Malaysian Society of Colorectal Surgeons

COLORECTAL SURGERY

3rd to 6th March 2016

Shangri-La Hotel, Kuala Lumpur, Malaysia

SOUVENIR PROGRAMME & ABSTRACT BOOK
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Malaysian Society of Colorectal Surgeons
Office Bearers 2015 – 2017

President  Dr M Sarkunnathas
Past President  Dr Lu Ping Yan
Vice President  Dato’ Dr Meheshinder Singh
Hon Secretary  Dr Paul Selvindoss
Hon Treasurer  Prof Dr April Camilla Roslani
Council Members  Dr Manohar Padmanathan
                  Assoc Prof Datuk Dr Ismail Sagap

Coloproctology 2016
Organising Committee

Chairman  Dr M Sarkunnathas
Scientific Chairman  Dr Paul Selvindoss
Scientific Committee Members  Assoc Prof Datuk Dr Ismail Sagap
                               Dato’ Dr Gerald Henry
                               Dr Samuel Tay
                               Datuk Dr Yunus Gul
                               Prof Dr April Camilla Roslani
                               Dr Akhtar Qureshi

Allied Health Professional Programme  Dato’ Dr Meheshinder Singh
                                      Dr Manohar Padmanathan
                                      Ms Mariam Mohd Nasir

Committee Members  Dr Lu Ping Yan
                   Dr P Sangar
                   Dr Law Chee Wei
I take great pleasure in welcoming you to Coloproctology 2016 held in the capital city of Kuala Lumpur.

The Organising Committee has put in great efforts to plan an interesting programme for the benefit of everyone. Topics chosen vary from the very basic to emerging and advanced procedures in colorectal surgery. The pre-congress workshop as always, will feature a selection of lively laparoscopic procedures, as well as complex ano-rectal surgeries. An interesting programme also awaits all participants on the last day of the conference entitled ‘Interventional Therapies for Colorectal Metastasis – A Multidisciplinary Tumour Board Meeting’.

This conference, which spans over four days, will cater for experienced surgeons and trainees alike.

We are fortunate in that we have, once again, been able to line up a distinguished faculty of speakers, both local and international, to provide us with the very latest developments in the practice of coloproctology. We wish to thank them sincerely for taking time off from their busy schedules to be with us here.

I am very certain that this four-day meeting will give ample opportunities to our members to interact with colleagues and faculty members, exchange ideas and update our knowledge.

Amidst this hectic meeting, I do hope our foreign participants and faculty will find some time to explore this culturally rich city of Kuala Lumpur.

I wish to express my heartfelt thanks to my fellow committee members for their untiring efforts and sacrifice in helping to put this meeting together.

To all our sponsors, your support as always, is much appreciated.

Dr M Sarkunnathas
President, Malaysian Society of Colorectal Surgeons & Organising Chairman, Coloproctology 2016
Faculty

Prof Dr April Camilla Roslani
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Department of Surgery
Faculty of Medicine
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Head of Medical Imaging
University of Notre Dame
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Sydney, Australia

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Pediatric Surgery
Enterostomal Therapist
University Malaya Medical Centre
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Kuching, Sarawak
Malaysia

Dato’ Dr Fuad Ismail
The National University of Malaysia
Kuala Lumpur
Malaysia

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Staff Nurse
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Petaling Jaya
Selangor
Malaysia

Ms Habibah
MAKNA

Ms Chiew How Leng
Sime Darby Medical Centre
Subang Jaya
Selangor
Malaysia

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State Registered Nurse
University Malaya Medical Centre
Kuala Lumpur
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Consultant Surgeon & Reader in Colorectal & Pelvic Floor
Chair “The Pelvic Floor Society”
United Kingdom

Mr Hamzan bin Arshad
Colorectal Cancer Survivor
Malaysia
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Cancer and Radiosurgery Centre
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Department of Surgery
Faculty of Medicine
University of Kelaniya
Kelaniya, Sri Lanka

Prof Dr Simon Ng Siu Man
Assistant Dean (Learning Experience)
Faculty of Medicine
Professor, Division of Colorectal Surgery
Department of Surgery
Institute of Digestive Disease
Faculty of Medicine, The Chinese University of Hong Kong, Hong Kong

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Registered Staff Nurse
Colombo South Teaching Hospital
Colombo
Sri Lanka

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Thailand

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Senior Nurse Clinician
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Singapore

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Director of Excellence Center for Colorectal Cancer, King Chulalongkorn Memorial Hospital, Bangkok, Thailand

Prof Dr Jirawat Pattana-arun
Assistant Professor
Colorectal Division
Department of Surgery
Faculty of Medicine
Chulalongkorn University
Bangkok, Thailand

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Registered Staff Nurse
Colombo South Teaching Hospital
Colombo
Sri Lanka

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Consultant Surgeon
The Royal Surrey County Hospital
Guildford, United Kingdom
Professor of Surgery, Surrey University
United Kingdom

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Medical Director
Seow-Choen Colorectal Centre
Singapore

Ms Karenita K Shandu
Queen Elizabeth Hospital
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Head of Department Colorectal Surgery
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Director of WOCARE Clinic
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Colorectal Cancer Survivor
CORUM, the Colorectal Cancer Survivorship Society
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Ipoh, Perak
Malaysia

Datuk Dr Yunus Gul
Consultant Colorectal & Laparoscopic Surgeon
Prince Court Medical Centre
Kuala Lumpur, Malaysia
# Programme Summary

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<td>1100 – 1200</td>
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<td>SYMPOSIUM 12 Allied Health Professional Session (5)</td>
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<td>1930 – 2200</td>
<td>FELLOWSHIP DINNER (by invitation only)</td>
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### Additional Events

- **3rd March 2016 (Thursday)**
  - PRE-Congress Workshop
    - (venue: Hospital Selayang, Selangor)

- **6th March 2016 (Sunday)**
  - Postgraduate Round (Colorectal Master Round)
    - (venue: UiTM Auditorium, Hospital Selayang, Selangor)

  - Post-Congress Workshop
    - (venue: Shangri-La Hotel, Kuala Lumpur)
Pre-Congress Workshop
3rd March 2016 (Thursday)

Time: 0800 – 1730 hrs
Venue: Hospital Selayang, Selangor
Coordinator: Gerald Henry
Faculty: Tim Rockall (United Kingdom)
Simon Ng Siu Man (Hong Kong)
Parvez Sheikh (India)
Lee Yoon-Suk (South Korea)
Francis Seow-Choen (Singapore)
Jirawat Pattana-arun (Thailand)

Programme:
0800 – 0830 Registration
0830 – 0835 Welcoming Speech by Coordinator of Pre-Congress Operative Workshop, Gerald Henry
0835 – 0840 Welcoming Speech by Organising Chairman of Coloproctology 2016, M Sarkunnathas
0840 – 0845 Officiation of Ceremony by Hospital Selayang Director, Siti Zaleha bt Mohd Salleh
0845 – 0900 TEA
0900 – 1300 OT 5: 3D LAPAROSCOPIC ANTERIOR RESECTION
          OT 6: PERIANAL SURGERY
              (VAAFT, Stapler Haemorrhoidectomy, STARR, Anal Sphincter Surgery)
1300 – 1400 LUNCH
1400 – 1700 OT 5: 3D LAPAROSCOPIC RIGHT HEMICOLECTOMY
          OT 6: PERIANAL SURGERY
              (VAAFT, Stapler Haemorrhoidectomy, STARR, Anal Sphincter Surgery)
1700 – 1730 CLOSING / TEA
# Daily Programme
## 4th March 2016 (Friday)

**0800 – 0930**

### SYMPOSIUM 1
Chairpersons: Wong Sze Ming, P Sangkar

- **Laparoscopic Extra-Levator APR For Lower Rectal Cancer** [pg 21]
  - Lee Yoon Suk
- **3D Camera For Laparoscopic Colorectal Surgery - Is There A Benefit?**
  - Simon Ng Siu Man
- **Laparoscopic Colorectal Surgery – Tips And Tricks** [pg 22]
  - Yunus Gul
- **Laparoscopic Para-stomal Hernia Repair** [pg 22]
  - Tim Rockall

**0800 – 0930**

### Allied Health Professional Session

#### WELCOME SPEECH

- Meheshinder Singh
- Mariam Mohd Nasir

**0930 – 1015**

### PLENARY 1
Chairperson: M Sarkunnathas

- **Treatment Of Rectal Cancer: The Journey From Open To Reverse TME** [pg 23]
  - Francis Seow-Choen

### SYMPOSIUM 2

- **Malaysian Enterostomal Therapy Nurses Association (METNA) Future Direction: Where We Are Now, Where We Are Heading** [pg 24]
  - Tan Guat Ee
- **Enterostomal Therapy Nursing: Who Is Norma Nottingham Gill Thompson?** [pg 24]
  - Mariam Mohd Nasir
- **Managing A Complicated Stoma** [pg 27]
  - Wong Jing Yin

**1015 – 1030**

- **COFFEE AND OFFICIAL POSTER ROUNDS**

**1030 – 1215**

### SYMPOSIUM 3
Chairpersons: Law Chee Wei, Ahmad Shansuani b Mohamed Sidek

- **Anal Stenosis - Prevention And Management**
  - Kemal Deen
- **Fistulectomy With Primary Suturing Of The Sphincter** [pg 25]
  - Parvez Sheikh
- **Current Role Of Seton In Management Of Fistula In Ano**
  - Kemal Deen
- **VAAFT (Video Assisted Anal Fistula Treatment) In The Management Of Fistula In Ano** [pg 25]
  - Francis Seow-Choen
- **Evolution Of Staplers In Haemorrhoidal Surgery** [pg 26]
  - Francis Seow-Choen

**1045 – 1245**

### SYMPOSIUM 4

- **“The Hole For A Better Whole” Improving Stoma Care Services In Philippines** [pg 26]
  - Ednalyn Bonayan Esmena
- **Managing A Complicated Stoma** [pg 27]
  - Wong Jing Yin
- **How To Prevent Peristomal Skin Excioriation?** [pg 27]
  - Rozita Mohamad
- **Malaysia In The World Ostomy Community** [pg 27]
  - Sri Tharan

**1045 – 1245**

### Allied Health Professional Session (2)

- **Chairperson: Norzieyati Abdul Kudus**
- **Chairperson: Norsehha Ahmad**
- **Chairperson: Widasari Sri Gitarja**
- **Chairperson: Mohd Rahime Ab Wahab**
10

11

15 – 1400

LUNCH SATELLITE SYMPOSIUM
CME And CVL For Right Colon Cancer Using Harmonic 7
Lee Yoon-Suk
Chairperson: Paul Selvindoss
LUNCH
FRIDAY PRAYERS
1400 – 1515

SYMPOSIUM 5
Chairpersons: Wan Khamizar bin Wan Khazim
Tharmarat T Renganathan
Sexually Transmitted Disease & HIV Infection In The Perianal Region
Kemal Deen
Peri-anal Crohns Disease - Surgical Management [pg 28]
Tim Rockall
Perianal Hidradenitis Suppurativa [pg 28]
Parvez Sheikh
Pilonidal Sinus - Flap Or Excision [pg 29]
Parvez Sheikh

1515 – 1630

SYMPOSIUM 6
Chairpersons: Mohamad Ismail bin Ali
Ong Kee Thiam
Pruritis Ani - What To Do [pg 29]
Francis Seow-Choen
Functional Anal Pain [pg 30]
Samuel Tay
Malignant Tumours Of The Anus
Kemal Deen
Management And Surveillance Of Rectal Carcinoids [pg 30]
Tim Rockall

1400 – 1500

Allied Health Professional Session
TRADERS WORKSHOP
Norsehha Ahmad
Farah Shakinah Mohd Taib
Hafizah Abdul Wahid
Catherine Jawat Anak Sultan
Workshop 1: Coloplast
Workshop 2: Convatec

1500 – 1630

SYMPOSIUM 7
Allied Health Professional Session (3)
Stoma Siting: The Challenges And How We Overcome It [pg 31]
Widasari Sri Gitarja
Chairperson: Mariam Mohd Nasir
The Development Of Enterostomal Therapy Nursing In East Malaysia
1. Hospital Umum Sarawak [pg 31]
Catherine Jawat Anak Sultan
2. Queen Elizabeth Hospital, Sabah [pg 31]
Karenita K Shandu
Chairperson: Tan Guat Ee
The Future Direction Of Enterostomal Therapy In Asia [pg 32-34]
Widasari Sri Gitarja
Ong Choo Eng
Udena Athula Kumara
Mariam Mohd Nasir
Chairperson: Chiew How Leng
## Daily Programme
### 4th March 2016 (Friday)

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<td>HOW I DO IT (incorporating Tea)</td>
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<td>Chairpersons: Jasiah binti Zakaria Ballan Kannan</td>
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<td>Repair Of Recto-Vaginal Fistula Using Surgisis Mesh</td>
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<td>Coring Of High Inter-Sphincteric Tract With No External Opening</td>
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<td>STARR</td>
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<td>Supan Prageeth Samarakoon</td>
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<td>ARTHUR’S BAR, LEVEL 1, SHANGRI-LA HOTEL</td>
<td>FELLOWSHIP DINNER (by invitation only)</td>
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</table>
# Daily Programme

## 5th March 2016 (Saturday)

### 0800 – 0930  SABAH ROOM

**SYMPOSIUM 9**  
*Chairpersons: Prabhu Ramasamy Buvanesvaran Tachina Moorthi*

- Treatment Of Colorectal Cancer In Geriatric Patients  
  *Tony Dixon*
- Management Of T1 Rectal Cancers  
  *Tim Rockall*
- Transanal Proctectomy  
  *Simon Ng Siu Man*
- Metastatic Incurable Colorectal Cancer - Is There A Role For Surgery  
  *Kemal Deen*
- Retrorectal Tumours, Imaging And Management  
  *Chucheep Sahakitrungruang*

### 0800 – 0900  SARAWAK ROOM

**Symposium 10**  
*Chairpersons: Meheshinder Singh Thomas Chin*

- Stoma Care In Ipoh Pantai Hospital: Our Successful Stories  
  *Wong Jing Yin Norzieyati binti Abdul Kudus*
- The Role Of MAKNA In Stoma Care  
  *Habibah*
- My Experience In Becoming An Enterostomal Therapist  
  *Supun Prageeth Samarakoon*

### 0800 – 0900  KEDAH ROOM

**REGISTRATION**

### 0900 – 1030  SABAH ROOM

**SYMPOSIUM 11**  
*Chairpersons: Reni Belon*

- Allied Health Professional Session (4)  
  *Manohar Padmanathan*
- Repeated Scans - Should I Be Concerned?  
  *Stephanie Heng Siew Ping*

### 1030 – 1100  SARAWAK ROOM

**CASE STUDY PRESENTATION**

by ETNEP 2015  
*Chairperson: Udena Kumara*

#### Case 1: Management Of Prolapsed Stoma  
*Chew Yen Xia*

#### Case 2: Stoma Siting  
*Nordiana Mohd Hashan*

#### Case 3: Effective Guidance Enhance Acceptance By The Patient  
*Catherine Jawat Anak Sultan*
# Daily Programme

**5th March 2016 (Saturday)**

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### Daily Programme
5th March 2016 (Saturday)

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Mutual Sharing Sessions  
Laughter Therapy Session |

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**PROFESSOR’S CORNER**  
Moderators: M Sarkunnathas Lu Ping Yan  
Tony Dixon  
Tim Rockall  
Simon Ng Siu Man  
Parvez Sheikh  
Kemal Deen
6th March 2016 (Sunday)

Postgraduate Round (Colorectal Master Round)

Time: 0900 – 1200 hrs
Venue: UiTM Auditorium, Hospital Selayang, Selangor
Faculty: Tony Dixon

Post-Congress Workshop

INTERVENTIONAL THERAPIES FOR COLORECTAL METASTASES:
A MULTIDISCIPLINARY TUMOUR BOARD MEETING

In collaboration with the
MALAYSIAN SOCIETY OF INTERVENTIONAL RADIOLOGY (MYSIR)

Venue: Shangri-La Hotel, Kuala Lumpur
Panel: Interventional Radiologists, Surgeons, Oncologists, Gastroenterologists

0730 – 0830 Meet-the-Experts Breakfast Session

0730 – 0745 “SIRT For Inoperable Liver Cancer: A Surgeon’s Perspective”
Yoong Boon Koon

0745 – 0830 “SIRT In HCC, mCRC And Other Metastasis – Tips & Tricks”
Lourens Bester

0900 – 1000 CASE 1 and CASE 2
Ablative Therapies And Its Armamentarium

1000 – 1030 TEA BREAK

1030 – 1130 CASE 3
Chemoembolisation

CASE 4
SIRT

1130 – 1230 CASE 5
Portal Vein Embolisation
CONFERENCE VENUE
SHANGRI-LA HOTEL, KUALA LUMPUR
11, Jalan Sultan Ismail, 50250 Kuala Lumpur, Malaysia
Tel: (603) 2026 8488    Fax: (603) 2032 1245

REGISTRATION
The registration hours are:
- 3rd March 2016 (Thursday) 1700 to 1900 hrs
- 4th March 2016 (Friday) 0700 to 1700 hrs
- 5th March 2016 (Saturday) 0700 to 1500 hrs
- 6th March 2016 (Sunday) 0800 to 1000 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 Sabah Anteroom, and the operating hours are:
- 3rd March 2016 (Thursday) 1700 to 1900 hrs
- 4th March 2016 (Friday) 0700 to 1700 hrs
- 5th March 2016 (Saturday) 0700 to 1500 hrs
- 6th March 2016 (Sunday) 0800 to 1000 hrs

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

POSTERS
The e-posters will be displayed at the Basement II of the hotel.

