshinder Singh**

Ethical issues in colorectal surgery (consent, disclosure of complications and research) [pg 42]  
*Mohd Akhtar Qureshi*

1500 – 1600

> Straits Ballroom East

**SYMPOSIUM 12 – Medico-Legal Issues in Colorectal Surgery**

**Chairpersons: Samuel Tay, Chong Hoong Yin**

Strategies in reducing medico-legal risk – A surgeon's perspective  
*Yunus Gul*

Current medico-legal trend in Malaysia  
*Sagadevan Thangavelu*

Medicolegal issues in colorectal surgery – case illustrations  
*Mohd Akhtar Qureshi*

Q&A and Panel Discussion

1600 – 1730

> Straits Ballroom East

**PROFESSORS' CORNER**

Managing Problems after Haemorrhoid Surgery

**Moderator: Lu Ping Yan**

*Panel: Samuel Tay, Francis Seow-Choen, Charles Tsang, Paul-Antoine Lehur*

Severe pain after stapled haemorrhoidopaxy

Stricture after haemorrhoidectomy (conventional and stapled)

Non-healing ulcer after conventional haemorrhoidectomy

Recurrence after stapled haemorrhoidectomy

Obstructed defecation after stapled haemorrhoidopaxy

Closing Remarks

1400 – 1430

> Meeting Room 3, Level 1

**VIDEO PRESENTATION**

Application of pouching system  
*Mohd Rahime Ab Wahab*  
*Mohamad Amiruddin Jaafar*

1430 – 1700

> Meeting Room 3, Level 1

**SYMPOSIUM 13 – Allied Health Professionals Session (5)**

**Chairperson: Mariam Mohd Nasir**

Colostomy "Irrigation" is the best solution: My personal experience [pg 43]  
*Harikesh Buch*

**Chairperson: Norsehha Ahmad**

An effective teaching tool for stomacare [pg 43]  
*Rozita Mohamad*

**Chairperson: Mohd Amiruddin Jaafar**

Clinical leadership: Is it important? [pg 44]  
*Mariam Mohd Nasir*

**Chairperson: Widasari Gitaraja**

Treat the whole, not just the hole [pg 45]  
*Mariam Mohd Nasir*

**Chairperson: Mohd Rahime Ab Wahab**

Ostomy worldwide: Their functions and roles in promoting ostomate's rights [pg 46]  
*Harikesh Buch*

Closing Remarks

*Matron Mariam Mohd Nasir*

1400 – 1700

> Meeting Room 2, Level 1

**ROUND TABLE DISCUSSION**

**CORUM**

Mutual sharing sessions  
Hands-on self hypnosis - For relaxation



## Conference Information

### CONFERENCE VENUE

#### Holiday Inn Melaka

Jalan Syed Abdul Aziz, 75000 Melaka, Malaysia

**Tel:** +606 285 9000 **Fax:** +606 285 9111

### REGISTRATION

The registration hours are:

12 <sup>th</sup> March 2015 (Thursday)	1600 to 1900 hrs
13 <sup>th</sup> March 2015 (Friday)	0730 to 1800 hrs
14 <sup>th</sup> March 2015 (Saturday)	0730 to 1400 hrs

### IDENTITY BADGES

Delegates are kindly requested to wear identity badges during all sessions and functions.

### ENTITLEMENTS

Registered delegates will be entitled to the following:

- Admission to the scientific sessions, satellite symposia and trade exhibition
- Conference bag and materials
- Lunches & Coffee/Tea

### SPEAKERS AND PRESENTERS

All speakers and presenters are requested to check into the Speaker Ready Room at least two hours prior to their presentation. There will be helpers on duty to assist with your requirements regarding your presentation. The Speaker Ready Room is located at the Board Room, Holiday Inn Melaka, and the operating hours are:

12 <sup>th</sup> March 2015 (Thursday)	1600 to 1900 hrs
13 <sup>th</sup> March 2015 (Friday)	0730 to 1800 hrs
14 <sup>th</sup> March 2015 (Saturday)	0730 to 1400 hrs

All presentations will be deleted from the conference computers after the presentation are over.

### POSTERS

Posters will be displayed at Ballroom Foyer. The Organising Committee bears no responsibility for the safekeeping of posters. Any posters not collected by the close of the poster session will be discarded.

### PHOTOGRAPHY & VIDEOTAPING POLICIES

No photography or videotaping of the presentations is permitted during the scientific sessions.

### MOBILE PHONE

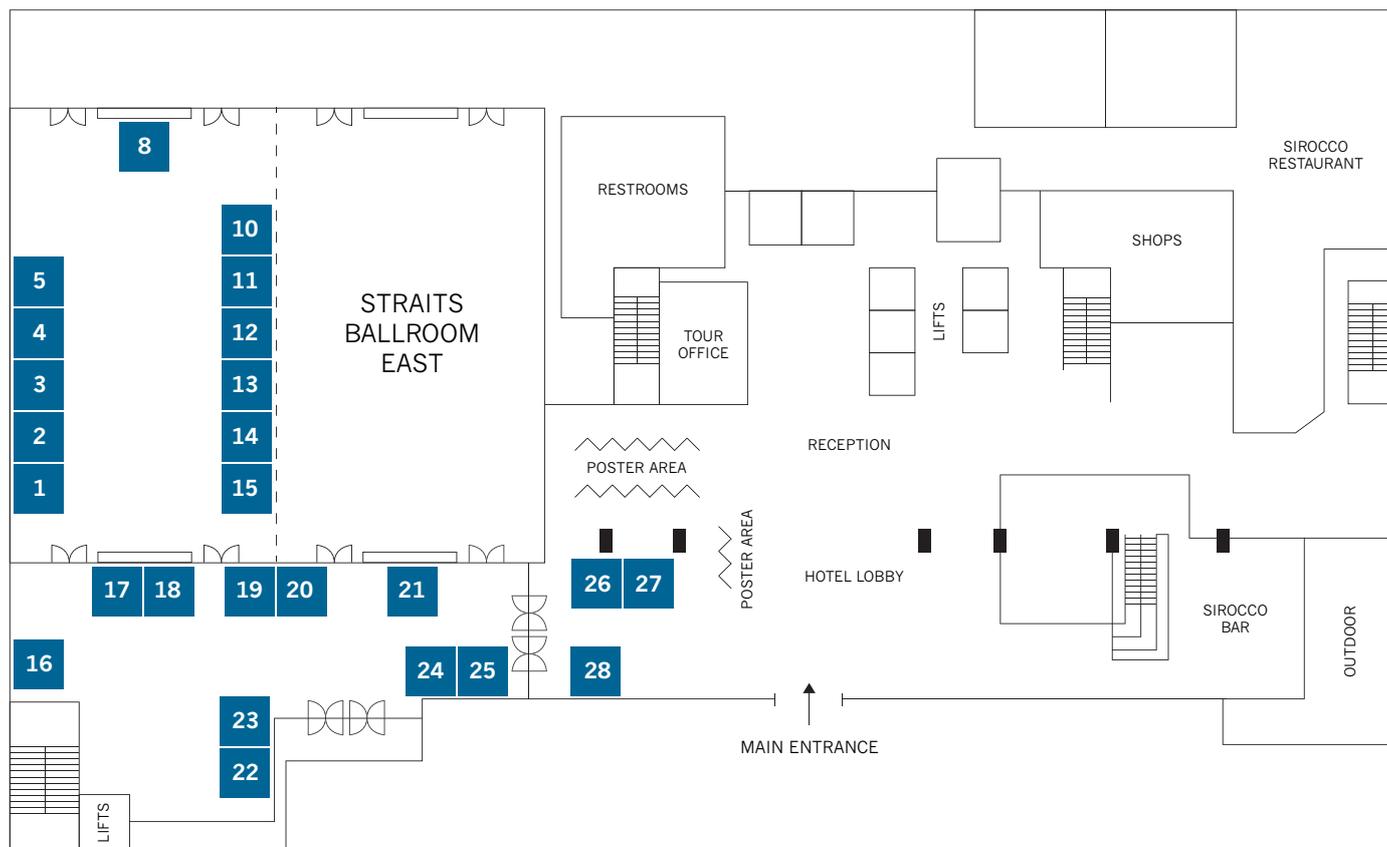
For the convenience of all delegates, please ensure that your mobile phone is silenced during the conference sessions.

#### DISCLAIMER

Whilst every attempt would be made to ensure that all aspects of the Convention as mentioned in this publication will take place as scheduled, the Organising Committee reserves the right to make last minute changes should the need arises.



## Function Rooms & Trade Exhibition



Booth No	Company
1 & 2	Takeda Malaysia Sdn Bhd
3	BioLitec (M) Sdn Bhd
4	Mundipharma Pharmaceuticals Sdn Bhd
5	United Italian Trading (M) Sdn Bhd
8	Fresenius Kabi Malaysia Sdn Bhd
10, 11 & 12	Roche (Malaysia) Sdn Bhd
13	Servier Malaysia Sdn Bhd
14	Medi-Life (M) Sdn Bhd
15	UMMI Surgical Sdn Bhd
16	Avro Medical Sdn Bhd
17	B Braun Medical Supplies Sdn Bhd
18	MKS Medic Sdn Bhd
19 & 20	Covidien
21	BH Enterprise Sdn Bhd
22	Convatec Malaysia Sdn Bhd
23	AstraZeneca Sdn Bhd
24 & 25	Johnson & Johnson Medical Malaysia
26 & 27	Olympus (Malaysia) Sdn Bhd
28	Medi Pro Supplies Sdn Bhd



## Acknowledgements

The Organising Committee of the Coloproctology 2015 wishes to thank the following for their support and contribution:

### MAJOR SPONSORS

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**Johnson & Johnson Medical Malaysia**

### SPONSORS

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**SYMPOSIUM 1**

Colorectal Cancer Updates

**AN UPDATE ON NATIONAL COLORECTAL CANCER PATIENT REGISTRY**

*Muhammad Radzi Abu Hassan*

Department of Medicine, Hospital Sultanah Bahiyah, Alor Setar, Kedah, Malaysia

National Colorectal Cancer Patient Registry was initiated in 2007 to evaluate health outcomes of patients with colorectal cancer in Malaysia. There were 34 source data providers when 2nd report was prepared in 2014. From 2008 to 2013, the incidence rate and mortality rate for colorectal cancer was 21.3 cases per 100,000 populations and 9.8 cases per 100,000 populations respectively. Chinese has the highest incidence of colorectal cancer among all ethnicities (27.4 cases per 100,000 populations). Most of our patients presented with altered bowel habit while 22.3% of our patients were also diabetic. Majority of them were diagnosed at stage III and left sided constituted more than three quarter of colorectal cancer.

**SYMPOSIUM 1**

Colorectal Cancer Updates

**COLORECTAL CANCER: ADVANCES IN GENETIC TESTING  
AND COUNSELLING**

*Abdul Rahman Jamal*

UKM Medical Molecular Biology Institute, Universiti Kebangsaan Malaysia, Selangor, Malaysia

Colorectal cancer (CRC) is now the third commonest cancer in Malaysia and the number one cancer in males. Both genetic and environmental factors play a huge role in the increasing prevalence of cancer. About 75% of CRC cases are sporadic and 25% have a family history which suggests a hereditary contribution, common exposures within the family members or both. Mutations involving specific genes which are inherited account for about 5-6% overall and this include those with familial adenomatous polyposis and the Lynch syndrome. The advances in genome sequencing has allowed a more comprehensive molecular profiling of CRC. Most investigators now divide CRC biologically into those with microsatellite instability (MSI; located primarily in the right colon and frequently associated with the CpG island methylator phenotype (CIMP) and hyper-mutation) and those that are microsatellite stable but chromosomally unstable. The large study by The Cancer Genome Atlas group (Nature 2014;487:330-337) has contributed a large body of data in terms of the somatic alterations in CRC. Some of the findings will be discussed. Appropriate genetic testing plus proper counselling will benefit the population at risk of familial or hereditary CRC and help save many lives through early screening via colonoscopy. The next generation sequencing platforms available now can provide rapid screening for mutations which is much less costly than before. Genetic testing of the tumour itself will also allow the detection of mutations which are druggable. For example. The identification of K-ras mutation which will indicate that cetuximab will not be effective.

## **CURRENT STATUS OF COLORECTAL CANCER SCREENING IN MALAYSIA**

*Nor Saleha I T*

Non Communicable Disease Section, Disease Control Division, Ministry of Health Malaysia

Cancer is a devastating disease with 14 million new cases in 2012. It is one of the leading causes of death worldwide, accounting for 8.2 million deaths in the same year. The incidence of cancers is expected to rise in light of the increasing ageing population, growing adoption of unhealthy lifestyles. About 30% of cancer deaths are due to the five leading behavioral and dietary risks, namely, high body mass index, low fruit and vegetable intake, lack of physical activity, tobacco use and alcohol use. In Malaysia, colorectal cancer is the second most important cancer after breast, contributed to 9.5% of all cancers diagnosed in 2007-2011 and reported to the National Cancer Registry until December 2014. In 2013, colorectal cancer contributed to 8.5% of total deaths occurred in hospitals throughout the country. In view of the fact that colorectal cancer is one of the cancers that can be detected early by screening and screening may reduce mortality by 33% if screened yearly or 20% if screened two yearly, colorectal cancer screening is considered as one of the important area in the National Cancer Control Programme. Following these, related local study and health technology assessment were conducted before the Ministry of Health embarked on the pilot project for colorectal cancer screening. Colorectal cancer is now being implemented in selected health clinic in Malaysia using immunological Faecal Occult Blood test followed by colonoscopy if the test was positive.



**PLENARY 1**

**FECAL INCONTINENCE MANAGEMENT: TRENDS OVER THE 25 LAST YEARS**

*Paul A Lehur, Guillaume Meurette*

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University Hospital of Nantes, Nantes, France

Fecal incontinence is a debilitating condition both physically and socially. Management can be challenging. Its primary aim is to improve quality of life. This involves individualizing treatment options using a graduated algorithm.

Conservative measures (dietary modifications, medications, biofeedback pelvic floor retraining and retrograde colonic irrigation) come first. In patients that do not improve or when the incontinence is severe at the outset, a surgical treatment can then be considered with various approaches, some having been recently developed at different levels of invasiveness.

An update of the surgical approaches to treating fecal incontinence over the last 25 years is proposed. An extensive overview of the procedures will be provided, from traditional sphincter repair techniques to more modern, less invasive but expensive modalities including the various neuromodulation techniques, or in the most severe cases or in case of significant soft tissue damage, the use of artificial sphincters, such as the Acticon™ Artificial Bowel Sphincter and the new Fenix™ Magnetic Anal Sphincter. Stomas used as a last resort in those who fail all the above measures or are not deemed to be suitable candidates for some of these advanced options will not be forgotten. In this area also new options to be mentioned have arisen with different procedures of caecostomy for antegrade colonic enemas (ACE).

Results and indications of these procedures will be discussed in order to impart an understanding of the available treatment modalities. A final algorithm issued from the last International Conference on Incontinence (ICI) consensus meeting (2012) will be displayed.

Abrams P, Cardozo L, Khoury S, Wein AJ. Incontinence: 5<sup>th</sup> International Consultation on Incontinence. Publisher, ICUD-EAU 2013.

**SYMPOSIUM 2**

Allied Health Professional Session (1)

**ENTEROSTOMAL THERAPIST: WHERE WILL YOUR JOURNEY TAKE YOU?**

*Rohani Arshad*

MAHSA University College, Kuala Lumpur, Malaysia

In this presentation, based on the concept of Clinical Nurse Specialist, the Enterostomal Therapists (ET) will be discussed. Who are they, what their roles are, why they exist and how to improve their status in Malaysia will be covered.



**SYMPOSIUM 2**

Allied Health Professional Session (1)

**ENTEROSTOMAL THERAPY NURSING SERVICES IN MALAYSIA:  
CHALLENGES AND THE WAY FORWARD**

*Mariam Mohd Nasir*

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Demands and challenges of health care system in general is emergent due to the changes trend of disease patterns and other socio-economic determinants of health. In this shift, roles of nurses are also transformed with elevated vision in role preparation.

The rapidly changing health care system requires nurses to possess increasing knowledge, clinical competency, greater independence, and autonomy in clinical judgment.

Enterostomal Therapy Nursing has also undergone significant changes and development since the birth of this Nursing Specialty in Malaysia since 1995. Many developments have taken place and more empowerment has been given to the Enterostomal Therapist in their clinical practice. It is indeed a great achievement for Enterostomal Therapist (E.T.) to be part of the health care providers those are able to make some clinical decision in the patient care and management.

These situations have challenged both individual practitioners and groups to be innovative and creative in their approach to the patient care. The years to come will be more challenging for them and expectation will be increasing.

Issues of patient safety and legal implications have also forcing Nurses to be well equipped for greater challenges ahead but nevertheless we still need to embark further in this preparation and a well-structured training program design is required to move forward.



**SYMPOSIUM 3**

Issues in Laparoscopic Colorectal Surgery

**CONTAINING COST OF LAPAROSCOPIC COLORECTAL SURGERY**

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Open surgery is currently the standard treatment for colorectal surgery, while laparoscopic surgery is less invasive which leads to rapid recovery and perhaps better long term outcomes. However there are some concerns of laparoscopic surgery including the longer operative time and the cost of treatment.

The cost for colorectal cancer surgery has been studied. The results showed that laparoscopic surgery had a significant increased cost of equipment in most studies (582.38-1237.76USD) and the operative time was equal or increased (range 7-43 minutes), while open surgery required more cost of blood transfusion than laparoscopic surgery significantly.(1-3)

For short term post operative outcomes, many studies showed that laparoscopic surgery had better results including time to first flatus, bowel movement, day to tolerating diet, a need for pain medication, and a significant shorter hospital stay (range 1.5-4.3 days) which resulted in better cost reduction in laparoscopic surgery group compared to open surgery group (range 1081.3- 1883.39 USD/days). (4,5) Moreover, systematic review and meta-analysis studies showed that postoperative complications such as wound infection, pulmonary infection, and urinary tract infection were higher in open surgery group while anastomosis leakage and readmission remained the same. Additionally laparoscopic surgery resulted in significant faster to return to normal activities (range 11-20 days). (5-8) In cost-effectiveness studies, laparoscopic surgery resulted in equal or decreased cost (range 0 - 4283 USD saver for laparoscopic surgery).(9-13)

For long term outcomes, there was no significant difference in rate of incisional hernia, mortality, and 5-year-disease-free survival. However, it has been noticed that less tissue trauma may cause less disruption of the immune system and hence reduces the risk of recurrence. This issue needs a further well-designed research.(8,14)

The up-to-date results concluded that laparoscopic surgery is better in term of faster recovery and lower complications despite the extra cost of the operation related. With an improvement of equipments and surgical techniques, this procedure could be performed with better cost saving manner while improving a quality of care.

