Your care was exceptional...

Because of you, I am with my family again.

Feel the Moment

Once a day dosing

Dual elimination pathway

Rapid & Deep Tissue Penetration

Effective Empirical Treatment

Rocephin® Basic Succinct Statement:
Composition: Ceftriaxone; Therapeutic Indications: Sepsis; meningitis; disseminated Lyme borreliosis (early and late stages of the disease); abdominal infections (peritonitis, infections of the biliary and gastrointestinal tracts); infections of the bones, joints, soft tissue, skin and of wounds; infections in patients with impaired defense mechanisms; renal and urinary tract infections; respiratory tract infections, particularly pneumonia, and ear, nose and throat infections; genital infections, including gonorrhoea and perioperative prophylaxis of infections; Dosage & Administration: Adult & child >12yr, 1-2 g once daily. Severe infections: Up to 4 g once daily. Neonate, infant & child (15 days-12yr) 20-80 mg/kg body wt. once daily. Neonate up to 14 days 30-60 mg/kg body wt. once daily, not to exceed 50 mg/kg. Meningitis: Infant & child, initially 100 mg/kg/once daily. Max: 4 g/day. Lyme borreliosis: Adult and child 50 mg/kg/once daily for 14 days. Max: 2 g/day. Gonorrhoea: 250 mg IM single dose. Perioperative prophylaxis: 1-2 g, 30-60 min pre-op; Duration of therapy: varies according to the course of the disease; Contraindications: Known hypersensitivity to cefalosporins. Neonate <28 days on treatment with calcium containing IV solution including continuous calcium containing infusions such as parenteral nutrition because of risk of precipitation of ceftriaxone-calcium. Hyperbilirubinaemia newborns and premie newborns should not be treated with ceftriaxone; Warnings & Precautions: Anaphylactic shock cannot be ruled out. Hypersensitivity to penicillins, superinfections, hyperbilirubinaemia neonates, severe renal & hepatic dysfunction. Monitor CRIC during prolonged treatment. Pregnancy & Lactation: Undesirable Effects: Gastrointestinal complaints. Haematological changes. Skin reactions; Drug Interactions: Diluents containing Calcium (Ringer’s solution, Hartmann’s solution). Amsacrine, vincsmycin, fluconazole & aminoglycosides; Pregnancy & Lactation: Safety in human pregnancy has not been established. Caution should be exercised when administered to a nursing woman; Packing: IM/IV via 250 mg x 1’s, 500mg x 1’s. 1 g x 1’s.

Full details on composition, indications, contraindications, side effects, dosage & precautions are available upon request. (FEPI July 2014)
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Join Us
For Lunch Satellite Symposium @ Friday, March 9
Speaker: Prof Yoshiharu Sakai, Kyoto University

Visit our booth # 25 & 26 for more exciting information.
Malaysian Society of Colorectal Surgeons Office Bearers 2017 - 2019 1
Coloproctology 2018 Organising Committee

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Malaysian Society of Colorectal Surgeons Office Bearers 2017 - 2019

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Dato' Dr Meheshinder Singh

Immediate Past President
Dr M Sarkunnathas

Vice President
Associate Professor Datuk Dr Ismail Sagap

Hon Secretary
Professor Dr April Camilla Roslani

Hon Treasurer
Dr Manohar Padmanathan

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Coloproctology 2018
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Dato' Dr Meheshinder Singh

Treasurer
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Scientific Chairman
Associate Professor Datuk Dr Ismail Sagap

Committee Members
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Professor Dr April Camilla Roslani
Dato' Dr Fitjerald Henry
Dr Jasiah Zakaria
Dr Lu Ping Yan
Dr Luqman Mazlan
Dr M Sarkunnathas
Dr Paul Selvindoss
Dr Samuel Tay
Dato' Dr Yunus Gul Alif Gul
Puan Mariam Hj Mohd Nasir
It gives me great pleasure to welcome each and everyone of you to COLOPROCTOLOGY 2018 in the historic state of Malacca.

The meeting this year is of historical significance as it marks exactly 15 years since we had our very first conference which coincidentally was held here in Malacca. Over the years, we have had the privilege of having the presence of distinguished and renowned experts from around the world who have imparted their knowledge and made our meetings a resounding success.

Similarly, this year, the Organising Committee has worked tirelessly to put together an interesting programme involving an array of colorectal topics presented by a distinguished faculty. The programme will begin with a pre-congress workshop on anorectal sepsis wherein experts shall share their views and demonstrate the roles and practical use of both an endoanal ultrasound and an MRI as a preoperative tool.

This will be followed by lectures on various colorectal topics - pelvic floor disorders, inflammatory bowel disease, colorectal cancers including a segment on genomics of colorectal cancer. These shall be delivered in various symposia, plenaries and the “how I do it video sessions”.

As always, an interactive allied health programme which has garnered lots of interest amongst enterostomal nurses from near and afar will run concurrently.

A special feature of our conference is a separate symposium held on the final day for Colorectal cancer patients and survivors. The objective is to impart knowledge and update patients / survivors on current issues in colorectal cancer at the same time create a platform of psychosocial support amongst them.

Let me take this opportunity to share with you an upcoming event that you may want to attend. We have been given the privilege of hosting the next Asia Pacific Federation of Coloproctology (APFCP) Congress which is scheduled from 14th to 17th March 2019 to be held in the capital city of Kuala Lumpur. Do block those dates and we hope to see you at this conference.

A word of thanks to the medical and pharmaceutical industry who has always been pillars of support in all our endeavors and in making our meeting a success.

May I wish you all an enlightening and a most fruitful meeting here in Malacca and do take the opportunity to visit the various historic sites.

Dato’ Dr Meheshinder Singh
President, Malaysian Society of Colorectal Surgeons & Organising Chairman, Coloproctology 2018
A Rahman A Jamal  
Director  
UKM Medical Molecular Biology Institute (UMBI)  
National University of Malaysia  
Kuala Lumpur  
Malaysia  

Azmi Mohd Nor  
Dean  
Kulliyyah of Medicine  
International Islamic University Malaysia  
Pahang  
Malaysia  

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Head of Surgical Services and Head of Department Surgery  
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Buvanesvaran Tachina Moorthi  
Consultant General & Colorectal Surgeon  
Gleneagles Penang  
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Kuching, Sarawak  
Malaysia  

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Registered Nurse  
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Kuching, Sarawak  
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Professor & Senior Consultant Colorectal Surgeon  
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Faculty of Medicine  
University of Malaya  
Kuala Lumpur  
Malaysia  

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Director  
Minimally Invasive Surgery Center  
China Medical University Hospital  
Taichung  
Taiwan  

Ns Asrizal  
CEO Asri Wound Care Centre  
Medan-North Sumatera  
Indonesia  

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Melaka  
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Nursing Administration  
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Malaysia

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Radiotherapy & Oncology  
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Head of Radiology Department  
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Dietitian  
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Khong Tak Loon  
Colorectal Surgeon  
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Malaysia

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Klinik Kanak-Kanak Kwan  
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Malaysia

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President
Malaysian Enterostomal Therapy Nursing Association
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National Federation of Ostomates
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Lawyer
Zaid Ibrahim & Co
Kuala Lumpur
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Graduate School of Medicine
Kyoto University
Japan

Zaidi Zakaria
Head Department of Surgery
Hospital Universiti Sains Malaysia
Kelantan
Malaysia
# Programme Summary

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<th>10th March 2018 (Saturday)</th>
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<tr>
<td>Time</td>
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<td>Registration</td>
</tr>
<tr>
<td>0730 - 0800</td>
<td>SYMPOSIUM 1 Colorectal Carcinoma</td>
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<tr>
<td>0800 - 0830</td>
<td>Welcome &amp; Opening Speech</td>
<td>SYMPOSIUM 8 Colorectal Tumours Genetics</td>
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<tr>
<td>0830 - 0900</td>
<td>SYMPOSIUM 2 Allied Health Profession Session (1)</td>
<td>FORUM</td>
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<tr>
<td>0900 - 0930</td>
<td>SYMPOSIUM 2 Allied Health Profession Session (2)</td>
<td>SYMPOSIUM 9 Allied Health Profession Session (4)</td>
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<td>0930 - 1000</td>
<td>PLENARY 1</td>
<td>PLENARY 3</td>
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<tr>
<td>1000 - 1030</td>
<td>Coffee</td>
<td>SYMPOSIUM 10 (CORUM 1)</td>
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<tr>
<td>1030 - 1100</td>
<td>SYMPOSIUM 3 Perioperative Issues in Colorectal Surgery</td>
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<tr>
<td>1100 - 1130</td>
<td>SYMPOSIUM 4 Allied Health Profession Session (3)</td>
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<tr>
<td>1130 - 1200</td>
<td>Lunch Satellite Symposium (Medtronic)</td>
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<tr>
<td>1200 - 1230</td>
<td>Lunch / Friday Prayers</td>
<td>Lunch Satellite Symposium (Servier)</td>
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<td>1230 - 1400</td>
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<td>1400 - 1430</td>
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<tr>
<td>1430 - 1500</td>
<td>PLENARY 2</td>
<td>SYMPOSIUM 14 Colorectal Potpurri</td>
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<tr>
<td>1500 - 1530</td>
<td>WORKSHOP 1</td>
<td>WORKSHOP 2</td>
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<td>1530 - 1600</td>
<td>SYMPOSIUM 5 Pelvic Floor Disorder</td>
<td>SYMPOSIUM 15 Allied Health Profession Session (6)</td>
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<tr>
<td>1600 - 1630</td>
<td>Official Poster Round / Tea</td>
<td>VIDEO SESSION</td>
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<tr>
<td>1630 - 1700</td>
<td>SYMPOSIUM 7 IBD</td>
<td>PROFESSORS’ CORNER</td>
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<tr>
<td>1700 - 1730</td>
<td></td>
<td>Tea</td>
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<tr>
<td>1730 - 1800</td>
<td></td>
<td>1700 - 1830 Meeting on Credentialing of Common Endoscopic Procedures</td>
</tr>
<tr>
<td>1800 - 1930</td>
<td>MSCR Annual General Meeting</td>
<td>OSTOMY CASE STUDIES</td>
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<tr>
<td>2000 - 2200</td>
<td>Gala Dinner</td>
<td></td>
</tr>
</tbody>
</table>

**8th March 2018**
- Pre-Congress Workshop - Anorectal Sepsis

**11th March 2018**
- Postgraduate Round
Anorectal Sepsis

VENUE: Function Room 2

CHAIRPERSONS: Ismail Sagap / Luqman Mazlan

PROGRAMME:

1345-1400  Registration

1400-1405  Introduction by the Chairperson

1405-1500  Endoanal Ultrasound
            Charles Tsang Bib Shiou

1500-1530  Coffee

1530-1630  The Role of MRI in Perianal Sepsis (PAGE 18)
            Hamzaini Abdul Hamid

1630-1730  Q & A
## Daily Programme
### 9th March 2018 (Friday)

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
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<tbody>
<tr>
<td>0730-0815</td>
<td><strong>REGISTRATION</strong></td>
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</tbody>
</table>
| 0815-0930 | **SYMPOSIUM 1**  
Colorectal Carcinoma  
Chairpersons: Ismail Sagap / Nil Amri Mohamed Kamil  
MDT in Managing Colorectal Cancers in Malaysia *(PAGE 18)*  
Luqman Mazlan  
Pre-Operative MRI Staging of Rectal Carcinoma *(PAGE 19)*  
Hamzaini Abdul Hamid  
The Role of Neoadjuvant Chemotherapy Alone in Improving Survival of CRC  
Fuad Ismail |
| 0930-1015 | **PLENARY 1**  
Chairperson: Wan Khamizar Wan Khazim  
The Post-CCRT Watch and Wait Strategy in Rectal Cancer - Challenges Ahead  
Samuel Tay |
| 1015-1045 | **Coffee**                                                          |
| 1045-1200 | **SYMPOSIUM 3**  
Perioperative Issues in Colorectal Surgery  
Chairpersons: Ibarmaraj T Renganathan / Zaidi Zakaria  
Best Approach in Treating Anastomotic Leak *(PAGE 20)*  
Yunus Gul Alif Gul  
The Role of ICG in Colorectal Surgery *(PAGE 20)*  
Paul Selvindoss  
Anterior Resection Syndrome  
Charles Tsang Bib Shivou  
Challenges in Setting Up ERAS Protocol in Malaysian Modern Practice *(PAGE 21)*  
Fitzgerald Henry |
| 1045-1200 | **SYMPOSIUM 4**  
Allied Health Profession Session (2)  
The IOA and the ASPOA: Organizations that Support the Rights and Quality of Life of Ostomates Worldwide *(PAGE 21)*  
Ronaldo Lora  
The Importance of Stoma Site Marking in Preventing Stoma and Peristomal Complications *(PAGE 22)*  
Madalinab Tan  
Special Considerations in Paediatric Ostomy *(PAGE 22)*  
Norlizah Turiman  
Addressing the Issue of Costing for Stoma Patients in Indonesia *(PAGE 23)*  
Idramsya  
Body Image and Intimacy: How do you Talk to your Patients About it? *(PAGE 23)*  
Madalinab Tan |
| 1045-1200 | **FUNCTION ROOM 2**  
Welcome & Opening Speech by Chairman Coloproctology 2018  
Meheshinder Singh  
Montage Presentation  
Mobd Rabime Al Wabab  
Tribute to late Mr Michiaki Takaishi  
Past-President of Japan Ostomy Association  
Mariam Hj Mobd Nasir |
| 0900-1000 | **SYMPOSIUM 2**  
Allied Health Profession Session (1)  
Enterostomal Therapy Nursing in Asia: What is the Future? *(PAGE 19)*  
Mariam Hj Mobd Nasir  
Advances in the Management of Colon Rectal Cancer  
Manohar Padmanathan  
Convexity: Addressing the Challenges Surrounding the Use of Convexity  
Rociza Mohamad |
Daily Programme
9th March 2018 (Friday)

1200-1240  Lunch Satellite Symposium (Medtronic)
Chairperson: Fitjerald Henry
The World's First Smart Stapler
Yosiharu Sakai
STRAITS BALLROOM

1240-1415  Lunch / Friday Prayers

1415-1500  PLENARY 2
Chairperson: April Camilla Roslani
TaTME in Rectal Cancer Surgery - Outcome Results
William Chen
STRAITS BALLROOM

1500-1615  SYMPOSIUM 5
Pelvic Floor Disorder
Chairpersons: Ahmad Shanwani / Jasiah Zakaria
Diagnostic Approach to Obstructed Defecation Syndrome
Azmi Mohd Nor
Pelvic Organ Prolapse in Women - Best Approach
Khong Su Yen
What's New in Rectal Prolapse?
Ridzuan Farouk
Anal Incontinence - When To Intervene?
Charles Tsang Bih Shiou

1400-1500  WORKSHOP
1: Convatec
FUNCTION ROOM 2

1500-1600  SYMPOSIUM 6
Allied Health Profession Session (3)
WCET International Ostomy Guidelines Review
Mariam Hj Mohd Nasir
Palliative Stoma Care Management
Rhyan A Hitalla
Performing Prayers: Advice and Tips for Muslim Ostomate
Mobd Rabime Ab Wabab