PHOTOGRAPHY & VIDEOTAPING POLICIES
No photography or videotaping of the presentations is permitted during the scientific 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

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Acknowledgements

The Organising Committee of the Coloproctology 2016 wishes to thank the following for their support and contribution:

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The Organising Committee of Coloproctology 2016 wishes to record its deepest appreciation to the following hospitals for their financial support to subsidise the participation of the Colorectal Cancer Patients and Survivors.

Putra Melaka

KPJ Klang

Pantai Bangsar

Subang Jaya Medical Centre

Sunway Medical Centre

UKM Specialist Centre

Hospital Desa Park City
The earliest surgical attempts to treat rectal cancer showed extremely poor prognosis with high local recurrence. One of the important steps to treat rectal cancer was introduction of APR, which was first published by Sir Earnest Miles in 1908, “A method of performing abdomino-perineal Excision for carcinoma of the Rectum and of the Terminal portion of the pelvic colon” in Lancet. In his original description of an abdomino-perineal Excision (APE), the rectum was bluntly mobilized down to the sacrococcygeal articulation, to the prostate, and to “the upper surface of the levator ani” laterally, thus leaving the mesorectum attached to the pelvic floor. And also he recommended that the levator muscle should be divided.

For many years, the Miles operation had been gold standard procedure for all rectal cancer.

Since the introduction of TME, as described by Heald and colleagues, local recurrence after rectal cancer surgery decreased dramatically and long-term oncological outcomes improved. And the oncologic outcome of APR for very lower rectal cancer is not better than LAR or ultralow anterior resection (uLAR); positive rate of CRM and local recurrence rate after APR are higher than those of LAR or uLAR.

The differences in oncological outcomes between the APR and LAR may be explained by several factors, including anatomical differences and the surgical techniques associated with standard APR. In the lower rectum, mesorectum is disappeared at the end of rectum and at the top of levator ani muscles. Below this level, sphincter muscles forms the CRM.

In conventional APR, the pelvic dissection is carried along outside the mesorectal fascia down the top of the anal canal and the perineal dissection is carried along the external sphincter. Two dissection planes meet at the level of the puborectalis muscle, which creates a waist on the specimen. So if the tumor is more advanced, growing close to or into the distal mesorectal fascia, the levator muscle, or the external sphincter and, thereby, threatens the potential CRM.

Basically, APR can be categorized into three type in relation to the perineal approach and the extent of dissection, Intersphincteric APR, Extra-levator APR, and Ischioanal APR.

Extra-levator APR (ELAPR), which was introduced in 2007, is usually indicated with tumors threatening the external sphincter or levator muscles and where an LAR or uLAR would not achieved a clear CRM.

In ELAPR, the pelvic dissection continues all the way down to the pelvis floor and the puborectalis muscles and it is important not to mobilize the rectum and mesorectum as low as the pelvic floor. The pelvic dissection should be stopped at the top of the levator muscles. The perineal dissection proceeds just outside the external sphincter and along the levator muscle fascia, up to its origin at the obturator internus muscle. When the perineal dissection is carried out as planned, the specimen is cylindrical, usually without a waist, because the levator muscle is attached to the mesorectum.

Because ELAPR removed more tissue from outside the smooth muscle layer, this surgical procedure is associated with less CRM involvement, intraoperative perforation, and rate of local recurrence.

With this new concept of APR, favorable oncological outcomes can be achieved. Indications for this procedure should be based on a through precise preoperative tumor staging and clinical assessment of patients. The essential part of APR to treat lower rectal cancer is to remove tumor with its surrounding tissue, in which resection margins is free from cancer. And this surgical procedure could improve oncological outcomes.
Laparoscopic colorectal surgery has inherent advantages compared to conventional surgery. Several important studies have demonstrated the benefits and safety of laparoscopic colorectal surgery, making it now the preferred approach in the surgical management of many colorectal diseases. Laparoscopic resections for colorectal diseases especially malignancies are advanced surgical procedures that require extensive training and teamwork.

Patient selection plays an integral role in laparoscopic colorectal surgery even though the majority of patients can be considered as suitable candidates with few relative and absolute contraindications. Apart from this, surgeons starting laparoscopic colorectal surgery need to be aware of complications varying from minor to major, in particular during the so called ‘learning curve’ period.

Topics discussed in this presentation include training methods, choosing suitable cases, conversion criteria, operative and surgical parameters, oncological principles, tips in dissection and hemostasis, and cost related issues.

The use of laparoscopic surgery in the surgical management of colorectal diseases will only be considered as the acceptable norm if complications are kept to a minimum with improved overall outcome.

Para-stomal hernia is an extremely common problem with all types of stoma. Surgical repair of para-stomal hernias is itself prone to recurrence with all techniques and the optimal method is yet to be described. Open, laparoscopic and combined approaches with or without a variety of meshes in a variety of positions within the abdominal wall are currently practiced but the long-term outcome is not well audited. There is increasing awareness of the potential for prevention at the time of primary surgery and also an appreciation of which patients should avoid reoperation where possible.
INTRODUCTION

Rectal cancer is a surgical disease. Chemo-irradiation may be applied where the pathology demands especially to decrease distant recurrences. However surgical technique remains the most important factor in ensuring a low local recurrence rate. Therefore meticulous attention to complete rectal resection is therefore of fundamental importance.

TEXT

Traditionally low rectal cancers were removed by a forcing tearing by the hand especially in difficult situations, of the rectum away from the pre-sacral fascia resulting in bleeding as well as a substantial local recurrence rate. Heald first formalized total mesorectal excision (TME) as the approach to take to be able to achieve the lowest recurrence rates for low rectal cancer in 1979. Since that time TME had become the standard operative approach in excision of any low rectal cancers. The technique as emphasized by Heald focuses on direct vision and sharp dissection that removes the mesorectum by staying in the plane between visceral and parietal pelvic fascia during the surgery. However, in a very few very obese male patients with large cancers, usage of blunt techniques may still be needed to complete the rectal resection. The initial TME technique as described was achieved through open surgery.

Over the last decade or so however minimally invasive techniques have gain prominence especially for the performance of TME. Laparoscopic techniques for TME had now overtaken open TME in most countries around the world as the new standard of care for low rectal cancers. In our experience low rectal cancers can be achieved easily for small cancers in thin ladies with a gynaecoid pelvis. Rectums in a fat narrow android pelvis with a large cancer are still difficult to remove with a good margin. In this situation, hand assisted laparoscopic rectal dissection may be useful to salvage the problem by enabling better retraction and also perhaps to help by blunt dissection. These techniques are however far from ideal and certainly against the spirit of TME.

A new development more recently is the use of the Da Vinci robotic system for low rectal dissection. The small and mobile robotic arms enable a fantastic view in the narrowest of pelvis and is often a great way of performing TME in a fat android pelvis with a large rectal cancer. Indeed the robotic scope enables vision beyond the sacral curve and underneath the prostate and other organs that would be very difficult to see even at open surgery. Hence conversion of robotic ultra-low rectal excision to an open technique may not make dissection easier.

A more novel and exciting development is the transanal approach to total mesorectal dissection using circular anal devices eg the TEO device. We have used this approach for very low rectal cancers and have found that this technique makes low rectal dissection much easier. The distal margin can be assured during rectal transection. The fat android pelvis does not pose as difficult a problem as in the transabdominal approach. Indeed TME approached by the transanal approach may become the new standard for really low rectal cancers in difficult situations.
In Malaysia, enterostomal therapy (ET) nursing started in the 1980s when the first HKL staff nurse Tan Tang Peng was sent to Perth, Australia to undergo Enterostomal Therapy Nurses Education Programme (ETNEP). Following that 7 more nurses were sent to Australia and 1 to Hong Kong. After training, the ET nurses went back to practise in their individual place of work.

“Alone we can do so little, together we can do so much” as said by Helen Keller.

Malaysian Enterostomal Therapy Nurses Association (METNA) came into being in 2002. Its area of interest is stoma, wound and incontinence care. METNA has been training new ET nurses locally in Malaysia. Trained ET nurses now provide professional enterostomal nursing care in their practice area all over Malaysia and globally.

ET nurses are involved in improving themselves and promoting their work in local, national or international arena.

“Coming together is a beginning; keeping together is progress; working together is a success”. Quote from Henry Ford.

The evolution of Enterostomal Therapy nursing is attributed to the visions of two very dedicated pioneers: Dr Rupert Turnbull, a colorectal surgeon at the Cleveland Clinic in the USA and Norma N Gill, a former patient who had undergone stoma surgery. Both were visionary in their belief that there was a need for specialized nursing care for those individuals who had undergone ostomy surgery. Hence, Enterostomal Therapy was founded in the 1970’s.

Norma N. Gill (1920-1998), was the world's first Enterostomal Therapist (ET).

She was an extraordinary person, despite being afflicted with a life-threatening and incapacitating 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 N Gill 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.

A 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, and this foundation have helped so many Nurses around the global to continue their education in Enterostomal Therapy Nursing.
SYMPOSIUM 3

Fistulectomy With Primary Suturing Of The Sphincter

Parvez Sheikh
Saifee Hospital, Mumbai, India

It has been impossible to devise a perfect surgery for fistula in ano - especially for a high trans-sphincteric fistula. One always has to maintain an optimum balance between recurrence & incontinence. Among the newer techniques, LIFT seems to be gaining popularity, but still has a significant recurrence rate. Among all the procedures available to treat fistula in ano, fistulectomy has the least recurrence rate, but it is usually accompanied by a higher incontinence score. If one could lower this incontinence score, then we could perhaps inch closer to devising a perfect surgery for fistula in ano.

High trans-sphincteric fistulas have a fixed pattern of spread - they always cross the external sphincter between the deep & superficial parts of the external sphincter. Thus, if one were to lay open such a tract, one would still not be dividing the deep part of the external sphincter and the anorectal ring. Primary suturing of sphincters, unlike delayed repair, results in good continence. A classic example of this is primary repair of a 4th degree perineal tear; the results of which are quite satisfying. The same satisfying continence can be achieved by primary suturing the sphincters after fistulectomy. Thus, fistulectomy with primary suturing of sphincters seems to have the combined advantage of a low recurrence rate and a satisfying continence score. Recent published papers & the author’s personal experience seem to substantiate these results. Thus, though fistulectomy with primary suturing of the sphincters is not the perfect surgery, but it may be the best that we have so far for a high trans-sphincteric fistula in ano.

SYMPOSIUM 3

VAAFT (Video Assisted Anal Fistula Treatment)
In The Management Of Fistula In Ano

Francis Seow-Choen
Seow-Choen Colorectal Centre, Singapore

Anal fistula is mainly easy to treat but recurrences are common especially in difficult cases. Difficult cases include cases where the fistula tract is high and surgery may compromise anal sphincter integrity or because there are secondary tracts. Such cases also include cases where the internal opening cannot be found. General treatment philosophy aimed to eradicate associated sepsis, identify the internal opening and secondary tracts and avoid anal incontinence during treatment. But these aims whilst in use since antiquity may not be totally correct. All methods of treatment actually aim primarily to close the internal opening securely or eradicate it completely. Methods with a high risk of not being able to close the internal opening are associated with a high risk of recurrence. VAAFT or Video Assisted Anal Fistula Treatment is a new method of totally non-invasive videoscope directed treatment of available for all sorts of anal fistula and which is especially suitable for high and difficult anal fistulas. The use of the fistuloscope allows the surgeon to follow the tract and identify the primary tract, internal opening and all secondary tracts. The surgeon then uses an electrode to coagulate granulation tissue in the tracts. This is followed by the use of an endobrush to curette granulation tissue and dirt. Following identification, the internal opening is closed with staplers. An accurate knowledge of anal sphincter anatomy in relation to the fistula is not absolutely essential. VAAFT is superior to any other current technique as there is no division of anal sphincter. Whatever wound is left is small in size and there is no tissue injury outside the fistula. VAAFT has the ability to trace accurately all primary and secondary tracts. It also has the capability to trace & deal with all internal openings and has an excellent cure rate.
Symposium 3

Evolution Of Staplers In Haemorrhoidal Surgery
Francis Seow-Choen
Seow-Choen Colorectal Centre, Singapore

The possibility of using a circular stapler to remove haemorrhoids was first proposed in 1990. Antonio Longo however was the first to suggest resecting the ring of mucosa above the haemorrhoids to pull up the entire haemorrhoidal tissues.

Initial procedures were performed with the usual circular intestinal staplers CDH 33. Ethicon was the first who produced a dedicated PPH01 staplers for haemorrhoidal surgery. Ethicon improved on the stapler with tighter stapler height and a more ergonomic design with the PPH03.

Not to be outdone Covidien produced their EEA Haemorrhoidal and Prolapse staplers allowing a larger amount of mucosal resection and better haemostasis.

Frankenmann then designed the CPH34HV with a large staple housing.

Touchstone then came out with Tissue selective therapy technology enabling selective selection of resection of haemorrhoidal tissues which enabled normal mucosal bridges in between resected tissues and avoids resection of non prolapsed mucosa.

Touchstone further modified their technology with the TST 36 with a megawindow and even staple pressure enabling the surgeon to select the amount and location of resection of anorectal mucosa.

Technology is improving the lives of both surgeons and patients and enabling a better fit between staplers and the patient’s situation.

Symposium 4

“The Hole For A Better Whole”
Improving Stoma Care Services in Philippines
Ednalyn Bonayon Esmeña
St Lukes Medical Center, Quezon City, Manila, Philippines

Colorectal cancer is the 3rd most common cancer as well as 3rd cause of cancer deaths in the Philippines (GLOBOCAN, 2012). In St Luke’s Medical Center, colorectal cancer ranked as 2nd most common cancer recorded from 2010-2014 data (Hospital Tumor Registry). Colorectal cancer is one of the indications in stoma creation. Referral to a nurse specializing in Stomal Therapy for assessment and teaching about managing a stoma during day to day living is beneficial for the patient and their support persons as they are qualified to provide holistic rehabilitation for people who need to have ostomy surgery. However, in the Philippines, training of nurses in Stomal therapy is limited. Most patients who will undergo stoma surgery don’t have the opportunity to be educated and counseled preoperatively.

After the operation, their concerns includes how to manage their own stoma at home, where to get ostomy appliances and accessories, where and whom to seek help once they were discharged, and how to resume their normal life. These were the problems encountered until the establishment of Ostomy Care Clinic last February 2013, manned by an Enterostomal Nurse. There had been an increase in the number of referred ostomy cases from 11% in 2013 to 55% in 2015. The launching of the Ostomy Care Clinic created awareness and promoted quality of life of patients that have ostomy or will undergo ostomy surgery. The clinic services include proper ostomy care, preoperative education & counseling, ostomy site marking, secondary appliance decisions and patient rehabilitation. Training of proper ostomy care for staff nurses was done subsequently. Further, the St. Lukes- Circle of Hope, Ostomy Support Group was created and organized last September, 2015. The Ostomy Care Clinic will further expand its borders by community involvement, trainings and research.
SYMPOSIUM 4

Managing A Complicated Stoma

Wong Jing Yin
Fatimah Hospital Ipoh, Perak, Malaysia

A stoma is created surgically to divert fecal material or urine in patients with gastrointestinal or urinary tract diseases or disorders. Stoma has no sensory nerve endings and is not sensitive to pain yet several complications can affect it. Complications may occur during the immediate postoperative period, within 30 days after surgery or later. Nearly three-quarters (73%) of people with a stoma experience skin problem, and over two-thirds try to resolve these without nurse involvement (Smith et al, 2002). Nurses should carry out a thorough assessment of the problem before starting any treatment (Black, 2011). It is important that nurses are knowledgeable in stoma surgeries and management of stoma complications so that prompt assessment and interventions can be carried out. Patients are already distressed of having stoma and when the complications arise it will further affect their quality of life. Postsurgical care and education by a dedicated enterostomal therapist can improve the patient quality of life.

SYMPOSIUM 4

How To Prevent Peristomal Skin Excoriation?