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## ROLE OF ULTRASOUND IN ANORECTAL SURGERY

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Ultrasonographic imaging is gaining a key role in the understanding of anorectal disorders. Endoanal and endorectal ultrasonography (EAUS/ERUS), endovaginal ultrasonography (EVUS) and dynamic transperineal US (DTPUS) are nowadays increasingly used in clinical practice for patients suffering from anorectal dysfunctions (fecal incontinence, posterior compartment prolapse, obstructed defecation syndrome, anal pain) and for patients with either benign (anorectal sepsis) or malignant conditions (anorectal tumors). These non-invasive techniques not only provide a superior depiction of the pelvic anatomy but also yield unique dynamic information.

Recently, several new ultrasound techniques have been developed that could significantly improve the diagnostic value of ultrasonography (US) in this field. Three-dimensional (3D) and real-time four-dimensional (4D) imaging have been introduced into routine medical practice. These techniques overcome some of the difficulties and limitations associated with conventional two-dimensional (2D) US. Although 2D cross-sectional images may provide valuable information, it is often difficult to interpret the relationship between different anorectal structures because the 3D anatomy must be reconstructed mentally. Three-dimensional reconstructions may closely resemble the real 3D anatomy and can therefore significantly improve the assessment of normal and pathologic anatomy. Complex information on the exact location, extent, and relation of relevant anorectal structures can be displayed in a single 3D image. Interactive manipulation of the 3D data on the computer also increases the ability to assess critical details.

It seems likely that these new diagnostic tools will be increasingly used in the future to provide more detailed information on the morphology and function of examined organs, to achieve better accuracy in the diagnosis of complex diseases, to facilitate planning and monitoring of operations, and for surgical training.

Endorectal ultrasound is the best modality for the preoperative staging of rectal cancer (T stage). Lesions confined to the rectal all may be resected by transanal excision, transanal endoscopic microsurgery or low anterior resection. Lesions involving or in close proximity to the anus might need abdomino-perineal resection. Patients with loco-regionally advanced lesions (extension onto the perirectal fat and/or perirectal or pelvic adenopathy) should be considered for neoadjuvant chemoradiotherapy. Neoadjuvant therapy has been shown to reduce local recurrence and permit an increased likelihood of a sphincter-sparing operation, with less toxicity compared with postoperative regimes.

Endorectal ultrasound is a safe diagnostic method that allows both tumor invasion and lymph node metastatic involvement to be staged, and it contributes significantly to the selection of an adequate surgical strategy in patients with rectal cancer. The rectal wall is seen as five alternating hyper- and hypoechoic layers, as a result of differences in acoustic impedance, corresponding to histological layers. Carcinomas are hypoechoic, and the degree to which they disrupt and penetrate the rectal wall layers suggests the local stage: uT0 lesion (villous adenoma) does not penetrate the submucosa; uT1 tumor is invading the submucosal layer; uT2 tumor penetrates the muscularis propria; uT3 tumor proceeds beyond the muscularis propria, infiltrating the perirectal fat to a variable degree; uT4 tumor infiltrates surrounding organs such as bladder, uterus, cervix, vagina, prostate and seminal vesicles. The sonographic criteria for identifying involved lymph nodes (Stage uN1) consist of size greater than 5 mm, mixed signal intensity, irregular margins, and spherical rather than ovoid or flat shape.

The accuracy of ERUS in numerous trials ranges from 80 to 95% for T- staging and 70 to 75% for N-staging. The American College of Radiology Guideline recommended ERUS as the best modality for the preoperative staging of early rectal cancer (T0-T2) and MRI as the best modality for the assessment of advanced tumors.



**SYMPOSIUM 4**

Allied Health Professional Session (2)

**INDONESIAN PERSPECTIVE – QUALITY OF LIFE OF AN OSTOMATE**

*Widasari Sri Gitarja*

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Religious and ethnic differences that could be related with patient perspective about their life especially people living with a stoma. Traditional medicine and spiritual healing is alive throughout the archipelago by shaman or dukun that cures some illnesses with herbal and black arts. Indonesian stoma nurses develop concept strategy for help people who lived with stoma. In some reason we believed that only care with profesional group will maintain or improve better quality of life. The examples of nursing intervention for quality of life are pain management, nutrition, hydration, psychosocial, and spiritual care. Care can begin at diagnosis and continue through treatment, follow-up care or rehabilitation and the end of life. The aim of quality of life usually provided by a team of Interdisciplinary group of professionals, includes: doctors, nurses, social workers, and nutritionists.

Keywords: concept, quality of life, nursing professional.

**SYMPOSIUM 4**

Allied Health Professional Session (2)

**STOMACARE: HOW COMPETENT ARE YOU?**

*Rohani Arshad*

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This 30 minutes presentation will focus on the competency of the nurses in caring the patients with stomas. The Novice- to- Expert scale, with the headings: Knowledge, Standard of work, Autonomy, coping with complexity and the perception of context will be discussed. Besides that, the discussion will also cover on the care of the patients holistically.

**SYMPOSIUM 4**

Allied Health Professional Session (2)

**PREVENTION IS BETTER THAN CURE: RECOGNISING, MANAGING & TREATING PERISTOMAL & STOMAL COMPLICATIONS**

*Rozita Binti Mohamad*

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Peristomal skin complications are the most common reason ostomy patients visit an outpatient wound, ostomy, and continence nursing service. Prevention and management of peristomal skin complications are critical components of ostomy care. Identifying risk factors for the occurrence of peristomal skin complications according to types of injury and clinical features can help optimize assessment and management approaches. Treatment can further be addressed based on etiology - chemical injury (irritant contact dermatitis, pseudoverrucous lesions, and encrustations); mechanical injury (pressure/shear, stripping, mucocutaneous separation, mucosal transplantation); infection (Candidiasis, folliculitis); immunologic disorders (allergic contact dermatitis); and disease-related lesions (varices, pyoderma gangrenosum, malignancy). The importance of prevention and the impact of having access to knowledgeable care providers cannot be over-emphasized.



**SYMPOSIUM 4**

Allied Health Professional Session (2)

**HOME CARE FOR STOMA PATIENTS IN INDONESIA**

*Edy Mulyadi*

Clinical Nurse Specialist in edWcare Clinic  
Cut Nyak Dhien Hospital, Nanggroe Aceh Darussalam, Indonesia

Indonesia is a big country consisting of 13.466 island, with the number of inhabitant is 240 million. Currently, Indonesia nurses have been given permission to carry out independent practice. The number of nurses independent practice in Indonesia is approximately 500 Balai Asuhan Keperawatan. Home care or home visit is a place of nursing care provided to patients with wound, stoma, and incontinence. Problems experienced when doing home care is limited stoma bag and distances. Service provided is a comprehensive nursing care and holistic with caring values. The value of caring in nursing care is expected to improve service quality and reduce psychosocial disorders impact. Caring behavior is an action that is based on caring, compassion, skill, empathy, responsibility, sensitivity, and support. Caring is a central aspect of nursing, caring identified as carative behavior, such as developing trust, provide support, help meet human needs.

**SYMPOSIUM 5**

Trauma

**NON OBSTETRIC PERINEAL AND ANORECTAL TRAUMA : GUIDELINES FOR EMERGENCY AND LONG-TERM MANAGEMENT**

*Paul A Lehur, Christophe Gaudin*

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This presentation will focus on the management of civilian injuries to the pelvis including pelvi-perineal and anorectal trauma, obstetrical injuries being excluded. These rare traumas are frequently associated with complex fracture of the pelvic brim. They are not always easy to handle either in emergency with a significant risk of death (10-25%) and also in the long term when sequelae are considered.

A) In emergency the principles of management of pelvic trauma are well established – high index suspicion of injury, laparotomy, stoma, drainage, antibiotics. It will be illustrated with some cases.

Blunt injury management, such as a road traffic accident, is likely to involve initial CT scanning. A multidisciplinary approach is usually requested for optimal management: resuscitation, reduction of the pelvic brim fracture, arterial embolization and pelvic packing are among the options in unstable patients.

Penetrating injury, such as knife and gunshot wounds, is carefully explored and treated knowing the risk of large blood vessels damage and massive haemorrhage difficult to control.

B) Sequelae from pelvi perineal trauma are of various severity. The first request is the closure of the stoma. It is usually the last step in the recovery process. Predicting the functional result after stoma closure is often difficult depending on the degree of visceral, sphincteric and nerve damage. Different options are discussed in case of faecal incontinence, including sphincter repair, retrograde or antegrade Malone type colonic irrigation.



**SYMPOSIUM 5**

Trauma

**COLONIC TRAUMA**

*Rattaplee Pak-art*

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Management of colonic injuries is complicated and it has been changed from times to times over this century. In the previous time, fecal diversion/colostomy was done in almost all cases. Nowadays, primary repair is becoming standard in majority of penetrating colonic injury, either right or left side. For blunt injury, primary repair is more popular and widely acceptable. Segmental resection and primary anastomosis can be performed safely in right colon injuries and in selected left side injuries. Fecal diversion/colostomy should be preserved for patients with severe condition and unrepairable defect. The location of colostomy in damage control operation or open abdomen should be placed away from incision such as between anterior and mid axillary line.

Intraperitoneal rectal injuries can be treated similar to left side colonic trauma. But fecal diversion is recommended in extraperitoneal rectal injuries. Intraoperative irrigation, presacral drainage and distal wash-out are rarely necessary in trauma for colorectum.



HOW I DO IT

## MAGNETIC ANAL SPHINCTER: AN OPTION TO TREAT FECAL INCONTINENCE

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In the field of artificial sphincters to treat severe fecal incontinence (FI), a new comer has recently appeared.

The magnetic anal sphincter (MAS)(FENIX™; Torax Medical Inc.) is a novel device that uses magnetic forces to reinforce the native anal sphincter. It consists of a series of titanium beads with magnetic cores hermetically sealed inside. The beads are interlinked with independent titanium wires to form a flexible ring resting around the anal sphincter in a circular fashion. The device is manufactured in different lengths based on the number of beads (14 to 20) to accommodate variation in anal canal circumferences.

One of the advantages of this device over previous artificial sphincters is that it begins working immediately once implanted, without need for further manipulation by either the patient or surgeon. Implantation procedure is greatly simplified with the only need of a perineal access but selection of the appropriate device requires intraoperative fluoroscopy.

FENIX™ has been granted CE mark on November 2011. Its commercial use has started in selected centres in Europe. FDA supervised Humanitarian Device Exemption (HDE) implantation in US centres is expected this year.

Middle-term results available in a limited number of patients have showed that the MAS withstand the test of time. However the current place of the MAS in FI has yet to be determined. It appears as a promising innovation as it offers a less invasive alternative of anal reinforcement compared to Acticon™ artificial bowel sphincter and therefore could easier to implement more liberally in specialist centres around the world.

Barussaud ML, Mantoo S, Wyart V, Meurette G, Lehur PA. The magnetic anal sphincter in faecal incontinence: is initial success sustained over time? *Colorectal Dis* 2013;15:1499-503.



HOW I DO IT

## SURGICAL TREATMENT OF ANAL ABSCESS

*Arun Rojanasakul*

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Incision and drainage is the most widely used technique for acute anorectal abscess. It is simple but there is a 30 to 50 percent risk of anal fistula which need another operation. The other option, immediate fistulotomy (sphincter cutting procedure) was recommended by some experts, although it is associated with higher risk of minor faecal incontinence.

Treatment of acute anorectal abscess with sphincter preserving technique (LIFT) was not recommended because the belief that anorectal abscess originate in the intersphincteric plane and the ligation of the intersphincteric tract may not be possible.

However, in recent years we have used the LIFT procedure for acute anorectal abscess. Surprisingly, the intersphincteric abscess were observed in only 20 percent of the cases and suture closure of the internal opening were applied to these patients. In 80 percent of the cases, there were no intersphincteric abscess and the intersphincteric tract can be identified and ligated as usual. Our outcome of LIFT procedure for acute anorectal abscess is promising and further active investigation is needed.

### SYMPOSIUM 6

Allied Health Professional Session (3)

## A CHALLENGING STOMA IN A PAEDIATRIC PATIENT

*Norlizah Binti Turiman*

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Paediatric Ward, University Malaya Medical Centre, Kuala Lumpur, Malaysia

This stories from the bedside is a case which highlights the challenging stoma care for a paediatric patient. The management of the stoma was particularly challenging as it can be a difficult adjustment for the child or young person and his or her family.

Paediatric stoma nurses provide support and education to the family at this time to help them with the changes. Nurses discusses the different type of stoma, why a stoma might be needed, how the paediatric stoma nurses can help prepare the child and his or her family for having a stoma. It is include the practical aspects of the stoma care and possible complications that might be experienced and how to manage them.

Achallenging stoma in a paediatric patient is a main role of the paediatric stoma care nurse highlighting the main challenges and appropriate management accordingly.



**SYMPOSIUM 6**

Allied Health Professional Session (3)

**SEXUAL REHABILITATION AFTER OSTOMY SURGERY**

*Alimuddin Ali Padu<sup>1</sup>, Sitti Khaeruni<sup>2</sup>*

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Wahidin Sudirohusodo General Hospital, Makassar, Indonesia

<sup>2</sup>Community Health Center Jumpandangbaru, Makassar, Indonesia

When meeting with the ostomate, one of the most frequent questions I get is “can I have intimacy?”. The question was pronounced while shy, because it is talk about sex, for some people in Indonesia this is still taboo. Undeniably, sex is one of the basic human needs. An ostomate certainly feel the same way, either already married before surgery or who are planning to get married after surgery.

The existence of ET nurse would be very helpful for that matter. Exchange ideas with ostomate and his partner is one of the very interesting experience. Each ostomate has a different problems. Provide health education without making ostomate feel embarrassed is mandatory. Required involvement and a greater understanding of spouses and people nearby.

Expected results are: an understanding of the physical condition, identify sexual practices that can satisfy, to explore alternative methods, and resume sexual intercourse corresponding with their faith. With sexual fulfillment as one of the basic needs, is expected to further improve the quality of life ostomate. ET nurse as nursing care providers need to be aware and pay attention to both aspects of quality of life ostomate.

Keywords : Ostomate, sexual, ET nurse

**SYMPOSIUM 6**

Allied Health Professional Session (3)

**BED SIDE STORIES: MANAGING CHALLENGING EXCORIATED PERISTOMAL SKIN**

*Azniwani Yusoff*

International Islamic University, Kuantan, Pahang, Malaysia

Hospital Tengku Ampuan Afzan, Kuantan, Pahang, Malaysia

The story that I will share with all is a story of a very challenging and complicated case faced by me while caring for a patient with stoma.

The management of the stoma is very challenging because the stoma needs to be refashioned. There are also two occasions that the abdominal sutures broke down, leaving an extensive and large wound with the stoma situated inside to be managed.

This sharing of experience may help and provide some ideas how we can achieve our goal in managing the case, for a better health and quality of life to the patients.

This is where we can prevent complications such as skin problem as to facilitate adaptation process for the patients and their family members. This skin problem can be preventing by patient and nurse know how to take care the stoma during hospitalization time and explain about care of stoma before discharge from hospital. In my conclusion, people living with stoma may experience a range of problems, can be often resolved with advice from nurse. Stoma accessories might be needed such as seals, adhesive paste and ostomy belt.



**SYMPOSIUM 6**

Allied Health Professional Session (3)

**STORIES FROM THE OSTOMY BEDSIDE: UNDERSTANDING BEREAVEMENT**

*Hamka*

NCI Centre, East Borneo, Indonesia

To be paired with an ostomate, to live together to witness the death of our spouse is a challenge to integrate loss and grieving. This was a sadness story from our journey looking for an ostomate and their family at home. Me and my colleague went with boat transportation in Mahakam river to We visited Mr Jun (initial name) on "Borneo ostomate visit program". There were only 2nd times visited and we learned that He had a high motivation about his life but sadness he died at the age of 40. This time we were visit for support Mr.Jun's family. Jun has one daughter who studies out of town. In everyday life, Jun lives with his wife, July. July seemed to be strong to live together with an ostomate, but it was different when we met her after Jun pass away. July turned out to be unprepared for the loss and grief of her husband. Behavior shown a portrait of a very painful feeling. She was looking for an answer and she often used her perception wrong. As a stoma nurse, one must be able to respond to such behavior. Emotional responses directed toward the nurses require them to respond to the loss phase. The ability of the mind, body, and soul must be integrated so that the resulting feedback is able to change maladaptive response into adaptive.

Key words: visit program, loss and grieving

**SYMPOSIUM 6**

Allied Health Professional Session (3)

**LEARNING TO LIVE WITH A STOMA. HOW DID I DO IT?**

*Tharan Sri*

CORUM - Colorectal Cancer Survivorship Society, Malaysia  
Malaysian Ostomy Association

Waking up after surgery and finding a colostomy bag attached to your abdomen and realising that it will be a part of you for the rest of your life is not easy to accept even if you went in well prepared. So it was with me, when in 2009, after an abdomino-perineal resection for rectal cancer I found myself a permanent ostomate.

Here I will recount how I managed my year of trials and tribulations, and eventual triumphs, in my life with a stoma. Deciding that I would be the master of my stoma, I immediately took on the task of cleaning the stoma and changing wafers and pouches by myself and of deciding which system and product was most suitable for me. I had to face and learn to manage problems such as pancaking, and leakages and peristomal skin excoriation. I had to look for and find products and accessories which made living with a stoma much easier. Since the stoma was not trainable, I had to learn to live with it, and eventually we settled into a comfortable routine. Now we understand each other very well. I give my stoma due respect and it doesn't spring any surprises on me.....I hope!



**SYMPOSIUM 6**

Allied Health Professional Session (3)

**REMEMBERING THE PIONEER IN ETN: NORMA N GILL DAY CELEBRATION**

*Mariam Mohd Nasir*

Department of Nursing, University Malaya Medical Centre, Kuala Lumpur, Malaysia

Norma is the world's first Enterostomal Therapist (ET). She is an extraordinary person, despite being afflicted with a life-threatening illness, she found the strength to look beyond her own situation to recognise the needs of others in similar circumstances.

Norma firmly believed that ostomy surgery should be a stepping stone to an improved quality of life rather than a sentence to a life of depression, isolation, rejection, and shame. She devoted her life to revolutionise ostomy care.

Norma was a leader with vision, creativity and innovation. As the founder and first President of the World Council of Enterostomal Therapists (WCET) she is internationally acknowledged as the first Enterostomal Therapist in the world. In 1980 Norma N. Gill Foundation was established to provide funding for international students. Norma N Gill Foundation was created in her honour under the auspices of the WCET to recognize Norma's life work in the field of Enterostomal Therapy (ET) and her dedication to helping others.