1600-1640  OSTOMY CASE STUDIES
Chairpersons: Tan Guat Ee / Norlizah Turiman
Management of Complicated Peristomal Skin Stripping Due to Complicated Stoma Site
Rhyan A Hitalla
"Honey, please be patient with me…" When Stress be a Part in Learning Stoma
Wan Nadia Nabila W Ismail
"No I'm too young…. " Low Rectal Cancer in Teenagers
Irfan Hazimie Othman
Management of Peristomal Complication with Enterocutaneous Fistula for Loop Stoma with NPWT and a Parcel Dressing
Ns Asrizal

1640-1700  The Impact of Excellent Enterostomal Therapist Nurse
Rohani Arshad

1630-1745  SYMPOSIUM 7
IBD
Chairpersons: Chieng Tiong How / Luqman Mazlan
Complex Perianal and Fistulizing Crohn's Disease. When to Call the Surgeons?
Ida Normiba Hilmi
Surveillance Strategy and Management of UC-Related Dysplasia: The Best Practice
Raja Affendi Raja Ali
Optimising Medical Treatment for IBD: What's New?
Nazri Mustafa
Role of Surgery in Inflammatory Bowel Disease - Surgeon's Perspective
April Camilla Roslani

1800-1930  MSCRS Annual General Meeting
FUNCTION ROOM 1

2000-2200  GALA DINNER
BALLROOM
### Daily Programme
10th March 2018 (Saturday)

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<thead>
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<tbody>
<tr>
<td>0800-1015</td>
<td>STRAITS BALLROOM&lt;br&gt;Symposium 8&lt;br&gt;Colorectal Tumours Genetics</td>
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<tr>
<td></td>
<td>Chairperson: Nurhashim Haron</td>
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<td>Whole Genome Sequencing of CRC: Are Our Tumours Different from Others?</td>
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<td>Syakima Ab Mutalib</td>
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<tr>
<td>0800-1015</td>
<td>Coffee</td>
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<tr>
<td>0800-0915</td>
<td>STAND BALLROOM&lt;br&gt;Symposium 8&lt;br&gt;Colorectal Tumours Genetics</td>
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<td>Syakima Ab Mutalib</td>
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<tr>
<td>0800-0915</td>
<td>Coffee</td>
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<tr>
<td>0830-0920</td>
<td>Function Room 2&lt;br&gt;Forum&lt;br&gt;Integrity &amp; Professionalism in Stomacare</td>
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<td></td>
<td>Panelist: Robani Arisb / Manobar / Padmanathan / Tan Guat Ee / Rhyaz A Hitalla / Ni Arizal / Madalina Tan</td>
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<td>Moderator: Mariam Hj Mobd Nasir</td>
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<tr>
<td>0915-1000</td>
<td>Plenary 3&lt;br&gt;Chairperson: Fitjerald Henry</td>
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<tr>
<td></td>
<td>Surgeons’s Perspective on IBS&lt;br&gt;(Page 30)</td>
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<td>Francis Seow-Cboen</td>
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<tr>
<td>0915-1000</td>
<td>Coffee</td>
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<tr>
<td>0900-1030</td>
<td>SYMPOSIUM 10&lt;br&gt;(CORUM 1)&lt;br&gt;Post Rectum Removal: Problems Poo-ing?</td>
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<td>Chairperson: Fitjerald Henry</td>
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<td>Chemotherapy: Overcoming the Common Side Effects</td>
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<td>Lam Kai Seng</td>
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<td>Lam Kai Seng</td>
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<tr>
<td>0900-1030</td>
<td>Coffee</td>
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<tr>
<td>1000-1030</td>
<td>Visit Booth / Coffee</td>
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<tr>
<td>1000-1030</td>
<td>Coffee</td>
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</table>

### Symposium 8
- **Colorectal Tumours Genetics**
  - Chairperson: Nurhashim Haron
  - Whole Genome Sequencing of CRC: Are Our Tumours Different from Others?
  - Syakima Ab Mutalib
  - Serum-Based Biomarkers for CRC: Current Status and Challenges
    - Chin Siok Fong
  - Microbiome in Colorectal Cancer: Our Local Experience
    - Neoh Hui Min
  - Translational Research in CRC: From Bench to Bedside
    - A Rahman A Jamal

### Symposium 9
- **Symposium 9**
  - Chairperson: Fitjerald Henry
  - Surgeons’s Perspective on IBS
    - Francis Seow-Cboen

### Symposium 10
- **Symposium 10**
  - Chairperson: Fitjerald Henry
  - Chemotherapy: Overcoming the Common Side Effects
  - (Page 30)
  - Lam Kai Seng

### Symposium 11
- **Colorectal Basics**
  - Chairpersons: M Sarkunnathas / Salabudin Baharom
  - Colorectal Cancer for General Surgical Trainees
    - Khong Tak Loon
  - Haemorrhoids Management
    - Zaidi Zakaria
  - Management of Acute Ano-Rectal Abscess
    - Ahmad Shanzawi
  - Lower Gastrointestinal Bleeding - Management
    - Buvanesvaran Tachina Moorthi

### Symposium 12
- **Symposium 12**
  - Chairperson: Fitjerald Henry
  - Setting Standards and Quality Care in Stoma Care
    - Mariam Hj Mobd Nasir
  - My Personal Experience in Sexuality: The Challenges to a Paraplegic Ostomate
    - Ronald Lora
  - Special Considerations for Elderly Ostomates and Special Needs
    - Catherine Jawat
  - Pouching System: How do We Recommend the System to the Patients
    - Ni Arizal
  - Food for Thought: Diet for Ostomates
    - Catherine Jawat

### Symposium 13
- **Symposium 13**
  - Chairperson: Lu Ping Yan
  - Extended Resections for Colorectal Cancer - Is it Worth Doing?
    - April Camilla Roslani
  - My Battle with Cancer - A Clinician and Survivor’s Story
    - Kwan Poh Woh
  - Diet and Nutrition Myths
    - Hanisab Yatim
  - The Role of a Spouse
    - Teo Eu Jinn

### Plenary 4
- **Plenary 4**
  - Chairperson: Lu Ping Yan
  - Extended Resections for Colorectal Cancer - Is it Worth Doing?
    - April Camilla Roslani

### Registration
- **Registration**
  - Function Room 1
  - Welcome & Opening Speech by CORUM President
    - Cynthia Chu Mei Ling

### Additional Events
- 1000-1030 Coffee
- 1030-1100 Coffee
- 1100-1230 Coffee
**Daily Programme**

**10th March 2018 (Saturday)**

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| 1230-1400 | STRAITS BALLROOM     | Lunch Satellite Symposium *(Servier)*  
Chairperson: Mebeshinder Singh  
Role of Probiotics in Gastrointestinal Diseases  
*Raja Affendi Raja Ali* |
| 1400-1515 | STRAITS BALLROOM      | **SYMPOSIUM 14**  
Colorectal Potpurri  
Chairpersons: Yunus Gul Alif Gul / Manohar Padmanatban  
Treatment of Pilonidal Disease *(PAGE 38)*  
Francis Seow-Choen  
**Debate**  
Robotic Surgery is better than Laparoscopic Approach for Rectal Cancers  
Proponent: William Chen  
Opponent: James Ngu |
| 1515-1615 |                      | **VIDEO SESSION** |
| 1630-1715 |                      | **PROFESSORS’ CORNER**  
Moderator: Lu Ping Yan  
Panel: William Chen / Ridzuan Farouk / Akhtar Qureshi |
| 1715-1730 |                      | Tea |
| 1700-1830 | FUNCTION ROOM 3       | Meeting on Credentialing of Common Endoscopic Procedures |

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| 1400-1500 | FUNCTION ROOM 2    | **WORKSHOP**  
2: Coloplast |
| 1500-1600 |                      | **SYMPOSIUM 15**  
Allied Health Profession Session (6)  
Performing Counselling: How Well Can We Do It? How Does It Help? *(PAGE 39)*  
Tan Guat Ee  
Community Service in Stoma Care in Philippine Setting *(PAGE 39)*  
Rhyan A Hitalla  
Pouching System (Stoma Bag) Selection *(PAGE 40)*  
Mariam Hj Mobd Nasir |
| 1600-1640 |                      | **OSTOMY CASE STUDIES**  
Chairpersons: Tan Guat Ee / Norlizah Turiman  
Management of a Complex Open Abdominal Wound, with 2 ECFs Using Pouching System  
Madalinab Tan  
Psychosocial Disability of Patient with Stoma Formation *(PAGE 40)*  
Choo Joon Keng  
Gangrenous Bowel, Burst Abdomen with Adhesions, Hemicolecotomy and Double Barrel Stoma *(PAGE 41)*  
Nurafifah Saad  
“Don’t move baby!....” A Challenge Caring for Paediatric Stoma *(PAGE 41)*  
Anastasia Ibesira Anak Jiliel |
| 1640-1700 |                      | Q & A  
Closing Ceremony |

**Postgraduate Round**

**11th March 2018 (Sunday)**

**VENUE:** Function Room 2

**FACULTY:** Ismail Sagap / Andee Zulkarnain / Khong Tak Loon / Luqman Mazlan / Zaidi Zakaria
CONGRESS VENUE

Holiday Inn Melaka, Malaysia
Jalan Syed Abdul Aziz, 75000 Melaka, Malaysia
Tel: +606-285 9000  Fax: +606-285 9108
Website: www.holidayinnmelaka.com

REGISTRATION

The operating times are:

- 8th March 2018 (Thursday) 1400 to 1800 hrs
- 9th March 2018 (Friday) 0730 to 1700 hrs
- 10th March 2018 (Saturday) 0800 to 1700 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 one hour prior to their presentation. There will be helpers on duty to assist with your requirements regarding your presentation. The Speaker Ready Room will be opened on:

- 8th March 2018 (Thursday) 1400 to 1800 hrs
- 9th March 2018 (Friday) 0730 to 1700 hrs
- 10th March 2018 (Saturday) 0800 to 1700 hrs

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

PHOTOGRAPHY AND VIDEOTAPING POLICIES

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

MOBILE PHONE

For the convenience of all delegates, please ensure that your mobile phone is put on silence mode during the conference sessions.

DISCLAIMER

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The Organising Committee of Coloproctology 2018 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.

PANTAI HOSPITAL
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Perianal sepsis is a very challenging topic both for physicians and surgeons. Both the disease and its improper surgical treatment can cause significant morbidity. Successful surgical management of anal fistulas requires accurate preoperative assessment of the course of the primary fistulous track and the site of any secondary extension or abscesses or else treatment failure or recurrence is inevitable.

Prior to the introduction of radiological imaging, management of patients with perianal sepsis included clinical examination of the perianal region and per rectal examination to know the approximate course of the tract and the presence or absence of internal opening and its location. However, it was impossible to differentiate between a fistula and a sinus, to know about exact location of internal opening of the fistula, any branching of the fistulous tract, associated collections, and associated inflammatory disease of the rectum if any.

Hence, radiological imaging was introduced in the management of perianal sepsis. The introduction of MRI as preoperative assessment, with its superior soft-tissue contrast resolution and multiplanar imaging capabilities, brought a dramatic change in imaging of perianal sepsis. Surgical procedures after MRI have showed significantly better results.

In this lecture, the role of MRI in perianal sepsis will be highlighted including the classification of the perianal fistula.

In conclusion, MR imaging is a reliable and accurate imaging technique for preoperative evaluation of perianal fistulas. MR imaging assessment has shown to reduce incidence of recurrence and avoid fecal incontinence. MR should be compliment with endoanal ultrasound for optimal management of nonhealing fistula in ano.

Colorectal cancer is now the most common cancer in Malaysia and up to 60% of patients present at a later stage. Managing these patients may therefore be a challenge and decisions on surgical or oncological management should be a team effort to achieve optimal outcomes. The roles, development and challenges of multidisciplinary teams in managing colorectal cancer in Malaysia is discussed and local outcomes will be presented.
Pre-operative staging is very important in the management of the patient with rectal carcinoma. The decision for pre-operation chemoradiotherapy will be base on the involvement of the mesorectal fascia. This treatment has proved to reduced the incidence of local recurrence. MRI has an excellent resolution especially in the assessment of local staging ie. the assessment of the mesorectal fascia involvement. US has good accuracy in differentiating T1 from T2 tumour. However, it has limitation in the assessment of high rectal tumour, assessment of mesorectal fascia, involvement of the adjacent visceral as well as involvement of the regional lymph nodes.

This lecture will highlight the role of preoperative MRI staging of rectal carcinoma in order to assist colorectal surgeon in the management of rectal carcinoma patient. Limitation of MRI will also be discussed.

ENTERO stomal Therapy nursing in Asia: What is the Future?
Mariam Hj Mohd Nasir
M & T Network Consultancy, Subang Jaya, Selangor, Malaysia

The speaker will be sharing the successful stories of Asian Enterostomal Therapy Nursing and Enterostomal Therapist (E.T) till date including their achievement, challenges and future planning based on her own experience working with all of them in the region.

The speaker is very optimistic that the future is very promising and challenging but with team spirit, enthusiasm and continuous support from relevant parties and organization, nothing is impossible.

She will also share the history of Asian ETN and the formation of APETNA (Asian Pacific Enterostomal Therapy Nurses Association).

Since the first APETNA conference in 2003 in Kuala Lumpur Malaysia, the practice of wound, ostomy, and continence nursing in the Asia-Pacific region has demonstrated significant growth with increases in the number of World Council of Enterostomal Therapy Nurses (WCET) recognized education programs in the region and a substantial growth in qualified Enterostomal Therapy Nurses (ETN).

She will highlight the crucial involvement of the ostomate and how the Enterostomal Therapist (E.T) and the Nurses can assist them.
ICG has been used in medicine since the late 50s by liver surgeons to measure the liver function reserve before hepatic resection and by ophthalmologist to study the anatomy of the retinal vessel. Lately it has be reintroduced in laparoscopic to provide detailed anatomical information during surgery.

ICG was initially used to define the anatomy of the biliary tree especially in difficult laparoscopic cholecystectomy.

Presently it is also used in colorectal resection.

It is mainly used to assess the perfusion of the bowel before transection of the bowel and anastomosis. This would lead to less leak rates among colorectal resections.

ICG can also be used for lymph node mapping during colorectal resections.
Enhanced recovery after surgery [ERAS] programs are evidence-based protocols designed to standardize medical care, improve outcomes, and lower health care costs. These protocols include techniques to minimize surgical trauma and postoperative pain, reduce complications, improve outcomes, and decrease hospital length of stay, while expediting recovery following elective procedures.

ERAS protocols have been developed for colorectal surgery patients to reduce physiological stress and postoperative organ dysfunction through optimization of perioperative care and recovery.