Rozita Mohamad
Enterostomal Therapist (ET), University Malaya Medical Centre, Kuala Lumpur

Peristomal skin complications are the most common reason ostomy patients visit an outpatient wound, ostomy, and continence nursing service. It is troublesome and the consequences are substantial, both for the patient and from a health economic viewpoint. 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. Thus peristomal skin complications should be diagnosed and treated at an early stage to prevent long term, debilitating and expensive complications.

SYMPOSIUM 4

Malaysia In The World Ostomy Community

Sri Tharan
Colorectal Cancer Survivorship Society

Malaysia is represented in the International Ostomy Association (IOA) through its membership in the Asia and South Pacific Ostomy Association, one of three regional associations that make up the IOA. Malaysia’s association with this organisation goes back to the time before the current structure of the IOA when Malaysia as the Ostomy Association of Malaysia was a full member of the IOA and Dr John Cardosa was President of the Asian Ostomy Association.

This brief presentation will take you through the history of the organisation, its aims and objectives, the Charter of Ostomates’ Rights, the organisation’s activities, House of Delegates meetings, current organisation and membership of ASPOA and who-is-who in ASPOA now.
SYMPOSIUM 5

Perianal Hidradenitis Suppurativa
Parvez Sheikh
Saifee Hospital, Mumbai, India

Hidradenitis suppurativa is a chronic inflammatory skin condition characterised by recurrent painful boils in flexural sites, such as the axillae, groin and anogenital area, that affects about 1% of the population, with onset in early adulthood. There is recurrent formation of abscesses, fistulating sinus and scarring in the apocrine-gland-bearing skin. The disease is now considered inflammatory and originating from the hair follicle.

Bacterial infection with staphylococci, Escherichia coli and streptococcus is considered as a secondary event in the pathogenesis. Smoking and obesity are both known as risk factors and are associated with more severe disease course. The disease is difficult to treat and has a severe impact on quality of life. Squamous cell carcinoma is the most serious complication.

Perianal disease can be easily mistaken for anal fistula. It may not be uncommon for patients to have been mistakenly operated for anal fistula. Therefore the examination of any patient who presents with multiple perianal openings, should also include examination of axilla & groin which are the common sites. Sometimes a MRI may be needed to confirm the diagnosis. Uncommonly, hidradenitis can co-exist with anal fistula.

Treatment options can be listed as follows:

Topical options consisting of antibiotic ointment, clindamycin solution

Systemic options consisting of systemic antibiotics, retinoids and immunosuppressive drugs such as anti-TNF-α biologics

Surgical methods- including excision with direct closure, secondary intention healing, grafts, flaps, laser therapy and radiotherapy

Adalimumab 40 mg weekly has shown to be effective, but its safety profile in that dosage is yet to be established. Multidisciplinary team work is necessary and the patients often require a long hospital stay.

SYMPOSIUM 5

Peri-anal Crohns Disease – Surgical Management
Tim Rockall
Royal Surrey County Hospital, Guildford, United Kingdom

Peri-anal Crohn’s is a chronic and debilitating condition. Repeated episodes of acute and chronic sepsis can lead to gradual destruction of the perineum with complex fistulae, sinus' and incontinence. The role of the surgeon is occasionally to attempt to heal fistulae but more often to control sepsis and allow medical management of active disease. The careful control of sepsis by judicious drainage and long term Setons can allow a patient to remain comfortable and maintain continence for long periods of time although ultimately difficult peri-anal Crohns may only be fully controlled by proctectomy. Defunctioning peri-anal Crohns disease has a role in some circumstances although reversal of a stoma is relatively infrequently achieved.

Perianal Crohns Disease – Surgical Management
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Pilonidal Sinus – Flap or Excision
Parvez Sheikh
Saifee Hospital, Mumbai, India

Pilonidal sinus usually require a surgical procedure for its cure. There has been an ongoing debate whether the wound should be left open after excision to let it heal by secondary intention, or whether the wound should be primarily closed. Further debate continues about what sort of primary closure is better.

The common procedures that are used for primary closure include the Karydakis procedure, Bascom’s procedure, Z plasty, Rhomboid flap & the rotational flap. There may not be much difference in the results between these procedures. All these are off midline procedures & are preferred over the midline closure. The recurrence rates may be lower if the wound is left to heal by secondary intention, but the healing time may be longer.

Treatment for Pilonidal disease can be frustrating. Both flap closure & excision have their pros & cons. Flap is more comfortable for the patient but can have a higher recurrence rate. If primary closure is to be done, then an off midline flap is preferable. De-roofing & curettage may provide a minimal post-op wound with lower recurrence rate esp. for small sinus.

Pruritis Ani - What To Do
Francis Seow-Choen
Seow-Choen Colorectal Centre, Singapore

Pruritis ani is the intense desire to scratch. This itch may be mild or intense and it may be idiopathic or secondary to other causes.

Secondary causes includes intestinal parasites, excessive moisture, faecal incontinence, bacterial or fungal infection, diabetes, dermatopathies, allergies and psychogenic causes.

General treatment includes maintenance of perineal hygiene, washing to remove stools but prevention of overzealous cleanliness, stoppage of steroids and allergens, treatment of anal infection and dermatopathies and management of medical associated problems.

The perineal skin can be kept clean by washing but avoiding toilet paper as this traumatises the skin. Regular washing is good but excessive washing is bad. The underwear should not retain moisture. Anti itch powder and the appropriate use of constipating agents may be useful. Weak steroids may be sued but prolonged use of strong steroids must be avoided.

The use of antihistamines and the discovery of food allergens may be a very useful step in the treatment of patients.

In intractable cases the use of subcutaneous methylene blue and marcaine or the application of Berwick’s dye or topical capsaicin may give long term relieve.

In the rare instances where obvious lesions are implicated, surgery may be curative eg, fistula, piles, fissure or Bowen’s or Paget’s disease.

Finally the patient may just have to scratch it.
Symposium 6

Functional Anal Pain
Samuel Tay
Sunway Medical Centre, Bandar Sunway, Petaling Jaya, Malaysia
Sime Darby Medical Centre, Subang Jaya, Petaling Jaya, Malaysia

Functional Anal pain can be acute or chronic. Acute pain is termed Proctalgia fugax.
Chronic pain is generally called Chronic Proctalgia. Rome III criteria defines it as chronic or recurrent rectal pain or aching lasting at least 20 mins in absence of structural or systemic disease explanation for these symptoms. It can be subdivided into Levator ani syndrome and Unspecified Functional Anorectal Pain. Levator ani syndrome is commonly associated with dyssynergic defecation and is more likely to respond to biofeedback therapy. There is need to clearly differentiate Chronic Proctalgia from Coccygodynia, Pudendal Neuralgia and Pelvic Pain in Women
Etiology is largely unknown, but factors like chronic spasm of pelvic floor muscle, inflammation of levator muscle, previous pelvic and anorectal surgery, childbirth and anxiety / depression disorders are thought to contribute.
Treatment is multimodality and multidisciplinary and results continue to be variable.

Symposium 6

Management And Surveillance Of Rectal Carcinoids
Tim Rockall
Royal Surrey County Hospital, Guildford, United Kingdom

Rectal carcinoids are relatively uncommon although the incidence of reported cases is increasing. They often represent incidental findings at endoscopy and 80% of them are less than 1cm in size. Most follow a 'benign' or indolent course but there is a risk of both local and distant metastasis. The nomenclature surrounding carcinoids in general has changed and they are now described as neuro-endocrine tumours, neuro-endocrine carcinomas and adenoneuroendocrine carcinomas. These are further graded into groups on the basis of proliferation, mitotic index and positivity for Ki-67 antigen. The malignant potential of rectal carcinoids is usually low and is related to both their size and histological features – in particular the presence of lymphovascular invasion. Malignant and aggressive carcinoids do occur and metastasise both to regional lymph nodes and distally. Management is by local excision at endoscopy by sub mucosal resection, trans-anal resection or by more radical rectal resection. The necessity for surveillance depends on the aggressiveness of the primary tumour. CT, PET and MRI all have their role as does functional imaging and urinary analysis.
Stoma Siting: The Challenges and How We Overcome It
Widastari Sri Gitarja, Sifing Lestari
WOCARE Clinic, Jawa Barat, Indonesia

A preoperative visit is the preferred option for the patient plan to have stoma surgery for both assessment and education of the patient and his or her family. Stoma site selection is a one of a priority during the preoperative counseling. In many reasons marking the site for a stoma preoperatively allows the abdomen to be assessed in a lying, sitting, standing position and patient activities such as spiritual activity. The purpose in these multiple positions allows determination of the proper site. Proper placement enhances the patient independence in stoma care and resumption of normal activities. This evaluation can help reduce postoperative problems such as leakage, fitting challenges, need for expensive custom pouches, skin irritation, pain and clothing concerns. Poor stoma placement can cause negative impact on psychological and emotional health. Furthermore, this preoperative visit allows the patient and his or her family to begin learning about stoma care.

KEY WORDS: stoma site; proper placement; spiritual activity

The Development Of Enterostomal Therapy Nursing In East Malaysia
Hospital Umum Sarawak
Cathrine Jawat Anak Sultan, Rusyina Daub
Sarawak General Hospital, Kuching, Malaysia

Sarawak land of the head hunters is no different than other states in Malaysia. As our population grow, so does the demand to the service of stoma and wound patients regardless to their races, religions and status. Content to this presentation will share on the current status of enterostomal therapy nurse development in Sarawak. It will detailed on challenges, services scopes and future planning in raising the bar of our enterostomal therapy nursing services in Sarawak.

The Development Of Enterostomal Therapy Nursing In East Malaysia
Queen Elizabeth Hospital, Sabah
Karenita K Shandu
Kota Kinabalu, Sabah, Malaysia

Wound and Stoma Care Unit in Queen Elizabeth Hospital is State reference hospital for wound and stoma care. This unit has conducted many courses and training for state level since I have become and ET nurse in 1999. I started the service since 1999 which only involve general surgical department (not full time). In 2000 there are 2 ET nurse and it started to receive referral from other surgical unit. In 2009 the service was open to all department. The clinic officially fully functions in 2013 with 4 ET nurse, but 2 in the clinic and another 2 in the surgical ward. In July 2013, 1 doctor has joint the clinic. In 2015, this unit has conducted a 2 month “Training for Trainer” course for 15 nurses and 3 paramedic from 9 specialist hospital in Sabah under State Health program. The clinic services involved inpatient, outpatient, hydro-surgery and hyperbaric treatment.
WOC nurse or Enterostomal Therapy Nurse is the one of important part in managing ostomy management. An ostomy refers to a temporary or permanent opening constructed in the abdominal wall or any part of the body as part of the treatment of disease or injury to the gastrointestinal tract and urinary tract. Patients with ostomies (ostomates) lost conscious control over urination or defecation and external pouching has to be applied for body waste collection. This patient population can range from neonate to elderly, male and female. Despite recent advances in surgery, ostomy still brings enormous physical and psychosocial impacts to the patient and his/ her family. Potential threat of life posed by the disease or injury, uncertainty, altered body image and lower personal esteem are commonly experienced. Alternation in sexual function, life style and work are all related issues that an ostomate has to deal with. The success in caring of patients with ostomies requires a multidisciplinary team approach. As a core member of the team, Enterostomal Therapy Nurse has a unique role in the identification of needs of patients and their caregivers, provision of holistic ostomy care, education and counseling. ET nurse also bears the responsibility to improve the quality of life of ostomates and ultimately contribute to their recovery and well-being. And to liase with Ostomy related products manufacturers for making them available these appropriate products to ostomates & give feedback for carrying our research and development of reliable as well as economical products for future use.

KEY WORDS
Enterostomal Therapy Nurse; Multidisciplinary Team
SYMPOSIUM 7

The Future Direction Of Enterostomal Therapy In Asia

Mariam Mohd Nasir
University Malaya Medical Centre, Kuala Lumpur, Malaysia

I was the only participant from Malaysia who attended the Wound, Ostomy & Continence Nursing Education Program for South East Asia Nurses in Princess Margaret Hospital, Hong Kong in 1995, which saw my journey into this specialty till now.

Upon my return, I set up University Malaya Medical Centre first ET Clinic and became the pioneer of Enterostomal Therapist in my hospital. At this point I knew that the future direction of ETN in Malaysia begins and I also for see this is going to be big and at that time my concern is what will I do further to ensure Norma Nottingham Gill vision and my promise to her become reality. It is not an easy journey but worthwhile.

There was no budget allocated to my ET Clinic so there were no staffs and I had to maintain clinic on a part time and pro bono basis while carrying out my duty as a Nursing Sister. But, this did not deter me to strive for excellence. With the support of the doctors and nurses, the clinic which was open in 1996 have flourished until now with 4 fulltime ET nurses to care for the stoma and wound patients and another 10 ETs being placed in the wards.

The clinic is now fully funded by the hospital and ET Specialist nurses is a now recognised subject matter expert in stoma and wound. Up to date I have trained approximately more than 200 Nurses in the field of ET Nursing all over Asian region.

My vision for the ET Nursing when beyond the setting up of the ET Clinic, I have pursued the area of Continence too. I continuously strive with my team to train more Nurses not just Malaysian Nurses but neighbouring countries Singapore, Thailand, Indonesia, Brunei, Hong Kong, China, Pakistan, Sri Lanka, Taiwan and Nepal.

I strongly feel and belief that we are moving into the right direction and keeping Nurses around the region to be trained as E.T. because we want our patients to be managed by competent nurses who can lift their lives and added more not just the quantity of life but quality life to them.

As I see it, all Asian countries shall work together, getting in place in the international arena, and perhaps get our own credential body to award recognition to the ET program.

The direction shall be patient centeredness, team work, collaboration and this will enhance the growth of more ET Schools in Asia.

Countries like Singapore, Thailand, Indonesia, Brunei, Nepal, Philippines, Sri Lanka, India and Pakistan are among the countries that have work together in improving ET Nursing. It is sad to know that patients have been left alone to deal with the condition just because their countries do not have ET Nurse.

Even countries that have many ETs still need assistance to train more ET and the need is becoming more especially in Asia, many ETs not able to practice because Clinical Nurse Specialist post is not available and some countries like Malaysia, they being posted to no related area with ET Nursing.

For the future of ETN in Asia, the need to form a task force with the support of WCET is crucial and this task force shall discuss, plan and execute more training in each countries as to avoid unnecessary financial burden.

The speaker will share her insight and vision towards what direction she thinks needed and how this can happen.
Benign rectal strictures can be the result of many conditions that cause scarring to the rectal wall. Management of benign rectal strictures may be challenging depends on the characteristic of the strictures and patients’ status. Short stricture can be treated with dilation or strictureplasty but long or full thickness stricture may be more suitable for rectal resection. Rectal resection or proctectomy can be accomplished by many approaches. Transabdominal approach is suitable for mid to upper rectal lesion in a fit patient. For the lower rectum, transanal approach might be a wisely decision. In special situation, mid rectal lesion which is too high to get it from transanal as well as the patient might be unfit for transabdominal surgery, transsacral or posterior approach could be the answer.

Posterior approach to the rectum can be achieved by 2 techniques. First, Kraske’s ‘s approach was first described by Kraske more than 130 years ago. He aimed to remove the mid rectum by excising the coccyx and a portion of the sacrum. Even it is easy to perform and gives wide access to the mid rectum but the drawback of the technique is high morbidity rate such as fistula formations. Second, York-Mason’s approach involves the complete anal sphincter division. This procedure has an increased risk of incontinence due to sphincteric dysfunction. Since high morbidity rates, both of posterior approaches have been almost abandoned by many surgeons.

So, is it necessary to learn how to perform a transsacral approach or Kraske’s approach? I would say “yes” because there might be some circumstance that transsacral approach can be the easy way out for example an unfit patient who has a full-thickness circumferential mid rectal stricture. There will be a video on my presentation about Trans-Sacral proctectomy step by step which I would like to share my experience with.
VRAM Flap For Large Perineal Defect

Jirawat Pattana-arun

Department of Surgery, Faculty of Medicine, Chulalongkorn University, Bangkok, Thailand

Multidisciplinary treatment is the key concept of locally advanced rectal and anal cancer treatment in the present. This approach typically starts with preoperative chemoradiotherapy, then radical surgery could be performed effectively. After tumor resection, there may be large perineal defect which could lead to wound complications if primary closure was planned (wound dehiscence, perineal abscess), or pelvic dead space which potentially cause infective collection. Utilization of myocutaneous flap plays major role in these situations, because it can fill perineal skin defect with healthy, non-irradiated skin flap and without tension. Furthermore, the bulky flap can also obliterate pelvic dead space and prevent small intestine from getting obstructed in pelvis.

Of all the flap used, vertical rectus abdominis myocutaneous (VRAM) flap is one with the simplest technique and reliable blood supply from deep inferior epigastric vessels, thus VRAM is the first choice for many surgeons to perform for perineal skin defect from rectal cancer surgery. The functional and cosmetic outcome are satisfactory as reported by many studies, and complications are very low in both donor site and recipient site. However, locally advanced rectal cancer is tend to be recurred, when confronting recurrence cancer after VRAM flap placement, would it be more difficult to do the redo surgery?