Norma N. Gill Day celebration is celebrated each year on the 26 June, which is Norma's birthday to remember her commitment and dedication towards promoting Enterostomal Therapy Nursing around the world.

The speaker will share more stories and achievement that Norma has achieved throughout her life as an ileostomist and how she became the first E.T in the world.

**SYMPOSIUM 7**

Managing Complications in Colorectal Surgery

**INCOMPLETE DONUTS AFTER DOUBLE STAPLING IN LOW  
RECTAL ANASTOMOSIS**

*Ismail Sagap*

*Department of Surgery, Universiti Kebangsaan Malaysia Medical Centre, Kuala Lumpur, Malaysia*

Anastomotic leak and strictures are two main complications of rectal surgery. Surgical techniques has been implicated to be associated with anastomotic complications in rectal surgery. The double stapling technique is perhaps the technique of choice nowadays. Detection of potential catastrophes upon performing the double stapling technique includes the use of air leak tests and the assessment of complete circumferential donuts. . Early detection of complications guided by these intra-operative diagnostic tests may lead to reduction in delay of diagnosis and prevent undesirable outcome. Several successful technical tips have been eluded to overcome future problems.



**SYMPOSIUM 7**

Managing Complications in Colorectal Surgery

**MANAGING COMPLICATIONS IN COLORECTAL SURGERY:  
ANASTOMOTIC STRICTURES FOLLOWING SUCCESSFUL MANAGEMENT  
OF ANASTOMOTIC LEAKS IN LOW RECTAL ANASTOMOSIS**

*Francis Seow-Choen*

Seow-Choen Colorectal Centre, Singapore

Strictures occurring after colorectal anastomosis vary from 3 to 30 percent. Most of these strictures are simple strictures that are easily dilated or do not require treatment. Proximal colonic strictures seldom obstruct as the lumen is wide and the stool is liquid. So dietary advice to advice any sort of fibre is often sufficient for those with minimal symptoms or no symptoms to avoid obstructing the stricture. Moreover many such strictures open up significantly after 6 or more months. Strictures in the rectum however present more of a problem as the rectal lumen is narrow and the stools are solid. Here obstruction is more often encountered. Various surgical techniques are available to deal with such strictures. Nonetheless most strictures requiring surgical correction are short and less than 1 cm thick and various surgical techniques are present to deal with these. However strictures following an anastomotic leak following ultra low anterior resection present particular problems. Such strictures tend to be thick and several centimetres in length and the luminal diameter may be a few mm at most. Further more many of these patients have severe extra rectal fibrosis and very hard thickened tissues around the rectum which do not dissect well. The two main issues are:

1. How to decide if at all the patient's ileostomy can be closed in the presence of an anastomotic stricture. It is foolhardy to give in to patient's request to close a defunctioning stoma in the presence of a distal stricture. Firstly this serves no purpose and secondly it will then result in acute intestinal obstruction and the recreation of another stoma at best. Defunctioning stomas should and can only be closed when the stricture is minimal or it is deemed not to be liable to result in intestinal obstruction
2. Management of the stricture itself can be a most difficult problem. Thin and soft stricture can be managed by dilation with the fingers, dilators or by balloons, endoscopic or stapling methods. These procedures are most easily done in cases of ultra low anterior resection where the anastomosis is very near the anal verge. Higher and very thickened or those associated with florid extra rectal fibrosis are very difficult to manage. Extensive pelvic surgery including repeat anterior resection and re anastomosis can be considered but must be weighed against the possibility of failure of surgery to achieve anastomotic reconstruction. In some cases the best the patient can hope for is that the stoma serves him well for the rest of his life



**SYMPOSIUM 7**

Managing Complications in Colorectal Surgery

**INCONTINENCE FOLLOWING SURGERY FOR FISTULAS-IN-ANO AND  
LATERAL INTERNAL SPHINCTEROTOMY**

*Paul A Lehur*

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Fecal incontinence can complicate some of the most common anal procedures such as sphincterotomy for fistula-in-ano or chronic anal fissure.

Management of anal incontinence of these iatrogenic types is complex and frequently non satisfactory regarding the patient's expectations. Incontinence symptoms may include either mild flatus incontinence but of significant impact on quality of life, or more severe faecal incontinence more invalidating especially when a disturbed colonic transit with loose stools from irritable bowel syndrome is present.

Prevention of faecal incontinence is a major concern when approaching surgically an anal problem. Therefore anal dilation (Lord's procedure) has been abandoned and lateral internal sphincterotomy less and less recommended nowadays in favor of conservative treatment (Botox, suppositories). Regarding fistula-in-ano management sphincter-saving procedures are highly recommended in high-risk patients (female, anterior location of the fistula, high trans-sphincteric or complex tract).

Once faecal incontinence is observed sometimes few years after the causative procedure but in many cases quickly after, a full work-up is recommended to confirm the cause of the symptoms, and the extent of the sphincter damage. Endo-anal sonography and anal physiology are useful tools to start with. Colonoscopy rules out another cause of faecal incontinence.

As for any type of faecal incontinence, first line treatment is to order for conservative measures and pelvic floor retraining. A step by step approach can then be offered in case of persisting symptoms. Bulking agents are a low-risk, but low-results treatment. In some instances SNS could offer a successful option. If there is an external sphincter defect limited to 90-120° of the sphincter circumference the recommended option is a direct overlapping repair, however often difficult to perform in a scarred area. Internal sphincter repair is not recommended, as not efficient if ever doable. Patients have to be informed of the unpredictability of the results.



**CASE STUDY**

**MANAGEMENT OF PAEDIATRIC STOMA WITH COMPLICATION**

*Norlizah Binti Turiman*

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Stomas are surgically created opening that allow free flow of urine or feces requiring a pouching system. Many challenges to face in supporting and educating a child or parent or carer with any stoma. Psychological, emotional and social issues dependence on others.

This study is about management of complication with patient having stoma. Complication after creation of stoma formation were included stoma prolapsed, stenosis, retraction, dysfunction, skin excoriation and peristomal hernia. The complication rate with paediatric stoma were higher and almost every paediatric patient.

In this case study presentation will discuss the management of paediatric stoma with complication. Skin excoriation was recorded as a significant problem in paediatric patient and responded well to treatment and expert stoma care given.

Although the complication can be manage, precaution before its happen is better than cure.

**CASE STUDY**

**HOLISTIC CARE IS  
HOW TO OVERCOME THE COMPLICATIONS AND IMPACT OF STOMA**

*Edy Mulyadi*

Magister of Nursing, Registerd Nurse, Wound Ostomy Continance (Enterostomal Therapys) Nurse, Certified Hypnotharapi Nursing, edWcare klinik, Sekolah Tinggi Ilmu Kesehatan Cut Nyak Dhien Langsa-Aceh

Mr P age 51 years is ostomet who had abdominal surgery perineal excision of rectum due to Colon Cancer. Type stoma Mr. P is the end stoma. when arriving at the clinic edwcare Mr P many experienced complications and psychological impact of post stoma one month ago. Complications that happened not only to the physical as stoma prolapse, wounds that are not fused, and can not erect, but also suffered severe depression as a result of physical changes, even Mr P never signaled suicide. Due to this holistic approach to care became a major goal by promoting the values of caring. The combination of the concept of mental nursing and medical surgical nursing is the right way to overcome the problem of psychosocial and physical complications experienced by Mr P. Psychiatric Nursing Approach done to overcome the problems of self-concept, while the Nursing Medical surgical nursing approach to improve the condition of the wound, stoma, and erection. The result of Mr P has regained his confidence and was able to move as usual.



**SYMPOSIUM 8**

Allied Health Professional Session (4)

**SETTING UP OF ENTEROSTHOMAL THERAPIST (E.T.)  
PRIVATE PRACTICE IN INDONESIA**

*Ikram Bauk, Dedy, Basit*

Majene, West of Celebes, Indonesia

Nursing is a kind of glorious and noble profession in a professional care. And many nurse inspire to make it become true in a nurse independent practice. Indonesia graduated nurse over one thousand person every year, which every person are dreaming to be a civil servants and we knows selection it's difficult. Indonesian Government and private owner health care not able to accept nursing graduates every year, and this situating is getting worse by low nursing salary in Indonesia. The other condition, estimate world 1.5 million people with colorectal cancer every year (world gastroenterology organitation, 2012), Base on data WHO estimate 700 thousand people died of colorectal cancer every year. In developing countries including of indonesia 60 % or more from 360.000 colorectal cancer case every year (YKI, 2012), other problem many patients in psicological situation (stress) after stoma surgery, and difficult patients to received stoma bag. Trough activities Etnep Program Wocare centre Bogor by Widasari srigitarja, produce more WOCN nurse in Indonesia, to increase the patients QOL Wound, Stoma dan Incontinentia. Indonesian Nurse regulation allow to private practice (Vocational Nurse, and Specialist Nurse). With compotence E.T.Nurse, we have opened a practice with a similar services polyclinic in Hospital by doing nursing care service and Nursing process for Wound, Stoma and Incontinentia in community and multidiscipline with the other healthcare and appropriate service standar for wound, ostomy and continentia care. Every patients must be served with Informed consent and clear documentation by tool assesment, clinically history and culturally safe, ethical, legal, effective and research based and responds to the holistically changing health needs of the person with a stoma. Patient stoma services generally with complication from hospital and the other heath care profession, post operatif Stoma siting and using stoma bag products tailored to their individual needs, education, stoma care services on the practice with appropriate STOMA care standar, home care services with patient apointment. Standar room facilities to practice; waiting room, stoma care room, custom built cabinet for ostomy supplies (stoma bag and accesories) forms & patient handouts, toilet, wastafel, water supplay facilities, and waste processing facilities. Administration services tailored to Private practice area in Indonesia.

Key point ; Setting up, Private practice, standard practice.



**SYMPOSIUM 8**

Allied Health Professional Session (4)

**COUNSELING: ARE WE DOING IT RIGHT? AND HOW SHOULD WE DO IT?**

*Widasari Sri Gitarja*

Wocare Center, Kota Bogor, Indonesia

Counselling for people with stoma is a unique situation and need specific investment of time between ostomate and health care members or stoma nurse. The aim of counseling for ostomate is independence care and return to normal activities. The counselling process becomes colored with emotions, pain, mental distress, physical limitation and language barriers. Anxiety is a high rank for stoma nurse issues when doing the counselling. Especially for a cancer patient under go ostomy surgery that they are bound to react emotionally to their illness with having a stoma. Stoma nurse as counsellor must have positive mind with a high motivation and positive reinforcement during the counselling process. Successful counselling is subjective measured with patient satisfied, confidence and trust in at least 21 days from begin to end.

Key words: ostomate, anxiety, and cancer

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**SYMPOSIUM 9**

CORUM (1)

**THE VALUE OF PEER SUPPORT IN COLORECTAL CANCER MANAGEMENT**

*Sri Tharan*

CORUM – Colorectal Cancer Survivorship Society, Malaysia  
Malaysian Ostomy Association

In 2013 some colorectal cancer (CRC) survivors and concerned colorectal surgeons felt that there was a need to provide peer-support to colorectal cancer patients, and thus the organisation CORUM, the Colorectal Cancer Survivorship Society was born. One of the primary aims of this society was to provide practical, emotional, and psychosocial support for colorectal cancer patients, on diagnosis, soon after surgery and on discharge from hospital.

The Peer-Supporters had to be CRC survivors themselves, including some permanent ostomates, who had undergone chemotherapy and who had recovered and returned to near-normal lives. They would provide counselling and motivation for these patients and also act as role models. A few willing volunteer survivors who had the right attitudes and personalities for the job were selected and trained.

Support clinics were started in Universiti Kebangsaan Malaysia Specialist Centre, Cheras, Pantai Hospital, Kuala Lumpur, and University of Malaya Medical Centre.

So far our support clinics have serviced more than 120 patients and caregivers, and feedback from patients has been more than positive. The general comment has been "if only I had seen you before my surgery!". Our founding belief has been vindicated. The need now is to find more survivors from at least the major population centres, who will make suitable Peer-Supporters and who have the will and the commitment to be trained and to serve and to go out and offer Peer-Support service to needy colorectal cancer patients.



**SYMPOSIUM 9**  
CORUM (1)

**UNDERSTANDING RADIATION THERAPY IN RECTAL CANCER**

*Daniel Wong Wai Yan*

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Radiotherapy is a form of ionizing radiation used in a controlled and precise manner to eradicate cancer cells.

It is most often used in rectal cancer prior to surgery to reduce the long term risk of local recurrence of the cancer. Clinical studies over the last 20 years have proven the efficacy of radiotherapy in this setting. The shorter course consists of 5 sessions of radiotherapy alone, to be followed by surgery within 1 week of the last session of radiotherapy. The longer course consists of 25-28 sessions of radiotherapy usually together with chemotherapy, to be followed by surgery 6-8 weeks later.

Radiotherapy, even at relatively low doses such as those used in rectal cancer, carries with it a risk of both acute and long-term side effects. Acute side effects include frequent urination, diarrhea, skin reaction and delayed wound healing. Long side effects include problems with bowel and bladder function, skin changes and second cancer. The risk of severe late effects is generally low but may involve surgical procedures to alleviate the problems.

The reasons for giving radiotherapy as well as the potential side effects need to be explained to patients as part of the consent process.

**SYMPOSIUM 9**  
CORUM (1)

**TESTS TO DETECT COLONIC POLYPS AND CANCER**

*Buvenesvaran Tachina Moorthi*

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Increased awareness of early detection of colonic polyps and cancer, promising better therapeutic outcome demands the availability of easy access to safe, inexpensive, reliable and reproducible test to detect these lesions. It is targeted at screening the asymptomatic person with average or high risk of developing polyps or cancer and for surveillance of post operative patients for recurrence. An established screening program is widely available in most developed countries but is at its infancy in Malaysia.

The U.S. Preventive Services Task Force and NHS(UK) Bowel Cancer Screening Programme recommend that people at average risk for colorectal cancer start regular screening at age 50 and 60 respectively and continue until age 75 as long as their results are negative. High-sensitivity immunohistochemical faecal occult blood test (iFOBT), Sigmoidoscopy or Colonoscopy are the best available test recommended.

Current evidence suggest a single sigmoidoscopy procedure reduces colorectal cancer incidence and mortality. In addition, long-term results from the National Polyp Study confirm that removing precancerous adenomas not only reduces the risk of colorectal cancer but also reduces the number of deaths from the disease by more than half. Hence, it is imperative that greater awareness is created amongst the population to gain benefits from such test.

## SURGICAL APPROACHES TO RECTAL PROLAPSE: TOWARDS A CONSENSUS IN 2015?

*Paul-Antoine Lehur*

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Laparoscopic ventral mesh rectopexy (LVMR) described by D'Horre and Penninckx<sup>1</sup> has become in many European centres the procedure of choice to manage and correct anatomical deficiencies connected to pelvic floor disorders of different types, including overt rectal prolapse, internal procidentia, and rectocele/enterocele.

LVMR is a new surgical development that has considerably modified our management algorithm for rectal prolapse syndrome<sup>2</sup>. In our unit it has become in a few years the most commonly performed procedure in functional colorectal surgery<sup>3</sup> with about 50-60 LVMR annually done by our dedicated team since 2008, including urologists' involvement when an anterior compartment mesh repair/suspension is required<sup>2</sup>, in approximately 40-50% of our series.

LVMR involves a laparoscopic dissection and mobilization limited to the anterior wall of the rectum with the placement of a mesh onto the viscus secondarily fixed at its upper end to the sacral promontory<sup>1</sup>. Robotic assistance has been also proposed with some benefits to achieve LVMR<sup>3</sup>. The procedure aims also to correct co-existing middle compartment prolapse by fixing posterior fornix/pericervical fascia to the mesh.

LVMR has several advantages over the numerous described repairs both in terms of limited invasiveness and functional outcome on continence and evacuation<sup>4-6</sup>. It has in our view to be part of the armamentarium of colorectal surgeons who deal with rectal prolapse syndrome and pelvic floor dysfunction.

As LVMR plays an increasing role in the surgical management of rectal prolapse syndromes, this presentation will question if there is still a place for the various perineal procedures that have been described to treat these conditions, including Delorme's plication procedure and Altemeier's perineal rectosigmoidectomy associated with levatorplasty. This discussion based on personal experience and published evidence will put in perspective the perineal procedures commonly used for rectal prolapse in terms of techniques, indications and results.

The approaches of the so-called "obstructed defecation syndrome" (ODS) with transanal rectal resection (STARR and Transtar techniques) will be discussed as well. Its place at the era of LVMR will be debated. We will report besides the main results of the literature, a survey done over more than 40 leading European colo-rectal surgeons, members of the European Society of Colo-Proctology (ESCP) on their present practice for ODS. Interesting data in a field in which a lot of "personal opinion" more than strong evidence drive actually the decision!

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**SYMPOSIUM 10**

Non-Healing and Recurrent Fistulas-in-Ano

**CAUSES AND PREVENTION**

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Recurrent fistula in ano and non-healing fistula in ano do not have the same meaning, but they are used interchangeably. In reality, the true recurrence fistula in ano after complete healing are rare but the non-healing right after the operations are not uncommon. There are two categories of fistula operations: sphincter cutting operations (fistulotomy and seton) and sphincter saving operations (advance flap and LIFT). Both operative categories share the common risk factors of non-healing, which are complex fistula, missed secondary tract(s), non-identification of internal opening and surgeon factor.

The average non-healing rate after sphincter saving operations is around 25 percent. The specific additional risk factor for non-healing after the advancement flap operation is flap failure. The specific risk factors for non-healing after LIFT operation are;

1. Wrong intersphincteric tract ligation.
2. Slippage of ligation of fistula tract
3. Breaching of internal sphincter and anal mucosa.
4. Retained granulation tissue in the fistula tract.
5. Inadequate drainage of fistulous abscess cavity.
6. Specific diseases eg. TB

The non-healing rate after fistula operations, especially the LIFT procedure can be decreased if the surgeons have correct knowledge of fistula patterns and pay more attention to the details of surgical technique.