I would be presenting our experience with ERAS in Hospital Selayang/Seremban.
Stoma site marking is an important practice based on evidence acquired by the wound, ostomy and continence (WOC) nurse during training and experience. Multiple studies indicate that patients who have their stoma site marked preoperatively have fewer ostomy-related complications such as leakage of the pouching system and peristomal dermatitis. If done correctly, predictability of a pouch’s wear time, ability of the patient to adapt to the ostomy and become independent, and control of healthcare costs can be well managed and controlled. It is sited within the rectus muscle to avoid a peristomal hernia and ectopic placement and must be visible to the patient, away from the midline incision. The use of multiple patient positions is to identify appropriate stoma sites, avoidance of folds and scars, and consideration of the occupation, clothing and beltline.

SPECIAL CONSIDERATIONS IN PAEDIATRIC OSTOMY

Norlizah Turiman
University Malaya Medical Centre, Kuala Lumpur, Malaysia

This story from the bedside is a case which highlights the special consideration in paediatric ostomy care. The management of the stoma need a special consideration as it can be a difficult adjustment for the child or young person and his or her family. Paediatric stoma nurses provide support and education to the family at this time to help them with the changes. Nurses discuss the different type of stoma, why a stoma might be needed, how the paediatric stoma nurses can help prepare the child and his or her family for having a stoma. It includes the practical aspects of the stoma care and possible complications that might be experienced and how to manage them. A challenging stoma in a paediatric patient is a main role of the paediatric stoma care nurse highlighting the considerations and appropriate management accordingly.
The stoma in patient can cause physical and psychological problems for the ostomate and his family. The problems can be intensified if the stoma is permanent and potential risks of various complications. The expenses for stoma care that face the ostomate include stoma bag purchases, stoma-related care products, stoma care services, transportation costs of stoma care services along with any further complication the ostomate faces. Moreover, stoma bags in Indonesia are imported and are relatively expensive ranging from Rp.30.000-100.000 per bag. If an ostomate buy a cheaper bag, then they are at risk of irritation, so the cost of stoma care will be even higher.

Various efforts have been made to overcome the problem of stoma care costing in Indonesia, including: (1) Minimize the occurrence of increased cost of caring for stoma complications by maximizing the role of collaborative stoma nurse in stoma setting. (2) Optimize the use of stoma pouch by increasing ostomate ability in stoma care well so that pouch can last longer. (3) Provide financial support through the National Health Insurance (JKN) program by the government through BPJS institutions. (4) Support by Non-Government Organization like Yayasan Kanker Indonesia (YKI) to provide stoma bag for ostomate. (5) Improve the quality of life ostomate to be able to have income for the purchase of stoma bags.

Conclusion: To overcome the cost of stoma patients in Indonesia needed role of stoma nurse to minimize purchase stoma complications, needed role of ostomate and his family to improve the ability and quality of life of ostomate, and the government to provide free stoma bag support.

Dealing with an altered body image can be particularly difficult after surgery. The patient’s wound will heal, leaving scars that often only they and their partners will see. There may be changes in how their body looks and behaves that they have difficulty accepting. These unexpected feelings can leave them feeling anxious or vulnerable, especially in an intimate setting. Intimacy can be a sensitive subject for people under ordinary circumstances, let alone after bowel surgery with/without stoma. They find that they have problems with both lack of interest in sex and performance as a consequence of their diagnosis and treatment.

Men might find that they have problems achieving or keeping an erection a result of inflammation and damage to tiny nerve endings and blood vessels in the area around the pelvis. These side-effects of treatment are often short-lived and gradually disappear over the course of a few weeks or months, but occasionally it can become something that remains a problem.

For women they may have associated problems associated with both intimacy and sex as a consequence of their diagnosis and treatment. Being self-conscious about how their body looks after surgery is only natural and they may feel low energy levels and discomfort from scar tissue. Radiotherapy can increase risk of vaginal dryness and tightening, which can make penetration and vaginal examinations uncomfortable or painful.
Pelvic floor prolapse (POP) is a common gynaecological problem with its prevalence expected to increase due to the world's growing aging population. Women with POP can present with significant morbidity affecting urinary, bowel and sexual functions.

Patients with large POP may complain of difficulty with walking or sitting secondary to the presence of a mass between their legs. The epithelium overlying the prolapsed uterus and vagina is generally atrophic and can be vulnerable to ulceration, bleeding and infection. Patients may complain of recurrent urinary infections and irritative symptoms such as urgency, frequency and nocturia due to incomplete bladder emptying. This may result from urethral kinking resulting in voiding dysfunction. Extreme cases may even have evidence of hydronephrosis due to bladder outlet obstruction or ureteric kinking. POP involving large rectoceles may result in incomplete rectal emptying requiring manual evacuation of stools. It is not infrequent that patients have to reduce the prolapsed mass into the vagina before micturition and/or defaecation can take place.

Asymptomatic POP does not necessarily require any intervention. Symptomatic POP can be managed with physiotherapy and the use of vaginal pessaries or surgery. Each of these modalities have their unique advantages and disadvantages.

Surgical approach for each patient needs to be individualized as various factors such as type of prolapse (single or multicompartiment), prolapse severity, patient characteristics (tissue quality, concurrent medical or previous surgical history) need to be carefully evaluated. Options for surgical route include vaginal, laparoscopic and abdominal with the choice of material for repair ranging from native tissue to synthetic/biological mesh.

Rectal prolapse on ambulatory anorectal physiology testing appears to simulate the rectoanal inhibitory reflex resulting in profound relaxation of the internal anal sphincter. Conventional anorectal physiology testing of these patients will typically reveal reduced anal resting tone, low/normal anal sphincter contractility, reduced anal/rectal sensation and reduced rectal compliance. Approximately 15% of patients will also exhibit evidence of reduced colonic transit. The role of defecography in the assessment has assumed increasing importance in assessing prolapse recently. The Oxford classification system graded 0-4 has become an accepted method for defining the extent of rectal intussusception.

The perineal approach to rectal prolapse repair has been the favored option in older or morbid patients. Historically this has been because the open abdominal approach was the only alternative. The increasing use of laparoscopy in colorectal surgery has translated into increasing use of the abdominal approach for older patients with rectal prolapse. Wijffels and colleagues reported good outcomes following laparoscopic mesh rectopexy in eighty patients with a median age of 84 years and two years follow-up with no mortality, one major complication and a recurrence rate of 3% to illustrate this point.

The PROSPER trial to date remains the only randomized trial assessing treatment efficacy for rectal prolapse. The paucity of randomized controlled trials is a reflection of the difficulty in designing and recruiting patients for such trials. Rapid changes in surgical practice have contributed to poor recruitment. The outcomes nevertheless from the DeloRes (Delorme's vs. resection rectopexy), ACTRN12605000748617 - (Lap resection vs. fixation) and the NCT00946205 (Lap posterior rectopexy vs. Lap anterior mesh rectopexy) trials are awaited to help guide practice. A Cochrane analysis published in 2015 in the interim has concluded no difference in recurrence rates between abdominal and perineal approaches.

Laparoscopic ventral mesh rectopexy has received much attention since it was described in 2004 by D’Hoore. The addition of anterior and posterior colporrhaphy plus vaginal sacrocolopexy to the technique in 2007 added the potential advantage of addressing all three compartments of the pelvic floor. Recent reviews of this operation have found that approximately 100 procedures need to have been performed to achieve good outcomes suggestive of the need for high volume specialist referral centers. Significant predictors of poor quality of life after surgery are older age and previous urological/gynaecological procedures. Mesh type has a significant influence on complication and recurrence rates with polypropylene mesh having the lowest risk. Co-existing solitary rectal ulcer is an independent predictor of recurrence after surgery.
The International Ostomy Guideline, developed by the World Council of Enterostomal Therapists (WCET), provides many rich resources for nurses worldwide for improving practice to patients with ostomy, wound, and continence needs. The Guideline were launched at the 18th WCET Congress in Gothenburg, Sweden in June 2014.

The guidelines was done for few reasons:
1. WCET’s mission, includes specialty care for all patients with OSTOMIES worldwide.
2. Need for ostomy practice guidelines that are internationally focused rather than country specific and can be applicable to all countries.
3. The WCET ostomy guidelines will provide practice recommendations that can be used regardless of the health care system and can be customized to the individual patient and country situation.
4. It includes cultural, religious and/or ethnic information for ostomy patients that is international in perspective.
5. For a person with an ostomy quality means the care provider must be aware of the cultural implications of ostomy care.
6. The guidelines will help the provider plan care using appropriate cultural considerations. The guidelines will also consider types of ostomy products that are used around the world as well as global resources that are available.

The speaker will be sharing the guidelines on stoma care with all in the conference.

When we take charge of taking care of patients with stoma we always focus on the changing of the bags, the availability of the appliance and supplies but we always tend to forget the most essential factor which is quality of life. Most of the time patients who have undergone stoma surgery do not know what to do when they get home, the anxiety level and depression is a factor, even their relatives and love ones do not know what to do and the thing is they left the hospital without even knowing what ostomy care is or for some they do not even know that they have a stoma and thought that it is just an ordinary wound that will heal in just a short period of time. Quality of life should always be the first thing that we should consider, especially for those who will have a stoma permanently and for those who are already in palliative care. The pouch changing and dressings may be important but we should always take counseling as the first priority. Involving the patient, relatives and the healthcare provider for the quality care that we can provide to our patients, most of all to improve their quality of life and helping them to be independently living a normal life despite having a stoma.
There is a strong association between long standing inflammatory bowel disease (IBD), in particular Ulcerative colitis (UC) with colorectal cancer (CRC). At present, there is lack of reliable molecular biomarkers, clinical factors, molecular imaging technique and imaging of mucosal inflammation for predicting the progression from normal to neoplastic mucosa in patients with UC. UC patients who are ‘at-risk’ of CRC should be identified, evaluated and should also be enrolled in systematic surveillance program, regardless of their disease activity. Early identification of dysplasia using various techniques and its appropriate management using endoscopic techniques or surgery are essential in patients with long-standing IBD, to minimize CRC morbidity and mortality. Gastroenterologists should work along with surgeons, specialized gastrointestinal pathologists and with fully informed and compliant IBD patients.

Performing a prayer is one of the five pillar in Islam. As a Muslim they are required to perform the prayer regardless of their conditions. Being an ostomate is not an excuse too, or exception to this duty.

Islam is a simple religion and provides a convenience way for the Muslim to perform their duties especially when the normal ways is not achievable by any reasons especially when the person is not well or recovering from an illness or surgery.

Every year the number of ostomates has increased and the spiritual concern is among the hot topic to be discussed and it is also considered very sensitive issues for discussion. However there are a few tips to share for a Muslims ostomates to practice while performing their duties such as prayer and other religious activity such as Haj. Basic needs to perform prayer in many religious are the same.

As we know, prayer is a spiritual practice of many individuals regardless whatever religion. This spiritual practice helps an ostomates in touch with God, decrease anxiety as effective as any medicatios and the most important things to cope with their new conditions and spiritually stronger to accept their condition more positively.

In this topic the speaker will discusse on a few religious needs and also focusing on the special needs for a Muslim Ostomate.
Crohn’s disease (CD) and ulcerative colitis (UC) are the two well-recognised forms of inflammatory bowel disease (IBD). Once a diagnosis of IBD has been made, it is important to classify the underlying diagnosis of CD vs. UC, as well as the severity of disease presentation. Based on these factors the clinician would then need to decide on objective targets in terms of patient outcomes, at the same time ensuring that optimal treatment is given to achieve these endpoints.

Conventional medical treatments for IBD include the 5-aminosalicylates, steroids and immunomodulator use. These remain useful for most patients with IBD, even though these medications have been in use for many decades. Nevertheless, these drugs have been updated with newer formulations that have been shown to improve patient outcomes. Studies have also shown that different dosing regimes could affect treatment results; thus, it is important to consider these factors to optimise medical treatment for patients with IBD.

At the same time, biologic therapy may also be considered for patients that have a more severe form of IBD. There are several well-known biologics that have been extensively used for treating IBD; however, newer biologics have been introduced which gives the clinician more options in addressing the complications associated with severe IBD.

In the era of personalised medicine, it is also important to mention additional tests that offer valuable information to the clinician. Serum drug or metabolite levels, genotyping for genetic polymorphisms as well as faecal sample testing may provide additional details which could be useful in treatment optimisation.

Finally, there are many IBD treatment guidelines which are readily available as sources of reference. However, many of these guidelines are country or region specific; there is a need to have a localised reference algorithm which considers the limitations present when initiating treatment for patients with IBD. Hopefully, application of this Malaysia-centric IBD treatment algorithm will further ensure optimal treatment of our IBD patients.

In developed countries, responsibility for IBD management has evolved from being primarily undertaken by surgeons, to currently predominantly by gastroenterologists. Nevertheless, surgical management can still be required, and in countries with a high prevalence of inflammatory bowel disease (IBD), surgical management is by colorectal surgeons specializing in IBD surgery.

There are significant limitations to achieving this in Malaysia. General surgeons number 1 per 100 000 population, and there are approximately 50 colorectal surgeons in the country, of whom about half are in public hospitals. This severe limits access to care for this socioeconomically challenged patient population. Very few surgeons have received specific training in the recognition and surgical management of IBD, and given the low prevalence, it is difficult to gain expertise.

Surgical expertise is most likely to develop in tertiary referral centres having gastroenterologists with an interest in IBD. In such centres, indications and management follow similar protocols to those in high-prevalence countries. Laparoscopic techniques are available for suitably selected cases, but incur significantly higher costs. Similar to the West, the majority requiring surgery are Crohn’s rather than ulcerative colitis, the former often requiring multiple surgeries.

Nonetheless, there are significant obstacles and differences. Many are high-risk for surgery, presenting in emergent or complicated states, such as intestinal perforation/obstruction, infective complications, toxic megacolon or even malignancy. They may exhibit the side effects of long-term steroid use and nutritional deficiencies, further compromising chances of surgical success. Furthermore, many patients are reluctant to undergo surgery for a multitude of reasons, including fear of surgical complications, stoma-aversion, and financial constraints. As such, even in a referral centre, the number of surgeries for IBD per year rarely exceeds 15-20.

The keys to improving surgical management of IBD will be early multi-disciplinary management, with centralization of specialized surgical services, and retention of such services within the public healthcare system.
“HONEY, PLEASE BE PATIENT WITH ME…” WHEN STRESS BE A PART IN LEARNING STOMA
Irfan Hazimie Othman
Hospital Tengku Ampuan Rahimah, Klang, Selangor, Malaysia

Patients can be motivated to adapt to new conditions imposed by their illnesses. The adaptation process may be enhanced by careful instruction that assists patients in coping with modification of lifestyles that are forced upon them. Perhaps just as importantly, a knowledge of health and illness allows patients to participate actively in their own care, including the prevention of and recovery from illness.

Professional nurses have come to realize that the concepts involved in the teaching-learning process are strongly embodied within the theoretical framework of their profession. If this framework is to guide the practise of nursing, the concept must be identified, tested, validated and implemented in clinical areas. Nurses further more, have an important responsibility to teach patient to be more confident in handling new cases.