In some situations that plastic surgeons are not available, colorectal surgeon or general surgeon should perform VRAM flap ourself. Because, the technique is not too difficult to do. This video shows the step-by-step approach of VRAM flap.

Robotic TME

Simon Ng Siu Man

Division of Colorectal Surgery, Department of Surgery, The Chinese University of Hong Kong, Hong Kong

The introduction of robotic surgery has revolutionized the management of rectal cancer in the past decade. The robotic surgical system offers a number of technical advantages over laparoscopy for total mesorectal excision (TME) in the narrow pelvis where precise dissection is needed. However, rectal surgery also requires dissection in multiple abdominal quadrants, and there are several disadvantages of the current robotic surgical systems (most units have installed the da Vinci S or Si systems) that limit its utility in multi-quadrant surgery, such as limited range of motion of the robotic arms, and inability to move the robotic cart or reposition the operating table after docking. In order to compensate for these limitations, various operative approaches have been developed, including the hybrid approach and the totally robotic approach (single docking or dual docking). This lecture will briefly discuss the technical steps and the pros and cons of various operative approaches for robotic TME. Our technique of totally robotic single docking TME will also be described.

Management Of Mucocutaneous Separation With Transverse Double Barrel Stoma

Norzieyati binti Abdul Kudus, Wong Jing Yin

Pantai Hospital Ipoh, Ipoh, Perak, Malaysia

This topic shown how we want to manage the complication that patient had. How to handle the complication and tried to used variety appliance to manage the complication till we achieved our target to solved their problem. Give the health education to help them improved their lifestyle and prevent the complication occur.
CASE STUDY PRESENTATION BY ETNEP 2015

Management Of Double Barrel Ileostomy

Ednalyn Bonayon Esmeña
St Lukes Medical Center, Quezon City, Manila, Philippines

BACKGROUND
A 64 year old female who had Laparotomy, Adhesiolysis, Small bowel resection and Double barrel ileostomy due to Intestinal obstruction secondary to adhesion. Two weeks after surgery, patient experienced effluent leakage problem.

OBJECTIVES
1. Protect the skin from effluent leakage
2. Provide stoma education

METHODS
In the peristomal excoriation, applied ostomy powder then followed by an ostomy paste around the stoma. One piece drainable pouch was placed in 45 degrees position. Reinforced to drain the pouch once 1/3 full. Stoma education was provided to the Nurse-in-charge.

CONCLUSION
Proper stoma care, good pouching techniques and use of accessory products can prevent effluent leakage, minimize skin irritation, and predict pouch wear time which will benefit not only the patient but the nurse as well.

SYMPHOSIUM 9

Management Of T1 Rectal Cancers

Tim Rockall
Royal Surrey County Hospital, Guildford, United Kingdom

The increased use of endoscopy and bowel cancer screening has resulted in an increase in the detection of early stage rectal cancers. This has been accompanied by an improvement in our ability to accurately stage tumours pre-operatively by endo-anal ultrasound and MRI. There is an appreciation that T1 cancers have a low risk of nodal or systemic metastasis and that local treatment may be curative and avoid the morbidity of organ resection. The key elements of management are accurate staging, informed patient choice and appropriate post-operative surveillance. There are a number of treatment modalities to consider including endoscopic resection for polypoid cancers, trans-anal full thickness resection by trans-anal endoscopic microsurgery (TEM) and brachytherapy.

SYMPHOSIUM 9

Transanal Proctectomy

Simon Ng Siu Man
Division of Colorectal Surgery, Department of Surgery, The Chinese University of Hong Kong, Hong Kong

Transanal total mesorectal excision (TaTME) or ‘down-to-up’ TME is an emerging surgical approach that has the potential to give the surgeons better views during mobilization and resection of the very distal part of the rectum. It is particularly advantageous in obese male patients with a narrow pelvis, where the conventional abdominal or ‘up-to-down’ approach is challenging. The better visualization and hence more accurate dissection may result in better functional and oncologic outcomes. This lecture will present our institutional experience of TaTME, summarize the current status and evidence of TaTME, and discuss whether TaTME will become a viable alternative to laparoscopic or robotic TME in the future.
Retrorectal or presacral space has a complex embryologic development, and this potential space is primarily composed of connective tissue, nerves, fat, and blood vessels. Because this area contains totipotential cells that differentiate into three germ cell layers, a multitude of tumor types may be encountered. Many authors divide these tumors into the broad categories: congenital, neurogenic, osseous, and miscellaneous. Some authors sub-classify them into benign and malignant.

In my point of view, the term ‘retrorectal tumor’ may be misleading in terms of diagnosis and treatment approach. For example, the location of the tumor may be retrorectal, pararectal, prerectal, or sacral bone itself. At Chulalongkorn University, we have classified these tumors into presacral tumors and sacral tumors which greatly impacts the surgical approach and management.

The role of preoperative biopsy has been controversial. We have selectively used it for unresectable or metastasized tumors and for the one who might get the benefit from the adjuvant treatment such as suspected GIST, Ewing’s sarcoma, or osteogenic sarcoma. Otherwise, en bloc resection is appreciated for all potentially resectable tumors.

Careful surgical planning is important for deciding which one is the best approach either anterior approach, posterior approach, or a combined anterior and posterior (abdominosacral) approach. CT and MRI will help to define clear margins of resection.

**SACRAL TUMORS**

En bloc approach for sacral tumors includes free surgical margin at least one sacral body level above the tumor. Small and low-lying lesions can be removed using posterior approach, whereas tumors extending above the S-3 level require a combined anterior and posterior approach. Total sacrectomy is required for S-1, S-2 involvement. En bloc resection of the iliac bone laterally to the sacroiliac (SI) joint should be done for the tumor invading closed to the SI joint. Two-stage sequential approach for high sacral resection has been recommended by many authors. Bleeding control is the key step for success. We have proposed the technique of total isolation of the external iliac vessels which has dramatically reduced the bleeding and blood transfusion requirement. Using the effective bleeding control technique, total sacrectomy can be done in one-stage approach in our institution.

We close the large sacral defect using the Hartmann stump suturing to the edge of the sacral defect covered by bilateral gluteus maximus flaps. In the past, we had poor results with spinopelvic reconstruction using the Galveston technique in total sacrectomy cases with nonunion and infections requiring instrument removal. Fortunately, patients could be able to ambulate using the walking aid. Nowadays, we had no longer used the spinopelvic reconstruction for total sacrectomy.

**PRESACRAL TUMORS**

The en bloc resection principle is applied. Small and low-lying lesions can be removed posteriorly through a parasacral incision. Resection of the tumor may be facilitated by transection of the anococcygeal ligament and coccyx.

For large presacral tumors extending above the S-3 level, the anterior approach is required. The combined anterior and posterior approach may be needed especially in cases requiring complex resection such as pelvic exenteration and sacrectomy.

Tissue reconstruction after extirpation of the tumor is challenging. Several authors have advocated the transabdominal rectus abdominis myocutaneous (TRAM) flap or gracilis myocutaneous flap, which fills dead space and can cover large cutaneous defects left by the resection, and markedly decrease the incidence of wound-related complications.
We have proposed the colonic flap which can be used for perineal and neovaginal reconstruction [6]. We have also proposed the mucosa-removed colonic flap for cases needing only vascularized tissue to fill up the dead space not the mucosa for reconstruction [7]. The outcomes is promising.

REFERENCES

FORUM FOR ET NURSES

Many Stories, One Voice

Mariam Mohd Nasir
University Malaya Medical Centre, Kuala Lumpur, Malaysia

This session shall be a sharing session of experiences and thoughts about Enterostomal Therapy Nursing in Asia and will be shared by speakers from Malaysia, Singapore and Indonesia.

The key person in this field will discuss and share their stories in their journey to provide Enterostomal Nursing including their challenges and obstacles in pursing their dreams and ambition.

The discussion shall also discuss their planning in networking and collaboration between all ETs in Asia and how this can be done efficiently and effectively.
SOS-group also develops as a unique group of collaboration between stoma nurse and ostomate, with different academic levels, cultures, and religions and social-economics status. The reason behind it was that there was a feeling of disease stigmatization from public and afraid of revealing themselves as ostomate to other people. SOS group were really aware; this situation will be improved if the public understands more about people living with ostomy or ostomate. The collaboration group creating education and guidelines for nurses and ostomate to be knowledgeable and skillful to look after stoma patients. Every month, there’s many event in national or local scale of seminars and ostomate gathering for introducing ostomate to public. Our campaigns beginning since 2007 about “Friends of Ostomate”, “Moslem Fatwa”, “Certified Stomanurse Program” and “1000 bags for Ostomates”. Further details of aims that SOS-group try to reach are follows:

- To help anyone who has or is about to have, a stoma, to return to a fully active and normal life as soon as possible.
- To help with all aspects of their rehabilitation (including social activities, and relationships with their families, friends, employers, colleagues and members of the general public).
- To work in close co-operation with the medical authorities, nurses and social workers as part of a team whose primary aim is the complete rehabilitation of patient.
- To improve knowledge about the management of pouches and encourage development of new ostomy equipment, skin-care preparations etc.

The unique group is undertaken by wocare center and collaboration with many resources such as NGO, private health care and government, Nurses Association, Doctors Association, and University, Hospitals, private practice and Public care.

**KEY WORDS**
stoma group; collaboration; wocare center
PLENARY 2

Selective Internal Radiation Therapy (SIRT) in Colorectal Liver Metastasis

Lourens Bester
University of Notre Dame, Sydney, Australia
St Vincent’s Hospital, Sydney, Australia

CRC is now the third most common malignant disease in both men and women in Asia. In the Asia-Pacific region, the incidence varies between regions, with high incidence in Australia and Eastern Asia and low incidence in south-central Asia. Treatment options include surgery, neo-adjuvant and adjuvant chemotherapy, local ablation techniques and liver directed therapies using drug eluting beads or selective internal radiation therapy (SIRT).

SIRT is now an established treatment modality that has been subjected to many improvements over the last 5 years affecting patient selection and treatment.

The aim of this plenary review will be to focus on:
1. Concept of selective internal radiation therapy
2. Overview of clinical studies in m-CRC.
3. Integration of SIRT into the m-CRC treatment paradigms.
4. SIRT and surgery
5. Adverse events.

The SIRFLOX Study showed that the addition of SIRT, using Y-90 resin microspheres, to FOLFOX-based first-line chemotherapy in patients with liver-dominant metastases:

a. It did not improve overall PFS
b. A 7.9 month improvement in median PFS in the liver, representing a 31% reduction in risk of disease progression in the liver [HR: 0.69; p=0.002] with
   i. No negative impact on duration of systemic therapy
   ii. Had toxicities that were acceptable and as predicted

Chemorefractory patients have median overall survival of 4 to 5 months a number of recent large cohort studies reported on the survival of patients undergoing Y90 radioembolisation in the salvage setting. The survival data are remarkably consistent and almost identical with a median overall survival of 10.6 months from first Y90 treatment.

SYMPOSIUM 10

Stoma Care in Pantai Hospital Ipoh: Our Successful Stories

Wong Jing Yin¹, Norzieyati binti Abdul Kudus²
¹Fatimah Hospital Ipoh, Ipoh, Perak, Malaysia
²Pantai Hospital Ipoh, Ipoh, Perak, Malaysia

Pantai Hospital Ipoh started off with only 76 beds, the newly refurbished Pantai Hospital Ipoh now has 180 beds and expanding with over 50 consultant specialist. One of the specialised area is colorectal surgery. There was no dedicated nurse to care for patient undergoing ostomy surgery in the past. Dr M Sarkunnathas, colorectal surgeon in Pantai Hospital Ipoh recognised the importance of having a stoma nurse to manage the patient pre and post-operatively. Nurses are sent for courses and attachment so that patients undergoing ostomy surgery are well taken care of and complications can be avoided. Every patient who undergoes ostomy surgery is required to be assessed by the stoma nurse so that patient will have better understanding about the care of stoma. Pantai Hospital Ipoh is one of the hospital with well-trained stoma nurses and also known as enterostomal therapists.
My Experience In Becoming An Enterostomal Therapist

Supun Prageeth Samarakoon
National Cancer Institute, Maharagama, Sri Lanka

ET Nursing is always challengeable. In my hospital I worked in surgical unit. There were a lot of wounds and stomas. Patients were unbearable pain. At that time I had to say wait until doctor comes, no more new things in my career and always dependable. This situation inspired me to become ET nurse. Then I searched everywhere regarding ET nursing and finally I found WCET website. There I saw NORMA N GILL scholarship and I applied for scholarship. They granted me to participating Malaysian ETNEP 2015. I went to Malaysia and there I learned a lot of new things. I got enormous experience pertaining to wounds and stomas. In earlier I had little difficulties to adapt Malaysia. But ET team in UMMC supported me well and helped me to overcome my barriers. Finally I graduated as an ET nurse and returned to my home country. There I faced a lot of difficulties as nobody knows my ET career properly. Then I did few lectures to the nurses and nursing managers to aware them. After that few nursing managers trust me and invited me to do a wound care in their ward settings. My first successful milestone was I prevented patient with leg ulcer from doing amputating. I tried hard and applied dressing in frequently. Also few debridement was done. This is stepping stone in my career. Finally I have to say I never give up my career and hope to develop and establish wound care clinic in my hospital.

Oncological Side Effects That One Should Know Of

John Low Seng Hooi
Pantai Hospital Kuala Lumpur, Kuala Lumpur, Malaysia

Most patients are put off from receiving treatment because of the side effects. They would happiness explore alternative or traditional methods as these modalities are being promoted as natural, effective, safe and without side effects. Modern medicine is like a double edge sword but by knowing and therefore avoiding, looking out for and treating the treatment related side effects, we can potentially decrease or prevent their occurrences and maximize on the therapeutic ratio. I hope to allay the fear and anxiety of our patients by discussing these potential oncological treatment related side effects.

Low Anterior Resection Syndrome
(What To Expect After Removal Of Rectum)

Manohar Padmanathan
KPJ Klang Specialist Hospital, Selangor, Malaysia

Low anterior resection syndrome is a collection of symptoms or issues patients have after undergoing a resection or removal of part of or the entire rectum (last 6-8 inches of the large intestine with an anastomosis or “hook up” of the colon low in the rectum). These symptoms may include the following: frequency/urgency of stools, clustering of stools (numerous bowel movements over a few hours), stool incontinence, no stool for a day or two or more and then numerous bowel movements another day, and/or increased gas.

Not all patients experience every symptom. Each patient is unique. Some patients may notice that their symptoms resolve over time while others may continue to have symptoms.

The aim of the talk is to familiarise patients with these changes and gives advice on how to cope and adapt as well as minimise these changes.
Repeated Scans - Should I Be Concerned?
Stephanie Heng Siew Ping
Cancer and Radiosurgery Centre, Sunway Medical Centre, Selangor, Malaysia

The growing use of medical imaging procedures has raised concerns about exposure to low dose ionizing radiation in the general population. Individual effective doses for a patient may occur between several mSv and several hundred mSv by one examination or a series of examinations. The purpose of this presentation is to update the current status of our knowledge on the risks of radiation related to medical imaging and to identify strategies to minimize radiation exposure for patients. Biological effects of ionizing radiation VII (BEIR VII) have developed the most up to date and comprehensive risk estimates for cancer and other health effects from exposure to low level ionizing radiation.

Management Of Prolapsed Stoma
Chew Yen Xia
Assunta Hospital, Petaling Jaya, Selangor, Malaysia

Ostomy creation is a common surgical procedure performed by a variety of surgical specialties. Complications associated with stomas are frequent and run the gamut from technical, mechanical, physiologic, and psychologic. Stoma prolapse after formation of a colostomy is a late complication. Stoma prolapse affects 2%-47% of individuals with ostomies. Transverse loop colostomy has the highest rate of stoma prolapse, especially because of the large redundant distal loop.

Effective Guidance Enhance Acceptance By The Patient
Cathrine Jawat Anak Sultan
Sarawak General Hospital, Kuching, Sarawak, Malaysia

Effective guidance on stoma care teaching post operative enhances acceptance of stoma creation. A case is presented illustrating how Enterostomal Therapy nurse teaches and demonstrates proper stoma care to the patient.
Rectal prolapse is commonly found in two different age groups, young man and advanced age woman. Some of advanced age group present with pelvic floor descent and rectal prolapse may be a part of pelvic floor descend. Amongst recommended surgical options, laparoscopic ventral rectopexy (LVR) has shown the superior outcomes and lower complications, and gains more popularity for treating rectal prolapse with pelvic floor descent. This technique helps fixing the leading point of rectal prolapse and hanging the pelvic floor. The impressive outcomes were demonstrated in many literatures.