**SYMPOSIUM 10**

Non-Healing and Recurrent Fistulas-in-Ano

**ROLE OF ULTRASOUND IN DIFFICULT FISTULAS**

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The pathogenesis of anorectal abscesses and fistulae is generally attributed to an infection of the anal glands, usually located in the subepithelial position, the intersphincteric space, or the external sphincter, with ducts that enter at the base of the anal crypts of Morgagni at the dentate line level. Infection of the glands can result in an abscess which can spread in a number of directions, usually along the path of least resistance, and can lead to the subsequent development of anal fistula. Five presentations of anorectal abscesses have been described: a. perianal abscess; b. submucosal abscess; c. intersphincteric abscess; d. ischioanal abscess; e. supralelevator and pelvirectal abscesses. Sepsis can spread through the different perianal spaces and become a horseshoe infection. Anorectal fistula represents a communication between two epithelial surfaces: the perianal skin and the anal canal or rectal mucosa. Any fistula is characterized by an internal opening, a primary tract, and an external or perineal opening. Moreover, the primary tract can present a secondary extension, or a fistula is without a perineal opening. In relation to the sphincters, fistulas have been classified into four types: a. intersphincteric tract; b. trans-sphincteric tract; c. suprasphincteric tract; d. extrasphincteric tract. Secondary tracts may develop in any part of the anal canal or may extend circumferentially in the intersphincteric, ischioanal, or supralelevator spaces (horseshoe extensions). According to the American Society of Colon and Rectal Surgeons (ASCRS), an anal fistula may be termed “complex” when the tract crosses more than 30% of the external anal sphincter (EAS) (high transsphincteric, suprasphincteric, and extrasphincteric), is anterior in a female, has multiple tracts, is recurrent, or the patient has pre-existing incontinence, local irradiation, or Crohn’s disease.

The configuration of perianal sepsis and the relationship of abscesses or fistulae with internal and external sphincters are the most important factors influencing the results of surgical management. Three-dimensional EAUS plays an important role in the preoperative identification of all loculate purulent areas and definition of the anatomy of the primary fistulous tract, secondary extension, and the internal opening in order to allow adequate planning of the operative approach, prevent early recurrence after surgical treatment, and minimize iatrogenic damage of sphincters and the risk of minor or major degrees of incontinence. A fistula affecting a minimal component of the muscles can be safely excised, but where the bulk of the anal sphincter is affected, it is best treated by seton drainage, fistula plug, fibrin glue injection or mucosal advancement flap.

An anal abscess appears as a hypoechoic dyshomogeneous area, sometimes with hyperechoic spots within it, possibly in connection with a fistulous tract directed through the anal canal lumen. Anal fistula appears as a hypoechoic tract, which is followed along its crossing of the subepithelium, anal sphincters, and through the perianal spaces. The internal opening can be visualized as hypoechoic (when acute inflammation is present) or hyperechoic area (when chronically inflamed). Due to its ability to provide multiplanar images with very high spatial resolution of the anal sphincter complex, 3D-EAUS offer many advantages compared to conventional 2D-EAUS. In addition, post-processing technique (volume render mode), may be used to limit the artifacts due to injection of hydrogen peroxide into the external opening of the fistula. In recurrent or complex fistulae, the reported accuracy of 3D-EAUS in detecting primary tracts is between 81% and 98.5%, secondary tracts between 68% and 98.5%, and internal openings between 90% and 96.4%. 3D reconstruction improves the accuracy of EAUS in the identification of internal opening compared to 2D-EAUS (89.5% vs. 66.7%; P = 0.0033).

In recent years, MRI has emerged as a highly accurate technique in diagnosing perianal fistulas. A variety of investigators have directly compared EAUS with MRI and these comparisons have found EAUS variously superior, equivalent, or inferior. Anal US has some clear advantages related to the fact that it is relatively cheap and simple to perform, it is rapid and well tolerated by patients and, unlike MRI, can be performed easily in the outpatient clinic or even intraoperatively since the machines are easily portable. MRI and EAUS provide complementary and additive information, and there are no disadvantages to performing both procedures in the same patient where local circumstances, availability, and economics allow this.



**WORKSHOP 3**

Allied Health Professional

**STOMA SITING**

*Enterostomal Therapist (E.T.) Team*

Enterostomal Therapy Nursing Services, Department of Nursing, University Malaya Medical Centre, Kuala Lumpur, Malaysia

Stoma siting is a procedure to mark the site for a stoma preoperatively as to allow the abdomen to be assessed in different positions such as lying, sitting and standing position. Such an assessment allows the determination of the optimal site of the creation of stoma to facilitate self-care.

This planning can help reduce postoperative problems such as leakage, fitting challenges, need for expensive custom pouches, skin irritation, and pain and also clothing concerns. Poor placement can cause undue hardship and impact psychological and emotional health. Good placement enhances the likelihood of patient independence in stoma care and resumption of normal activities.

Enterostomal Therapist (E.T.) is the optimal provider to mark stoma sites besides the colorectal surgeons.

There are many key points to consider when making the mark such as positioning issues: contractures, posture, and mobility e.g. wheelchair confinement, use of walker etc. Besides that the physical considerations: large/protruding/pendulous abdomen, abdominal folds, wrinkles, scars/suture lines, other stomas, rectus muscle, waist line, iliac crest, braces, pendulous breasts, vision, dexterity and also the presence of hernia.

Other considerations will be patient considerations such as diagnosis, history of radiation, age and occupation. Surgeon preferences, patient preferences, type of ostomy or diversion, anticipated stool consistency are also other considerations that need to be considered.

The workshop will allow some of the participants to perform the stoma siting and experience the process that involved in performing this procedure.



**WORKSHOP 4**

Allied Health Professional

**COUNSELLING PRE OPERATIVELY**

*Enterostomal Therapist (E.T.) Team*

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Counselling is talking therapy that allows a person to talk about their problems and feelings in a confidential and dependable environment. Sometimes it is difficult to say something in our minds especially if it is very private. This is because people normally feel embarrass to talk about it especially with people who are foreign to them.

As an Enterostomal Therapist (E.T.) it is crucial to develop a good rapport with your patients and their family members even before you can talk or discuss about the surgery.

Listen, listen and listen is the best thing we need to do, giving them an opportunity to talk or probably ventilate to you what is it inside them.

The objective of counselling preoperatively is to certain that the patient and their family understand what is happening and what they will undergo and what to expect post operatively. This is vital because how success post operatively will be, depends on it.

There are steps that need to be taken during the counselling session and what to say and show.

The workshop will expose the participants with the practical technique on how to perform the counselling session.



**WORKSHOP 5**

Allied Health Professional

**ASSESSMENT AND CLASSIFYING PERISTOMAL SKIN EXCORIATION  
USING SACS INSTRUMENT**

*Enterostomal Therapist (E.T.) Team*

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How well ostomy patient adapt to their new life, depends to a great extent on the preservation of peristomal skin integrity. The peristomal skin should be intact with no evidence of redness, loss of epidermis or sensations such as itchiness, warmth, or pain.

The peristomal skin should be intact and clean because this will have a great impact to the patient's life because of few factors such as:

- i. Adaptation process for the patient.
- ii. Fewer problems initially will be a pre requisite for better acceptance.
- iii. Facilitate application of pouching system
- iv. Reduce pain
- v. Adhesiveness of the wafer will be higher thus less changes, reduce cost.
- vi. Maintain intact healthy peristomal skin.
- vii. Motivational aspect for patients and family

The manifestations of a peristomal skin changes range from skin redness, papules and vesicles through, until erosions and ulcerations.

Itching, burning and pain are the most common symptoms and if these are added to the improper equipment, the condition of the patient becomes intolerant; sometimes the symptoms can be reversed fast but sometimes it takes time.

The rehabilitation of people living with an ostomy depends mainly on the integrity of their peristomal skin. Maintaining a healthy peristomal skin is the main objective of any healthcare professional that manages stoma.

For that reasons we need to continuously assess and classify the peristomal lesions to ensure it is intact and healthy. In order to assess and classify the peristomal skin, we need a validate tool as to ensure accuracy but simple and easy to use.

In the workshop participants will be introduce to an instrument called "SAC Instrument" that have been validated to help us to assess and classify the peristomal lesions.



**SYMPOSIUM 11**  
CORUM (2)

**CLINICAL HYPNOTHERAPY: AN ADJUNCT IN THE MANAGEMENT OF  
COLORECTAL CANCER**

*Alan Soh*

London College of Clinical Hypnosis, Kuala Lumpur, Malaysia

For almost 200 years, hypnosis has been used by physicians to provide psychological and physical comfort to patients diagnosed with cancer.

The aims of this presentation are:

- 1) to describe hypnosis and to dispel myths
- 2) to give an overview of the use of hypnosis as a tool for lifestyle change in the prevention of colorectal cancer
- 3) to explain the role of hypnosis as an adjunct to diagnostic and treatment procedures
- 4) to show the role of hypnosis in the management of oncological distress
- 5) to explore the relationship between hypnosis and cancer survivability
- 6) to discuss future research directions

Overall, the literature demonstrates the benefits of using hypnosis to improve quality of life of cancer patients. However, more work needs to be done to explore the use of hypnosis in survivorship, to understand the mediators and moderators of hypnotherapeutic interventions, and to develop effective adoption strategies.



LECTURE

**SEXUALITY: WHEN IS THE RIGHT TIME TO TALK ABOUT IT?**

*Mariam Mohd Nasir*

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For most ostomates, a stoma has little effect over the ability to enjoy sex, regardless of sexual preferences or lifestyle before surgery. Sexuality and ostomy are complex subjects with many facets: the physical, emotional, and psychological pressures are major influences in ones' life.

Ostomy can be hard for both the patient and the healthy partner. In some instances where a patient has had surgery for debilitating health problems like cancer, the healthy partner helps to take care of the ostomate and "certain" bodily functions. Working through these hard times without sex can take a toll on the sex life, and it can take time for these couples to adjust and recoup to a healthy sexual lifestyle again.

So the question of when is the right time to talk about it, with the patient and also with her/his partner.

Sexual relationships and intimacy are important and fulfilling aspects of your life that should continue after ostomy surgery. But there is a period of adjustment after surgery. Their attitude is a key factor in re-establishing sexual expression and intimacy and this will determine when they can talk about it or resume the activity.

It is also vital for them and us as healthcare provider in defining sexuality itself. We tend to see sexuality as the act itself but in actual facts sexuality is more than just the intercourse itself.

Any sexuality concerns the ostomates have are best discussed openly between them and their partner and as an Enterostomal Therapist (E.T.), we will be the mediator to help and assist the discussion. It is not easy to discuss something very personal with someone else who can be considered as stranger, to do this the E.T. need to develop a good rapport with the patient and her/his partner so that the relationship based on trust can be developed.

The speaker will share with all some tips for ostomates in the conference.



PLEANARY 4

ETHICAL ISSUES IN COLORECTAL SURGERY

*Akhtar Qureshi*

Sunway Medical Centre, Selangor, Malaysia

The code of professional conduct as adopted by the Malaysian Medical Council:

The practice of Medicine is an ancient profession and the community has great expectations of its practitioners and places great trust in them. Without this trust it would be impossible to practice medicine and the profession as such expects a high standard of professional and personal conduct from its members. These are embodied in various Codes of Ethics which vary in detail from country to country but all place first and foremost the health and welfare of the individual and the family under the care of a practitioner.

The Malaysian Medical Council endorses the Declaration of Geneva which embodies these ideals. Underpinning the Code of Ethics are statutes which make it an offence punishable under the law of the country to transgress certain outer limits of the expected norms of professional conduct. These minimum standards of conduct are assessed by their peers in the profession, assembled as the Malaysian Medical council established under the Medical Act 1971. Breaches of these minimum standards are referred to as 'infamous conduct in a professional respect' or 'serious professional misconduct'.

The practice of colorectal surgery is no different from any other branch of medicine and surgery and patients expect the highest standards from colorectal surgeons. We have to aim for these highest standards so as maintain trust as well as our professionalism.



**SYMPOSIUM 13**

Allied Health Professional Session (5)

**COLOSTOMY “IRRIGATION” IS THE BEST SOLUTION:  
MY PERSONAL EXPERIENCE**

*Harikesh Buch*

B.A.N.Hospital, Mumbai

S.L. Raheja Hospital & Asian Institute of Oncology, Mumbai

Defecation or passing of stool can be natural or could be artificially created process.

After birth human beings learn to have sphincter control on their bowels and urinary system by the age 3-4 years. But when patient under goes stoma surgery either of GI tract or Urinary system he loses control on the sphincter mechanism.

For patients with permanent end colostomy “Irrigation” or doing a colonic wash out on a daily basis can bring 23 hours of stool free in a day. It is a simple method to learn & appropriate “Irrigator” (appliance & accessories required for irrigation ) which is easy to use is easily available in most countries of the world.

It saves money for the patient in the long term basis & gives a wider choices of diet. Most importantly it improves the self image of the patient and therefore he/she leads a better quality of life.

**SYMPOSIUM 13**

Allied Health Professional Session (5)

**AN EFFECTIVE TEACHING TOOL FOR STOMACARE**

*Rozita Binti Mohamad*

University Malaya Medical Centre, Kuala Lumpur, Malaysia

Teaching patients practical skills in stoma care is a complex process and although, arguably, at the very heart of stoma care nursing practice has been largely ignored in the literature. Teaching principles are based upon social learning theory and educationalists provide guidelines on the most effective way to teach a practical skill. These guidelines have been utilized by nurses when teaching patients with newly formed stomas how to change a pouch. The process of adapting to a stoma and its daily management takes time. Psychologically, however, some patients will adapt more easily than others and researchers have attempted to identify factors which may account for this. Studies have demonstrated that patients who are satisfied with the amount of preoperative information they receive are less likely to develop psychological problems. Psychological adjustment may be affected if patients feel that they have developed insufficient pouch changing skills or have problems with leakage from their pouch or sore skin around their stoma. Studies have also demonstrated that cognitive factors, such as patients feeling in control of their illness and stoma, have been found to play a role in psychological adaptation. Enterostomal Therapist is an ideal position to target these cognitive factors using a variety of strategies including effective practical teaching to empower patients, thus facilitating psychological adaptation following stoma surgery.



**SYMPOSIUM 13**

Allied Health Professional Session (5)

**CLINICAL LEADERSHIP: IS IT IMPORTANT?**

*Mariam Mohd Nasir*

Department of Nursing, University Malaya Medical Centre, Kuala Lumpur, Malaysia

Leadership is a process by which a person influences others to accomplish an objective and directs the organization/association/work force in a way that makes it more cohesive and coherent to achieve something that they desire.

Good leaders are made not born. If you have the desire and will power, you can become an effective leader. Good leaders develop through a never ending process of self-study, education, training and experience. Becoming an effective leader is not easy... skill development together with experience. Remember, Leadership is Action, not Position. Power does not make you a LEADER...it simply makes you the BOSS.

Mullally (2001) suggested that effective nursing leadership is central to the success of the 'NHS Plan' (Department of Health (DH), 2000), therefore, if nurses are to make a profound contribution and support the Government's change agenda with, 'a new breed of clinical leaders'. This is also applicable to our scenario in Malaysia,

Understanding clinical leadership should be central to the goals of the nursing profession. Gaining an understanding of clinical leadership is also pivotal in recognizing who the clinical leaders are and to further explore the values associated with bedside, clinical care.

The term 'clinical leadership', although recognizable in nursing and allied health literature, has rarely been the subject of detailed study. The speaker will address the questions: 'what is clinical leadership?' and 'how it is defined and whether it is important in our clinical setting especially related to us as and Enterostomal Therapist (E.T.).



**SYMPOSIUM 13**

Allied Health Professional Session (5)

**TREAT THE WHOLE, NOT JUST THE HOLE**

*Mariam Mohd Nasir*

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When a person get a stoma, this will at first have great impact to their lives. The process of adaptation and acceptance will takes time and these changes will then become part of their life, although it will take some more time at first, but with experience they will get faster. Getting used to it in the beginning is not easy, but sooner or later, it will become a habit and feel natural.

Nursing school has thought us about the importance of holistic care, how to completely care for our patients and care plan should be a comprehensive care from head to bottom.

The American Holistic Nurses Association defines holistic nursing as “all nursing practice that has healing the whole person as its goal.” This ideal of caring for the entire person, not just their physical body, is one that dates back to Florence Nightingale herself.

It can be easy to simply treat the physical being and move on to the next patient, but we need to understand that it is important to care for the whole person and to see them as just that; a whole person, not just a patient, a diagnosis or a stoma.

Holistic nursing care involves healing the mind, body, and soul of our patients. It involves thinking about and assisting patients with the effects of illness on the body, mind, emotions, spirituality, religion, and personal relationships. Holistic care also involves taking into consideration social and cultural differences and preferences. Every person is their own individual. Shouldn't our care of each patient be individualized?

Stoma care is a self-care and we have been emphasized on this throughout our pre-operative counselling, post-operative counselling and before we discharge the patients. Nevertheless when we care for the patient during their recovery we need to focus to the patient as a whole not just the opening. Sometimes we forgot that caring for the stoma is also as important as caring for the patient other requirement such as their nutrition aspects, rehabilitation, medication, bowel habits, spiritual aspects an so on.



**SYMPOSIUM 13**

Allied Health Professional Session (5)

**OSTOMY WORLDWIDE: THEIR FUNCTIONS AND ROLES  
IN PROMOTING OSTOMATE'S RIGHTS**

*Harikesh Buch*

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S.L. Raheja Hospital & Asian Institute of Oncology, Mumbai

Ostomy groups are synonymous with any patients support groups. Patients support groups exists around the world for many decades. Primarily they are formed by likeminded patients for exchanging ideas and share all kinds of experiences in personal life after having suffered a disease and going through its treatments to get better but along the way having to go through different kinds of personal experiences and issues while facing all related processes.

Ostomy groups are formed with the similar objectives in mind by likeminded patients who have undergone ostomy surgery. Initially, in early sixties, they were formed in the developed western countries. But towards late sixties these countries formed larger groups in the form of regional groups which eventually united, in mid seventies, to form International Ostomy groups which eventually gave a birth to International Ostomy Association with proper constitution and structure.

Currently approximately ostomy groups are existing in about 80 plus countries in the world. Individual country groups united to form regional groups which in turn united to become International Ostomy Association ( IOA).

Most important functions of the ostomy groups ( Associations ) are

- 1) To give hope to new or would be patients by sharing with them their personal positive experiences and how they have overcome certain problems along the way to live a near normal life
- 2) To give information about the current development in medical field regarding the ostomy related subjects as well as ostomy products to ostomates and their care givers
- 3) To give information to ostomates about how best to use all available ostomy products to lead a near normal life.
- 4) Co-ordinate with different health care professional bodies to give knowledge and create awareness about standard of care for ostomates to their members.
- 5) To create awareness amongst the society in general about the issues that are faced by the ostomates and their needs.
- 6) With the help of the members of the ostomy groups along with health care professionals create a advocacy program and promote as well protect the rights of the ostomates within the society in general and within the country with the help of governmental bodies.