“NO I’M TOO YOUNG…” LOW RECTAL CANCER IN TEENAGERS
Wan Nadia Nabila W Ismail
Hospital Sultanah Bahiyah, Alor Setar, Kedah, Malaysia

A loop transverse colostomy is a surgical opening that’s bring a loop of bowel through incision to the abdominal walls with a stoma include proximal opening and distal opening. The bridge is put underneath the stoma to support. If bridge is removed too soon, stoma will retracted and sunk into abdominal wall.

My case study is a 16 years’ old gentleman with no underlying of disease who came with bowel distended about 3 days and not passing flatus about 4 days. Colonoscopy done showed an extra luminal mass at 8cm near anal verge and defunctioning colostomy was done by next 3 days.

Patient will referred to the nearest colorectal centre for further opinion and also oncology to determine whether it is a tumour or carcinoma.
In Malaysia, colorectal cancer (CRC) is the most common cancer for men and the second most common for women. The gut microbiome (bacteria which resides in the colon) has been reported to be associated with CRC. Reports from different world populations found over-representation of certain gut microbiome bacteria in CRC patients compared to healthy subjects. Several studies showed that specific gut microbiome in CRC patients may trigger specific signaling pathways and provoke intestinal inflammation that leads to carcinogenesis. In our study, biopsy tissue samples were collected from 18 Malaysian CRC patients and 18 subjects with normal colonoscopy results (controls). 16S Metagenomics Sequencing on DNA extracted from these tissues were carried out using the Illumina® MiSeq platform with primers targeting the V3/V4 region. Bioinformatics analysis was carried out using the QIIME v1.9.1 and One Codex software based on the Greengenes database v2013.08. Bacterial genus Fusobacterium and Bacteroides were found to be abundant in Malaysian CRC patients compared to controls, underscoring the association of these bacteria with CRC.
This forum will discuss issues on integrity and professionalism in our day to day work and also in the industry itself, involving healthcare providers, mainly Doctors and Nurses. Ideas, opinions and recommendations shall be shared among the panelist with the participants.

A very outstanding and experience panelist within their field of expertise will participate and represent their countries within the Asian regent.

The panelists are, Assoc. Prof. Dr Rohani Arshad, an Academician, Malaysia. Dr Manohar Padmanathan, Consultant General, Laparoscopic & Colorectal Malaysia, Ms Tan Guat Ee, E.T. who is the President of Malaysian Enteralostomal Therapy Nurses Association (METNA), Mr Rhyann A. Hitalla, E.T. Philippines, Mr Afrizal from Indonesia and Ms Madalinah Tan, Colorectal Nurse, Singapore.

The session will be an interactive session with all the delegates and will be moderated by Ms Mariam Mohd Nasir, the Past President of METNA and ex-Chief Nursing Officer of University Malaya Medical Centre, Kuala Lumpur and currently is a Nursing Consultant and Director of M&T Network Consultancy.
What is research and what is evidence practice will be explained. The focus of the presentation will be on how significant will be research and evidence based practice to our practices to ensure outstanding benefits.
The burden of colorectal cancer on patients and their relatives, and the community at large is significant. Given the incidence of the disease is predicted to continue to rise in Malaysia, the impact of colorectal cancer is unlikely to abate. Thus, it is more important now than ever that as healthcare providers, we must strive to provide high quality patient centred care based on evidence, whilst efforts should be made to curb the burgeoning healthcare costs and avoid societal inequity. This session will:

• Provide a brief overview of the evidence behind current approaches to combat colorectal cancer, from the perspective of an individual patient to population based strategies such as bowel screening.

• Highlight the basis of a paradigm shift towards minimally invasive surgery in the context of enhanced recovery after surgery (ERAS) to improve overall patient outcomes by attenuating the physiological stress of surgery.

• Introduce the advent of ‘Precision Medicine’ and the rapid developments in molecular medicine to drive innovation particularly in the discovery of novel targeted therapies - could this spell the end of oncological surgeons?

The surveillance and follow up are part of important management of care in patient with post colorectal cancer surgery. About 80% recurrences occur in first 2 to 2-5 years after date of surgery and recent evidence show that 95% recurrences occur within 5 years. The purpose of these are to detect possible complications of treatment modalities, to detect early tumour recurrence which is potentially cure after resection and to detect new metachronous lesion at early stage or at pre cancerous lesion, polyps thus will allow the survival advantage with initiation of appropriate surgical strategies. The intensiveness of surveillance and follow up depend on the stage of the disease and the risk stratification group of colorectal patient. The modalities used for the surveillance and follow up include symptoms and physical examination, blood Carcino-Embrionic Antigen (CEA), imaging such Chest X-ray, Ultrasound abdomen, Computed Tomography (CT) chest abdomen pelvis, Positron Emersion Tomography (PET), PET/CT and colonoscopy. One must weigh the risk and the benefit of intensive surveillance schedule with possible harm include radiation exposure due to repeated CT scan, psychological stress with surveillance visits and scans, risks from following up false positive results and also about cost effective and availability of each modality used to detect early metachronous, recurrence disease and polyps.
Hemorrhoids are among the most common causes of anal pathology, and always blamed for any anorectal complaint by patients and medical professionals.

Hemorrhoidal venous cushions are normal structures of the anorectum, unless a previous intervention has taken place. Because of their rich vascular supply, highly sensitive location, and tendency to engorge and prolapse, hemorrhoidal venous cushions are common causes of anal pathology. Symptoms can be range from mild problems such as pruritus, to quite concerning, such as rectal bleeding.

Hemorrhoids are responsible for majority of anorectal complaints, but it is important to rule out other more serious conditions that causes of gastrointestinal (GI) bleeding, before conclude on hemorrhoids. Treatment can be non-surgical to surgical procedure.

Guidelines has recommend that
1. Patients with symptomatic hemorrhoids initially treated with increased fiber and adequate fluid intake.
2. Office procedures, including banding, sclerotherapy, and infrared coagulation, ligation probably being the most effective treatment.
3. Surgery if refractory or unable to tolerate office procedures, accompanied by large symptomatic external tags, or if they have either fourth-degree or large third-degree hemorrhoids.

There are many different type of surgical intervention from classic operation such as Milligan-Morgan haemorrhoidectomy till now using laser for haemorrhoid operation.

Perianal and perirectal abscesses are common anorectal problems. The infection originates most often from an obstructed anal crypt gland, with the resultant pus collecting in the subcutaneous tissue, intersphincteric plane, or beyond - ischiorectal space or supralelevator space where various types of anorectal abscesses form. Anorectal abscess should be suspected in patients who present with severe pain in the perineal area, especially when accompanied by fever.

The primary treatment of anorectal abscess is surgical drainage. Once diagnosed, all perianal and perirectal abscesses should be drained promptly. Lack of fluctuance should not be a reason to delay treatment. Any undrained anorectal abscess can continue to expand into adjacent spaces as well as progress to generalized systemic infection.

All skin incisions should be made as close to the anal verge as possible to minimize the length of a potential fistula while still providing adequate drainage of the abscess. High-risk patients (signs of systemic infection, extensive cellulitis, diabetes, valvular heart disease, immunosuppression) should receive antibiotics after drainage of an anorectal abscess, but until further data are available, surgeons may use antibiotics at their discretion in average-risk patients.
Defined as bleeding distal to the ligament of Treitz, lower gastrointestinal bleeding could be either overt or occult. Principles of management include resuscitation, investigation and timely appropriate intervention when necessary, as most lower gastrointestinal bleeding cease spontaneously.

Extended resections for colorectal cancer may refer to extended lymphadenectomy or multi-visceral resections. While lymphadenectomy has been fairly well-studied, less clear is the role for multivisceral resections, particularly in the emergent setting. While achieving an R0 resection offers a chance of cure, with 5-year survivals exceeding 50% in experienced centres, the quality of life outcomes are uncertain, as is the cost-benefit, when resources are limited. Furthermore, for those in whom R0 has not been achieved, it could be argued that a less aggressive approach would have been preferable. Full and frank discussions with patients and the multidisciplinary tumour board is therefore essential in achieving consensus on the value of extended resections in each individual.
When we think about intimacy following stroke, injury or surgery, it does not mean that a satisfying sex life must end. After the first phase of recovery is over, people find that the same forms of lovemaking they enjoyed before are still possible and rewarding.

The most important thing to remember is that sexual function and pleasure is mostly psychological. Human beings can experience a great deal of physical damage without losing their sexual desire. People after spinal cord injury and a stoma surgery can still have a rewarding sex life as they did before unless you tell yourself you can't.

Having sex after spinal cord injury and undergoing ostomy surgery is a lot like having sex for the first time all over again. People who approach sex with an open mind and a willingness to experiment to find out what works and doesn't work after their injury tend to have the most success and reported satisfaction.

Fears over the changes in sexual function after SCI and concerns about satisfying your partner may decrease as you become more comfortable with your body and more aware of your own sexuality. You may find that there are other parts of sexuality that may satisfy you and your partner more. The physical act of sex may not be as important as other aspects of sexuality. Being aware of your partner's likes and dislikes and being able to express yourself are very important to having good communication - an important key to you and your partner having a satisfying sexual experience.
Eating is one of life's great pleasures. Having an ostomy should not change your enjoyment of food. Most people with ostomies return to their normal diet soon after the operation. Many individuals with ostomies can enjoy a normal diet within 6 weeks of surgery: however, food tolerances can vary from person to person. Contents of this presentation will include the sharing of guidelines to help your ostomy easier.

Undergoing surgery and having the formation of a stoma may be required for a number of reasons and how patients accept their new body image and changes to their lifestyle can be greatly determined by the support and care they receive from their stoma nurse and other health professionals involved in their recovery after stoma formation. Preparing a patient pre-operatively and taking time to listen to their individual needs will enhance their perception of living with a stoma and accepting their stoma, thus not negatively impacting on what they perceive to be their quality of life. Acknowledging the quality of life of an individual and taking measures to maintain a person's quality of life at an early stage within the surgical pathway will have a positive impact on a patient's recovery from surgery and ability to cope with the daily routine involved when living with a stoma. Nurses need to understand what their patients perceive as a good quality of life and how to alter any negative factors that may inhibit a patient's ability to care for and accept their stoma.
This presentation will describe a clinician’s journey in his battle against Stage 4 colorectal cancer. It focuses on the different phases that one goes through when diagnosed with this disease. Personal account of three major phases will be examined. Phase 1 Diagnosis (Shock, Bewilderment and Denial). In this phase the initial conflicts that subsumes the individual and ways to cope with these conflicts will be discussed. Phase 2 - (Treatment and Change) - the value of seeking relevant information to make informed decisions will be highlighted in Phase 2. Phase 3 (Acceptance and Planning) - this final phase will emphasise on the cultivation of a positive mindset to manage and achieve a holistic approach to living with cancer. Subsequent to that, significant factors pertaining to Lifestyle and Care giver/Family support will also be considered.

Food and nutrition are critical parts of any successful cancer treatment. Nutrients support the growth of healthy cells in your body; they also go a long way toward helping you maintain energy and strength.

A personalized nutrition plan based on an individual’s likes, dislikes, lifestyle, symptoms and concerns is an integral part of cancer treatment. Misinformation can cause people to make unnecessary or sometimes harmful changes to their diets that could affect their health.

Once cancer treatment is complete, maintaining a nutritious diet helps the body heal and offers protective effects for the future. A diet comprised mainly of fruits and vegetables, whole grains, beans, peas, lentils, nuts and plant-based fats is best for people with a history of cancer. Limiting refined grains, added sugars, red meat and alcohol offers additional protection.
The treatment of pilonidal disease is controversial despite numerous options for treatment. There is a high recurrence rate, and many patients end up with recurrent procedures and huge wounds. Treatment may be non-surgical or surgical. Non-surgical methods include hair removal, injection of sclerosants, and fibrin sealants. Surgical methods include various modifications of Bascom nit-pick and drain, deroofing and currettage, midline incision and primary closure, Bascom II cleft lift, Karydakis procedure, rotation flaps e.g. Limberg, Duformental etc, and Epit endoscopic procedures.

The Guidelines of the Italian Society of Colorectal Surgery 2015 stated that on the whole there is no clear benefit of one technique over another in the treatment of pilonidal disease.

Growing up was tough. At the age of eight, I had faced immense challenges when my mother was diagnosed with Colon Cancer. While that period was undeniably rough, it escalated my maturity and appreciated the importance of treasuring life. At such young age, I witnessed my mum’s pain and suffering. Being the only son / mummy’s boy, it bruised my heart tremendously.

15 years later, my mum was diagnosed with a rare cancer, the Multiple Neuroendocrine Carcinoma. It happened when I just started my legal career. As my eldest sister was pregnant and my dad is aging, I took most of the responsibilities to stay at the hospital with my mum. I experienced the entire process and with my own eyes, I witnessed her inability to walk / sleep, her multiple sessions of chemotherapy, tomography, radiotherapy, blood and platelet transfusion and surgery.

People care so much on the patients which is normal but they tend to overlook the burden and feelings of care givers. The psychological game faced by care givers is insane. They have to juggle with the patient’s pain and feelings, being super understanding, constantly pouring love and support despite their exhaustion, sleepless nights and perpetual stress. Care givers are like mediators who need to balance difficult situations and to put things in order. Most vitally, care givers can never lose themselves because the patients and family depend on them.

My objective today is not inspire people but to provide aids, advice and helping hands to current and on-going care givers on how to handle themselves and all sorts of tough situations. I was in their positions TWICE and it would be my ultimate pleasure to give back to the needs as god has answered my prayers to give my mother a brand new life.
Stoma care in the Philippines is still something not new but needs encouragement and motivation. For the past 10 years of practice in the world of ostomy and wound care we have started to do counseling services in the hospitals and little by little moving to the communities and also to the far areas of the province. The Philippines of course composes of more than 7,000 islands and the archipelago is surrounded by ocean, education and location are of course one of the challenges. Ostomy associations are few and financial challenges are one of the main concerns. Ostomy care in the country is also not subsidized by the government and such care is through personal payments and very rarely through health insurance. Lay forums and ostomy education are most of the time conducted by company sponsored events and some by ostomy core groups, nursing associations and different hospital charities. Ostomy care is now being introduced to the different regions of the country wherein the main concern is awareness and education of not only the patients and relatives but also the nurses, doctors and allied health professionals as well. The care should not only end after hospital discharge but be extended the to care in the patient's home.

Counselling
- is a professional relationship that empowers diverse individuals, families and groups to accomplish mental health, wellness, education, and career goals.

(Definition agreed upon by 29 leaders of participating organisations at the ACA Conference in Pittsburgh 2010)

What does counselling mean to an enterostostomal nurse?
Providing preoperative information on surgical procedure, impact of stoma on patient, stoma site selection and sexual counseling. Postoperatively, giving instruction and guidance to patient and family on stoma care, dietary, stoma management and continuous follow-up care and support.

Williams J. found the truth in the proverb "A problem shared is a problem halved"
- He noted that listening and actively responding to patient’s fears and concerns about stoma will help to allay his worries and thereby raising confidence in selfcare.
Bags, pouches, appliances, pouching system, whatever you choose to call them, come in many shapes and sizes. The trick is to find the right one for you and your skin type.