Anyway, LVR has some limitations in patients who risk for general anesthesia or not suitable for transabdominal approaches. Furthermore the rectum mobilization may lead to autonomic nerve injury. To come over these limitations, Translevator ventral rectopexy (TLVR) was developed and proposed as Video vignette in the Diseases of the Colon and Rectum. This technique can be done under spinal anesthesia through translevator approach. However the operative outcomes have not been reported yet.

From May 1, 2013, to March 30, 2014, I underwent 23 cases of TLVR and analysed on the prospective data collection, in terms of peri-operative and short-term outcomes in the patients who had complete rectal prolapse with pelvic floor descent.

Outcomes showed that Translevator ventral rectopexy, for complete rectal prolapse with pelvic floor descent, is safe and significantly improved in obstructive defecation symptom and incontinence symptom with acceptable low recurrence rate.

I would like to endorse that TLVR will provide the benefits of LVR in rectal prolapse with pelvic floor descent patient when LVR does not possible.
Posterior Approach Pelvic Organs Suspension

Arun Rojanasakul
Colorectal Surgery, Bumrungrad International Hospital, Bangkok, Thailand

At present there is no surgical procedure aims at correct all components of descending perineal syndrome (DPS). There are only surgical procedures for specific organs disorder such as procedures for rectal prolapse, procedures for uterine prolapse or procedures for cystocele. The DPS patients usually present with one major symptom e.g. uterine prolapse, rectal prolapse, or urinary incontinent but there may be other hidden problems of other organs which also need to be corrected.

We have proposed the new surgical technique aiming at the correction of all pelvic organs descent.

The essential steps of the technique are:

1. Transverse incision just above the tip of coccyx approximately 6 cm. in length.
2. Transect all the ligaments and fascia that attach to the coccyx and distal sacrum.
3. Mobilised the rectum from the sacrum and vagina.
4. Sutures upper vagina to the sacrospinous ligament on the right side.
5. Sutures rectum to sacrospinous ligament and sacrum on the left side.

Short term outcomes in 15 patients are impressive. There are no peri-operative complications and recurrence. The other associated symptoms such as incontinence, urinary urgency, proctalgia are also improved.

The posterior approach pelvic organs suspension for the treatment of DPS is a novel technique. This technique is simple, inexpensive, low risk of complications, and satisfied short-term results.

Ostomate Bill Of Right: Do Ostomate Get Their Right?

Nor Azah Aziz
University Malaya Medical Centre, Kuala Lumpur, Malaysia

Stoma forming surgery is a life changing event that can be distressing physically and psychologically. So before surgery have been decided, patient have their right to be informed and expectation after the surgery. The International Ostomy Association has declared a Charter of Right, for people experiencing ostomy surgery, stating that “ all shall have the right to a satisfactory quality of life after their surgery. As an enterostomal therapy nurse, it is our responsibility to help and support them as much as possible to gain independence after surgery and improving their quality of life.
Enterostomal Therapy Nursing Education Program In Malaysia: Can We Organise It In Our Hospital?

Mariam Mohd Nasir
University Malaya Medical Centre, Kuala Lumpur, Malaysia

Enterostomal Therapy Nursing Education Program or ETNEP is a program that trained registered nurses to become more competent in caring for stoma, wound and incontinence patients. Once graduated from the program which normally within 10 to 12 weeks, and on successful completion of the program the nurses will be identified as Enterostomal Therapist or E.T.

It started when Norma Nottingham Gill Thompson had her ileostomy surgery done by Dr Ruppert Turnbull at the Cleveland Clinic, Ohio, USA. Dr Ruppert for seen the problems that Norma will be encountered and need to find a solution how can this be overcome. He then decided the best solution is to train Norma herself to care for her own stoma. That was the beginning of Enterostomal Therapy Nursing.

ETNEP is being organized all over the world and Malaysia as started the ETNEP way back in the General Hospital, Kuala Lumpur since as early as 1997. The program shall be recognized by the World Council of Enterostomal Therapist(WCET) a body that control the training of E.T.

Malaysian ETNEP was re-recognized by WCET in 2010, when Malaysian Enterostomal Therapy Nurses Association(METNA) took the initiative to train more E.T. It was done in University Malaya Medical Centre, Kuala Lumpur.

Following that we had another program in 2013 and for this year which started on the 29 February 2016. We were given maximum recognition for 4 years which will be expired in 2017.

The recognition was given to Malaysia and any hospitals in Malaysia shall be able to organize the program provided certain standard and quality is being preserved.

The speaker will share with all on how you can organize the program in your hospital.

Psychosocial Issues In Cancer Survivorship

Bharathi Vengadasalam
Pantai Hospital Kuala Lumpur, Kuala Lumpur, Malaysia

With advances in treatment, colorectal cancer (CRC) is transformed into an illness that is increasingly curable. There are unique problems, risks, needs, and concerns of survivors who have completed treatment. Psychosocial issues are sometimes neglected in the early periods after diagnosis. Once the acute crisis has passed, the focus shifts from surviving to thriving. Thus we need to navigate some mental and emotional aspects associated with cancer. This session aims to discuss issues such as self image, uncertainty, fears, mood disturbances and how to approach such challenges.
SYMPOSIUM 14

Getting Back To Life As A Survivor

*Hamzan bin Arshad*
Colorectal Cancer Survivor, Malaysia

Hamzan Arshad will be sharing his experience as a stage 4, Colorectal Cancer Survivor. He was diagnosed in February 2006 after discovering blood in his stools. After two major operations, eight months of aggressive chemotherapy treatment and nine months of oral chemotherapy, Hamzan was declared to be in remission in October 2007. What followed after that was five years of great health, enabled by a healthy diet, regular exercise and routine check-ups with his oncologist and gastroenterologist. However, towards the end of 2012, his blood test results showed that his CEA tumour marker had elevated beyond normal and in December 2012 a PET scan discovered a tumour in a lymph node under his navel. What followed was another operation to remove the tumour and 24 sessions of radiotherapy and eight sessions of chemotherapy treatments. In September 2013 Hamzan was again declared to be in remission. He has remained well ever since.

SYMPOSIUM 14

Laughter Therapy: Coping With The Stress Of Cancer

*Sukhveer Kaur*
Colorectal Cancer Survivor, Malaysia

Laughter can change your mood and emotions within minutes when the body releases Endorphins (the feel good hormones) which makes you feel good, joyous and cheerful and also provide relieve for physical pain and reduce the stress hormones.

Laughter in times of challenges and distress helps to create a positive mental state and to deal with negative situation. It gives hope and optimism to cope with difficult times.

Being a survivor and carer who is always practicing Laughter Therapy and advocating for it and laughed during the challenging times in LIFE is every proof of it.

SYMPOSIUM 15

Management Of Post-operative Ileus

*Ismail Sagap*
Universiti Kebangsaan Malaysia Medical Centre, Kuala Lumpur, Malaysia

Postoperative Ileus (POI) which is an interruption of bowel motility seemed to be an inevitable event in every abdominal surgery. It imposes significant morbidities and elevates cost in health service. POI is usually characterized by distressful pain accompanying abdominal distension which than lead to prolonged hospital stay. Not infrequently POI leads to respiratory and other organ dysfunction that made surgeon resort to abdominal re-explorations.

Post-operative ileus happens by a multitude of cellular processes. It is made worse by the excessive use opioids as pain control. The management of POI includes its preventive strategies such as ERAS protocol with the use thoracic epidural, pain control using NSAIDs and laparoscopic technique. Pharmacological treatments which use medications that target specific GIT receptors to promote gut motility were also found to be useful.
Preventing Anastomotic Leak In Colorectal Surgery

Gerald Henry
Department of Surgery, Hospital Selayang, Selangor, Malaysia

Despite much advances, anastomotic leaks in Colorectal surgery is still a significant problem with morbidities and mortalities recorded. I would be discussing the underlying causes, preventive measures to achieve optimal results and recent advances.

DVT Prophylaxis In Colorectal Surgery

Paul Selvindoss
Gleneagles Hospital Kuala Lumpur, Kuala Lumpur, Malaysia

Patients who undergo colorectal surgery have a higher risk for deep vein thrombosis (DVT) and its associated complications of pulmonary embolism (PE) than other general surgery counterparts.

The incidence of DVT in colorectal surgery patients who do not receive prophylaxis can be as high 30%. As such there can be a four-fold increase in the incidence of pulmonary embolism. There are many contributing factors including need for pelvic dissection, patient positioning (eg, use of stirrups), length of surgery and indications for surgery (eg, inflammatory bowel disease, cancer) and also advanced age in colorectal patients.

The potential impact of venous thromboembolism and the need for effective thromboprophylaxis often are underestimated in these patients.

Despite the clear evidence that supports the safety and efficacy of DVT prophylaxis, appropriate preventive measures are frequently not used.

Mechanical compression in combination, TED stocking along with heparin preparation likely represents the most appropriate prophylactic regimen in these high-risk patients.

Newer oral agents are also available for prophylaxis of deep vein thrombosis.
Electroacupuncture is widely accepted in China as well as throughout the world as an effective treatment option for various functional gastrointestinal disorders, but good quality evidence in the Western literature is scare. Our Division of Colorectal Surgery at The Chinese University of Hong Kong is dedicated to promote the development of evidence-based Integrative Traditional Chinese and Western Medicine. We are particularly interested in investigating the application of electroacupuncture in the field of colorectal surgery. Supported by several research grants from the Hong Kong Government, we have conducted a series of randomized controlled trials that aimed to investigate the efficacy of electroacupuncture/Acu-TENS (transcutaneous electric nerve stimulation on acupoints) in enhancing the outcomes of treatment for colorectal diseases. For instance, we have demonstrated that the application of electroacupuncture or Acu-TENS can reduce procedure-related pain and the consumption of sedatives/analgesics during colonoscopy. In another randomized sham-controlled trial, electroacupuncture has been shown to be effective in reducing the duration of postoperative ileus and hospital stay after laparoscopic surgery for colorectal cancer. The faster postoperative recovery brought about by the use of electroacupuncture may help reduce the financial burden to the hospital/healthcare system. We are currently conducting another randomized controlled trial that aimed to compare the efficacy of electroacupuncture and fast-track program in reducing the duration of postoperative ileus and hospital stay after laparoscopic colorectal surgery. Finally, we are also searching for more effective therapies for patients with fecal incontinence, which is one of the most psychologically and socially debilitating colorectal conditions. A randomized sham-controlled trial is currently underway in our Division that aimed to evaluate the efficacy of Acu-TENS in treating fecal incontinence and improving the quality of life of these patients.

Colostomy irrigation is a way to regulate bowel movements by emptying the colon at a scheduled time. The process involves instilling water into the colon through the stoma, which stimulates the colon to empty. By repeating this process regularly – once a day or once every second day – the colon can be trained to empty with minimal to no spillage of stool in between irrigations. Colostomy irrigation also can help avoid constipation. Colostomy irrigation is a personal decision by the patient. If the patient is a candidate, the doctor or a nurse who is specially trained to help people with colostomies will discuss this option with the patient. Patients with permanent colostomies made in the descending or sigmoid portion of the colon and who had regular bowel function before having a colostomy are good candidates for irrigation. This is because their stools tend to be more formed. Patients who are able to perform irrigation will definitely save cost for their pouching system but they have to meet certain criteria before this is being done. The speaker will be sharing with all more information on this topic and a hands on session will follow after this.
Personalised medicine or Genomic medicine has been the hottest trend in modern medicine in recent times especially so in the rapidly evolving field of Oncology. This is made possible by the advances in gene sequencing technology leading to the identification of various predictive and prognostic molecular markers. The field has totally transformed the landscape of treatment in various solid cancers especially breast, lung and colorectal cancers. EGFR, RAS, BRAF, mTOR, PI3KCA, MET, PTEN and various other oncogenic drivers have been identified. Molecular targeted agents have been successfully developed and used in routine clinical practice to target some of these specific mutations. Many more are in the pipeline. The ability to simultaneously study multiple genes in the cancer has produced various gene expression arrays to assist the clinicians to select the best treatment approach for each individual patient. The current development of molecular profiling in Colorectal cancer and its clinical application will be presented in this short overview.

Colorectal cancer (CRC) has emerged as the most common cancer in Hong Kong and is also the second leading cause of cancer deaths. Many studies have proven that early screening can result in a remarkable reduction of CRC incidence and mortality. Although colonoscopy is currently regarded as the most reliable CRC screening tool, the invasive nature of the test and the labor and equipment cost incurred have hampered the wide application of this procedure. Moreover, currently used fecal occult blood test to screen for CRC has the limitation of low sensitivity and suboptimal specificity. Thus, there is a pressing need for developing alternative noninvasive tools for CRC screening. This talk provides a comprehensive overview of various emerging and innovative CRC screening modalities that are relatively noninvasive and acceptable to patients, and have great potential for further development. These modalities include CT colonography, colon capsule endoscopy, modified/novel endoscopy, and stool-based/blood-based molecular biomarkers.

Colorectal cancers are now the 1st and 2nd most common cancer in Malaysian men and women respectively. Treatment with chemotherapy has reached a plateau many years ago and new approaches are needed to improve results. Newer antibodies against EGFR has resulted in small incremental increase in survival in the palliative setting. Antiangiogenic agents and tyrosine kinase inhibitors are also adding to the armamentarium of drugs. However these new therapies have yet to make an impact in the overall cure rates and newer modalities are needed such as immunotherapy and gene therapy.
SYMPOSIUM 16

Microbiota And Colorectal Cancer
April Camilla Roslani
University of Malaya, Kuala Lumpur, Malaysia

While the genetic pathways to development of colorectal cancer have been greatly elucidated, much has yet to be understood regarding individual variations in phenotype, particularly in sporadic cases. The association with dietary components, the deleterious effects of antibiotics, and the explosion of omics methods in recent years, has led to a greater understanding of how human microbiota interact physiologically to maintain health, or indeed, contribute to the development of disease, thus providing a potential explanation for such variability.

However, key questions to be answered are, whether changes in the gut microbiome are causative, or a consequence of, colorectal cancer, how the gut and dietary microbiota interact, and why the same organisms could be pathogenic or protective under different circumstances.

Current evidence suggests a potential role for microbiota manipulation in the prevention, diagnosis and treatment of colorectal cancer. Nevertheless, while, for instance, animal studies support efficacy of probiotics, prebiotics and polyphenols in positively altering the gut microbiome, the evidence in humans is still ambiguous.

Further work is needed to determine if the microbiome will prove to be a clinically useful component of individualized healthcare.

SYMPOSIUM 17

Counseling In Stoma Care – How I Do It?
Udena Athula Kumara
Colombo South Teaching Hospital, Colombo, Sri Lanka

OBJECTIVES
Improve the quality of life of the patient, independence and lower the peri operative complications

BACKGROUND
When the patient learns of the need for an ostomy surgery is the most receptive period of time. This is period that patient and family are seeking information, dealing the fear and anxiety of the unknown. This is the excellent time for nursing intervention.

Colombo South Teaching hospital where I work is a territory care centre. It consists of 1200 beds.

Patient assessment and counseling begins on admission of the patient.

ASSESSMENT
In this stage assessment is more comprehensive and it includes physical, social, cultural, spiritual, emotional and educational components and sexuality. Assess patients individually and do counseling for their needs and characteristics.

For breaking bad news I follow up the SPIKES protocol.

Improperly placed stomas complicate the patients self care may have a negative effects of adaptation which leads to poor QOL.

Therefore, I assess factors individually prior to the surgery and mark the topographically correct site for ostomy surgery.
WOC Nurse or Enterostomal Therapy Nurse is one of healthcare provider to help people living with stoma but really hard to find nurses who interested in stoma care. Especially in hospitalized and discharged programs that people who lived with stoma have introduced various situation and problems and they will be asked to consider how the situation can be problem solved. They are offers counseling and role models to patient and their families, before and during their rehabilitation process having stoma surgery. They help them to understand what happening situation, answering their problems is and dealing with the non-medical problems and support them when they have the operation and follow up after. The biggest discussion between stoma nurse and ostomy patient after stoma surgery is pouching system. Pouching system supply in Indonesia is not much easier than other country and sometimes will make frustration in clinical practice. We know that politics can have implications for nurses, health care organizations, industry, and patients. We can all work together to fight for appropriate care. Reform is a vital component of the specialty practice of an Enterostomal Therapy Nurse.

KEY WORDS:
stoma care; pouching system; reform

Nursing is a noble career. The responsibility of a nurse is providing care to patients. Therefore, patients who wear the stoma must be assisted and provided with emotional support and sympathy with the circumstances.

Therefore, it is appropriate to the topic though I am not a stoma nurse but considering that my obligations towards patients, feelings and love, wants to help patients that are pushing me to do stoma care. My philosophy, “If someone offers you an amazing lifetime and if you’re not sure you can do it, say yes, then learn how to do it later.”
Planning for home management for all stoma patients should start as soon as possible. This is to help patients develop confidence needed for caring for the stoma.