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BEST POSTER AWARD PRESENTATIONS

**PP 01**

**FECAL M2-PK VS COLONOSCOPY AS FIRST-LINE SCREENING TOOL FOR  
COLORECTAL CANCER SCREENING. IS IT TIME TO CHANGE?  
ASIAN TERTIARY CENTER PERSPECTIVE**

*M M Hajhamad<sup>1</sup>, Raja Affendi Raja Ali<sup>2</sup>, M A Zairul<sup>1</sup>, Nur Afdzillah Rahman<sup>1</sup>, R J Ruhi<sup>1</sup>, Sagap I<sup>1</sup>*

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**BACKGROUND**

Proliferating cells, particularly the tumor cells, express a dimeric isoenzyme of pyruvate kinase, termed M2-PK. The detection of tumor-specific pyruvate kinase (M2-PK) in stool is a promising tool for colorectal cancer (CRC) screening.

**AIM**

To evaluate the efficacy of faecal M2-PK as a screening biomarker for colorectal cancer.

**METHODS**

We evaluated fecal M2-PK as a screening biomarker for colorectal cancer comparing to colonoscopy. Seventy seven consecutive subjects from general surgery and gastroenterology clinics were included. Stool specimens were collected before purgation, processed appropriately and were tested for M2-PK. Colonoscopies were performed by experienced endoscopists who were unaware of fecal assay results. Patients' demographics and clinical characteristics were obtained from patients records. Primary objective (specificity and sensitivity) of the test in comparison to colonoscopy was calculated. Independent t-test and chi-square tests were used to test the level of significance between sociodemographic and clinicopathological characteristics of our study population.

**RESULTS**

A total of seventy seven patients, [n=36] males (46.8%) and [n=41] females (53.2%), with mean age 61.7±11SD years, participated in the study. Five patients (6.5%) had adenocarcinoma of the colon confirmed by colonoscopy and histopathological examination, while 70 (90.9%) had either normal or benign pathology; and another two patients (2.6%) final diagnosis were not established till the time of analysis; ten patients have had positive faecal M2-PK test, five of them were true positives, and the other five were false positives. The calculated sensitivity and specificity for stool M2-PK was 100% and 92.9% respectively. There was significant relation between diagnosis of adenocarcinoma with age of 72±SD3.7 (p-value 0.048) and with altered bowel habits as a presenting symptom (p-value 0.001) in our study population.

**CONCLUSIONS**

Faecal M2-PK narrows the gap in clinical practice because it detects bleeding and non bleeding tumors with high sensitivity and specificity. We recommend faecal M2-PK as a routine test prior to colonoscopy for CRC screening.



BEST POSTER AWARD PRESENTATIONS

**PP 02**

**ANASTOMOTIC LEAK-A SINGLE CENTER 5 YEARS RETROSPECTIVE  
HOSPITAL BASE DATA ANALYSIS OF FACTORS INFLUENCING  
ANASTOMOTIC LEAK**

*Ragu Ramasamy, Loh Soon Khang, Datuk Gerald Henry*

Hospital Selayang, Selangor, Malaysia

**OBJECTIVE**

The purpose of this study is to analyze patient factors influencing anastomotic leak after large bowel surgery

**METHODS**

This is a 5 years retrospective, hospital base data analysis of a single center (Hospital Selayang Colorectal Unit). All patients who undergone elective large bowel resection for cancer (from January 2009- December 2013) with primary anastomosis was included in this study analysis. Some of the predictor variables were neoadjuvant therapy, preoperative transfusion, bowel preparation, stoma creation and diabetes mellitus(DM)

**RESULT**

Of the 294 patients, 57.5% were male and 42.5% female. The median age of the patients was 63.4 years. The anastomotic leak (AL) for the total duration of 5 years was 4.4 %( 13) patients. Of total 96 patients who had DM (32.7%), AL occurred in 3(23.1%) patients. 54 patients were transfused preoperatively. Of these 1(7.7%) had AL. Intraoperative stoma was created for 96(32.7%) patients and these contributed to 61.5 %( 8 patients) in AL arm. Total of 197(67%) patients underwent bowel preparation. 10 patients from this arm had AL (contributing to 76.9% of total leak patients) compared to 3 patients in no bowel preparation (23.1%) who had AL. Total of 26(8.8%) patients had neoadjuvant therapy. 12 patients had chemoradiotherapy(4.1%) and none of this patients had AL. Of the 4(1.4%) who had radiotherapy alone, 1 patient had AL (7.7% in AL arm). 10(3.4%) had chemotherapy alone and of these patients 1 patient had AL (7.7% in AL arm). In multivariate analysis we did not find any of these factors to be significant independent predictors for AL.

**CONCLUSIONS**

Anastomotic leak is compounded by both patient factor and intraoperative surgical technique. No single significant factor exists to say that the patient is at increased risk of AL. Preoperative management of known factors and intraoperative technique has to be optimized to minimize this complication.

Risk factors should be considered before and during the surgical care of colorectal patient

- A description of the methods used
- A summary of the results obtained.
- A statement of the conclusions reached.



BEST POSTER AWARD PRESENTATIONS

**PP 03**

**COLORECTAL CANCER IN SARAWAK GENERAL HOSPITAL, KUCHING:  
AN EIGHT YEAR REPORT (2007-2014)**

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**OBJECTIVE**

Colorectal cancer (CRC) is the second leading cause of cancer in Malaysia and represents itself as a major cause of morbidity. We here present a report of colorectal cancers managed in Sarawak General Hospital (SGH) from January 2007 till December 2014.

**METHODS**

Data from our department's CRC database were used for creating this report. A total of 821 patients were in the database, however, 226 patients were excluded due to incomplete data. The remaining 595 patients' data was analyzed statistically to create this report.

**RESULTS**

The median age of presentation of CRC at our hospital is 61 years (range: 18 – 89). The male: female ratio is 1.2:1. Chinese patients constituted the majority of cases (47.2%), followed by the Malays (20.3%), Iban (16.0%), Bidayuh (12.3%) and other races (4.2%). 21.5% of patients presented young (<50 years old), while the peak age of presentation is the 50-69 age group (56.6% of patients). More than half of patients presented at the late stage, 44.4% of patients presented at Stage III while 19.7% presented at Stage IV. Only 12.2% of patients presented early at Stage I. Cancers of the sigmoid colon and rectum represented the bulk of the cases; 39.6% and 37.0% (of total cases) respectively. A total of 513 patients underwent operations during this period, of which, 87.1% were elective and 12.9% were emergency operations.

**CONCLUSION**

CRC is a disease which affects the older (>50 years old) and the Chinese population more frequently. Most patients with CRC in SGH present at the late stage of disease and with cancers commonly located at the sigmoid colon or rectum. Better patient education and screening will allow early detection and treatment which could improve the overall survival rates.

Keywords: Colorectal Cancer; Epidemiology; Sarawak.



BEST POSTER AWARD PRESENTATIONS

**PP 04**

**NECROTIZING FASCIITIS; AN ATYPICAL PRESENTATION OF  
SIGMOID COLON CANCER**

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Colorectal cancer is fast rising to be one of the most common form of cancer in Malaysia, especially of those in the elderly age group, beyond the age of 40, with a peak incidence at 50 years of age. In Malaysia, the most common site of tumour presentation is the Sigmoid Colon and many patients present at Stage III of the disease, and their usual presentation is with per rectal bleed, altered bowel habits or constitutional symptoms. We report an unusual case of sigmoid cancer presenting on a young 38 year old woman with necrotizing fasciitis of the anterior abdominal wall, which was diagnosed and subsequently treated with a laparotomy surgery. Pre-operatively we have ultrasound and CT findings of anterior abdominal wall collection with presence of massive air within the abdominal wall, with subcutaneous collection extending to the muscularis layer with pelvic collection and an inflammatory mass over the sigmoid colon. She underwent an exploratory laparotomy, Hartmann Procedure and an extensive wound debridement during which it was noted she had faecal and pus contaminant in her peritoneal cavity and a sigmoid tumour perforation that had fistulated to the anterior abdominal wall. Sigmoid colon cancer is a very prevalent type of cancer and as such it is important to identify all possible manifestations and complications a patient may present with.



BEST POSTER AWARD PRESENTATIONS

**PP 05**

**AN OBSERVATION ON THE EFFECT OF SEMI-ELEMENTAL ORAL  
NUTRITIONAL SUPPLEMENTS ON THE REDUCTION OF SMALL BOWEL  
OSTOMY OUTPUT**

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Semi-elemental oral nutritional supplements are also referred to the oligomeric, hydrolysed or peptide formula, the nitrogen source of the formulas derived from hydrolyzed oligopeptide of shorter lengths such as the dipeptides and tripeptides. The ingredient of casein and lactalbumin hydrolysates in this formula are believed to be capable of stimulating the jejunal absorption of water and electrolytes. The postulated stimulation of improves absorption increased our curiosity on its effect on those patient with high output ostomy. We understand that this formula is more costly compared to the other polymeric formula available in the market. We would like to share an observation of two ostomies output that are managed conservatively along with the supplementation of a semi-elemental formula. We retrospectively review the case notes of two patients with small bowel ostomies and graphs were plotted to demonstrate the relationship between the output and the intake of the semi-elemental formula. We observed an interesting pattern of the ostomy output in relationship to intake volume. The ostomy output decreases as the patients increase the intake of the semi-elemental formula. From our observation, we concluded that semi-elemental formula improved clinical nutrition outcome and also quality of life in terms of stoma output reduction, making the stoma care more manageable. However, we hope that through our observation case studies, we would encourage more researchers to conduct a larger prospective and clinical study to explore the true clinical effects and also cost-effectiveness of this formula.



BEST POSTER AWARD PRESENTATIONS

**PP 06**

**VIDEO-ASSISTED ANAL FISTULA TREATMENT (VAAFT) -  
JOHOR BAHRU'S HUMBLE BEGINNINGS**

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**BACKGROUND**

Anal fistula is an abnormal tract communicating between the perianal region to the anal canal and occasionally to the lower rectum. Video assisted anal fistula treatment (VAAFT) is a minimally invasive technique to treat fistulas

**AIM**

To describe the technique and our initial experience with video-assisted for anal fistula treatment performed in patients with complex fistulas.

**TECHNIQUE**

A Karl Storz video equipment system is used. Main steps included the visualization of the fistula tract using the fistuloscope, the correct localization of the internal fistula opening and branching under direct vision, endoscopic treatment of the fistula and closure of the internal opening if present.

**RESULTS**

Mean operative time is 39 minutes. Internal fistula opening could be identified in 3 patients after complete fistuloscopy. The mean pain score observed is 3 using the numeric pain score scale. There were no intraoperative or postoperative complications. During the due course of follow-up, it was observed that in 37.5% of patients had non-resolving symptoms.

**CONCLUSION**

Video-assisted anal fistula treatment has less morbidity post-operatively and well tolerated by patients. It enables direct visualization of the fistula tract, internal opening and secondary paths.

BEST POSTER AWARD PRESENTATIONS

**PP 07**

**A RARE CAUSE OF BOWEL OBSTRUCTION**

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Mdm KCC a 77 year-old lady presented to the emergency department with a one-weeks' history of abdominal pain, nausea and vomiting. She had a history of a right hemicolectomy for adenocarcinoma in 2013 and gallstones. She presented with a similar history 2 weeks prior to this admission but her symptoms resolved after hydration and non-surgical decompression.

On admission, abdominal examination revealed right upper abdominal tenderness but no peritonism. She had a white cell count of  $10.8 \times 10^9/L$ , amylase 70U/L.

Plain abdominal x-ray showed dilated small bowels with aerobilia. Contrast-enhanced CT scan revealed small bowel dilatation with a large calcified object in the small bowel suggestive of gallstone ileus. She underwent a laparotomy- intra-operative findings of a chole-jejunal fistula with a stone impacted in the jejunum was noted. We proceeded with a cholecystectomy and small bowel resection and she was discharged well within 3 days of surgery.



BEST POSTER AWARD PRESENTATIONS

**PP 08**

**GASTROINTESTINAL NEUROENDOCRINE TUMOUR:  
THE GREAT MASQUERADER**

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**INTRODUCTION**

The incidence of neuroendocrine tumour (NET) of the gastrointestinal tract is on the rise, albeit still a rare form of neoplasia. Its clinical presentations varies from being an incidental finding during colonoscopy to symptoms arising from metastases. Treatment differs greatly based on tumour classification and stage. We present three cases to demonstrate the different clinical masquerades of this disease.

**CASE SERIES**

- Case 1: An 18 year old lady had underwent appendicectomy for clinically suspected acute appendicitis. Histopathological examination (HPE) was reported as carcinoid tumour with negative resection margins. Subsequently she had a computed tomography (CT) of the abdomen showing a soft tissue mass near the caecum with pericaecal nodes, necessitating a fomal right hemicolectomy. The final HPE results was reported to be free of malignancy.
- Case 2: A 66 year old lady with a month's history of worsening perianal pain and altered bowel habit was found to have a low rectal mass. Biopsy of the mass showed a Neuroendocrine Carcinoma. An endorectal ultrasound (ERUS) showed involvement of the anorectal sphincter complex. There was also posterior vaginal infiltration with nodal involvement on staging CT. This necessitated an abdominal-perineal resection with posterior vaginectomy. The HPE came back as Grade 3 Neuroendocrine Carcinoma.
- Case 3: A 64 year-old lady had a colonoscopy investigation after having multiple daily bouts of diarrhoea for 8 months. This revealed a low rectal polyp which was removed with a HPE of carcinoid tumour. CTPET scan was done to assess disease extension as the patient had carcinoid syndrome which revealed midgut carcinoid of the small bowel (in the pelvis) with nodal metastases.

**CONCLUSION**

The differences in clinical presentation illustrated above with utilisation of different diagnostic modalities, has posed a clinical challenge. Hence it is of utmost importance that a multidisciplinary approach is adopted in its management.



BEST POSTER AWARD PRESENTATIONS

**PP 09**

**DIAGNOSING AND MANAGING COLORECTAL CANCER IN PREGNANCY IS CHALLENGING: TWO CASES REPORTED IN HOSPITAL MELAKA**

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**BACKGROUND**

Colorectal cancer is one of the 3 most common cancer in women. Lifetime risk of having colorectal cancer in women is 1 in 17. However, colorectal cancer during pregnancy is uncommon in which the incidence is only 0.008%. Diagnosing colorectal cancer in pregnancy is challenging as the common presenting symptoms such as anaemia, abdominal pain and constipation are often overlooked. Optimal treatment involved ethical issue as the safety of both mother and fetus need to be considered.

**CASE REPORT**

In 2013, 2 cases of colorectal cancer in pregnancy were reported in Hospital Melaka. The 1<sup>st</sup> case was diagnosed in the first trimester when she presented with mass per rectum. The 2<sup>nd</sup> case was diagnosed incidentally when she was investigated for pulmonary embolism after delivery.

**CONCLUSION**

Colorectal cancer in pregnancy is rare. Managing colorectal cancer in pregnancy poses significant ethical, religious, and scientific challenges. Principles of treatment is similar to those in the general population, but special care regarding fetal safety should be considered. There is no existing guideline, hence therapy should be individualized and defined by multidisciplinary team that considers the best management for both the patient and her fetus. Early detection by increased awareness among the primary care physician and obstetrician improve its prognosis. Early referral to a colorectal surgeon is essential for prompt evaluation and treatment of colorectal cancer in pregnancy.



BEST POSTER AWARD PRESENTATIONS

**PP 10**

**ROLE OF ASPIRIN IN PREVENTION OF COLORECTAL CANCER RECURRENCE:  
DOES IT TRANSLATE WELL IN LOCAL POPULATION? RETROSPECTIVE  
OBSERVATIONAL STUDY IN A TERTIARY CENTRE**

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**INTRODUCTION**

Colorectal cancer (CRC) in Malaysia poses a large burden to the healthcare system. Since there is currently no formal screening program in the country, we should strive to prevent recurrence of CRC in patients who have undergone curative treatment. Many literature published around the world have looked into Aspirin as a chemopreventive agent in the development of CRC and the results look promising. However these studies were largely displaying retrospective data from Europe and America and were not looking at prevention of CRC recurrence as a primary aim. Hence the reason we performed a retrospective observational study on our cohort of CRC patients who have undergone curative resection looking into the role of Aspirin in preventing cancer recurrence and mortality.

**METHODOLOGY**

We looked at all patients who were diagnosed with CRC from year 2000 to 2013. Of these we included patients who had underwent curative resections. We excluded patients with incomplete data as well as those who defaulted the cancer surveillance protocol or who were lost to follow up. The total number of patients were 74, these were then divided into group A (GrA) 40 patients who did not take Aspirin and group B (GrB) 34 patients who were on Aspirin on a daily dosage. We then analyse the demographic data, incidence of CRC recurrence and mortality.

**RESULTS**

There were similar demographic data between the two groups however there appears to be more male patients in GrA 68% vs 50% in GrB. GrA patients presented more with altered bowel habit (40%) whereas GrB presented more with per rectal bleed (41%), bear in mind that these patients were already on Aspirin low dose (75-150mg daily), which may explain this occurrence. In both groups, majority of the tumour location were either in the rectum, rectosigmoid or sigmoid colon (79%, 85%). Eight patients (20%) in GrA developed distant cancer recurrence and 1 patient (3%) developed local recurrence. There were 2 incidences of mortality. Whereby 10 patients (30%) in GrB developed distant recurrence, 2 patients (6%) had local recurrence, of these 2 died of disease progression.

**CONCLUSION**

Although several studies have looked at Aspirin as chemoprevention with positive results, these studies do not reflect the Asian population. It appears that low dose aspirin in our cohort of patients did not prevent local or distant metastases in patients who have undergone curative resection for CRC. The results appear to be similar in both groups regardless whether they were on Aspirin. Future study with larger patient cohort in a randomised prospective manner should be undertaken in order to derive any valuable association in our local population.



**PP 11**

**CASE REPORT: PUDENDAL THIGH FASCIOCUTANEOUS FLAP AS A SURGICAL OPTION FOR POUCH VAGINAL FISTULA FOLLOWING ILEAL POUCH ANAL ANASTOMOSIS IN CROHN'S DISEASE**

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**INTRODUCTION**

Pouch vaginal fistula following ileal pouch anastomosis in Crohn's disease patient underwent restorative panproctocolectomy can be a devastating complication. Management would depend on severity of symptoms and location of fistula in relation to the anastomotic site. Fecal diversion with local surgical technique (i.e: transanal or transvaginal repair, mucosal advancement flap, fibrin glue) is considered effective in most patient. Reconstructive surgery is an option in cases where local repair failed. This is a case report of successful reconstructive surgery for pouch-vaginal fistula.