According to the pouching system history, the first pouch similar to today's plastic bags only appeared after World War II had ended. And, there was no guarantee that these 'new' plastic pouches would be odour-proof anyway, so, because these plastic bags looked so flimsy, it took a while before ostomates considered them as alternatives to rubber pouching systems. Plastic would soon be here to stay and become an absolute necessity for ostomates.

Antiques were very pricey, bulky, heavy and complicated to use. Some were well designed with the ostomate's well-being in mind. But all the appliances needed a belt to stay put as Karaya was still in the laboratory!

The innovations were left to the stoma wearers as they were sent home without any collection equipment.

The speaker will be sharing with all the evolution of stoma bag or we called it Pouching System.

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**OSTOMY CASE STUDIES**

**PSYCHOSOCIAL DISABILITY OF PATIENT WITH STOMA FORMATION**

*Choo Joon Keng*

Pantai Hospital Kuala Lumpur, Kuala Lumpur, Malaysia

Stoma is generally known as an opening on the surface of the abdomen which has been surgically created to divert the flow of feces or urine.

Evidence suggests patient who has undergone stoma formation surgery can experience psychological difficulties resulting from physiological change which have a detrimental effect on quality of life over time.

Studies also shown psychological difficulties is correlated to colostomy pouch change and disposal practices. It can be improved with PRE-OPERATIVE counselling.

Patient undergoing EMERGENCY surgery without postoperative counselling and preparation has impact on patient PSYCHOSOCIAL well-being; as a result of altered body image and physiological changes.

Effective pouching and disposal have shown to elevate the psychosocial disability of the patient Hence, effective and efficient preoperative counselling will prepare patient for better post-op outcome reducing Psychosocial Diabilities.
Gangrenous bowel is defined as the blood flow being blocked to an internal organ and it can affect one or more organs. This can occur due to injury, infection or an underlying condition that can affect blood circulation.

I would like to present about my patient Mr L who was admitted in HKL for several surgeries. The contents of my case study will be about how this patient developed gangrenous bowel, burst abdomen with adhesions and underwent hemicolecotomy operation which ended up with a double barrel stoma and, lastly, I will mention the management of ileostomy double barrel stoma and wound.

Anorectal anomalies are common in Hospital Umum Sarawak, Sarawak.

Paediatric surgical ward 4A in Hospital Umum Sarawak is a place where children are admitted for ostomy surgery. Referrals come from all over Sarawak such as Miri, Sibu, Bintulu and others. Most are emergency cases and the surgeons need to gently explain to worried parents nature and outcome of the operation.

Post operatively, Enterostomal Therapy (ET) nurse and ward staff will care, guide and teach parents how to manage their child's stoma such as pouching, using cotton application and distal loop washout.

With good support from Surgeons, doctors, ET nurses, ward staff and family members, parents will be able to manage their child's stoma independently and able to be discharged home.
PO 01 BRAIN METASTASIS OF ADOLESCENT MUCINOUS ADENOCARCINOMA OF DESCENDING COLON CANCER
Yusri Rahimi J1, Abd Jamil A1, Andee D Z2, Michael W P K1, Wan Zainira W F1, Mohd Nizam M H1, Syed Hassan S A A1
1Department of Surgery, Hospital Sultanah Nur Zahirah, Terengganu, Malaysia
2Department of Surgery, Hospital Universiti Sains Malaysia, Kelantan, Malaysia

PO 02 INITIAL EXPERIENCE OF STAPLED HEMORRHOIDOPEXY IN HUSM
M Azem Fathi1, Zainira W Z1, Wong M P K1, Andee D Z2, Zaidi Z2, Syed Hassan S A A1
1Department of Surgery, School of Medical Sciences, Universiti Sains Malaysia, Kelantan, Malaysia
2Colorectal Unit, Department of Surgery, School of Medical Sciences, Universiti Sains Malaysia, Kelantan, Malaysia

PO 03 COMPARISON OF SURGICAL FLAPS FOR COMPLEX HIGH ANAL FISTULA: AN ANALYSIS OF LONG-TERM OUTCOMES
Shaveen Kanakaratne, Kirk Austin, Michael Solomon, Tan Ker Kan
Royal Prince Alfred Hospital, Camperdown, Australia

PO 04 FACTORS ASSOCIATED WITH INCOMPLETE COLONOSCOPY: SINGLE TERTIARY CARE INSTITUTION RETROSPECTIVE STUDY
Ragu Ramasamy, Fitjerald, Ho Kit Lum
Department of Surgery, Selangor Hospital, Selangor, Malaysia

PO 05 PERITONEAL TUBERCULOSIS - A DIAGNOSTIC CHALLENGE IN ACUTE ABDOMEN
Azihan Zahari1, Zubaidah Saizul1, Asyilla Che Jali2, Sharifah Emilia Tuan Sharif1, Maya Mazuwin Yahya1, Andee Dzulkarnaen Zakaria1, Zaidi Zakaria1, Syed Hassan Syed Abd Aziz1, Michael Pak-Kai Wong1
1Department of Surgery, Universiti Sains Malaysia, Kelantan, Malaysia
2Department of Pathology, Universiti Sains Malaysia, Kelantan, Malaysia

PO 06 RECTAL FOREIGN BODIES: “JUST BIDET”, LETS BEAT IT: A CASE REPORT AND MANAGEMENT
Corinne E J1, Nasheef M H2, Yap L M1, N Akmalrudin1
1Department of Surgery, Shah Alam Hospital, Selangor, Malaysia
2Department of Surgery, Patrajaya Hospital, Patrajaya, Malaysia
3Department of Surgery, Sungai Buloh Hospital, Selangor, Malaysia

PO 07 RECURRENT APPENDICITIS AFTER APPENDICECTOMY: A CASE REPORT OF RETROGRADE DUPLICATION OF APPENDIX
J Y Yeong, C C Tang, G Mohamad Bazli
Hospital Seberang Jaya, Pulau Pinang, Malaysia

PO 08 GROSS PYURIA: UNUSUAL PRESENTATION OF A COMMON DISORDER
Department of Surgery, Hospital Universiti Sains Malaysia, Kelantan, Malaysia

PO 09 AGGRESSIVE PIGMENTED ANAL BERRIES
Hasnali Mohamad, Wan Zainira Wan Zain, Andee Dzulkarnaen Zakaria, Syed Hassan Syed Abd Aziz, Michael Pak-Kai Wong
Department of Surgery, Hospital Universiti Sains Malaysia, Kelantan, Malaysia

PO 10 DEVELOPMENT OF A SEMICONDUCTOR SEQUENCING-BASED PANEL FOR SCREENING INDIVIDUALS WITH LYNCH SYNDROME
Ryia-Illani Mohd Yunus1, Nurul-Syakima Ab Mutalib1, Luqman Mazlan2, Rahman Jamal1
1UKM Medical Molecular Biology Institute (UMBI), Kuala Lumpur, Malaysia
2Department of Surgery, Faculty of Medicine, Universiti Kebangsaan Malaysia, Kuala Lumpur, Malaysia
PO 11 CASE SERIES OF INTESTINAL METASTASIS FROM PRIMARY GYNECOLOGICAL CANCER IN PENANG GENERAL HOSPITAL
Siaw Hui Ha, Sahul Hamid
Department of General Surgery, Penang General Hospital, Pulau Pinang, Malaysia

PO 12 CROHN’S DISEASE ON THE RISE: CASE SERIES FROM A SECONDARY DISTRICT HOSPITAL
J S N Ng1, Y C Leow1, R Umasangar2, T L Wong2
1Surgery Department, Taiping Hospital, Perak, Malaysia
2Pathology Department, Taiping Hospital, Perak, Malaysia

PO 13 AN AUDIT OF FISTULA-IN-ANO MANAGEMENT IN A GENERAL SURGERY TERTIARY HOSPITAL
E H B Ng, G K Ooi, D Y S Ding, Y W Yan
Department of Surgery, Hospital Raja Permaisuri Bainun, Perak, Malaysia

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Sabrina J D1, Tang C C1, Avinat A P2, Ng C B1, Yoong C C1, Mohan Nallusamy2, V Nagarajan1
1Department of General Surgery, Seberang Jaya Hospital, Pulau Pinang, Malaysia
2Department of Pediatric Surgery, Sultanah Bahiyah Hospital, Kedah, Malaysia

PO 15 COLORECTAL EMERGENCIES ASSOCIATED WITH RETAINED FOREIGN BODIES
Sabrina J D1, Tang C C1, Ng C B, Fitreena A A3, Fahmey S1
1Department of General Surgery, Hospital Seberang Jaya, Pulau Pinang, Malaysia
2Institut Perubatan Dan Pergigian Termaju, Pulau Pinang, Malaysia

PO 16 NEONATAL PERFORATED APENDICITIS MIMICKING VOLVULUS NEONATARUM: A CASE REPORT AND LITERATURE REVIEW
Sabrina J D1, Tan C W2, Mohan Nallusamy2
1Department of General Surgery, Seberang Jaya Hospital, Pulau Pinang, Malaysia
2Department of Pediatric Surgery, Sultanah Bahiyah Hospital, Kedah, Malaysia

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M Adenan, Kenneth Voon, Zaidi Z, A Shanwani
Department of Surgery, Hospital Raja Perempuan Zainab II, Kelantan, Malaysia

PO 18 DELAYED SIGMOID COLON PERFORATION BY TENCKHOFF CATHETER IN A CAPD PATIENT: SUCCESSFUL NON-OPERATIVE MANAGEMENT BY ENDOSCOPIC GUIDED CATHETER REMOVAL
Kenneth Voon, Zaidi Z, A Shanwani
Department of Surgery, Hospital Raja Perempuan Zainab II, Kelantan, Malaysia

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Khairil Irham Ahmad, Wan Zainira Wan Zain, Mohd Nizam Md Hashim, Andee Dzulkarnaen Zakaria, Zaidi Zakaria, Michael Pak-Kai Wong
Department of Surgery, Hospital Universiti Sains Malaysia, Kelantan, Malaysia

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W Ling, Y P Lim, Z Y Tee, T H Chieng
Department of Surgery, Hospital Umum Sarawak, Sarawak, Malaysia

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P F Koh, Yogeneswaran Pachiaffen, Maszuraidah M C, Patrick S J Chang
General Surgery Department, Hospital Sarawak, Sarawak, Malaysia
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  Husna Harun, Norhashimah Khadir, M Maathichusudhaar, Ahmad Shanwani  
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In Malaysia, colorectal cancer (CRC) is the second most common cancer in males and the third most common cancer in females. The incidence is now more common in younger population and the commonest type is adenocarcinoma. Mucinous type is a distinct form which found in 10-15% of patients and comprise approximately 1 to 6 percent of all colorectal epithelial cancers. It has a different entity in terms of clinical and histopathological characteristics as compare to adenocarcinoma. It is still considered an unfamiliar and unfavorable and has long associated with an inferior response to treatment. The mucinous histological type itself was an independent factor for poor prognosis. The debate concerning the prognostic implications of mucinous tumour in patients with CRC is ongoing and subtype of the disease. Nevertheless, current studies have shed new light on the management of patients with mucinous cancer. We presented a 20 years old young male with mucinous CRC of descending colon with metastasis to brain.

BACKGROUND
Hemorrhoids are usually managed by surgical hemorrhoidectomy which is associated with postoperative pain, long hospital stay and multiple post operative complications. Stapled hemorrhoidopexy is a newer alternative for the treatment of haemorrhoids.

OBJECTIVE
To report our early experience with stapled hemorrhoidopexy (SH) and the data evaluation of treatment outcome regarding postoperative pain score, length of hospital stay and post operative complications.

METHODS
A retrospective study of the patients undergoing stapled hemorrhoidopexy in Hospital Universiti Sains Malaysia between 2012 and 2017 was carried out.

RESULT
Thirty six (36) patients with grade III (75%, n=27) and grade IV (25%, n=9) haemorrhoids were underwent stapled hemorrhoidopexy during the study period. The mean age was 48.06 (22-72) years with females (55.6%, n=20) and males (44.4%, n=16). The main presenting symptoms was per rectal bleeding (86.1%, n=31) followed by prolapse (61.1%, n=22), painful defecation (44.4%, n=16) and straining (25%, n=9). The mean operation time was 50.47 minutes and the hospital stays was 3.42 days. The means of day one post operative pain using the Wong-Baker scale was 3.75. Post operative complication showed recurrence (22.2%, n=8), acute urinary retention (16.7%, n=6), stricture (11.1%, n=4) and bleeding (2.8%, n=1).

CONCLUSION
Stapled hemorrhoidopexy is a safe, convenient and effective treatment of haemorrhoids. It is associated with low post operative hospital stay, minimal post operative pain and low rate of post operative complications.
OBJECTIVES
Surgical options for complex high anal fistula remains a challenge, with concern of recurrence, incontinence and adequate control of sepsis. Importantly, there is a lack of data to guide management and no single technique has been shown to be universally suitable. Both Mucosal advancement flap (MAF) and Anocutaneous flap (ACF) repairs demonstrate good healing rates with a low risk of recurrence, however MAF can be complicated by ectropion. The aim of this study is to determine the long-term outcomes of MAF compared with ACF for high complex anal fistula.

METHODOLOGY
A retrospective analysis of a prospective database was performed. All MAF and ACF procedures performed by a single surgeon over a 10-year period at Royal Prince Alfred Hospital for complex high anal fistula were reviewed. Data collected included demographic factors, type of fistula, surgical procedure details, morbidity, recurrence rates, and incontinence scores. Statistical analysis was performed using SPSS.

RESULTS
Seventy-four patients underwent flap surgery for their complex high fistula. 40 patients underwent a ACF repair and 34 patients underwent MAF repair. The recurrence rate was 17% (MAF) vs. 28% (ACF). The mean post-operative St Mark incontinence score improved for both groups and was 2.68 (ACF) vs. 3.09 (MAF). No patients experienced incontinence post operatively.

CONCLUSION
This study demonstrates that MAF and ACF repair for high complex anal fistula disease can provide good treatment options with acceptable recurrence rates and good functional outcomes.
FACTORS ASSOCIATED WITH INCOMPLETE COLONOSCOPY: SINGLE TERTIARY CARE INSTITUTION RETROSPECTIVE STUDY

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INTRODUCTION
This study aims to identify factors associated with incomplete colonoscopies which are patient factor, level of endoscopist, bowel preparation and endoscopic setting (screening or diagnostic versus surveillance).

METHODOLOGY
This is a retrospective study. We analyze data that we obtain from endoscopy daycare system in year 2016. The raw data was compiled and interpret in SPSS version 20.

BACKGROUND
Colonoscopy is currently recommended for initial screening and as a surveillance test for the evaluation of colorectal polyps, cancer, and other lower gastrointestinal tract diseases, such as inflammatory bowel disease (IBD). Reducing the rate of incomplete colonoscopies by identifying these factors is important because it can reduce the cost and time of diagnosis for the patients.