Managing and dealing with all aspects of stoma care can be a challenging experience. As an Enterostomal Therapist (E.T.), we need to give the message to the patient and their relatives that they are not alone. The E.T. is there to help them return to as normal life as possible. Besides teaching sessions with them and their significant others on all aspects of stoma management, we can also teach them some simple tips and tricks when caring for the stoma. This will enhance their acceptance and will further improve the way they care for their stoma.

When the patient and their family members are able to manage the stoma independently, and the E.T. is happy with it, the patient will be able to go home - with supply of stoma bags and the accessories as required. Once home, the patient will start taking care of the stoma on his/her own and sometimes they might still need the family members to help. Simple tips and tricks can help them in dealing with some problems or improve the way they handle their stoma.

Nevertheless, tips and tricks need to be practical for the patients and it is supposed to be easy for them to carry out and the most important is, it should not incur more cost to them.

Tips and tricks will be learnt throughout the years as they progress in their life and many of them shared with their E.T. and other ostomate.

The speaker will share all the tips and tricks, such as handling their pouches, food intake, managing odour, gases, activities of daily living etc.
POSTER PRESENTATIONS

PO 1 Serum Procalcitonin Saves Colorectal Surgery From Anastomotic Leak
H Firdaus1,3, N Nasruddin Dian2, M A Zairul1, I Sagap1
1Department of Surgery, Universiti Kebangsaan Malaysia, Kuala Lumpur, Malaysia
2Department of Pathology, Universiti Kebangsaan Malaysia, Kuala Lumpur, Malaysia
3Department of Surgery, Universiti Malaysia Sabah, Kota Kinabalu, Sabah, Malaysia

PO 2 Colonoscopic Yield Of Colorectal Tumour Biopsy And The Influence On The Timing Of Surgery. “Informed Decision” As A Way Forward To Reduce Waiting Time For Operation And Time To Initiation Of Chemoradiotherapy: 5-Year Retrospective Review Of Single Centre Colorectal Unit
Ragu Ramasamy, S K Loh, Gillian M Counter, Gerald Henry
Hospital Selayang, Selangor, Malaysia

PO 3 Internal Anal Sphincter Thickness As A Predictor Of Benign Anal Disease
Muhd Ash-Shafhawi bin Adznan1,2, Gerald Henry1, Ismail bin Sagap1
1Colorectal Unit, Surgical Department, Selayang Hospital, Selangor, Malaysia
2Colorectal Unit, Surgical Department, Pusat Perubatan Universiti Kebangsaan Malaysia, Kuala Lumpur, Malaysia

PO 4 Synchronous Colorectal Adenocarcinoma And Renal Clear Cell Carcinoma
Y Z Tay, H L Sha, N K Milaksh, T H Chieng
Department of Surgery, Sarawak General Hospital, Kuching, Sarawak, Malaysia

PO 5 The Histopathology Of Colorectal Cancers In Sarawak General Hospital Kuching, Sarawak
H L Sha, R A Idi, K Kharlina, T H Chieng
Sarawak General Hospital, Kuching, Sarawak, Malaysia

PO 6 Case Series Of Colorectal And Gynecology Malignancy
Firdaus A K, R Thinesh, Z Q Goo, T H Chieng
Department of Surgery, Sarawak General Hospital, Kuching, Sarawak, Malaysia

PO 7 Primary Colonic Lymphoma Presenting As Acute Abdomen: A Case Report
M A Munawwar, T P Kelvin, A R Amin, A G A Aziz
Department of Surgery, Hospital Kulim, Kulim, Kedah, Malaysia

PO 8 Malignant Transformation Of Anal Paget’s Disease: A Rare Malignancy Of Anus
Z Q Goo, Y Z Tay, Firdaus A K, T H Chieng
Department of General Surgery, Sarawak General Hospital, Kuching, Sarawak, Malaysia

PO 9 Malrotated Caecum With Subhepatic Appendicitis
H C Chong1, S M D Asilab1, K Z Syibrab2, F Y Chai2
1Department of Surgery, Hospital Queen Elizabeth, Kota Kinabalu, Sabah, Malaysia
2Department of Surgery, Hospital Keningau, Keningau, Sabah, Malaysia

PO 10 Synchronous Rectal Carcinoma: The Common Among The Rare Cancers
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Hospital Seberang Jaya, Penang, Malaysia
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<td>¹Department of Surgery, Sarawak General Hospital, Kuching, Sarawak, Malaysia</td>
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POSTER PRESENTATIONS

PO 21 A Randomised Controlled Trial Of Novel Treatment For Hemorrhagic Radiation Proctitis
W C Pui1, T H Chieng2, S L Siow1, N A Nik Azim1, I Sagap2
1Hospital Umum Sarawak, Kuching, Sarawak, Malaysia
2Pusat Perubatan Universiti Kebangsaan Malaysia, Kuala Lumpur, Malaysia

PO 22 Short Term Result Of Laparoscopic Rectopexy Without Resection For Full Thickness Rectal Prolapse In Sarawak General Hospital
R A Idi, R Thinesh, K Kharlina, T H Chieng
Department of Surgery, Sarawak General Hospital, Kuching, Sarawak, Malaysia

PO 23 A Case Report: Gardner's Syndrome Revisited
F Y Lee, Andee D Z, Luqman Mazlan, Ismail Sagap
Department of Surgery, Faculty of Medicine and Health Sciences, Universiti Kebangsaan Malaysia
Kuala Lumpur, Malaysia

PO 24 UKMMC Colorectal Centre In Managing Complete Rectal Prolapse: Altemeier's Revisited
Viknes G, Andee D Z, Ismail Sagap, Luqman M
Department of Surgery, Pusat Perubatan Universiti Kebangsaan Malaysia, Kuala Lumpur, Malaysia

PO 25 Colonic Stenting: Hospital Seberang Jaya Experience
Sumaraj A, C W Yong, M Aeruan, Fahmey S, Imran Khalid
Hospital Seberang Jaya, Penang, Malaysia

PO 26 An Interesting Case Of Retrocaecal Internal Herniation Causing Small Bowel Obstruction
Rubi F J1,2, Hady S1, Hana H1, Aizat T2, Gerald H2
1Universiti Sains Islam Malaysia, Kuala Lumpur, Malaysia
2Hospital Selayang, Selangor, Malaysia

PO 27 Adult Hirschprung Disease: Case Series
Roshini R, Aizat T, Mohan R, Gerald H
Department of General Surgery, Hospital Selayang, Selangor, Malaysia

PO 28 A Case Report Of Young Patient With Perforated Diverticulitis
Huzairi Y, Ann K, Ahmad S, Zaidi Z
Department of Surgery, Hospital Raja Perempuan Zainab II, Kota Bharu, Kelantan, Malaysia

PO 29 A Case Report Of Leiomyosarcoma Of Sigmoid Mesocolon
Ann D K, Huzairi Y, Ahmad S, Zaidi Z
Department of Surgery, Hospital Raja Perempuan Zainab II, Kota Bharu, Kelantan, Malaysia
Serum Procalcitonin Saves Colorectal Surgery From Anastomotic Leak

H Firdaus1,3, N Nasruddin Dian2, M A Zairul1, I Sagap1
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2Department of Pathology, Universiti Kebangsaan Malaysia, Kuala Lumpur, Malaysia
3Department of Surgery, Universiti Malaysia Sabah, Kota Kinabalu, Sabah, Malaysia

BACKGROUND
Anastomotic leak (AL) is a dreadful complication in colorectal surgery. Early diagnosis reduces its complication but it is often delayed. Computed tomography is the gold standard to diagnose but not routinely performed. Procalcitonin (PCT) has been described as early, sensitive, and specific marker of sepsis. In the era of modern fast-track protocol, looking for a reliable marker is crucial. The aim of this study is to determine whether PCT is a good predictor of AL in colorectal surgery.

METHODOLOGY
From July 2014 to October 2015, 70 patients undergoing colorectal surgery were prospectively analyzed in a single-center tertiary hospital. Serum PCT was taken before surgery and at postoperative day (POD) 3. They were observed for features of AL. The primary outcome was to determine an association between PCT level and clinically diagnosed AL. Statistical analysis between variables was done via fisher’s exact test and t-test. The receiving operating characteristic curve and Youden index were used to select cut-off value. Sensitivity, specificity, positive predictive value and negative predictive value were obtained.

RESULT
The rate of AL was 4.5% (3 patients) with mortality rate of 4.3% (3 patients). PCT was statistically significant among patients with AL. The optimal PCT cut-off level at POD 3 (area under the curve 0.92) was 5.27 ng/mL. It resulted in 100% sensitivity, 85% specificity, 23% positive predictive value and 100% negative predictive value. None of the variables showed statistical significance with AL.

CONCLUSION
PCT is a good biochemical marker to help in diagnosing AL. It emphasizes that a level of 5 times beyond normal is significant. It should be taken upon clinical suspicion just before radiological confirmation. When the test is being established upon leak suspicion, a result of PCT lesser than 5.27 ng/mL has proven to be absence of leak, hence permitting safe and early discharge.
Colonoscopy biopsy is on the increasing trend due to better awareness of colorectal cancer and initiation of random screening program. However frequently surgeons are challenged with the dilemma of inconclusive biopsy. In the current age of medico legal issues, surgeons are more inclined to repeat the biopsy instead of operating on suspicion with radiological and clinical diagnosis. This however has prolonged the time of resection and the initiation of chemo or radiotherapy if needed later. The maximum number of repeat biopsy has never been capped and “informed decision” making has become the cornerstone if the repeat biopsy turned out negative. This is a retrospective review of colorectal biopsy suspected of colorectal cancer with radiological suspicion for new cases referred to us from 2010 to 2014. Mean time to surgery was 45.99 days if the 1st biopsy turns out conclusive. The mean time to surgery was delayed to 56.75 days if 2nd biopsy was done and 70.50 days if 3rd biopsy is needed. 22 patients were taken straight for operation without repeating biopsy after “informed decision” making with the patient with mean waiting time for surgery at 34 days. The final histopathology report was confirmed carcinoma in all the cases. Although we were unable to prove statistical significance between operating straight after an inconclusive biopsy and repeating another biopsy (p=0.177), this provides an avenue for “informed decision” making to reduce the waiting time and the initiation of chemo or radiotherapy if needed later.
Internal Anal Sphincter Thickness As A Predictor Of Benign Anal Disease

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INTRODUCTION
Benign anal disease (BAD) is a very common disease and simple to treat. However it is associated with multiple complications with high morbidity rate. Hemorrhoid, anal fissure, fistula in ano and rectal prolapse are among the common disease. BAD and its complications are in close relation with anal pressure, which is determined by its sphincter muscles.

PATIENT AND METHODS
This study has taken 45 patients with BAD and scheduled for Endo Anal Ultrasonography (EAUS). An average of all four quadrants of the internal anal sphincter (IAS) was taken. This was compared to 45 normal patients with same age, gender and race variation.

RESULT
We had a good comparison data from both group of disease and normal patients with almost similar mean in regards of age, race and gender. The difference of IAS thickness between the two groups is 2.3142 vs 2.1013 with a p value of 0.08. In our study IAS thickness increases with age from a range of 1.852 mm (21-30 years old) to 2.3045 mm (61-70 years old). Male patients have a thicker IAS muscle with mean of 2.1308 mm, compare to women (2.0644 mm) in our normal group of patients. In regards of ethnicity Chinese (2.2855 mm) patients have thicker IAS muscle followed by Indian (2.0344 mm) and Malays (1.9865 mm).

DISCUSSION
The anatomy and physiology of the anal canal is fairly complex but IAS plays a major role in establishing basal anal canal pressure, which contributes to the pathophysiology of BAD. Although endoluminal MRI is superior in assessing anal canal anatomy, specifically in BAD patients, EAUS has proven to be more efficient. Patients with BAD are more likely to have thicker IAS muscle due to previous interventions or induced fibrosis by mere inflammation. In rectal prolapse patients, the thicker IAS muscle is due to its compensatory hypertrophy mechanism. As among the first study that looks into the Malaysian population and documenting the normal range of IAS thickness, there were multiple factors including diet intakes and exercises besides genetic contributions that differentiates our normal ranges compared to other region studies data.

CONCLUSION
In general the IAS in patients with BAD are thicker when compared to normal population. However there is no significant association between IAS thickness and BAD. Although having a thick IAS does not carry a significant risk of having BAD, good prevention is important in avoiding this multi-complication disease. The normal range of IAS thickness can also be a guide for further comparisons in the future.
Synchronous Colorectal Adenocarcinoma And Renal Clear Cell Carcinoma

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INTRODUCTION

The incidence of synchronous colorectal cancer (CRC) and renal carcinomas (RCC) is raising which attributed to routine preoperative imaging. We reported 2 cases of CRC and RCC.

CASES

Case 1: A 67 years old man with no family history of malignancy presented with PR bleeding for 6 months. Biopsy taken from colonoscopy revealed moderately differentiated adenocarcinoma from fungating circumferential mass at rectosigmoid colon. CT staging showed enhancing mass in upper pole of left kidney measuring 4.0cm x 4.0cm x 2.4cm with a heterogeneously enhanced fungating sigmoid colon tumor. He underwent laparoscopic anterior resection and left partial nephrectomy. Histologically reveals T2N2M0 rectosigmoid adenocarcinoma and Fuhrmann grade 2 clear cell renal carcinoma. He recovered well post-operatively and had adjuvant therapy, with no recurrence at 6 months follow up.

Case 2: A 58 years old lady with no family history of malignancy presented with per rectal bleeding, had a colonoscopy showed low rectal tumour. Biopsy revealed moderately differentiated adenocarcinoma. CT staging showed low rectal tumour with mesorectal fascia involvement and 8.0cm x 6.0cm x 3.5 cm left renal mass. Neoadjuvant chemotherapy was commenced and she underwent laparoscopic assisted APR and left nephrectomy. Histologically reveal pT3N2 low rectal adenocarcinoma and Fuhrman grade 2 left renal clear cell carcinoma. No complication recorded post-operatively and she received adjuvant therapy, with no recurrence at 9 months follow up.

DISCUSSION

Synchronous CRC with RCC mostly diagnosed during staging imaging for either cancer. Hereditary non-polyposis colon cancer (HNPCC) should be suspected, and further testing is needed to look for associated tumor(s). Patient should preferably have genetic testing. Treatment options should be discussed in the multidisciplinary team meeting.
INTRODUCTION
In Malaysia, colorectal cancer is the second most common cancer. Similar to other cancers, histopathological classification and staging prognosticates and determines the further treatment needed by a patient.

Methods: Histopathological data of patients with colorectal cancer who were operated in our centre between January and November 2015 were collected prospectively. Characteristics such as grade, type, lymph node (LN) harvest, margins and final staging were tabulated and analysed to create this report.

RESULTS
From January to December 2015, 167 new cases of colorectal cancer were diagnosed at our centre. Adenocarcinoma was the commonest type of cancer seen, representing 95.8% (n = 160) of cases. A total of 99 (59.2%) patients were operated on during this period. The median number of LN harvested was 15 (Range: 1-63) with positive LN metastasis noted in 52.1% (n = 49) of cases. Inadequate LN harvest (<12 LNs) was seen in 25.5% (n = 24) of cases. Margins were involved in 5.3% (n = 5) of cases. Majority of the patients (55.6%) were having late stage (TNM Stage III and IV) disease, while 25.2% were in Stage II and 16.2% were in Stage I.

CONCLUSION
Adequate lymph node harvest and negative margins are important markers of surgical standards as it will define the prognosis and further management of the patient. Audits and analysis of the histopathological characteristics of colorectal cancers allows us to identify the shortcomings to facilitate improvement of the standard of care for patients with colorectal cancers.

KEYWORDS
Colorectal cancer; Histopathology; Lymph node harvest.
INTRODUCTION
Hereditary nonpolyposis colorectal cancer (HNPCC) and familial adenomatous polyposis (FAP) represent the most common hereditary syndromes associated with colorectal cancer (CRC). The former, HNPCC, is a disorder caused by mismatch repair gene mutations and accounted for about 5-8% of CRC. This mutation leads to synchronous or metachronous colonic and extracolonic malignancies.

METHODS
Data were prospectively collected on patients newly diagnosed to have colorectal malignancy with past history of gynaecological malignancy between January 2015 and December 2015. Patient’s demographic data, duration of CRC detection, location of CRC, types of gynaecological malignancy and short term outcome were analyzed.

RESULTS
Three patients were enrolled in this study, and consist of 1.8% of all new CRC cases (n=167). None has family history of malignancy. Median age of presentation of CRC was 52 years old (range: 37 – 63). One patient had synchronous CRC and endometrial cancer, while the other two developed metachronous colorectal malignancy after 8 and 15 months after detection of ovarian cancer respectively. Two patients presented with per rectum bleeding while one patient detected during staging CT scan for endometrial cancer. CRC seen was at ascending colon, hepatic flexure and descending colon each. Two patients had right hemicolectomy and one had synchronous left hemicolectomy with TAHBSO and pelvic lymph node dissection. All CRC were adenocarcinoma. After median follow up of 3 months, one patient developed pelvic recurrence.