**CASE REPORT**

We report a case of 40 year old lady underwent restorative panproctocolectomy with ileal pouch anal anastomosis and ileostomy for her underlying Crohn's Disease. Unfortunately she developed symptomatic pouch vaginal fistula 2 months post surgery. She had undergo several local transanal repair that failed. Fistula closure finally achieved following reconstructive surgery with Pudendal Thigh Fasciocutaneous Flap by our plastic surgery team. It is a pedicled neurovascular pudendal thigh fasciocutaneous flap where the flap received blood supply from posterior labial artery and perineal branches of the pudendal artery, innervated by pudendal nerve. Patient seen at two year follow up revealed successful closure of fistula and satisfactory functional outcome.

**CONCLUSION**

Rarity of pouch vaginal fistula makes it difficult to determine the ideal surgical technique. Fistula can be due to the progressive disease or surgical complication. However, in cases of where local transanal repair failed, surgical repair with pudendal-thigh fasciocutaneous flap (Singapore Flap) is a versatile surgical option in managing complex problem of pouch vaginal fistula following ileal pouch anastomosis in Crohn's Disease.



## PP 12

### A RARE CASE OF THIGH ABSCESS: THE FIRST MANIFESTATION OF RECTAL CANCER

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Thigh abscess is rare, and although easily diagnosed, we have to focus in finding the underlying cause. An unusual case is described in which thigh abscess was the first manifestation of rectal cancer. A 68-years old man presented with right thigh swelling and fever. Underwent incision and drainage of right thigh based on ultrasound finding of intramuscular collection. Intraoperative finding of feculent pus with pockets extending into ischiorectal fossa and rectum. Computed tomography revealed a constricting rectal mass with no clear plane, and collection in postero-upper right thigh with surrounding subcutaneous tissue streakiness extending into the right perianal region. Patient then proceeds with laparotomy and diverting stoma in view of advanced disease, subsequently succumbed after 10 days of surgery.

## PP 13

### PEUTZ-JEGHERS SYNDROME

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#### **INTRODUCTION**

Peutz-Jeghers Syndrome (PJS), is an autosomally dominant inherited condition determined by a mutation localized at 19p13.3 responsible for mucocutaneous pigmentation and gastrointestinal polyps. Polyps may appear in the stomach, small bowel or colon, with hamartomatous aspects on histology. Acute upper gastrointestinal bleeding and chronic fecal blood loss may appear during the course of disease.

#### **CASE REPORT**

We report a case of 18 years old Malay girl who previously healthy and no past medical history, presented with history of intermittent per rectal bleeding for 3 month associated with tenesmus and symptomatic anemia. There were no obvious mucocutaneous pigmentation seen in our patient.

Multiple polypoidal growth was felt during digital rectal examination. Colonoscopy done revealed a multiple small polyps at rectum, rectosigmoid junction and descending colon.

Histo-pathological examination of the polyps confirmed hamartomas with smooth muscle arborisation, compatible with Peutz Jeghers polyps. She was underwent a panproctocolectomy with ileo-ileal pouch anal anastomosis.

#### **CONCLUSION**

Peutz-Jeghers syndrome is a rare disorder characterized by mucocutaneous pigmentation & gastrointestinal hamartomatous polyps. Because of the inherited disease, it is necessary to investigate all the siblings or first degree relative. There is a higher risk of intestinal and extraintestinal cancers in those patient. Surgical treatment is the mainstay treatment for symptomatic patients.



**PP 14**

**FULMINATING AMOEBIC COLITIS WITH PERITONITIS :  
A DIAGNOSTIC DILEMMA WITH HIGH MORTALITY**

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*Entamoeba histolytica* is an intestinal protozoa that causes Amoebiasis. Most of the humans harbouring this protozoan parasite feel well. Small percentage develop symptoms. Fulminant amoebic colitis (FAC) is a rare manifestation. There is a high mortality rate if associated with peritonitis. Diagnosis is confusing as it has similar and overlapping clinical features with other colonic diseases like Infectious colitis, enteric fever, inflammatory bowel disease, gastrointestinal tuberculosis even appendicitis. We herein report a case of FAC with an initial diagnostic dilemma, presented with peritonitis and multiple colonic perforations with gross contaminations, Hartmann's procedure was done. However, patient developed peritonitis, sepsis and multi-organ failure postoperatively. Re-laparotomy was done and noted extensive gangrenous ileum all the way to the rest of the large bowel proximal to the exteriorised stoma.

**PP 15**

**APPENDICOCOLIC FISTULA: UNUSUAL COMPLICATION OF  
ACUTE APPENDICITIS**

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Appendicocolic fistula is a form of internal fistula that rarely complicates acute appendicitis. The relatively mobile and redundant transverse and sigmoid colon are the common part of colon involved due to their close proximity to vermiform appendix. We presented a case of middle-aged lady who presented with painful central abdominal mass who underwent exploratory laparotomy without confirmatory preoperative diagnosis. Intraoperatively the inflamed appendix was seen forming a fistula into the transverse colon, which was later consistent with the histo-pathological report. A limited right hemicolectomy was performed and she recovered well postoperatively.



**PP 16**

**IT IS NOT A CAECAL TUMOUR! AN UNUSUAL PRESENTATION  
OF MUCINOUS APPENDICEAL TUMOUR**

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**INTRODUCTION**

Appendiceal tumours are rare and represent only 0.5% of all gastrointestinal malignancies. Most of these tumours are asymptomatic or present with non-specific right lower quadrant pain, frequently mistaken for appendicitis.

**CASE SUMMARY**

We discuss a 71 year-old lady who had a mucinous appendiceal tumour being incidentally discovered from a routine blood screening. She was referred initially for an elevated CEA of 17.1mcg/L. She was otherwise asymptomatic with no significant clinical sign. Computed tomography scan (CT) revealed a 9cm cystic ileocaecal junction mass with no appendix identifiable. Colonoscopy showed caecal extramucosal mass with normal appendiceal lumen. She underwent right hemicolectomy for suspicion of caecal gastrointestinal stromal tumour (GIST). Intra-operatively, there was a huge retrocaecal cystic tumour which released mucinous material upon mobilisation. No tubular structure resembling an appendix was recognisable. Histology evaluation revealed appendiceal mucinous cystadenoma. Patient was discharged following an uneventful recovery. After multidisciplinary team discussion, she was planned for close CT surveillance with another CT scheduled at three months after surgery.

**DISCUSSION**

The majority of appendiceal tumours are carcinoids (80 – 90%) with the rest made up of mucinous cystadenoma, adenocarcinoma and lymphoma. Ruptured mucinous appendiceal tumours are associated with pseudomyxoma peritoneii, necessitating regular follow-up and surveillance CT scans. Though prognosis for pseudomyxoma peritoneii is poor, patients with low grade tumours who have undergone complete cytoreductive surgery and intraoperative or early post-operative hyperthermic intraperitoneal chemotherapy (HIPEC) have the best outcome.

**CONCLUSION**

Cystic caecal tumour in the absence of an identifiable appendix should raise one's suspicion of appendiceal mucinous tumour.



**PP 17**

**NEGLECTED BREAST CARCINOMA PRESENTING AS ACUTE  
INTESTINAL OBSTRUCTION**

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According to the Malaysian NCR 2006, 18% of breast carcinoma presented in Stage IV disease. Common sites of metastasis are lung, bone, liver and brain. Gastrointestinal metastasis is rare, with stomach being the commonest and colon comprising only 11%. Most cases reported occurrence years after treatment of the primary lesion. The commonest histology which metastasize to gastrointestinal organs is the lobular type.

Here we report a case of a 46 year old lady presenting with acute intestinal obstruction, with an incidental finding of a right breast mass, clinically T4N2. A laparotomy performed showed an obstructed caecal mass, necessitating a right hemicolectomy. Postoperative recovery was uncomplicated. The breast lesion trucut biopsy was reported as invasive ductal carcinoma showing the same histological type with the caecal mass, which was metastatic breast carcinoma. There were no lung nor liver metastasis on staging CT scan. She is currently undergoing chemotherapy.

**PP 18**

**CHRONIC ABDOMINAL PAIN IN A 21 YEAR OLD GIRL – IBS? IBD? NET? CRC?**

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Chronic abdominal pain is defined as continuous or intermittent abdominal discomfort lasting for at least 6 months. Diagnosis and management are often challenging, especially in a young patient without alarming symptoms and family history of carcinoma.

Here we report a case of 21 year old, single, unemployed girl with multiple visits to health clinics and hospital emergency departments for intermittent abdominal pain. She was treated for common conditions like gastritis, gastroenteritis, non specific abdominal pain and irritable bowel syndrome before a detailed evaluation performed.

Clinical examination revealed a small built, malnourished girl with unremarkable abdominal findings. Blood investigations showed presence of mild anaemia and hypoalbuminaemia. Due to non specific presentation and rare age of colonic malignancy, we sent blood for Chromogranin A to rule out rare disease like neuroendocrine tumor, but was normal.

A colonoscopy done detected a mass in hepatic flexure of transverse colon while staging CT scan did not show distant metastasis. She underwent a right hemicolectomy and postoperative recovery was uncomplicated. Histopathological examination of the colon tumor revealed a mucinous carcinoma with no mesenteric nodal involvement.

This case highlights the need to have a high index of suspicion in managing cases with unresolving intermittent abdominal pain, and organic causes have to be ruled out by imaging and endoscopy before labelling it as irritable bowel syndrome.



**PP 19**

**RECURRENT METASTATIC LARGE CELL NEUROENDOCRINE  
CARCINOMA OF CAECUM**

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Neuroendocrine carcinoma of the colon is rare, comprising 0.6% cases of colorectal cancer and only 0.2% out of these is of the large cell type. There are three grades based on the number of mitoses/ 10 high-power fields and ki-67 index. Serum Chromogranin A is elevated in 60% to 100% of NETs, thus useful for diagnosis and monitoring recurrence.

For caecal NETs, surgical excision along oncological principles is the main treatment modality. Somatostatin analogs and Interferon alpha are commonly used to control symptomatic carcinoid syndrome. More recently, VEGF inhibitors and mTOR inhibitors are introduced and may lead to improved outcome in advanced and metastatic NETs.

Here we report a case of a 45 year old man, who underwent a right hemicolectomy at a private hospital. It was a neuroendocrine tumor, with involvement of lateral margin. A staging CT scan did not show metastasis. However, this patient defaulted oncology referral and presented to us one year after the operation with a right lumbar mass.

Serum Chromogranin A was elevated, and a colonoscopy showed recurrence at anastomotic site. Staging CT scan showed liver and lung metastasis.

We performed a resection of the recurrent tumor and right nephrectomy as it was invaded. Postoperative recovery was complicated by superficial surgical site infection.

This case highlights the rarity and aggressiveness of large cell neuroendocrine tumors, with no established management protocols. Therefore, oncological resection as the primary treatment followed by entry into a clinical trial in a multidisciplinary setting would be optimal at present.



**PP 20**

**INTUSSUSCEPTION IN ADULT SECONDARY TO MECKEL'S  
DIVERTICULUM: A CASE REPORT**

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Intussusception is the telescoping of proximal bowel wall into the lumen of a distal segment. Whilst it is common in children, only around 5% intussusception occurs in adult, of which around 1%-5% causes bowel obstruction. Adult intussusception predominantly occurs secondary to an underlying malignant neoplasm (50%). Other non-malignancy causes are inflammatory bowel disease, Meckel's diverticulum, post-operative adhesion, stoma creation site, etc. Although most cases of intussusception diagnosis on table, abdominal and pelvic computed tomography (CT) is preferred test for detection of lead point and lesion localisation. We present the case of a 19-year-old male with a two-day history of colicky abdominal pain, followed by obstipation, abdomen distension, and fever, with generalised guarding. As patient presented with sign and symptom of peritonitis, emergency laparotomy was carried out and revealed a segment of small bowel loop passing through ileocecal junction up to the ascending colon (ileo-colic intussusception). After reduction reveals a perforated Meckel's diverticulum with fecal impaction as lead point. As patient's initial diagnosis was perforated viscus, emergency laparotomy was done, with wedge resection of Meckel's Diverticulum and end to end anastomosis. HPE reveal Meckel's Diverticulum with abnormal gastric mucosal. Patient recovered post operatively and discharged well.



**PP 21**

**MALIGNANT SMALL BOWEL GIST WITH LIVER AND PERITONEAL METASTASIS: A CASE REPORT**

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**INTRODUCTION**

Gastrointestinal stromal tumors (GIST) make <1% of all gastrointestinal neoplasms and 20% of small bowel neoplasms. The most common presenting symptom is gastrointestinal bleeding. GIST may also present as vague abdominal pain or discomfort, abdominal mass or sometimes with intestinal obstruction. Malignant GIST of small bowel is extremely rare. We present a case of malignant small bowel GIST with liver and peritoneal metastasis.

**CASE REPORT**

59 year-old women presented with dull aching lower abdominal discomfort for 4 months duration. On examination, the abdomen was distended and there was huge firm, nontender intraabdominal mass occupying almost whole abdomen. CT scan showed a large, irregular and heterogeneous enhancing solid tumor, likely arising from small bowel or mesentery measuring 22.2cm x 11.4cm x 16.6cm. No bowel dilatation. Tumor abutted the abdominal wall anteriorly and superior wall of urinary bladder inferiorly. There were five focal hypodense lesions in the liver, one in left and other four in the right lobe, largest measuring 1.5 x1.5cm. Ultrasound guided biopsy of the tumor showed gastrointestinal tumor with neural differentiation.

Resection of the tumor was performed through midline laparotomy. Postoperatively, she was put on T Imatinib 400mg twice daily. Repeat CT scan at 4 and 8 months postoperatively showed no recurrence and stable liver lesions. The patient is under our follow up and is currently asymptomatic. HPE of resected specimen confirmed GIST of small intestine with 90% risk of malignant potential. The tumor cells expressed strong diffuse CD117 immunoreactivity.

**CONCLUSION**

Malignant Small Bowel GIST is rare. Surgery is the main stay of treatment and should be offered even in the presence of distant metastasis. Tyrosine kinase inhibitors (Imatinib) play a key role in the management of locally advanced, bulky and metastatic GIST.

Key words: small bowel GIST, Liver metastasis, Imatinib



**PP 22**

**PNEUMOPERITONEUM, PNEUMORETROPERITONEUM, TENSION  
PNEUMOTHORAX AND DIFFUSE SUBCUTANEOUS EMPHYSEMA SECONDARY  
TO CAECAL PERFORATION POST COLONIC STENTING : A CASE REPORT**

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Colonoscopy is a widely used diagnostic and therapeutic procedure. The incidence of intraperitoneal colonic perforation post colonic stenting is estimated to be 7.4%. However, combination of intraperitoneal and extraperitoneal perforation with pneumoretroperitoneum, tension pneumothorax and diffuse subcutaneous emphysema is an extremely rare and lethal complication. We report a case of a 87-year-old women with underlying sigmoid colon carcinoma who underwent palliative colonic stenting and complicated by caecal perforation and extraperitoneal perforation. This case may raise the awareness on the likelihood of these serious complications after colonic stenting.

**PP 23**

**MEDICAL TREATMENT FOR RECTOVAGINAL FISTULA SECONDARY TO  
CROHN'S DISEASE: A CASE REPORT**

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**INTRODUCTION**

Crohn's Disease (CD) is a type of inflammatory bowel disease that can affect any part of gastrointestinal tract from mouth to anus. CD also may present with complex perianal fistula and sometimes it can lead rectovaginal fistula. We report a case with rectovaginal fistula secondary to CD and successfully treated with infliximab

**CASE REPORT**

Puan KMC, presented with passage of feces through vaginal associated with per-rectal bleeding. Digital rectal examination noted low rectal mass with rectovaginal fistula. The finding was confirmed by colonoscopy. CT TAP showed suspicious lesion at vagina or anterior rectal wall with possible fistulous communication. MRI revealed rectovaginal fistula, most likely inflammatory in origin. Multiple biopsies taken, however the results were inconclusive. We performed trephine diverting colostomy. After discussion with gastroenterologist, first line IBD regime was started to this patient. Due to poor respond, infliximab was added and completed for 6 cycles. Serial sigmoidoscopy done showed much improvement and finally spontaneous closure of fistula achieved.

**DISCUSSION**

CD is a type of inflammatory bowel disease that difficult to diagnose and treat. Usually treatment of CD depends on the presentation. It can be divided into surgical and medical treatment. Decision to start Infliximab in this patient is because of the first line IBD regime that was given initially had poor respond. After administration IV Infliximab, we noted speedy recovery of the inflammation and eventually lead to spontaneous closure. Eventhough Infliximab is not a first line drugs for inflammatory bowel disease, it has shown an effective outcome in patient with progressive IBD.



**PP 24**

**PRIMARY ANORECTAL MELANOMA: A CASE REPORT**

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Anorectum is a rare anatomic location for primary melanoma. Malignant melanoma of the anorectum is highly aggressive and it portrays worse prognosis than cutaneous melanoma with distant metastases being the overwhelming cause of morbidity and mortality. Surgery is the mainstay of treatment, but significant controversy exists over the extend of surgical resection. Here in, we present a typical patient along with relevant literature to illustrate the multimodality approach to Anorectal mucosal melanoma and discuss important factor associated with the treatment and prognosis of anorectal mucosal melanoma.

Key words: Cutaneous Melanoma (CM), Anorectal mucosal melanoma (ARMM)

**PP 25**

**NEUROENDOCRINE CARCINOMA OF THE RECTUM WITH LIVER METASTASIS**

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**INTRODUCTION**

Neuroendocrine carcinomas are a heterogenous group of neoplasms that can arise in most organs of the body commonly seen in the lung, gastrointestinal and pancreas. Neuroendocrine carcinoma involving the rectum is a rare tumours, comprising less than 1% of colorectal cancers.

**CASE REPORT**

We report a case of neuroendocrine carcinoma, grade 3, of the rectum in a middle aged man whom presented with hepatomegaly and obstructive jaundice. CT scan showed evidence of liver metastases. Colonoscopy showed a fungating mass 15cm from the anal verge. Biopsy confirmed the diagnosis and he died 2 weeks after presentation due to acute liver failure.

**CONCLUSION**

High grade neuroendocrine carcinomas involving the rectum are rare and aggressive tumours with poor prognosis as most patients presented with metastatic disease. Surgeons should aware of this disease in a patient who suspected to have colorectal cancer.



**PP 26**

**SMALL BOWEL LIPOMA: A RARE CAUSE OF INTUSSUSCEPTION AND  
OBSCURE GASTROINTESTINAL BLEEDING**

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**INTRODUCTION**

Intussusception in adults is rare and usually caused by a malignant bowel lesion acting as a lead point. Small bowel lipomas are rare benign gastrointestinal (GI) tumours, whose signs and symptoms are often obscure. Intussusception due to a gastrointestinal lipoma constitutes an infrequent clinical entity.