RESULT
This study reviewed that age group above 60 year old associated with most of the incomplete colonoscopies in Hospital Selayang, which was 51.8% of the incomplete colonoscopies. Incomplete colonoscopies associated with the age factor, as the age group factor increases, the higher risk for incomplete colonoscopies. There is no significance of both male and female associated with incomplete colonoscopies. The factors of history of abdominal surgery, history of pelvic surgery and history of diverticular disease associated with 19.4%, 6.9% and 6.7% of the incomplete colonoscopy respectively. The factor of endoscopist level, both mo/registra and surgeon are not significant in this study because in comparison, the percentage of surgeon encountered with incomplete (72.5%) colonoscopies and complete colonoscopies (68%) are about the same. There was 30.6% of the incomplete colonoscopies were associated with poor bowel preparation. This percentage was significant because we can reduce the rate of incomplete colonoscopies by educating patient regarding method of bowel preparation. The most popular bowel preparation method that we use in Hospital Selayang is Fortrans. There was 53.4% of the incomplete colonoscopies were associated with difficulty due to angulation.

CONCLUSION
In year 2016, 24.8% (494 colonoscopies) of total colonoscopies done (1989 colonoscopies) were incomplete colonoscopies. This number was significant. Among these factors that we can intervene to improve the outcome of complete colonoscopies is the bowel preparation. Good knowledge or instruction that health care provider educate patient on colonoscopies and bowel preparation are very important.
PERITONEAL TUBERCULOSIS - A DIAGNOSTIC CHALLENGE IN ACUTE ABDOMEN

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Peritoneal Tuberculosis is a rare form of extrapulmonary tuberculosis. It commonly presents as acute abdomen. We are presenting two cases of peritoneal tuberculosis which presented to us as acute abdomen - peritonitis. The initial diagnosis was acute appendicitis whereby they had undergone open appendicectomy and another laparoscopic appendicectomy. We would like to highlight the intraoperative findings of peritoneal tuberculosis both in open surgery and laparoscopic surgery. Both of our patients are in their twenties, fit with no co-morbidity and denies previous contact to pulmonary tuberculosis, hence, making the provisional diagnosis of peritoneal tuberculosis unlikely. The common intra-operative findings of peritoneal tuberculosis are whitish peritoneal nodules overlying the peritoneal wall or bowel wall and inflamed thickened omentum with ascites fluid due to chronic exudative inflammation. The duration of anti-tuberculous treatment for peritoneal tuberculosis should be tailored individually, however, most physician will adopt the extrapulmonary tuberculosis treatment regimes which is 9 to 12 months. In conclusion, the diagnosis of peritoneal tuberculosis is a challenging endeavor in clinical setting, however, it is important for surgical residents to be able to recognize the intraoperatively to initiate prompt treatment.

RECTAL FOREIGN BODIES: “JUST BIDET”, LETS BEAT IT: A CASE REPORT AND MANAGEMENT

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Foreign bodies found in the rectum may be inserted intentionally or accidentally. There are several reports on rectal foreign bodies where the causes include criminal assault case, self-treatment, sexual gratification, body packing and even occasionally by accident.12 Of recent, foreign bodies found in rectum are mostly related to anal auto-eroticism and homosexual practices. The insertion of rectal foreign bodies can cause morbidity such as pain, impaction, obstruction, perforation, and inability to be removed.3 We report a case of a young male with impacted rectal foreign body of a toilet bidet complicated with fistula-in-ano, requiring laparotomy for removal.
The incidence of duplicate appendix is very low and it is one of the most commonly missed diagnosis. This is a case report of a patient with duplicated appendix presented 2 years post open appendicectomy. A 16 years old girl presented with 2 days history of right iliac fossa pain. Physical examination are similar with acute appendicitis with fever, right iliac fossa tenderness and guarding. Contrast Enhanced CT abdomen done showed retrocaecal tubular collection. Diagnostic laparoscopy showed dense adhesion of caecum to abdominal wall, conversion to lower midline laparotomy done, noted phlegmon retrocaecal appendix. Appendicectomy done. Histopathology showed acute suppurative appendicitis with perforation. The awareness of duplicated appendix is critical to prevent misdiagnosis of duplicated appendix intraoperatively.

We present a 34 years old lady who complained of 2 weeks of lower abdominal pain and constipation, with palpable suprapubic mass on examination. No other significant history. She was seen by the Gynecology team, and was diagnosed as twisted ovarian cyst on clinical ground and ultrasonography examination. She agreed for laparotomy. However, on table, no ovarian cyst was found, and uterus was normal. Abscess collection was found at right pelvis. Foley’s catheter insertion revealed gross pyuria. She was referred to General Surgery team for further evaluation. Diagnostic difficulty and subsequent management is discussed.
INTRODUCTION
Anorectal melanomas are rare, and they usually presented as an aggressive tumour. Most of the patient presented with perianal complains such as anal pain, bleeding, tenesmus, mass before the emergence of metastatic complaints. It contributes to less than one percent of all colorectal cancers. It is commonly affected females in their sixties.

CASE PRESENTATION
We are reporting a case of a 53 years old lady, presented with progressive enlargement of left inguinal mass with a small pigmented berry-like anal mass. She was initially presented to a private hospital with a left inguinal abscess which she had incision and drainage done. She presented to us after 2 weeks later with poor healing wound and progressive enlargement of left inguinal mass with pigmentation. Incisional biopsy of the left inguinal lump shows metastatic melanoma. Colonoscopic examination shows a small pigmented lesion confined to the anal canal. The biopsy of the lesion shows malignant melanoma. Staging computed tomography scan showed extensive regional lymph nodes metastasis with lungs and liver metastasis.

CONCLUSION
The prognosis of Anorectal Melanomas is poor as they are usually presented as advanced metastatic disease. It is not unusual for anorectal melanoma to present as metastasis disease, however, it is rather unusual that the patient does not have any predominant anorectal complains upon initial presentation.

Lynch syndrome (LS) is associated with mutations in mismatch repair (MMR) genes and individuals who have one of these mutations have 20 to 65 % lifetime risk of colorectal cancer (CRC). Because inheritance of these mutations is autosomal dominant, close biological relatives are also at high risk. Early detection of CRC may lead to both better health outcomes and considerable savings in treatment costs. Therefore, the aim of this study is to develop a rapid and sensitive method of screening LS. We designed an Ion Ampliseq™ Custom Panel with four MMR genes associated with LS (MLH1, MLH2, MSH6 and PSM2) and two genes which are not categorized as MMR genes (EPCAM and BRAF), for sequencing on the Ion Torrent PGM™ sequencer. Sequencing was performed on 16 DNA samples representing various stages of CRC. The sensitivity for mutation detection was determined by sequencing serially diluted DNA from two human cancer cell lines. Upon completion of NGS, on average, 92 % of reads were mapped to the target region with 98 % uniformity. No amplicons dropout was observed across all samples. 58 variants were identified and chosen to be validated in 19 samples using MassARRAY and Sanger sequencing. A pathogenic variant in MSH2 gene was identified in a 44 years old Dukes’ D CRC patient. The Ion Torrent PGM clearly identified a single base pair C to T substitution in MSH2 gene with a variant frequency of 52%. This was also confirmed by MassARRAY. Genetic counselling was provided for this patient and genetic testing was recommended for the other family members at risk. We achieved 92% specificity, 93.4% accuracy and a sensitivity of about 13% allelic frequency for the Lynch syndrome panel. With the development of this method, hereditary CRC can be detected at early stage using rapid and sensitive approach.
**INTRODUCTION**

The colon is an infrequent localization of tumour metastases originating from gynecological cancer. Hence, primary gynecological cancer with colorectal metastasis can be easily misdiagnosed as primary colorectal cancer.

**METHOD**

We present three cases of colon metastasis in women with primary gynaecology cancer in our centre.

**RESULTS**

All cases have similar initial presentation of bowel related symptoms. Our first patient has a recurrent ovarian cancer metastasizes to caecum and ascending colon with a disease free interval of three years while our second patient has a recurrent cervical cancer in two years with metastasis to sigmoid colon. Our third case entails a case of synchronous ovarian cancer with sigmoid colon metastasis. The clinicopathological features of these cases are discussed and related literature is briefly reviewed.

**CONCLUSION**

These cases highlight that colon metastasis must be considered in the differential diagnosis of bowel symptoms in patients with gynecological cancer.

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**OBJECTIVE**

Crohn’s Disease (CD) is a great mimicker of various intestinal pathologies, often creating diagnosis dilemma. Thus, this paper aims to share our experience in the clinical presentation, diagnosis as well as management of 3 different cases of CD.

**METHOD**

Retrospective review of 3 CD cases encountered in year 2017.

**RESULTS**

Three male patients of age 20, 22 and 27 years old respectively were diagnosed with CD through typical presentation and histology. The first and third subjects were Indians while the second patient was Malay. All three patients were previously healthy with no tuberculosis contact or symptoms and nil family history of Inflammatory Bowel Disease. The first two patients presented with subacute intestinal obstruction symptoms while the latter had an active disease of CD complicated with perianal fistula and abscess. All three patients had Computed Tomography scans which assisted the diagnosis and plan for surgery. The first patient had rectosigmoid junction stricture due to impingement by ileocecal inflammatory mass (Montreal A2L3B3) thus underwent right hemicolectomy and Hartmann’s procedure. For the second patient, right hemicolectomy with primary anastomosis was done as intraoperatively noted dusky segment of terminal ileum with ulcerative mesentery as well as isolated length of viable small bowel serositis (Montreal A2L1+4B1). The last patient had perianal fistula with ischiorectal abscess and stricturing disease (Montreal A2L3B3P) which required panproctocolectomy with incision and drainage of abscess by colorectal specialists. All three patients were discharged well after a single operation and immunosuppressive drugs were initiated subsequently. During 5 months post-surgery review, all three subjects were in disease remission with good weight gain and reducing trend of inflammatory markers.

**CONCLUSION**

CD is no doubt a heterogenous entity. With its emerging incidence in the East, it should always be kept as a differential diagnosis especially in patients with chronic diarrhoea and abdominal pain.
INTRODUCTION
Fistula-in-ano has been reported as early as more than 2000 years ago with Hippocrates being the first to describe the use of seton in its management in 430BC. Many surgeons have described multiple theories on pathogenesis and advocated different types of treatment over the years. However, fistula-in-ano continues to baffle even the most prominent colorectal surgeons due to its variety of presentation and lack of complete comprehension on its pathogenesis and key to treatment.

OBJECTIVE & METHODOLOGY
This is a retrospective audit of management of fistula-in-ano over 4 years (2014 - 2017) in Hospital Raja Permaisuri Bainun, Ipoh. This audit aims to assess the management trend among General Surgeons to improve patients’ outcome.

RESULTS
A total of 1002 perianal procedures were performed. 150 were for fistula-in-ano. 4 patients were below 12 years whereby 50% had fistulotomy performed and the other 50% had anoplasty for congenital anovestibular fistula. Among the 146 adult patients, 19 had emergency procedures - 17 drainage or setons and 2 had fistulectomy. 35 endoanal ultrasounds were performed electively with the aid of our Visiting Colorectal Consultant and had delayed definitive procedures performed. The remaining elective procedures included 2 advancement flaps, 15 fistulectomies, 14 fistulotomies, 37 LIFTs and 26 drainages / setons. There was 13.5% recurrence rate for LIFT and 23.5% for fistulectomy.

DISCUSSION & CONCLUSION
Management of fistula-in-ano remained rather conservative among General Surgeons and definitive procedures remained elusive unless there is a dedicated resident Colorectal Surgeon in the unit. Usage of endoanal ultrasound aids decision-making for definitive management of fistula-in-ano.
INTRODUCTION
Colonic perforation and pneumoperitoneum are complications often seen in cases of forced air entry into the perineum at a high velocity in a short duration of time. Hereby we present two cases of blow gun dust cleaner (BGDC) compressed air induced injury.

METHODS
Patients presenting history, clinical and diagnostic findings were reviewed.

CASE REPORT 1
A 42 year-old gentleman presented with one day history of abdominal pain. On examination, patient’s abdomen was grossly distended, with signs of peritonitis. Chest and abdomen radiograph revealed gross pneumoperitoneum. During emergency laparotomy, we found 3 different perforation sites along the distal sigmoid to rectosigmoid junction, with peritoneal faecal contamination. Primary repair and diverting transverse colostomy were performed. Further history post operatively revealed that patient’s perineum was sprayed using BGDC.

CASE REPORT 2
A 6-year-old girl presented with swelling over the face, neck and chest along with abdominal distension following insufflations of compressed air to the perineum by her brother. On examination, abdomen was distended but with no sign of peritonitis. There was extensive crepitus over the abdominal wall, chest, neck and face. Perineal examination revealed abrasion over the vulva with hymen tear. Patient was subsequently intubated for respiratory distress. Chest and abdomen radiograph demonstrated subcutaneous emphysema and pneumoperitoneum. A lower gastrointestinal contrast study did not show any evidence of rectal or colonic perforation. Colpography examination showed a diffuse leak from the upper half of the vaginal wall bilaterally. The patient was managed conservatively and she made an uneventful full recovery.

CONCLUSION
Hollow organ perforation should be suspected in compressed air driven pneumatic tool injury. The majority of cases will need surgical intervention. The decision to go for conservative management should be taken cautiously and guided by the clinical and imaging findings of the patient.
INTRODUCTION
Rectal foreign body is an uncommon clinical problem. Most of the patients usually presented late after multiple failed attempts to retrieve the anal foreign body (FB) or after suffering from unbearable abdominal pain. Reluctance to seek medical help and to provide details about the incident further delayed the diagnosis. Hereby we describe our experience as a District Hospital in diagnosing and managing these interesting cases.

METHODS
Patients presenting history, clinical and diagnostic findings, type of FB used, extraction method and post operative period were reviewed.

CASE 1
A 42 years old gentleman, with underlying learning disabilities, presented with passing loose stool, loss of appetite and loss of weight for 3 weeks. On abdominal examination, a hard mass at the suprapubic region was felt. Colonoscope examination showed a glass bottle, conical in shape, in the lower rectum. Examination under anaesthesia (EUA) was performed. During surgery, the FB was not able to retrieve via anus, hence we proceeded with laparatomy, enterotomy and retrieval of FB, with proximal diverting colostomy.

CASE 2
A 7 years old boy alleged sat onto a toilet brush which penetrated his anus. On examination, patient was in pain. Abdomen was soft no signs of peritonitis. He underwent EUA, the toilet brush was gently removed. Post operative day one, patient developed peritonitis. Computer tomography scan of the abdomen and pelvis showed pneumoperitoneum with leakage of contrast from rectum. Emergency laparotomy revealed upper middle rectal perforation with fecal contamination. Rectal perforation repaired and diverting sigmoid colostomy was done.

CONCLUSION
Patient with retained FB patients should undergo a thorough physical and rectal examination followed by appropriate imaging for correct diagnosis and localization. Anaesthesia provides adequate sphincter relaxation for removal of FB, rectal mucosa inspection and avoids complication such as further migration of object or iatrogenic rectal perforation.