DISCUSSION AND CONCLUSION
Synchronous and metachronous CRC with gynaecology malignancies only consists a small proportion of new CRC cases seen in our hospital. When detected, HNPCC should be suspected, and further testing is needed to look for associated tumor(s). Patient should preferably have genetic testing for microsatellite instability. Long term follow of patient in this group is need to ensure no malignancy at other organ(s).
Primary Colonic Lymphoma Presenting As Acute Abdomen: A Case Report
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INTRODUCTION
Primary colonic lymphoma is a rare cause of gastrointestinal malignancy accounting for 0.1-0.5% of colon malignancies worldwide[1]. We report a rare case of peritonitis secondary to perforated ascending colon lymphoma.

CASE REPORT
A 66-year-old gentleman with underlying hypertension presented with severe abdominal pain associated with fever and giddiness. Clinically he was pale and in septic shock. His abdomen was tender and guarded with generalized peritonitis. An emergency laparotomy revealed hugely dilated thick-walled ascending colon with perforation. Patient underwent right hemicolecction with end to side anastomosis. Patient had a remarkable recovery postoperatively. The histopathology showed a diffuse large B-cell lymphoma with immunohistochemistry showing CD20-positivity. Patient is currently started on his chemotherapy regime.

DISCUSSION
Primary colonic lymphoma presented with perforation and peritonitis is rare[2]. Early symptoms usually non specific and diagnosis can only be made histologically[3]. The treatment options involve chemotherapy, radiotherapy, surgery or combination of these[3]. However, the optimal treatment is still debatable and further research is required.

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Malignant Transformation Of Anal Paget’s Disease: A Rare Malignancy Of Anus
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INTRODUCTION
Extra-mammary Paget’s Disease (EMPD) was initially described by Radcliffe Crocker, an English dermatologist in year 1889. Anal EMPD may be present over a period of 10-15 years before evidence of cancer surface. We report a rare case of anal adenocarcinoma with background of Paget’s disease.

CASE PRESENTATION
KU is an 87 year old Iban lady with no known medical illness. She was referred to our colorectal out-patient clinic progressively increasing anal mass for 1 year. Her colonoscopy examination found an external anal canal tumour around the anus. Biopsy was taken and histopathology examination confirmed adenocarcinoma with background of Paget’s disease. She had abdomino-perineal resection done and histopathology examination revealed mucinous adenocarcinoma with underlying Paget’s disease.

DISCUSSION
Adenocarcinoma with underlying Paget’s disease is a very rare malignancy of anus. The most effective treatment is to obtained margin free surgical excision of all the involved epidermis.

CONCLUSION
Anal Paget’s disease with malignant transformation has very subtle presentation, a high level of suspicion should be considered in any patient with non-healing anal lesion, and biopsy is mandatory to exclude this diagnosis.
PO 9

Malrotated Caecum With Subhepatic Appendicitis

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Subhepatically located caecum and appendix is a very rare entity. It occurs due to the congenital anomaly in fetal gut rotation that results in incomplete rotation and fixation of the intestine. Appendicitis, which is a common surgical emergency, in combination with the abnormal subhepatic location, presents a great challenge in its diagnosis and management. Here, we describe a 42 year-old female with chronic dyspepsia who presented with severe epigastric pain and sepsis. The final diagnosis was acute appendicitis of the subhepatic appendix. Our discussion focused on the diagnostic approach, clinical and surgical management. We hope our report will increase the awareness among the clinicians and hasten the management of such rare condition to avoid complications.

PO 10

Synchronous Rectal Carcinoma: The Common Among The Rare Cancers

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Synchronous colorectal carcinoma is not infrequently encounter in day to day basis, nonetheless it still remains one of the rare colorectal tumor, with overall incidence of around 2%-5%.

Here we report a case of 56 years old lady with no known medical illness, presented to our surgical clinic with altered bowel habit, per rectal bleeding, loss of weight and loss of appetite for 2/12. No family history of colon cancer. Clinically patient not pale, hydration fair, not cachexic looking. Patient undergone colonoscopy examination on nearest date, and subsequently detected to have synchronous rectal tumor at 6cm and 15cm from anal verge, with narrow lumen but still able to push through colonoscope. Compute tomography done noted to have liver nodules suspicious of metastasis with two mass seen at rectal and recto sigmoid region.

Patient subsequently underwent anterior resection with covering ileostomy with no neoadjuvant chemo radiotherapy. Intra operation noted sealed perforation at distal tumor with no contamination. Liver nodules removed for histopathology examination.

Post-operative patient recovering well. Histopathology examination showed moderately differentiate adenocarcinoma from resected bowel. Liver nodules show hemangioma in nature.
Liposarcoma is a malignant tumor of mesenchymal origin in which the bulk of tumor differentiates into adipose tissue. The major sites of liposarcoma are the extremities, retroperitoneum and inguinal region. Retroperitoneal liposarcoma is a rare, biologically heterogeneous tumor that present considerable challenges due to its size and deep location. As a consequence, the majority of patients with high-grade retroperitoneal liposarcoma will develop locally recurrent disease following surgery, and this constitutes the cause of death in most patients.

Here we report a case of 50 male with no known medical illness, presented with abdomen distention for 5 years. Slowly progressive with no other bowel symptoms. Clinically patient well hydrated, not cachexic looking. Abdomen examination noted to have a firm to hard, non-tender, mobile, lobulated surface mass with size of 20cmx20cm noted over the epigastric regions. Computed tomography done showed a large retroperitoneal liposarcoma at right hypochondriac region, above right kidney with displacement of pancreatic body anteriorly.

Patient subsequently undergone exploratory laparotomy, with resection of retroperitoneal mass, partial pancreatectomy, splenic flexure resection and splenectomy. Post op patient complicated with pancreatic juice leak which treated conservatively. Patient subsequently undergo full recovery and discharge home. Histopathology showed liposarcoma.
OBJECTIVES
Fecal Occult blood Tests (FOBT) have become an important adjunct in screening patients for occult gastrointestinal bleeding in recent years. With newer FOBT kits like Fecal Immunochemical Test Kits, we would like to evaluate the role of performing same day upper and lower scopes in patients with positive results.

METHODS
All patients referred to our department with positive FOBT during the time period of 1st February 2015 to 31st December 2015 were subjected to same day upper and lower scopes at our center. The demographic data and scope findings from our scope room and clinic cards were reviewed.

RESULTS
46 patients were recruited for our study (29 males, 63%) during the study period. The median age in our study is 62 years (range 15-80 years). Majority of them were Chinese (56.5%), followed by Malays (23.9 %) and Iban (17.4%). 10 patients (21.7%) had normal upper and lower scopes and 36 patients (78.3%) had positive findings. From the upper scopes 3 patients (6.5%) each had Gastric ulcers and duodenal ulcers respectively all of the Forrest 3 classification. There were 2 patients (4.3%) with gastric polyps and one each with a duodenal and esophageal polyp respectively. The colonoscopic findings revealed 13 patients (28.2%) with adenomas, 12 patients with hemorrhoids (26.1%), 5 patients with diverticular disease (10.9%), 3 patients with ulcers (6.5%) and colitis and one rectal malignancy (2.2%).

CONCLUSION
In view of the recent widespread use of the FOBT kit for colorectal cancer screening, it is clear that when faced with a positive result further early endoscopic evaluation is highly recommended and essential in clinching vital diagnoses. Colonoscopic assessment is clearly indicated, whereas the upper endoscopy may be reserved for symptomatic patients.
Catastrophic Bleeding Post-Haemorrhoidectomy Due To Rare Diagnosis Of Acquired Haemophilia
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INTRODUCTION
Acquired form of haemophilia is rare and occurs due to spontaneous development of inhibitors to factor VIII (FVIII), typically presenting later in life despite no prior history of bleeding disorder. We present such case of catastrophic per rectal bleeding episodes post-haemorrhoidectomy secondary to acquired haemophilia.

CASE REPORT
A 68-year-old lady presented with gross fresh per rectal bleeding post haemorrhoidectomy. She was diaphoretic and tachycardic on presentation with haemoglobin of 7.7 g/dl. She had a history of Milligan-Morgan haemorrhoidectomy done a week ago. Serial checking of coagulation profile revealed isolated prolonged activated partial thromboplastin time (aPTT), ranging from 60-80 seconds. Sigmoidoscopy was performed which showed blood clots in rectum with blood oozing from open haemorrhoidectomy area. Rectal packing was done. She was transfused multiple units of packed red blood cell (RBC) and fresh frozen plasma (FFP). Another episode of fresh per rectal bleed followed for which she underwent evaluation under anaesthesia where only blood clots over the raw haemorrhoidectomy area was seen with no active bleeding. Haemostatic suturing of the area was done and transfused further with FFP as aPTT was still prolonged. Two days later she redeveloped bleeding and went into hypovolaemic shock. Further work-up showed deficiency of FVIII, less than 2.5% of normal and positive presence of FVIII inhibitors. She was diagnosed with acquired haemophilia. After consultation with haemotology, patient was given recombinant factor VIIa and VIII. She was also started on steroids. Patient was then transferred to a tertiary centre with haemotology expertise.

DISCUSSION
In this case of routine haemorrhidectomy, continuous per-rectal haemorrhage with isolated prolonged aPPT despite multiple transfusion of FFP, lead to further investigations which aided in diagnosis of acquired haemophilia.
Omental torsion is an uncommon cause of acute abdomen. It can present as right iliac fossa pain mimicking the presentation of acute appendicitis. The symptoms are unspecific and preoperative diagnosis is difficult. We report 2 cases of omental torsion who presented with right iliac fossa pain.

CASE 1
29 years old gentleman, no known illness, presented with fever and right iliac fossa pain. He was diagnosed with acute appendicitis and underwent open appendicectomy. Intraoperative findings showed white appendix with congested and twisted omentum. HPE of omentum came back as inflammation.

CASE 2
73 years old lady, underlying hypertension, presented with fever and right iliac fossa pain. She was diagnosed with acute appendicitis and underwent open appendicectomy. Intraoperatively, the appendix was white and the omentum was gangrenous twisted at a point where there is a presence of nodule. Postoperatively patient remained well. HPE of omentum came back as inflammation and nodule as lipoma.

Omental torsion occurs when omentum twists around its long axis causing ischemia and necrosis. It can be primary (idiopathic) or secondary (tumor/cyst). Omental torsion presentation are less systemically unwell compared to acute appendicitis. The increasing use of computer tomography (CT) in acute abdomen and diagnostic laparoscopy is helpful. Diagnosis is usually made intraoperatively and the mainstay of treatment is resection.

Our recommendation is routine inspection of the omentum in the presence of a normal appendix and terminal ileum. Preoperative high suspicion for the use of imaging and diagnostic laparoscopy may help in better surgical management.
Metachronous Tumor At Colostomy Site: A Rare Case Report

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Colorectal carcinoma is the most common malignancy in GI tract. Multiple primary carcinomas can occur as synchronous or metachronous tumor in the rectum and colon. We report a case of metachronous tumor present at colostomy site post resection of the primary carcinoma.

75 year old gentleman, with multiple comorbidities, presented with intestinal obstruction. Colonoscopy showed obstructing tumor near descending colon. Urgent CT abdomen showed proximal sigmoid colon carcinoma with nodes involvement. Patient was stabilized and underwent emergency defunctioning transverse colostomy under local. CT staging showed no local invasion or distant metastasis. Elective open anterior resection was done within a month. Postoperatively, patient was well but not fit for chemotherapy. Follow-up a year later revealed a polyp at distal limb of stoma. Full colonoscopy and excision of polyp done with histopathology of intramucosal carcinoma. CT re-staging showed no evidence of distant metastasis and distal loopogram was normal. Patient underwent wedge resection and closure of stoma.

Multiple primary adenocarcinoma of colon is rare with reported incidence of 2-5%. Metachronous tumor is defined as tumor present at different part of bowel after 6 months post surgery. Multiple hypotheses presented; undetected polyp adenoma-carcinoma sequence, familial cancer syndrome, cancer cell seeding from obstruction and persistent physical damage at colostomy site by faecal matter. The recommended management are case-specific based on clinical presentation which consist of broad local resection with wide resection of the muscle the abdominal wall for clear margin.

In conclusion, metachronous tumor at stoma is rare but can occur. High suspicion and detail stoma examination by surgeon and stoma nurses during follow up is an important for early detection to initiate intervention for better survival rate.
Endoscopic Clipping For Anastomotic Leak: An Alternative To Surgery

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Colorectal surgery can cause severe complications such as anastomotic leaks and fistulas. Surgical interventions is the best treatment but it increases the risk of morbidity and mortality. An effective and minimally invasive procedure might be a good alternative. We present a case of chronic colonic leak after colorectal cancer surgery which was successfully treated by colonoscopy clipping.

51 year old lady, with underlying hypertension and diabetes, was diagnosed to have rectal carcinoma in late 2013. She underwent transverse colostomy and neoadjuvant chemotherapy. Elective laparoscopic anterior resection was done in mid 2014. Post-operatively, was well and given adjuvant chemotherapy. Subsequently, she was planned for closure of stoma. Distal loopogram showed contained leaked near the anastomotic site but patient remain asymptomatic. Colonoscopy was performed and clipping over the leaked area was done. Repeated distal loopogram showed no evidence of contrast leaked as seen in previous images. Patient underwent closure of stoma and remained well.

Anastomotic leakage after a colorectal resection is one of the devastating complication encountering 3-21% of incidence and mortality up to 6-22 %. The presentations varies from clinically asymptomatic to generalized peritonitis or as fecal discharge from the wound requiring abdominal reoperation. Treatment for these patient can be long and complicated. Surgery is the mainstay of treatment but sometimes are not effective. Endoscopic clipping is a technique that enables the closure of gastrointestinal defect. A successful closure of leak or fistula is possible when no extraluminal abscess is present.

In conclusion, endoscopic clipping appears to be safe and effective in treating colorectal postsurgical leak or fistulas. We propose that chronic colonic leak/fistula who are not fit for surgery may be treated with endoscopic clipping.
Adult Onset Neuronal Intestinal Dysplasia With Concurrent Hirschprung’s Disease: A Rare Case

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Neuronal intestinal dysplasia (NID) is an entity of chronic intestinal pseudo-obstruction. Clinical presentation varies and the diagnosis is often delayed. We report a case in an adult man presenting with acute intestinal obstruction.

31 years old man, presented with constipation and abdominal distension. Bloods and radiological investigation was inconclusive. He underwent emergency laparotomy with intraoperative findings of dilated sigmoid colon and kinked descending colon causing closed loop obstruction. Transverse colostomy and per rectum manual stool evacuation was done. Suction rectal biopsy was done showing aganglion segment suggestive of Hirschsprung. He was schedule for elective panproctocolectomy. Intraoperative frozen section showed presence of ganglion cells at the descending colon. Final HPE revealed short segment of Hirschsprungs disease with concurrent neuronal intestinal dysplasia involving entire part of bowel. Postoperatively was discharge well.

Clinical presentation of NID is rather non-specific especially when dealing with adult age group. The median age of onset is between 17 years old. Majority presented with complete intestinal pseudo-obstruction at initial stage. Radiological assessment is needed to rule out mechanical cause of obstruction. However, high index of suspicion is important when dealing with patient with pseudo-obstruction. Only 20 to 66% of NID are associated with Hirschsprung’s disease. Conservative management showed effective for 64% of patients only. Thus, surgical intervention is the best option.

In conclusion, NID with concurrent Hirschprung’s disease is rare but should included as a differential diagnosis in those presenting with constipation. Biopsy is the best tool for diagnosis. We propose, the best long term treatment is still surgical intervention.
Rectal Gastrointestinal Stromal Tumour: A Rare Mesenchymal Tumour Of Gastrointestinal Tract
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Gastrointestinal stromal tumor (GIST) is a rare gastrointestinal tumor which arises from mesenchymal tumor. It can occur anywhere along the gastrointestinal tract, most commonly stomach. We report a case of GIST arising from rectum.

52 years old lady, underlying diabetes, presented only with per rectal bleeding. Colonoscopy showed external compression at rectum. CT TAP showed large extraluminal rectal mass. Open biopsy was done with histopathology suggestive of GIST. No regional lymphadenopathy or distant metastasis. Patient was treated with imatinib for 6 months. Repeated scan showed no improvement. Subsequently, patient was scheduled for elective ultra low anterior resection. Final histopathology showed tumor with positive immunochemistry stain for GIST in the spindle cells. Patient was discharge well.

Rectal GIST is rare with incidence of only 3% throughout the gastrointestinal tract. Clinical presentation varies and depending on its location. Colonoscopy is the modality for direct visualization of submucosal lesion. Tissue biopsy is crucial for making diagnosis which typically expresses CD117 or DOG1. The important management of GIST is risk assessment consist of location, size and mitotic rate. Neoadjuvant chemotherapy with Imatinib (tyrosine kinase inhibitor) is advisable for cytoreduction in large tumor. Radiological assessment for tumor respond should be done after 6 months. Standard treatment of localize GIST is complete surgical resection with negative tumor margins. Post treatment follow up requires imaging every 3 to 6 monthly for 3 years during adjuvant therapy.