**CASE SUMMARY**

We report an unusual case of intussusception caused by a lipoma of ileum in a 26 year-old male, who presented initially with malaena associated with anaemic symptoms and nonspecific abdominal discomfort. Full blood picture revealed severe normochromic normocytic anaemia with reticulocytosis likely due to blood loss. Iron study was unremarkable. Repeated esophagoduodenoscopy (OGDS) and colonoscopy were inconclusive. Capsule endoscopy showed abnormal mucosa at distal ileum with possibility of a polyp. The diagnosis of intussusception was finally raised by a computed tomography (CT) scan of the abdomen. The patient underwent laparotomy and segmental small bowel resection with primary anastomosis, which achieved permanent cure of his symptoms. Intraoperatively, there was a protruding 6x1.5cm small bowel tumour located 80cm from ileocaecal junction, intussuscepted into its adjacent distal ileum. Histology evaluation of the resected specimen subsequently revealed a small bowel lipoma.

**DISCUSSION**

It is very difficult to make a precise preoperative diagnosis of gastrointestinal lipomas. When symptoms are clinically present, one of the most common is usually gastrointestinal (GI) bleeding. Definitive diagnosis can only be made through histopathological examination, after the surgical resection. The clinical picture of intussusception in adults is subtle and the diagnosis is, therefore, elusive. This case highlights the difficulties of diagnosing adult intussusception promptly in the absence of evident signs, and the fact that it can also be caused by a benign lesion. Surgical resection appears to be the most successful approach as good short- and long-term results are achieved.



**PP 27**

**COLORECTAL CANCER: TAWAU HOSPITAL EXPERIENCE**

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**OBJECTIVES**

The aim of this paper is to determine the basic demographic features of patients with colorectal cancer who has presented to Tawau Hospital as well as the stage of disease on presentation.

**METHODS**

Data was collected from the Surgical Department registry of colorectal patients with confirmed diagnosis from histopathological examination between the periods of January 2008 to December 2014.

**RESULTS**

There were a total of 103 patients diagnosed with colorectal cancer from Jan 2008 to December 2014. The majority of patients with colorectal cancer presented to the hospital are between the ages of 50-79 years old. The Chinese ethnicity, followed by Bugis and Bajau ethnic groups represents the bulk of the patients. Unfortunately, most of the patients presented to the hospital were at stage IV of the disease.

**CONCLUSION**

In conclusion, the data corresponded to the national statistics in regards to age and the Chinese ethnic group. However, there is a lack of published data on the incidence of colorectal cancer in the other ethnic groups of Sabah. As a majority of patients present at a late stage, the lack of screening in this area is apparent. Hence, increasing awareness amongst the population and establishing screening programmes in Tawau are necessary.



**PP 28**

**PERFORATED AMOEBIC COLITIS IN THE YOUNG AND FIT:  
SHOULD RETROVIRAL DISEASE BE SUSPECTED?**

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**INTRODUCTION**

Annually there are approximately 50 million cases of Invasive Amoebiasis resulting in a staggering toll of near 100 000 deaths. However only 10-20% of affected patients will become symptomatic and even less requiring surgical intervention. When it occurs in the immunocompromised, Amoebic colitis is not recognised as an Acquired Immune Deficiency Syndrome (AIDS) defining illness. Therefore its presence does not point towards the suspicion of retroviral disease. However we present a case of severe Amoebic Colitis with multiple colonic perforations in a young patient, which revealed an underlying diagnosis of retroviral disease.

**CASE REPORT**

A 26 year old Malay gentleman undergone appendectomy in a private hospital and was discharged well, the histopathological examination showed acute appendicitis. He presented again 1 week later with hematochezia and severe abdominal pain. A sigmoidoscopy was done revealing multiple rectal ulcers, which biopsy revealed as amoebic colitis. After being admitted for 3 days, he developed peritonitis and was referred for financial reasons. He was decided for laparotomy on arrival, and intraoperatively was noted to have large perforations in the caecum and sigmoid colon while the rest of the bowel appeared grossly diseased, resulting a total colectomy with end ileostomy. Throughout the course of his illness, he had normal levels of total white cells prompting the need of investigations for retroviral disease which turned out to be positive. With no concurrent AIDS defining illnesses, he is currently being investigated for AIDS.

**CONCLUSION**

There are many reported cases of perforated amoebic colitis, occurring mainly among the immunocompromised. However it has never been reported towards the likelihood of AIDS, or even retroviral disease. This case illustrates how a perforated amoebic colitis reveals an underlying retroviral disease and further research should be carried out to look into this possible link.



**PP 29**

**THE IMPACT OF INCOMPLETE DOUGHNUT TOWARDS RECURRENCE IN STAPLED HAEMORRHOIDOPEXY**

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**INTRODUCTION**

In stapled haemorrhoidopexy, a doughnut will inevitably be formed at the end of the procedure. This doughnut is a result of circumferential stapling and resection of haemorrhoidal tissue, and its completeness marks a complete resection of haemorrhoidal pedicles. In the literature, presence of squamous cells and smooth muscle in the doughnut specimens are associated with increased postoperative pain and incontinence respectively. However to date, no reports have been found to correlate doughnut completeness with postoperative recurrence.

**OBJECTIVE**

This retrospective study investigates the impact of incomplete doughnut towards recurrence in stapled haemorrhoidopexy

**METHODS**

Operative notes of each patients who had underwent stapled haemorrhoidopexy from 2007 to 2014 were retrieved and evaluated for good documentation on the completeness of the doughnut. Each patient was then called and asked regarding symptoms to suggest onset of recurrence, documented in a data proforma. The results were then tabulated and statistical analysis was performed using SPSS version 22.

**RESULTS**

A total of 50 patients, 27 males and 23 females, had complete documentation and data according to the data proforma. Ethnic group were dominated by Malays (56%), followed by Chinese (42%) and 1 Orang Asal (1%). Out of these, 33 doughnuts were found to be complete and 17 were not. Each arm had 3 cases of haemorrhoid recurrence with early onset of 3-6 weeks. This corresponds to a percentage of recurrence in complete doughnuts of 9% vs 17% in cases of incomplete doughnut.

**CONCLUSION**

There appears to be a higher incidence of recurrence after stapled haemorrhoidopexy if the resultant doughnut was found to be incomplete. We also observe an early trend of haemorrhoid recurrence implying a failure of surgical technique. It would be interesting to study this pattern further in a larger volume and controlled manner prospectively to test out our observed hypothesis.



**PP 30**

**DELAYED PRESENTATION OF GENERALIZED SUBCUTANEOUS EMPHYSEMA  
POST-LAPAROSCOPIC HERNIA REPAIR, A CASE REPORT**

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**INTRODUCTION**

Laparoscopic surgery is being performed in many surgical facilities and is growing in popularity. Laparoscopic operations are considered relatively safe and non-invasive; however, there exists a small but important risk of developing complications related to insufflation with carbon dioxide (CO<sub>2</sub>) gas. These include, among others, hypercarbia, subcutaneous emphysema, pneumothorax, and pneumomediastinum. Thus, it is important that physicians involved in the postoperative treatment of these patients be familiar with these complications, their natural history, and their management

**CASE SUMMARY**

We are presenting a 61-year-old woman with history of granulomatous inflammatory bowel disease, admitted for laparoscopic hernia repair. The patient was discharged on the next day, free of any clinical evidence of a complication. On the 8<sup>th</sup> postoperative day, the patient presented with generalized subcutaneous emphysema. CT scan of chest, abdomen and pelvis showed generalized extensive subcutaneous emphysema with pneumomediastinum and small pneumoperitoneum. Exploration laparotomy showed a perforation in the cecum, with gross fecal contamination of peritoneal cavity, right hemicolectomy was done and a double barrel stoma was created.

**CONCLUSION**

The colonic perforation may be due to ischemic effect of increased intraperitoneal pressure in the perioperative period, as confirmed by histologic examination, which showed ischemic changes near the perforated part with underlying non-specific granulomatous inflammation. Longer operative times, higher maximum measured end-tidal CO<sub>2</sub>, greater number of surgical ports, and an older age group are predisposing factors to this complication.



**PP 31**

**AN AUDIT OF COLONOSCOPY IN A SPECIALIST CENTRE**

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**INTRODUCTION**

Colonoscopy is a commonly performed procedure. Poor quality colonoscopy is associated with complications and reduced effectiveness in disease prevention. There is no colonoscopy standards set for our local setting in Malaysia. This audit is done in order to ascertain whether we are providing high quality colonoscopy that is safe, effective and adheres to the best practice. The Quality Assurance Guidelines by NHS Cancer Screening Programmes was used as standard for this audit; Overall perforation rates < 1:1000, Caecal intubation rate >90%, Excellent or adequate bowel preparation ≥90%, Post polypectomy bleeding rate <1:100.

**OBJECTIVE**

To audit the procedure and outcome of colonoscopy performed in the surgical unit, HPSF.

**METHOD**

A retrospective review of all colonoscopic procedures done by surgical unit, HPSF from 1 January 2012 until 31 December 2012.

**RESULTS**

Majority of our patients were male (63.0%) and Malay (50.4%). The indications were mostly altered bowel habit (74.0%), surveillance for colorectal cancer (61.0%) and unexplained GI bleeding (51.0%). Top three endoscopic findings were normal (38.7%), polyps (23.0%) and diverticulosis (11.2%). Excellent bowel preparations were only achieved in 24% of cases. Completion of colonoscopy were achieved in 82.5%. Poor bowel preparation has been found to be the reason of failure of procedure completion in 52.4%, which is significantly associated with completion of procedure (p < 0001%). We managed to achieve two standard set for this audit (perforation rate 1/240: 0.004% and post polypectomy bleeding 0/240: 0%).

**CONCLUSION**

Our center is providing a colonoscopy service that is almost up to the standard as set in the audit. Good patient's education regarding bowel preparation and more training for endoscopists are needed to improve our quality performing the colonoscopy procedures.



**PP 32**

**RECTAL PSEUDOLIPOMATOSIS – CASE REPORT**

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Colorectal Pseudolipomatosis is a poorly understood rare and benign condition. It is thought to be iatrogenic in etiology, after endoscopic procedure with air infiltration into the colonic mucosa. We present a case of rectal pseudolipomatosis confirmed by histopathology. A 30 year old lady presents with intermittent per rectal bleeding past 15 years with a family history of colon cancer. Her first colonoscopy revealed a large ulcer in the ascending colon which biopsy is chronic active colitis. She was treated with oral metronidazole. Repeat colonoscopy after 6 months showed inflammation at rectum with multiple white patches which were biopsied. It had not existed in the first colonoscopy.

Histopathological examination showed presence of lamina propria oedema, with clear coalesced vacuoles. There was also a communication between vacuolized surface and colonic mucosa mimicking adipose tissue and a diagnosis of pseudolipomatosis was made.

**CONCLUSION**

Although rare, pseudolipomatosis is a condition that can appear months after colonoscopy.

**PP 33**

**GALLBLADDER PERFORATION MASQUERADING AS ACUTE  
PERFORATED APPENDICITIS**

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**INTRODUCTION**

Gall bladder perforation is a rare complication of cholecystitis and is associated with high morbidity and mortality. Despite the advancement of imaging modalities, definitive diagnosis before surgery is still uncommon.

**CASE DESCRIPTION**

A 38 years old Malay lady with no medical co-morbidity presented with one day history of severe right lower abdominal pain associated with high fever and vomiting. Abdominal examination showed maximal tenderness at right iliac fossa, with guarding and rebound tenderness. A clinical diagnosis of perforated appendicitis was made, and arranged for open appendicectomy via Lanz incision. Intraoperatively, there was abundant bilious fluid and appendix was found to be normal. Thus midline laparotomy was done with finding of a small perforation near the fundus of gall bladder and presence of a 2x1cm gallstone. Total cholecystectomy was done. Postoperatively, patient made an excellent recovery and was discharged on day three.

**CONCLUSIONS**

This case illustrates that gallbladder perforation may present with right iliac fossa pain, mimicking acute appendicitis due to the misleading site of maximal tenderness. It is hope that this case report will increase the awareness amongst clinicians to consider gallbladder perforation as a differential diagnosis of acute right iliac fossa pain.



**PP 34**

**A CLINICAL AUDIT ON ADEQUACY OF BOWEL PREPARATION FOR COLONOSCOPY IN A GENERAL SURGICAL DEPARTMENT**

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**OBJECTIVE**

To perform an audit on the adequacy of bowel preparation for colonoscopy performed by surgical department Hospital Tuanku Fauziah, Kangar, Perlis.

**STANDARDS**

According to the American Society for Gastrointestinal Endoscopy (ASGE) and US Multi Task Force on Colorectal Cancer (USMSTF) guidelines, adequate bowel cleansing should be 85% and above.

**METHODS**

Retrospective study. All the patients who underwent colonoscopy from April 2014 till September 2014 by surgical department are included in the study. Data was retrieved from the endoscopy suite computer operative log and colonoscopy book.

**RESULTS**

A total of 122(n) colonoscopy was performed, with overall of 87% of patients achieving good bowel preparation. 90.2% of outpatients and 80% of inpatients has good bowel preparations.

**CONCLUSIONS**

This audit shows that the rate of adequate bowel preparation was good amongst outpatients, but unsatisfactory amongst patients admitted to the ward. The audit also identifies certain key areas which require future improvements including staff education, checklist for colonoscopy, and protocol for bowel preparation.



**PP 35**

**PERFORATED JEJUNAL DIVERTICULA: A CASE REPORT**

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**INTRODUCTION**

Jejunal diverticula are rare and usually asymptomatic. However, it may cause chronic non specific symptoms, and rarely lead to an acute presentation.

**CASE DESCRIPTION**

We report a case of 83 year old Malay women, presented with 1 week history of generalized abdominal pain with distension and watery stool. Clinical examination revealed peritonism. Erect chest x-ray shows air under diaphragm. Patient underwent an emergency laparotomy with findings of multiple jejunal diverticulum with single perforation. Affected small bowel was resected with end to end anastomosis done. Unfortunately, post operatively patient passed away because of cardiac complications.

**CONCLUSIONS**

Jejunal diverticulosis in elderly can lead to significant morbidity and mortality. Thus it should be suspected in elderly patients presenting with chronic crampy abdominal pain and altered bowel habits.



**PP 36**

**2 IN 1: WHICH ONE TO REMOVE?**

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**INTRODUCTION**

Synchronous primary appendiceal tumor in colorectal cancer is very rare. Unexpected appendicular neoplasm diagnosed intraoperatively posed a management dilemma.

**CASE**

This is a 68 years old gentleman with underlying diabetes, hypertension and history of stroke 3 years ago with right hemiplegia presented with per rectal bleeding for 2 weeks. Colonoscopy found clinically obstructing tumor at rectosigmoid junction and biopsy of the tumor came back as moderately differentiated adenocarcinoma. CT scan for staging showed no distant metastasis. After discussing option with family, we decided to proceed with surgery. Intraoperatively, we found a huge rectosigmoid tumor with multiple mucinous cysts around it. We also found a bulky appendix (1.5cm) with healthy base. We did appendicectomy, resected the rectosigmoid tumor with oncologic margin and brought out the descending colon as stoma. He recovered and discharged well. Surprisingly, the rectosigmoid tumor was moderately differentiated adenocarcinoma (not otherwise specific) with good surgical margin and staging as pT2N0Mx. The appendix's histology reported as mucinous adenocarcinoma with involved surgical margin and presence of metastatic tumor deposit on the pericolic fat and serosal layer of the rectosigmoid specimen. The appendiceal tumor staging was pT4Nx M1. Family was not keen for another surgery so we had a close follow-up for recurrence and oncology referral for chemotherapy.

**DISCUSSION**

Unexpected appendiceal neoplasms were managed according to size, involvement of the base or mesoappendix and also presence of mucinous cyst. Here, the management dilemma is the synchronous tumor of primary appendiceal tumor in clinically symptomatic rectosigmoid tumor. Multidisciplinary approach with patient's interest as a whole is important in the management of this patient.

**CONCLUSION**

Holistic approach of patient's care is important.



**PP 37**

**NEUROENDORINE TUMOR IN THE BACKGROUND OF  
ADENOCARCINOMA OF MIDRECTUM**

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**INTRODUCTION**

Synchronous neuroendocrine tumor in the background of midrectal adenocarcinoma is rare. It is a very slow-growing tumor and symptomatic only late in the course of the disease.

**CASE**

This is a 60 years old gentleman with no past medical illness presented with persistent loose stool with mucus for 3 months. Colonoscopy found clinically not obstructed upper rectal tumor and biopsy came back as adenocarcinoma. CEA was not raised. CT scan staging showed no distant metastasis and MRI staging reported as T3N0. Intraoperatively, we found midrectal tumor with mucosal ulceration and small liver nodule at segment V. Low anterior resection with covering ileostomy was done. Moderately differentiated adenocarcinoma of midrectum with staging of p T2 N0 Mx. However, after consultation with few experienced pathologist noted neuroendocrine tumor, grade 1 at the distal doughnut of the specimen with positive immunohistochemical staining. PET scan was arranged to confirm the suspicious liver nodule to rule out metastasis. Serum chromogranin A was pending. He was arranged for oncology review after the PET scan for futher plan.

**DISCUSSION**

There is an increasing evidence of neuroendocrine tumor in rectum. Incidental rectal carcinoid <2cm have excellent prognosis provided it was non-functioning and had no metastatic lesion. 111 Octreotide scan is required for staging if residual or metastatic disease is suspected. Otherwise, local resection using standard oncological criteria is appropriate for small tumours.

**CONCLUSION**

In dual pathology of surgical specimen, each one of them needs to be address and manage accordingly.



**PP 38**

**THE ONCOLOGICAL PATTERN OF OUTCOME IN GASTROINTESTINAL STROMAL TUMOUR: A RETROSPECTIVE OBSERVATIONAL STUDY**

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**INTRODUCTION**

Gastrointestinal Stromal Tumour (GIST) is a very unique and rare form of gastrointestinal (GI) malignancy, its' incidence is reported as approximately 1% of all GI cancers. Management, prognosis and survival markedly differs depending on whether the tumour is benign or malignant. The latter is generally associated with a poorer prognosis and survival, and a higher recurrence rate. However, recent advances with imatinib use have shown some improvement in its' oncological outcome, necessitating re-evaluation of therapy. We report a retrospective analysis of survival and progression of GIST in our centre.

**METHODS**

We acquired all GIST cases from the GIST cancer registry of histopathology department UKMMC, diagnosed from biopsies or surgical resection specimens from year 2007 to 2013. All data were recorded into a proforma which included demographical information, histopathology, treatment received, recurrence and mortality. The results were then collated and analysed.