COLORECTAL EMERGENCIES ASSOCIATED WITH RETAINED FOREIGN BODIES
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INTRODUCTION

Neonatal perforated appendicitis is a rare condition associated with significant morbidity and mortality. The rarity of neonatal appendicitis together with lack of specific signs and low index of suspicion has led to delay in diagnosis and surgical intervention. Here we report an unusual case of neonatal perforated appendicitis mimicking volvulus neonatarum.

METHODS

Patient’s case notes were reviewed, presenting history, clinical, diagnostic and intraoperative findings were analyzed.

CASE REPORT

A baby girl, born at 31 weeks of gestation by normal delivery weighing 1.88kg was referred to surgical team on the 5th day of life for persistent bilious ryles tube aspirate.

On examination, abdomen was not distended, no visible peristalsis seen, abdominal wall appeared normal. Abdomen was not tensed, no mass was palpable. No other systemic abnormalities were detected. Abdominal x-ray done revealed a gasless abdomen. Impression at that time was midgut volvulus.

Patient was scheduled for an emergency laparatomy. Intraoperatively, there was no gush of air, peritoneal fluid was cloudy, no malrotation seen. On gross examination of the bowels, small bowels appeared to be edematous, there was slough and pus over the right iliac fossa. On further exploration, the appendix was located at the retrocecal position with perforation at the body and its base was healthy. Large bowel was of normal caliber. Appendicectomy and peritoneal lavage with warm saline was performed.

Histopathological examination showed mucosal ulceration associated with transmural neutrophilic infiltration. The mucosal layer is intact. The histopathological diagnosis was acute suppurative appendicitis.

CONCLUSION

Neonatal perforated appendicitis continues to be a diagnostic challenge and requires a strong clinical suspicion. This case illustrates an unusual manifestation of neonatal appendicitis in which the clinical and radiological features were there of midgut volvulus. This fortuitously led to emergency laparatomy which revealed the actual diagnosis.
HERNIATION OF SMALL BOWEL THROUGH THE FORAMEN OF WINSLOW: A RARE CAUSE OF INTESTINAL OBSTRUCTION

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INTRODUCTION
Internal herniation through the foramen of Winslow is extremely rare which account about 0.1% of all abdominal hernias and 8% of all internal hernias. Clinical diagnosis maybe difficult or even can be missed causing delayed in management which can lead to high morbidity and mortality.

CASE PRESENTATION
We reported a case of 44 years old lady presented with history of abdominal pain for a week duration associated with distension, vomiting, fever and not passing motion. Examination revealed distended abdomen with peritonism. Abdominal x-ray showed features of small bowel obstruction. Patient underwent emergency laparotomy with intraoperative findings of herniation of small bowel through the foramen of Winslow causing obstruction with segmental bowel ischemia. Segmental bowel resection and anastomosis was done. The foramen of winslow was left opened. Post operatively patient recovered and discharge well.

CONCLUSION
Herniation through the foramen of Winslow is a rare condition. Patient can presented with sudden onset severe abdominal pain and intestinal obstruction. Early imaging may help in diagnosis which can prevent further complication such as bowel ischemia. Most of the reported cases was managed by open surgery and reduction of herniation in view of diagnostic uncertainty. In current literature there was no consensus on certain procedure or technique to prevent recurrent herniation through the foramen of Winslow.

DELAYED SIGMOID COLON PERFORATION BY TENCKHOFF CATHETER IN A CAPD PATIENT: SUCCESSFUL NON-OPERATIVE MANAGEMENT BY ENDOSCOPIC GUIDED CATHETER REMOVAL

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INTRODUCTION
Delayed erosion of indwelling peritoneal dialysis catheter into bowel lumen has been reported, duration of indwelling ranging from 2 months to 4 years. Peritonitis was more common, however many reported chronic diarrhea as main symptom. We report a case of delayed erosion of PD catheter into sigmoid colon after 3 years using, presented with lower gastrointestinal bleeding.

CASE SUMMARY
A 58 year old lady was referred for lower gastrointestinal bleeding, without peritonitis and sepsis. She has end stage renal failure on continuous ambulatory peritoneal dialysis (CAPD) for the past 3 years. Tenckhoff Catheter was functioning well until 4 months prior, where outflow was obstructed. Colonoscopy discovered tip of Tenckhoff Catheter within the mid-sigmoid colon lumen with surrounding chronic inflammation. CT scan confirmed catheter perforating mid-sigmoid colon with its tip curled within the sigmoid colon, without evidence of pneumoperitoneum or intra-peritoneal collection. Combined strategy by Surgical and Nephrology team to safely remove the catheter non-operatively involved mobilizing the catheter's subcutaneous segment under local anaesthesia until the rectus sheath, and cutting the catheter at the entry point into peritoneal cavity. Simultaneous removal of the catheter via colonoscopy was done to deliver the remaining intra-abdominal portion. 2 endoscopic clips were applied to the perforation site. Patient was given a course of antibiotics and bowels were rested for several days post-procedure. She did not develop any adverse complication post-procedure and was discharged well.

CONCLUSION
Non-operative management with endoscopic guided removal and endoscopic clips of perforation site is feasible in delayed bowel perforation without evidence of intra-peritoneal faecal spillage, peritonitis and sepsis.
BACKGROUND
Sigmoido-rectal intussusception is uncommon. This type of adult intussusception may rarely present as rectal prolapse.

CASE SUMMARY
We present a 63-year old man who presented with large mass protruding per rectum associated with a large polypoidal lesion. Laparoscopy revealed a sigmoido-rectal intussusception protruding through the anus. The mass was resected via a perineal recto-sigmoidectomy with accompanying lymphatics without reduction. Bowel continuity was constructed with primary hand-sewn end-to-end anastomosis. Histopathology examination confirmed adenocarcinoma with clear surgical margins.

CONCLUSION
Adult colonic intussusception is associated with malignancy. Treatment for prolapsed sigmoido-rectal intussusception is oncological resection without reduction of the intussuscipiens due to risk of tumor dissemination and perforation.

CASE REPORT: SIGMOIDO-RECTAL INTUSSUSCEPTION PRESENTING AS RECTAL PROLAPSE
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INTRODUCTION
The incidence of colorectal cancer (CRC) during pregnancy is so rare and has been estimated at approximately 1 in every 1000 pregnancies. Therefore diagnosis of cancer during pregnancy can be a devastating situation with serious emotional and physical stress for the pregnant women and her family.

CASE REPORT
Herein we present a case of colorectal cancer diagnosed during the 1st trimester. The patient was a 34 years old woman (gravid 3, para 2) was referred to surgical clinic complaint of altered bowel habit with per rectal bleeding. Initial assessment showed palpable mass over anterior rectum with faecal material in vagina. Ultrasonography showed mass at pouch of Douglas. Colonoscopy revealed sigmoid colon tumour. Histologically it was a moderately differentiated adenocarcinoma. Her CEA was 185.50 (markedly raised). CT scan confirmed locally advanced sigmoid colon tumour with regional and multiple small lung metastases. Patient and husband were counselled for options of treatment with benefits and risks of each option, for example: continuing with the pregnancy, or termination of pregnancy with radical surgery. They opted for latter option and elective laparatomy and anterior resection with total abdominal hysterectomy and bilateral salpingectomy was done. Final histopathological finding showed sigmoid colon adenocarcinoma (moderately differentiated), T4N2M1. Patient received chemotherapy post-operatively and latest CT scan (3 months post chemotherapy) showed disease progression worsening lung metastases and new liver lesion.

DISCUSSION
Colorectal cancer in pregnancy is associated with diagnostic and therapeutic challenges which mostly lead to late diagnosis in advanced stages and poor prognosis. Pregnant patients with unexplained rectal bleeding should be evaluated by anorectal examination and colonoscopy. The optimal therapy of cancer in pregnancy requires a collaborative and interdisciplinary approach between surgeon, obstetrician, oncologist, neonatologists, psychologist, nursing staff and other disciplines.
INTRODUCTION
Lipomas are a benign growth of fat cells, rarely found in the gastrointestinal system. They usually arise from the submucosa and found in the ascending colon. Clinically, the patients are asymptomatic. However, large lipoma may cause obstructive symptoms. We hereby report a case report of symptomatic giant caecal lipoma with small bowel obstruction in adult.

CASE PRESENTATION
A 61-year-old Iban lady presented with colicky abdominal pain over the right side abdomen for the last 3 months. On examination, a 7 cm x 5 cm mobile mass was palpable over right iliac fossa. An abdominal computed tomography (CT) revealed a large irregular mass measuring 6.5cm x 8.0cm x 8.5cm at the ascending colon causing intussusception of the small bowel. We proceeded with exploratory laparotomy.

Intra-operatively, a giant caecal polyp with dilated small bowel was identified. A right hemicolecction was performed. Macroscopic examination revealed a well-circumscribed, soft and yellowish mass. The recovery was uneventful. Histological evaluation reviewed a giant benign lipomatous polyp. On follow up, the patient is doing well.

CONCLUSION
Caecal lipoma is a rare benign gastrointestinal pathology. It can only be problematic if the size is big. In our case, it is more than 5cm.

Is acute right iliac fossa pain always appendicitis: A case report of diffuse large B cell lymphoma of caecum

INTRODUCTION
Primary lymphoma of gastrointestinal tract is a rare condition as compared to other colorectal malignancies. It was first described in 1961 by Dawson *et al* which reported 37 cases of primary malignant lymphoid tumours of the intestinal tract. Clinically, patients present with non-specific symptoms. Hence, accurate diagnosis is often difficult. Delay in treatment is inevitable. We hereby report a case of caecal B cell lymphoma mimicking perforated appendicitis.

CASE PRESENTATION
A 60-year-old Iban lady presented with right iliac fossa pain with fever. On physical examination, a vague mass was palpable over right iliac fossa. Abdominal ultrasonography revealed ruptured appendix with peri-appendicular abscess. We proceeded with open appendectomy using lanz incision. Intraoperatively, a huge caecal tumour with multiple palpable mesenteric lymph nodes was identified. Right hemicolecction was performed, in view of possible colonic malignancy. Immunohistochemistry reported diffuse large B cell lymphoma of caecum. The patient recovered well. He was currently managed by oncology.

CONCLUSION
This case highlights the diagnostic dilemma of rare caecal lymphoma against the common appendicitis. However, colorectal malignancy still needs to be excluded especially in the elderly group of patients.
Uterine leiomyomas are the most common pelvic tumors in women and occur in 20-30% of women over 30 years of age. Many complications are seen with fibroid however superior mesenteric vein (SMV) thrombosis is very rare to occur as a complication to it. We report a case of a large uterine fibroid associated with SMV thrombosis. 34-year old presented to us with sudden onset of generalized abdominal pain associated with vomiting. She was anemic and tachycardic while the abdomen was distended with generalized guarding. CT scan revealed superior mesenteric vein thrombosis, extending till confluence of portal vein. There was also a large uterine fibroid and right adnexal mass. Exploratory laparotomy proceeded with small bowel resection and end-to-end anastomosis was done. Iron deficiency anemia and thrombocytosis due to uterine leiomyoma was recognized to be the cause for SMV thrombosis. Usually its clinical signs are unspecific and urgent CT imaging is crucial. Treatment requires aggressive approach and in our case, surgical intervention. If this is absent, intestinal necrosis with septic state, Multiple Organ Dysfunction Syndrome (MODS) and Multiple Organ Failure (MOF) lead to mortality of a patient.

Colorectal cancer is the second most common malignancy in Malaysia, whereas renal cancer is rare with the incidence of 1.9 per 100,000 in the Malaysia population in the year 2006. Renal cell carcinoma has been well known to be the most common renal malignancy. Synchronous primary malignancies are rare presentation and there has not been many case report published yet in Malaysia.

This is a case report of a 77 years old Chinese lady presented with altered bowel habit which was indicated for a colonoscopy for screening for colorectal malignancies. The resulting histopathology taken from the biopsy during colonoscopy was moderately differentiated adenocarcinoma of the transverse colon. Renal cell carcinoma with bony metastases was incidentally detected through Computed Tomography (CT) during radiological investigation for staging of the disease prior to surgery. She was then subsequently underwent synchronous resection, right hemicolecotomy with right nephrectomy. 3 weeks post-operatively, patient presented with 1 week history of bilateral lower limb weakness, MRI shows T3 compression fracture with cord compression. Patient subsequently succumbed to illness one month postoperatively.

In this study, we review the literature and discuss the prevalence, histopathology of the synchronous primary malignancy.
INGUINAL HERNIA CONTAINING PERFORATED CAECUM PRESENTED AS NECROTIZING FASCIITIS OF GROIN
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The sac of inguinal hernia in adult frequently contains omentum and small bowel. The unusual organ in the sac includes appendix, colon, urinary bladder, Fallopian tubes and ovaries. We report a case of 78 year old gentleman with multiple comorbidities who presented with severe sepsis due to necrotizing fasciitis of the right groin. He was planned for extensive wound debridement following resuscitation. Intraoperatively, there was right irreducible inguinal hernia containing perforated caecum which is the aetiology of the overwhelming infection. Extensive wound debridement, limited right hemicolecctiony, right inguinal hernia repair with right orchidectomy was performed. He had a prolonged stay in ICU postoperatively but was discharged home about 3 weeks following the surgery. This case report highlights the possibility of complicated inguinal hernia as the aetiology of severe cutaneous infection over the groin area.

OBJECTIVE OF THE STUDY
Appendicectomy is the most common emergency surgical procedure worldwide. It has both short-term and long-term post-operative complication. Incisional hernia causing small bowel obstruction and stump appendicitis are example of long term complication of appendectomy which happens rarely.

CASE SERIES 1
50 years old lady, with history of open appendicectomy 9 days ago was readmitted. He presented with colicky abdominal pain and obstructive symptoms for 2 days. CECT abdomen revealed distal small bowel obstruction secondary to post-operative changes. Intra operatively, a loop of ileum herniated through gap in the external oblique aponeurosis. The failure to approximate the external oblique aponeurosis had contributed to the obstruction. The herniation was reduced and the gap was closed. Patient had an uneventful recovery.

CASE SERIES 2
17 years old girl presented with right iliac fossa pain and vomiting for 3 days. She had history of open appendectomy 12 days ago. CECT abdomen was performed and it was reported normal. We proceed to wound exploration in view of persistent pain. Intraoperatively, inflamed and swollen stump appendix was identified. The stump was excised. Patient recovered well and discharged home.

DISCUSSION
Stump appendicitis and incisional hernia are rare late complication of appendectomy. These complications are related with incomplete surgical procedure.

CONCLUSION
1. Proper ligation of appendix by clearly visualizing the appendicular base and the appendicular stump less than 3mm will reduce the risk of stump appendicitis. Treatment choices are re-appendectomy with or without stump inversion or even limited right hemicolecctiony.
2. Proper abdominal muscle wall closure and adequate tension during suturing will reduce the incisional hernia.
BACKGROUND AND OBJECTIVES
The incidence of colorectal anastomotic leak ranges between 6-11% and remains a major cause of morbidity and mortality following left sided colonic surgery. The objective of the study is to determine the diagnostic value of intra-operative endoscopy to detect post-operative anastomotic leak in left-sided colorectal anastomosis.