In conclusion, rectal GIST is rare but one should include as a differential when dealing with rectal tumor. Although complete surgical resection is the principal curative procedure, the neoadjuvant adjuvant chemotherapy with imatinib can improve the overall survival rate in high risk GIST.
An Uncommon Cause Of A Common Condition: Appendicular Polyp Causing Appendicitis

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INTRODUCTION

Acute appendicitis is the commonest cause of acute abdomen encountered in surgical practice. However, acute appendicitis secondary to appendicular polyp is a rare occurrence. Literature search revealed the incidence of appendicular polyp based on autopsy series varies from 0.004% to 0.08%. Here, we describe a case of acute appendicitis secondary to appendicular polyp discovered during diagnostic colonoscopy.

CASE REPORT

A 19-year old lady presented to our department with history of right iliac fossa pain of 1 week duration. She otherwise has no other symptoms. Clinical examination revealed a tender mass and minimal guarding at right iliac fossa. Systemic review was unremarkable. Her total white count was high – 23.6 x 10⁹/L. Ultrasound abdomen revealed an appendicular abscess measuring 6.2 cm x 3.2 cm. She was started on antibiotics and managed conservatively. She responded and was discharged well. Diagnostic colonoscopy arranged 6 weeks later revealed a sessile growth in the appendicular lumen. There were no polyps in the rest of the large bowel. Biopsy revealed a benign inflammatory polyp. She was planned for an interval laparoscopic appendicectomy.

CONCLUSION

The presence of polyp in the appendicular lumen may leads to occlusion. This cause increased intraluminal pressure, compromised vascularity followed by inflammation and infection causing appendicitis. Appendicular polyp likely behaves similar to another colonic polyps hence polypectomy is warranted. Endoscopic removal of appendicular polyp is feasible, however our patient was offered interval laparoscopic appendicectomy in view of history of previous appendicular abscess.
Emergency Presentation Of Colorectal Cancer In Sarawak General Hospital And Its Outcome

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INTRODUCTION
Emergency presentation for colorectal cancer (CRC) has been associated with high morbidity and mortality. The aim of this study is to analyze the parameters and the outcome of CRC patients with emergency presentation.

METHOD
In total, 44 CRC patients with emergency presentation between January 2015 and November 2015 in Sarawak General Hospital (SGH) were analyzed in this study.

RESULTS
There were 26(59.1%) male patients and 18(40.9%) female patients. The median age of presentation was 65.5(31-85) years old. Chinese patients were 16(36.3%), Malays were 15(34.1) and the local Dayaks made up the rest 13(29.5%). 29(65.9%) of them presented with intestinal obstruction. 5(11.4%) of the patients has positive family history for CRC. Left sided tumour was more common and was found in 32(72.7%) patients. 32(72.7%) of patients were operated, of them 13(40.6%) patients needed peri-operative ICU admission with a mean of 4(1-15) days. 4 (12.5%) patients had early mortality. Post-operative hospital stays were prolonged with a median of 11(4-67) days.

CONCLUSION
Emergency presentation of CRC is more common in males with equal racial profile amongst Sarawakians. Left sided tumours are far more common than the right sided tumours, with only about 70% of all them were operated as the rest 30% were deemed unfit or having far too advance disease. ICU admission was warranted for the 40% of patients operated on. Mortality rate was high at 12%. Post-operative hospital stay was also lengthened. A comprehensive and vigorous screening program has to be implemented to reduce the incidence of emergency presentation of CRC.
A Randomised Controlled Trial Of Novel Treatment For Hemorrhagic Radiation Proctitis

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BACKGROUND
Chronic radiation proctitis is a troublesome condition. Various methods have been used for treatment of hemorrhagic radiation proctitis with variable results. Currently, the preferred treatment is formalin application or endoscopic therapy with argon plasma coagulation. Recently, a novel therapy with colonic water irrigation and oral antibiotics showed promising results and more effective compared to 4% formalin application for hemorrhagic radiation proctitis.

OBJECTIVE
To compare the effect of water irrigation and oral antibiotics versus 4% formalin application in improving per rectal bleeding due to hemorrhagic radiation proctitis. We also looked at other symptoms such as diarrhoea, tenesmus, stool frequency, stool urgency and endoscopic findings.

PATIENT AND METHOD
We conducted a study on thirty four patients with hemorrhagic radiation proctitis and randomly assigned patients to two treatment arm groups (n=17). The formalin group underwent 4% formalin dab for 3 minutes then another session 4 weeks later. The irrigation group self administered daily rectal irrigation with 1000ml of water at home for 8 weeks and consumed oral metronidazole and ciprofloxacin during the first one week. We analyzed the patients’ symptoms and endoscopic findings before and after total of 8 weeks of treatment in both groups.

RESULTS
The formalin group showed significant improvement in bleeding (p = 0.003) where as the irrigation group showed improvement in diarrhoea (p = 0.018) and tenesmus (p = 0.024). When compared between the two treatments, irrigation technique demonstrated better improvement in tenesmus (p = 0.043).

CONCLUSION
This novel treatment of water irrigation and oral antibiotics technique showed benefit in treating hemorrhagic radiation proctitis. It could be a new treatment option which is safe and conveniently self administered at home or used as a combination with other therapies to improve the treatment outcome for hemorrhagic radiation proctitis.
INTRODUCTION
Rectal prolapse is a socially debilitating, and affects elderly female predominantly. Its surgical management depends on patient’s fitness for surgery, predominant symptom and any concomitant bowel pathology.

OBJECTIVE
This study was undertaken to evaluate the early short term result of laparoscopic rectopexy without resection for the surgical management of a full thickness rectal prolapse.

METHODS
Data were prospectively collected on patients who underwent laparoscopic rectopexy without resection for full thickness rectal prolapse between January 2015 and December 2015. Patient’s demographic data, operative time, duration of inpatient stay, prolapse recurrence, post operative bowel frequency including operative morbidity and mortality were recorded during clinic follow up.

RESULT
There were 3 female patients with a mean age of 71.6 years (range 62 to 82 years). All patients included in this study presented with a full thickness rectal prolapse with a diarrhoea predominant symptom. Mean duration of surgery was 65 minutes (range 45 to 90 minutes) Intraoperative recorded blood loss were less than 100 mls and no patients required packed cells transfusion. The recorded median hospital stay was 3 days. Of note, patients experienced a mean reduction of 4 episodes (range 1 to 7 bowel openings) of bowel opening per day following surgery compared to baseline. There were also no prolapse recurrence nor other surgery related morbidity and mortality recorded after a mean follow up of 27 weeks (range 22 weeks to 29 weeks)

CONCLUSION
Based on these initial results, laparoscopic rectopexy without resection offers a good option with low morbidity and mortality for the management of a full thickness rectal prolapse in patients with accompanying diarrhea predominant symptoms in expert hand.
A Case Report: Gardner's Syndrome Revisited
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BACKGROUND
Desmoid tumors are rare benign tumors. They account for about 0.03 percent of all neoplasms and less than 3 percent of all soft tissue tumors. Desmoids may arise sporadically or in association with familial adenomatous polyposis (FAP) in Gardner's syndrome. Although benign, desmoids can cause substantial morbidity and mortality.

CASE PRESENTATION
We report a young female patient with a background history of papillary thyroid cancer and FAP, who presented with intraabdominal desmoid tumor. She was in sepsis at presentation and severely malnourished. She was eventually optimized nutritionally and proceeded with the surgery. Post operatively, her recovery was complicated with intraabdominal sepsis which required a re-laparotomy. Fortunately, she recovered well thereafter and was discharged.

CONCLUSION
The natural history of desmoid tumor is prolonged, variable and unpredictable, and it is not clear that any intervention improves survival. Management of dermoid tumors consist of surgery, radiotherapy and systemic therapy in various combinations. However, approaches to the optimal treatment and outcomes are confounded by many factors. This includes the unpredictable natural history of desmoid tumor which possibly regresses in absence of any treatment. The optimization of the nutritional status in surgical patients remains a challenge, especially in critically ill patients. It is known that malnutrition and weight loss before surgery has a strong prognostic indicator of poorer outcome in terms of survival and response to surgical treatment. Therefore, in cases of desmoids post total colectomy, it is important to assess the risk and benefits of surgery in this group of patients.
UKMMC Colorectal Centre In Managing Complete Rectal Prolapse: Altemeier’s Revisited

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INTRODUCTION
Complete rectal prolapse is a socially disabling condition afflicting both the very young and the old. Demography shows that about 80 to 90% of women is effected than man. On the early days rectal prolapse is managed with honey suppositories and gravity to reduce the prolapsed bowel. Modern management has since evolved with a better understanding of the aetiology and pathophysiology of the disease. The myriad of methods available to correct the underlying anatomic defects in complete rectal prolapse poses a difficult question for the surgeon, i.e., the choice of an ideal operation. Among factors to consider in the selection of a treatment option are the age and health of a patient, functional status, and the benefits vs. the disadvantages of a surgical technique.

CASE
A 74 year old male underlying diabetes and hypertension presented to emergency department with complaint of having hematochezia, mass protrusion through the anus, otherwise no alteration of bowel habit and no prior history of pelvic surgery. Further investigation was performed with colonoscopy and it showed rectal mucosa ulceration. Anal manometry results were bowel incontinence due to rectal mucosal prolapse at anal sphincter. Subsequently this patient underwent Altemeier’s Rectosigmoidectomy. Patient was discharged home and during clinic follow up he was doing well and no active complaint.

CONCLUSION
The choice of an ideal operation for complete rectal prolapse remains a perplexing problem for the surgeon. Factors that influence the choice of procedure include the age and health of the patient, reported success rates, and complications of a procedure. Abdominal procedures have traditionally been associated with a lower recurrence rate and better functional outcome. Previous studies have reported recurrence rates of 2 to 9 percent. This procedure remains popular for younger patients with low operative risk. Perineal rectosigmoidectomy, first described by Mikulicz and popularized by Altemeier, remains a popular procedure for elderly and high surgical risk patients because it is technically easy to perform with low morbidity and reported recurrence rates as high as 50 to 60 percent. Even though the recurrence rate is much higher than that reported for abdominal rectopexy, most proponents argue that a repeat perineal procedure can be performed safely if necessary. Furthermore, recent reports on perineal rectosigmoidectomy have been favourable.
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Colonic Stenting: Hospital Seberang Jaya Experience

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OBJECTIVE
This study is to review our experience and assess the effectiveness of colonic stenting in malignant colon obstruction, as a “bridge to surgery” or as a palliative treatment, in terms of safety, efficacy and clinical outcomes.

METHOD
This is a retrospective study conducted in Hospital Seberang Jaya from January 2012 to April 2015

RESULT
A total of 30 patient underwent colonic stenting (mean age 64.7 years, range 33 - 92 years, 19 men and 11 women). The procedure was performed as bridge to surgery in 18 patients and for palliative managements in 12 patients. The site of obstruction was at the hepatic flexure 1 patient (3.33%), splenic flexure 1 patient (3.33%), descending colon 1 patient (3.33%), sigmoid 13 (43.3 %), rectosigmoid 9 patient (30%), rectum 4 patient (13.33) and stoma 1 patient (3.33%). Technical success was obtained in 28 patients (93.33%), failure occurred in two patients, one was due to perforation during the procedure (n=1) and migration of stent causing colovesical fistula (n=1). Clinical success obtained in all 28 patients with successful stent placement. In the case of rectal perforation, emergency Hartman’s procedure was done. While for the colovesical fistula case a new non covered SEMS was inserted and the patient symptoms resolved.

CONCLUSION
Colonic endoscopic stenting is safe and effective in the management of malignant colorectal obstruction for palliative care or “bridge to surgery” with a low complication rate 6.7%
OBJECTIVE
Hirschprung’s disease in the adult is a rare condition but needs to be considered as a diagnosis in any case of intractable constipation. Diagnosis of the disease in adults are challenging.

METHOD
Patient diagnosed with Adult Hirschprung based on rectal biopsy or barium enema from 2011 – 2015 in single centre (Hospital Selayang) were included.

RESULTS
A total of 7 patients were identified. Out of the 7 patients, 4 (57%) were male and 3 (43%) were female with a mean age of 28 years old (ranging from 14-42). 5 (71%) patients presented with chronic constipation and the remaining 2 (29%) presented with intestinal obstruction symptoms. Modality of diagnosis was by rectal biopsy for 3 (43%) or combination of rectal biopsy and barium enema for 4 (57%). Out of 7 patients, 6 (68%) underwent operation. Out of that number, 2 (33.3%) people underwent 2 staged surgery and 4 (66.7%) people underwent single staged surgery. Definite surgery performed for them was anterior resection (1), panproctocolectomy with ileoanal pouch and defunctioning ileostomy (5). All patient were discharged relatively well, 3 had AUR secondary to neurogenic bladder, 1 was complicated with anovaginal fistula that spontaneously healed. On longer term followup, 2(33%) patients were found to have incontinence and occasional soiling.

CONCLUSION
Though very rare, high index of suspicion of adult Hirschprung’s should be maintained especially in patients with recurrent chronic constipation needing lifelong laxative, enema or mechanical washout.
A Case Report Of Young Patient With Perforated Diverticulitis

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INTRODUCTION
Colonic diverticular disease refers to small outpouchings of colon resulting from mucosal herniation via the colonic wall at sites of vascular perforation. Case of symptomatic diverticulosis in young age group is often rare and isolated. Here, we report on case of young patient who presented with perforated sigmoid diverticulitis.

CASE REPORT
23 year old gentleman presented with lower abdominal pain for 3 days. He had fever. No history of per rectal bleeding. On abdominal examination noted maximal tenderness at lower abdomen with positive rebound tenderness. A diagnosis of acute appendicitis were made and he was scheduled for open appendicectomy. Intra-operatively noted white appendix however there were pus collection in the abdomen. Converted to lower midline laparotomy and noted slough at mid sigmoid colon and thickened wall. We proceed with sigmoid colectomy with primary anastomosis and covering ileostomy. Recovery was uneventful. Subsequent distal loopogram was normal without any residual diverticular. Colonoscopy showed normal remaining colon.

DISCUSSION
Incidence of colonic diverticular disease is rare in young patient. It prevalence rises with age and most patients are asymptomatic. However, only 10-20% might presented with clinical syndrome of diverticulitis or diverticular bleeding. Majority of the study on diverticulosis define patient age 50 years or less were young patient to have the disease. Diverticulitis in young patient usually occur from true diverticulum i.e: meckel’s diverticulum. False or sigmoid diverticulum in young patient is difficult to diagnose unless patient is symptomatic. It often diagnosed incidental during colonoscopy or intra-operatively like our patient.

CONCLUSION
Colonic diverticulitis can be one of the differential diagnosis of young patient come with acute abdomen and complete resection of the of the colonic diverticular segment is the treatment of choice to prevent recurrent complication.
INTRODUCTION
Retroperitoneal leiomyosarcomas arising from the mesentery are rare. These account for 5.8% of all soft tissue sarcomas. Most of these tumors present in late life with female preponderance. Diagnosing these tumors at an early stage is difficult due to their location. We report a case of leiomyosarcoma arising from the sigmoid mesocolon due to its rarity and unusual clinical presentation.

CASE REPORT
A 56 years old lady presented with chief complaint of abdominal discomfort for 4 months duration which is more prominent on left side. It is associated with abdominal mass that is increasing in size. However there was no obstructive symptoms.

On examination, the mass size is equal to 32 weeks size uterus, soft and not mobile.

CT abdomen reported that the mass is arising from the pelvic region most likely ovary in origin with liver metastasis. She was scheduled with exploratory laparotomy by gynaecology team and was referred on table to us in view of the mass was arising from sigmoid mesocolon. It was a huge sigmoid mesocolon tumor which is hard & mobile. Left ureter was iatrogenically cut during mobilization and repaired by urology team. Tumor was removed and proximal sigmoid anastomosed with upper rectum.

Patient is currently doing well and planned for chemotherapy by oncology team.

DISCUSSION
Smooth muscle cells make up the involuntary muscles, which are found in most parts of the body, including the uterus, stomach and intestines, the walls of all blood vessels, and the skin. It is therefore possible for leiomyosarcomas to appear at any site in the body. They are most commonly found in the uterus, stomach, small intestine and retroperitoneum. Gastrointestinal leiomyosarcomas might come from smooth muscle in the GI tract or, alternatively, also from a blood vessel.

CONCLUSION
Retroperitoneal leiomyosarcoma is a rare disease and presented late due to its location. Like in this patient, the cancer has already spread to the liver. The tumor need to be resected and systemic chemotherapy given in view of distant metastasis.