**RESULTS**

There were a total of 18 GIST cases diagnosed. The majority of tumour originated in the stomach (56%) followed by small bowel (17%) and large bowel (17%) then intraperitoneal (6%) and lastly retroperitoneal (6%). Only 6 patients were on imatinib (33%), of which 2 have passed away while the remaining 4 are still alive. Of these 18 patients, 13 patients are still alive to this day. Overall survival figures at 1, 3 and 5 years after diagnosis are 88.9%, 77% and 76.4% respectively. We also looked at survival of the high risk group (size > 5cm plus mitotic index > 5/10) and found 8 patients in this group. Five are still alive with 2 of them on imatinib. From the 3 patients that had succumbed, none were on imatinib.

**CONCLUSION**

Our data regarding incidence and survival of GIST stands are at par with reported literature. Interestingly we found that 40% of surviving high risk patients (62.5%) are on imatinib versus those who succumbed (38.5%). It will be beneficial to see the survival of the remaining patients in terms of response to surgical resection alone vs surgical resection and imatinib.



**PP 39**

**ACTINOMYCOSIS OF MESOCOLON AND OMENTUM**

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**BACKGROUND**

Actinomycosis is an anaerobic infection caused by actinomyces, which are part of normal flora in the intestinal, anal and genital tracts. Cervicofacial actinomycosis is the most common clinical form, comprising about 60% while abdominal actinomycosis is rare and reported only 20% of cases. In view of difficulty to diagnose clinically, hence diagnosis is made after surgical intervention. As in our case, we describe a rare presentation and location of this disease that only diagnose postoperatively.

**CASE PRESENTATION**

We report a case of a 37 years old lady who presented with right sided abdominal pain for 2 weeks with history of IUCD insertion 8 years ago. Clinically abdomen is tender over right iliac fossa and right hypochondriac, hence ultrasound abdomen was performed and noted very minimal free fluid at left paracolic gutter and pelvic region, well defined hyperechoic lesion in segment V of liver, likely to present liver hemangioma with right complex renal cyst. Our patient underwent emergency diagnostic laparoscopy and converted to exploratory laparotomy with extended right hemicolectomy and omentectomy. Intraoperatively noted tumor at hepatic flexure with omental cake formation which clumped to the stomach. Macroscopic examination showed normal gut mucosa and wall with fibrotic and necrotic center of mesentery and mesocolon. The histopathological examination showed actinomycosis surrounded by acute inflammatory exudates and extensive fibrosis. Post operatively IUCD was removed by Gynaecological team and sent for culture, however no growth obtained.

**CONCLUSION**

Correct diagnosis is difficult and it is important because the appropriate treatment is needed. Surgical intervention is indicated only in cases of obscure diagnosis and for necrotic debridement removal.



**PP 40**

**RECTAL TUBERCULOSIS: A CASE REPORT**

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**INTRODUCTION**

Tuberculosis (TB) around the anorectal is a rare extra pulmonary form of the disease. Any part of gastrointestinal tract (GIT) can be affected by TB. Though it is frequently encountered in tropical countries, TB of bowel distal to ileocecal junction is rare and rarely considered as a differential diagnosis of proctological disorders.

**CASE REPORT**

79years old male, went to hospital initially complaint of dizziness post alleged fall at home. During physical examination, his undergarments stained with fresh blood. Further questioning, he had painless perrectal bleed 2days prior to admission, fresh blood, soaked his 'sarong'. He denied altered bowel habit, but had loss of weight past 2 months, no anorexia and able to tolerate orally. There was no chronic cough or night sweats. Apart from hypertension, there was no significant past medical history or family history of malignancy.

On examination, patient was mild pallor, cachexic and mild tachypenic, hemodynamic stable but saturation was 92% under room air. He had right pleural effusion. Abdominal examination was unremarkable, no mass felt perrectally, and only blood seen on proctoscopy. Right chest tube was inserted and pleural fluid sent for investigations. Sigmoidoscopy finding was a large inflamed irregular margin ulcer and had contact bleeding, 10cm from anal verge and biopsy taken.

CECT was done, showed right lung mass with multiple bilateral lung nodules and thickening rectal wall. Pleural fluid was negative for acid fast bacilli or malignant cell. However, HPE of the ulcer biopsy showed positive for TB, no dysplasia or malignancy noted. He was treated with anti TB under medical team.

**CONCLUSION**

Tuberculous proctitis is caused by the dissemination from the pulmonary focus via hematogenous and lymphogeneous spread in few patients, while in others the lesion may be present in the GIT. It is necessary to recognize it due to a specific treatment.



**PP 41**

**UNEXPECTED CAUSE OF ACUTE ABDOMEN IN ADULT**

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Midgut malrotation is a congenital anomaly of intestinal rotation which is generally regarded as pediatric pathology with the majority of patients presenting in childhood. The diagnosis is rare in adult population which sometimes leads to delay in diagnosis and treatment. Due to the non specific presentation, it should be kept in mind as differential diagnosis of acute abdomen. We present a case of 23 years old woman who presented with an acute abdomen with preoperative computed tomography scan and operative findings confirming midgut volvulus with midgut malrotation. The patient underwent an emergency laparotomy with an uneventful postoperative recovery. Conclusion, high index of suspicion is crucial in order to ensure prompt surgical intervention and thereby preventing an attendant bowel ischaemia with its associated high fatality.

**PP 42**

**A NOVEL TECHNIQUE FOR IATROGENIC COLONIC PERFORATION:  
THE FIRST HKL EXPERIENCE**

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**BACKGROUND**

Colonic perforation is one of most serious complication following lower gastrointestinal endoscopies with high rate of morbidity and mortality. The most common site of colonic perforation is rectosigmoid colon with associated factors making this bowel segment vulnerable to being injured include a sharp angulation at either the rectosigmoid junction or the sigmoid-descending colon junction and the great mobility of the sigmoid colon.

**CASE PRESENTATION**

We present a case of iatrogenic colonic perforation following lower gastrointestinal endoscopy in a 62 years old lady for screening for average risk of colorectal carcinoma as an elective case. Colonoscopy was performed upto terminal ileum. After thorough examination of colon along the way out from colon, a J manoeuvre was performed at mid-rectum to assess for internal haemorrhoids in view of the main complain of patient is painless per-rectal bleeding. However, iatrogenic perforation about 0.8cm at mid-rectum during the J manoeuvres. Patient did not have peritonism post perforation and perforation was closed with over the scope clip via endoscopic method. Patient was followed up and repeated colonoscopy revealed presence of over the scope clip still holding on the sealed perforation.

**CONCLUSION**

Colonic perforation is one of the complication of colonoscopy procedure. The colonic perforation can be sealed via endoscopic method with invention of Over-The-Scope Clip without patient undergoing major surgery provided the perforation is amenable for closure.



**PP 43**

**PORTAL VEIN THROMBOSIS: AN UNEXPECTED FINDINGS  
IN A 26 YEARS OLD MAN**

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**BACKGROUND**

Portal vein thrombosis is a rare clinical entity and necessitates early diagnosis and treatment of mesenteric ischaemia for restoration of portal venous flow and reduction of mortality and morbidity. Myeloproliferative disease is common conditions that result in PVT. Septicaemia, intraabdominal infections, cirrhosis and primary or secondary liver tumours are other condition that can cause PVT.

[Keywords:- PVT – portal vein thrombosis]

**CASE PRESENTATION**

We present a case of 26 years old man presented with epigastric pain, vomiting and diarrhoea for 2 days duration with epigastric tenderness on clinical examination. His past medical, family and social history was unremarkable. Blood parameters such as full blood count, liver function test, renal profile were normal. Erect chest x-ray did not reveal air under diaphragm. However, ultrasound abdomen revealed intraperitoneal free fluid collection with normal liver, renal and unable to visualize bowel due to dilatation. Computed tomography revealed portal vein thrombosis with hepatomegaly and dilated thickened small bowel with intraperitoneal free fluids. Conclusion of portal vein thrombosis with portal venous hypertension and small bowel ischaemia is presented based on computed tomography. Midline laparotomy and small bowel resection with primary anastomosis was performed. Post operatively, patient was started on unfractionated heparin and overlap with warfarin prior to discharge. Thrombophilia and connective tissue screening to rule out underlying pathology revealed negative. The cause of portal vein thrombosis in this patient is indeterminate.

**CONCLUSION**

Portal vein thrombosis is a rare clinical condition. High index of suspicion needed if nonspecific symptoms without comorbid and common causes have been ruled out. Early diagnosis and treatment is crucial to reduction of morbidity and mortality.



**PP 44**

**LOWER GASTROINTESTINAL HAEMMORHAGE SECONDARY TO A SMALL BOWEL HAEMANGIOMA: A CASE REPORT**

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**OBJECTIVE**

GI hemangiomas are rare and benign pathologically. It represents 0.05 % of all gastrointestinal tumours. Patients with a small bowel haemangioma can present either with anaemia due to insidious and intermittent bleed over a period of time or in an acute setting with profuse bleeding and hypovolaemic shock

**METHODS**

We report a case of a 62 year old lady who presented to us with a massive and recurrent lower gastrointestinal (GI) haemorrhage secondary to a small bowel haemangioma who required an emergency laparotomy to arrest the bleeding.

**RESULTS**

Mdm RB is a 62 year old lady who presented with recurrent lower GI haemorrhage which required multiple blood transfusions. Despite best efforts of localizing the source of the bleeding via endoscopic as well as radiological means, the patient eventually had to undergo an emergency laparotomy. Intraoperatively, there were a large lobulated small bowel tumour which with multiple feeding vessels branching from the mesenteric arcades. It was resected and a primary small bowel anastomosis was fashioned. Histopathological examination revealed the tumour to be a haemangioma. She was subsequently discharged well after surgery.

**CONCLUSION**

Despite GI haemangioma being one of the possible varying aetiology of lower GI haemorrhage, prompt resuscitation, bleeding localization and control via endoscopic and radiologic methods should be the preferred algorithm for patients who presents with massive GI haemorrhage with surgery reserved as the last definitive treatment strategy

Keywords: Gastrointestinal (GI) haemangioma, Lower GI haemorrhage, Massive blood transfusion



**PP 45**

**GALLSTONE ILEUS: A CASE REPORT AND REVIEW OF ITS SURGICAL APPROACHES**

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**OBJECTIVE**

Gallstone ileus accounts for 0.5% of the complications associated with cholelithiasis. Moreover, the incidence of gallstones ileus constitutes to 1% to 4% of patients who present with mechanical small bowel obstruction.

**METHODS**

We report the case of a 65 year old lady who presented to us with symptoms and signs of mechanical small bowel obstruction secondary to gallstone ileus and perform a literature review which highlights on the possible surgical approaches to this condition and its relative merits.

Results: Even though patients commonly manifest with vomiting and abdominal distension, the timing of clinical presentation and its accompanying symptoms can vary depending on the location of the fistula that forms as a result from this condition. Diagnosis can usually be definitively clinched by its classical findings on plain abdominal radiographs which include the presence of pneumobilia, dilated small bowels as well as the presence of aberrantly positioned gallstone. Demographically, gallstone ileus affects predominantly elderly females and can result in a significant morbidity if diagnosis and surgery are delayed.

**CONCLUSION**

Gallstone ileus should always be considered as a differential diagnosis in patients presenting with a mechanical small bowel obstruction. Surgery remains the definitive treatment for this condition but the jury remains on the most appropriate surgical approach. At present, a two-stage procedure (either enterotomy alone or enterotomy and subsequent cholecystectomy) has been shown to be associated with a low mortality rate.

Keywords: Cholelithiasis, Gallstone ileus, Small bowel obstruction.



**PP 46**

**SYNCHRONOUS COLORECTAL CANCER WITH RESECTABLE LIVER METASTASES: WHICH TREATMENT COMES FIRST?**

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**INTRODUCTION**

A multimodality approach of colorectal cancer (CRC) with liver metastases have led to improve in the survival outcome of patients. However, the timing and sequence of therapeutic interventions in patients presenting with synchronous CRC and hepatic metastases remains unanswered.

**OBJECTIVE**

We aim to dissect four treatment option and its perioperative morbidity and mortality among patients whom presented with synchronous CRC with resectable hepatic metastases

**METHODOLOGY**

All CRC patients with synchronous resectable liver metastases who underwent surgical intervention from the year 2010 to 2014 at Pusat Perubatan Universiti Kebangsaan Malaysia were reviewed.

**RESULTS**

A total of 20 patients who were diagnosed with synchronous CRC and resectable liver metastases underwent operative intervention at our centre. 40% were rectal tumours, and 20% each respectively were rectosigmoid, left and right sided tumours. 60% underwent colorectal resection followed by adjuvant chemotherapy and hepatic resection. 25% underwent colorectal resection followed by hepatic resection then adjuvant chemotherapy. 10% underwent hepatic before colorectal resection.

Where perioperative chemotherapy was administered for hepatic metastases, the mean interval between colorectal resection to adjuvant chemotherapy was 44 days as opposed to a mean of 117 days before the first cycle of chemotherapy in the group without up-front chemotherapy. However up-front chemotherapy delayed hepatic resection from a mean of 79 days between colorectal resection and hepatic resection to 110 days.

30 days operative mortality was nil across the board. The group with the highest morbidity was the colorectal resection - adjuvant chemotherapy - hepatic resection group with 25% morbidity (1 patient with wound infection and 2 developed pneumonia).

**CONCLUSION**

Timing and sequence of therapeutic interventions in patients presenting with synchronous CRC and hepatic metastases are individualized depending on the symptomatology of the primary tumor. Chemotherapy should not be delayed as to avoid micrometastases.



**PP 47**

**EXTRAMAMMARY PAGET'S DISEASE: PERINEAL PAGET'S**

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**PERINEAL PAGET'S**

Extramammary Paget's disease (EMPD) is an uncommon cutaneous disorder in the area of distribution of apocrine glands. Typically affecting a single site, it may be benign or malignant (20-30%) (1) with metastatic potential. Its clinical features vary and easily misdiagnosed, hence appropriate management may be delayed. Complete surgical excision with reconstruction, radiotherapy and topical chemotherapy are the mainstay of treatment.

**CASE REPORT**

60 years old Chinese Gentleman presented with per rectal bleed and perianal pruritus for 1 year with no altered bowel habits or family history of malignancy. Clinical examination revealed grade III haemorrhoids in three columns with perianal excoriation at the 3 o'clock position measuring 2.5cm in diameter. Colonoscopy excluded presence of polyps or tumour proximally. Patient underwent Examination Under Anaesthesia (EUA) with stapled haemorrhoidopexy and biopsy of the perianal skin lesion. Histopathology proved to be Paget's disease of the perineum.

**DISCUSSION**

Paget's disease of Perineum is the second most commonly reported EMPD (20%) after Vulval Paget's (65%). Occurring commonly after the 5th decade, its prevalence is four times greater in males than females. Though commonly an incidental finding, clinical presentation depends on location, size and extent of the disease. Strong cytoplasmic staining for Periodic Acid Schiff (PAS), Muccarmine and Alcian blue indicates presence of Paget's cell of EMPD. Carcino-Embryonic Antigen (CEA) is positive in 93-100% of cases involving EMPD(2). Positron-emission tomography (PET) / Magnetic Resonance Imaging (MRI) has high specificity in assessing regional lymph nodes and locating distant disease. Wide surgical resection guided by preoperative mapping with photodynamic substances such as fluorescein has sensitivity and specificity of 99.8% and 98%(3), for the detection of EMPD margins and a successful margin-free excision often requiring flap reconstruction. Annual physical examination and proctosigmoidoscopy is suggested with colonoscopy every two to three years of follow-up.



**PP 48**

**AN UNUSUAL CAUSE OF SMALL BOWEL PERFORATION: TOOTHPICK**

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**INTRODUCTION**

Accidental ingestion of foreign body in adult usually does not pose significant problems. Ingested foreign bodies usually pass the intestinal tract uneventfully, and perforation occurs in less than 1%.

**CASE SUMMARY**

We report a case of small bowel obstruction with perforation in a 59-year-old male due to the accidental swallowing of a toothpick. He presented with persistent colicky lower abdomen pain for 2 week, which was treated 1 week earlier at a private Centre as diverticulitis. After a day of admission, patient shows no clinical improvement. Emergency laparotomy reveals a toothpick causing perforation at terminal ileum near ileocecal valve. Limited right hemicolectomy done. Post-operative recovery was uncomplicated.

**DISCUSSION**

Ingestion of a foreign body is an uncommon presentation in adult. Previous studies have estimated that the majority of foreign bodies, around 80–90%, will pass spontaneously. Despite this, a significant morbidity can result, particularly, when there is a delay in the diagnosis, as there was in this case. It is important that clinicians maintain an open mind when managing SBO—knowledge of the patient's diet preceding admission may be essential in forming an accurate diagnosis.



**PP 49**

**SMALL BOWEL GISTS PRESENTED AS ACUTE ABDOMEN: A CASE REPORT**

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**INTRODUCTION**

Gastro-intestinal Stromal Tumour (GISTs) is an uncommon tumour that usually arise from gastro-intestinal tract. About 60% tumor occur in stomach and small bowel is second commonest site of GISTs. Here we report a case of benign small intestinal GISTs that presented with acute abdomen.

**CASE PRESENTATION**

A 44 years old male, presented with 2 days history of right lower abdominal pain, fever, nausea and vomiting. He also had poor oral intake. Clinically he was febrile and tachycardic, abdomen was tender and guarding over right iliac fossa area. Our initial diagnosis was perforated appendicitis. After resuscitation with fluids he underwent open appendicectomy and there was a suspicious mass with area of necrosis and slough. We converted to midline laparotomy and there was proximal small bowel tumour arising from 30 cm from DJ junction measuring 5cm x 4cm with area of gangrenous and slough. Tumour adhered to terminal ileum. Proximal intestine was thickened. The tumour was resected and end to end bowel anastomosis was performed. Histopathological examination reveal benign tumour arising from muscularis propria composed of proliferation of spindle cells with condense of eosinophilic cytoplasm. Skenoid fibers are present and nucleus are mildly pleomorphic. Mitotic activity is not seen and no mucosal invasion. CD 117, Vimentin and Actin was positive. Desmin and S-100 were negative. Patient recovered well and able to be discharge few days after surgery.

**CONCLUSION**

Patient with GISTs of small bowel can presented with nonspecific symptoms and 20 percent are found incidentally. GISTs are often silent and become symptomatic until it reach large size, bleed or ruptured. The diagnosis is by surgery and immunohistochemistry. Surgery is the mainstay treatment of localized GISTs and usually wide margin are not necessary. Smaller size of tumour has lower risk of progression. Patient with GISTs has better prognosis compare to other types of small bowel tumour.