METHODS
This is multi-centre prospective cohort study conducted from July 2016 to August 2017. Seventy-eight consecutive patients undergoing either left sided colon or rectal resection with end-to-end anastomosis with a negative air leak test were included. Intra-operative endoscopic assessment of the anastomotic line was performed looking for mucosal defects, haematoma or bleeding, and dusky mucosa. Post-operatively, patients were diagnosed with colorectal anastomotic leak either clinically, or radiologically with the use of gastrografin enema.

RESULTS
A total of 78 patients were included in the study. Eight (10.3%) patients had an anastomotic leak; 5 (6.4%) of which were clinical leaks and 3 (3.9%) were radiological leaks. Twenty-two patients (28.2%) had a positive intra-operative endoscopy with a finding of anastomotic line haematoma, out of which 2 (9.1%) patients had an anastomotic leak. None of the patients with a negative air leak test had mucosal defects or dusky mucosa. The overall sensitivity, specificity, positive predictive value, negative predictive value, positive likelihood ratio, negative likelihood ratio and accuracy of intra-operative endoscopy are 25% [95% CI; 3.2-65.1%], 71.4% [95% CI; 59.4-81.6%], 9.1% [95% CI; 2.7-25.9%], 89.3% [95% CI; 84.5-92.7%], 0.88 [95% CI; 0.25-3.07], 1.05 [95% CI; 0.69-1.61] and 66.7% [95% CI; 55.1-76.9%] respectively. Area under the receiver operating characteristic curve is 0.48 [95% CI; 0.27-0.69].

CONCLUSION
Intra-operative white light endoscopy is not an effective diagnostic tool to detect anastomotic leak in patients undergoing left sided colorectal anastomosis with negative air leak test.
OBJECTIVE
To present a 18 months review of Colonoscopy service with respect to demographic, indication, endoscopic findings and outcome.

METHODS
A retrospective review of all patients who underwent colonoscopy between July 2016 until December 2017.

RESULTS
379 colonoscopy were performed from July 2016 to December 2017. 302 (80%) were elective and 77 (20%) were emergency cases. 203 (54%) are male and 176 (46%) are female. They were 173 (46%) Iban, 113 (30%) Chinese and 93 (24%) Malay. The mean age group was 57.

The common indication for elective colonoscopy was per rectal bleeding 73 (24%), altered bowel habit 62 (21%) and anemia for investigation 59 (20%). The common findings for elective colonoscopy was normal finding 150 (50%), hemorrhoid 50 (17%), polyps 35 (12%), diverticulum 25 (8%) and colorectal carcinoma 17 (6%).

The common indication for emergency colonoscopy was lower gastrointestinal bleeding 31 (42%), abdominal and rectal mass 10 (13%), suspected colorectal carcinoma 9 (12%). The common findings for emergency colonoscopy was normal findings 30 (39%), colorectal carcinoma 9 (11.6%), diverticulum 9 (11.6%), hemorrhoid 5 (6.4%) and proctitis 4 (5.2%). There was one sigmoid perforation during the colonoscopy which account for 0.3 percent. No mortality documented.

CONCLUSION
1) Colonoscopy service in Hospital Sarakei has achieved a satisfactory standard from the audit, despite managed by a single surgeon.
2) The detection rate of colorectal carcinoma was 26 (7%).
COLORECTAL CANCER IN SARAWAK GENERAL HOSPITAL: A 3 YEARS REVIEW

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BACKGROUND
Colorectal cancer is one of the major health problems and is the second most common cancer in Malaysia (12.3%) as reported in Malaysian National Cancer Registry Report 2007-2011. It has become increasingly important as a public health concern. The aim of this study is to provide an overview on epidemiology of colorectal cancer treated in Sarawak General Hospital.

METHOD
Patients with newly diagnosed colorectal cancer from prospectively collected Colorectal Cancer Database from 2015 to 2017 were analyzed.

RESULTS
A total of 601 patients were included, which consisted of 366 male (60.9%) and 235 female (39.1%) (range: 21-90 years old). Majority of the cases were aged between 61-70 years old (33.4%) with 8% of aged below 40 years old. Among the 601 patients, the majority were Chinese (42%), followed by Malay (23%) and Iban (20%), while other races accounted for 15%. 79% of them presented treated in elective setting while 21% were in emergency setting. 96.2% of the them had histology type of adenocarcinoma (578 patients) with majority of the tumour were moderately differentiated (92.2%). The commonest site of cancer was rectum (41.4%), followed by sigmoid colon (22.8%), and rectosigmoid colon (9.5%). Significantly high proportion of our patients presented late with 36.9% of them in stage IV and 29.0% in stage III, while only 14.2% were at stage I.

CONCLUSION
With the tendency of increasing number of colorectal cancer cases annually, and late presentation, efforts are much needed to create awareness of the colorectal cancer among Sarawakians and also to strengthen colorectal cancer screening program in Sarawak.

A REVIEW OF ENDOSCOPY FINDING OF PATIENTS WITH POSITIVE iFOBT IN SARAWAK GENERAL HOSPITAL

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OBJECTIVES
Faecal occult blood test (FOBT) remained an important screening tool for colorectal cancer in the recent years. We would like to review the diagnostic accuracy of FOBT used in screening for gastrointestinal pathologies; namely malignancies.

METHODS
All patients included were tested positive for iFOBT for colorectal cancer screening program in health clinic during the period of time from 1st of August 2016 to 31st of October 2017. They were subjected to oesophagogastroduodenoscopy (OGDS) and colonoscopy at our facility. The demographic data, OGDS and colonoscopy findings from our facility were reviewed.

RESULTS
A total of 119 patients were analyzed. 25 patients (21%) had normal OGDS and colonoscopy findings. From the OGDS, 5 patients (0.4%) had gastric/duodenal ulcers while 2 (0.1%) had gastric (hyperplastic) polyps. On the other hand, colonoscopy findings revealed significantly high colorectal malignancies (20.1% or 24 patients), 38 patients (34.9%) with with colorectal polyps or adenomatous lesions, 12 patients (10.1%) with diverticular disease, 6 patients (5.5%) with rectal ulcers, 6 patients (5.5%) with colitis and 8 (6.7%) patients with haemorrhoids. Up of the 24 patients, majority of them had cancer at stage 3 (41.7%) followed by stage 1 and 4 (20.8% each).

CONCLUSION
With high rate of detection of colorectal malignancies and its precursor (adenomas / polyps), FOBT remain a useful screening tool for gastrointestinal malignancy whereby endoscopic assessment is highly recommended if screening results are positive. Colonoscopy assessment is mandatory while OGDS may be considered if colonoscopy findings are insignificant or in symptomatic patients.
INTRODUCTION
Colorectal neuroendocrine tumors (NETs) are a group of neoplasms traditionally referring to carcinoid tumors. The incidence of rectal neuroendocrine tumors is approximately 1/100,000. Despite the increasing incidence of NETs in recent decades, these tumors remain uncommon, accounting for 20% of all NETs.

CASE REPORT
A 47 year old gentleman, active smoker with no known illness presented with complaint of dysphagia for a month. It was associated with intolerance to solid food. He lost around 10% of his weight during that period. By the end of the week, he started noticing yellowish discoloration of his sclera. Clinically he was jaundiced. Per rectal examination reveal a pedunculated polyps at 5 o’clock 4cm from anal verge. OGDS finding was an antral gastritis. He was subjected to a CT liver 4 phase which reveal an ill defined hypodense lesion in segment IVb measuring (1.8x1x1.2cm), Radiologist suggested that it may represent a hemangioma. Colonoscopy revealed a sessile polyps at lower rectum 4cm from anal verge, snare polypectomy was done. Macroscopically the lesion was a size of 9x8x2mm. Pathologist reported this as Neuroendocrine tumour, Grade I. His blood investigation revealed a slight raised liver function test, otherwise other parameters were all normal. His Chromogranin A level pre-polypectomy was 81.2.

DISCUSSION
Neuroendocrine tumour of rectum constitute about 20% of NETs. Historically Rectal NETs were regarded as indolent tumour with only small number of patient developing complication from their disease. The 5-year survival rate approaches 90% for localized lesion. Well differentiated NETs <20mm that do not invade muscularis propria can be endoscopically resected without any follow up. However recent studies suggested there is considerable risk & regional metastases might occur. There is a reported case of recurrent metastases in a localized rectal NETs after curative resection.

CONCLUSION
Rectal NETs have a favourable prognosis compared to other colorectal carcinomas. However there is a real risk of recurrent even in low risk lesion. So a regular follow up is important.
INTRODUCTION & OBJECTIVE
Patients who undergo stoma surgeries often depend on their caregivers for assistance and the presence of a stoma significantly predicts a higher burden of care. This is a screening assessment on the caregivers of our patients with ostomies in our local setting with aims to identify families who would benefit from a more comprehensive assessment and support.

METHODS
This is a retrospective screening survey over a period of 12 months in Hospital Raja Permaisuri Bainun, Ipoh. The data of all patients who underwent stoma surgeries between 1/1/17 to 31/12/17 were obtained from the operating registry. Caregivers were interviewed using the Caregiver Strain Index (CSI) with consent.

RESULTS
34 out of 70 patients responded to our interview. Maximum CSI score was 13 and the minimum was 1; with a mean of 5.5 (SD=4.00, var 16.1, CV 0.7). 11 (34.3%) caregivers scored 7 or more. Analysis using Fishers exact test showed that caregivers schedules were affected the most (Question 6) compared to other components of the survey (p=0.045). There was no significant correlation between CSI scores with malignancy cases (p=0.396) or survival status of the patient (p=0.636).

DISCUSSION
Even though the average CSI among our population was lower than the cut-off point of 7, attention should be placed upon the 11 caregivers who have high level of stress. A younger age patient, single, and presence of co-morbidities may predict a higher burden of assistance. Time involved in caring predicted a higher burden, consistent with an Irish study.

CONCLUSION
Caregivers of ostomy patients should be screened upon discharge from the ward and those with high levels of stress should be followed up and offered tailored support. Efforts to reduce burden of care would hopefully translate into better outcomes for both patient and caregiver.
AN AUDIT OF OSTOMY SURGERY IN A YEAR IN A TERTIARY CENTRE WITHOUT OSTOMY CARE TEAM

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INTRODUCTION
The history of ostomy began when surgeons realized presence of fistula (outlet) in diseased bowel or intestinal obstruction saved lives. There has been many changes in techniques, indications and guidelines for stoma creation. We conducted a 12-month audit of stoma surgeries performed in Hospital Raja Permaisuri Bainun, Ipoh to identify the incidence and indications for our patients and hopefully with this audit, we are able to increase awareness about ostomy surgery, improve education among healthcare providers, patients and their caregivers. This audit may also demonstrate the burden and need for appropriate budget and staff allocation to assist the practical and financial aspects of stoma care.

METHOD
Data was collected retrospectively from our operating registry and patient management system between 1/1/17 until 31/12/17. Paediatric cases below 12 years of age were excluded.

RESULTS
There were a total of 70 stoma surgeries performed during this period; 62 were creations, 6 reversals, 2 refashioning. We had an equal number of transverse and sigmoid diverting colostomy (n=19), 15 Hartmann procedure, 7 double barrel stomas and the rest were ileostomies. Half (n=35) of our cases involved colonic malignancy and the other half involved diversion colostomy for infected wounds, diverticulitis and trauma. Majority of our patients were Malay (51.4%) and the average age was 64.5 in the cancer group versus 58.0 in the non-cancer group. The male:female ratio was 5:2 and 88.5% were performed in the emergency setting.

DISCUSSION & CONCLUSION
Irregardless of the indication for surgery, the impact of stomas on patients quality of life and distortion of their self-image is undeniable. They are vulnerable to both physical and psychosocial health changes which may affect their self-efficacy and ADL independence. Absence of a stoma care team and pre-stoma education by stoma care nurses puts additional burden onto ward nurses, anxiety to unprepared patients and their caregivers.
LEIOMYOSARCOMA OF SIGMOID MESOCOLON: A RARE CASE REPORT

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INTRODUCTION
Mesocolon leiomyosarcomas are extremely rare tumours by incidence of 1:350,000. Pre-operative diagnosis is difficult due to its low incidence and is often mistaken with other mesenchymal tumours eg: gastrointestinal stromal tumours. We report a rare case of sigmoid mesocolon leiomyosarcoma which was referred on table by gynaecological team.

METHODS AND MATERIALS
Madam K is a 27 years old lady, with 3 children and no underlying illness. She presented to Hospital Bintulu with complains of lower abdominal mass for 2 weeks. It was associated with cramping like tenderness and radiates to the lower back. She does not have any significant gastrointestinal, gynaecological, constitutional or family history of malignancy. Examination revealed palpable mass at pelvic region. CT scan showed a left pelvic tumour suggestive of malignant ovarian tumour. She was then referred to Gynaecological team of Sarawak General Hospital. She was then planned for a left salphingo-oophorectomy. Intraoperatively noted a mass arising from the mesocolon with dense adhesion to sigmoid colon, left ureter and left fallopian tube. Surgical team was called and an en-mass resection, sigmoid colectomy primary anastomosis and left salphingo-oophorectomy was performed. HPE revealed sigmoid mesocolon leiomyosarcoma. FNCLCC histologic grade II. Patient is currently undergoing adjuvant chemotherapy.

CONCLUSION
Mesocolon leiomyosarcoma is extremely rare with poor prognosis. The only accurate diagnostic modality currently available is via histopathological examinations with immunohistochemical studies, often only available post operatively. Early detection and surgical resection remains the mainstay of management. Recurrence and metastasis primarily to the liver and lung is common. However there is no standard modality of chemotherapy or radiotherapy currently available.


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INTRODUCTION
Anastomotic leaks are among the most dreaded complications after colorectal surgery. It can give rise to significant morbidity and even mortality in delayed detection and intervention, leading to delayed recovery and subsequent initiation of adjuvant therapy which may adversely impact upon prognosis.

MATERIAL AND METHODS
Patients with intestinal anastomosis after surgical resections for colorectal cancer were extracted from the prospectively collected Colorectal Cancer Database of Sarawak General Hospital from 2015 to 2017 were analysed. The incidence of leak by surgical site, timing of diagnosis, method of detection, and treatment were analysed.

RESULTS
A total of 276 patients underwent resection and anastomosis during the study period. Median age was 65 years old (range: 26-90 years old). Leaks occurred in 21 patients (7.6%). Median time of diagnosis was 5 days (range: 3-11 days) post-operatively. 18 of the cases had surgery under elective setting (9.25%, n=227); while 3 patients had anastomosis leak after emergency surgery (6.12%, n=49). The leak rate is the highest for left hemicolectomy (3/13 cases or 23.1%); followed by right hemicolectomy (6/63 cases or 9.5%); and anterior resection (12/200 cases or 6%). All leaks were diagnosed clinically and confirmed radiographically. Contrast enema correctly identified only 1 of 4 leaks, whereas CT correctly identified all of the leak cases. Only 1 patient (4.76%) had his leak diagnosed only after readmission. All 21 patients required fecal diversion post anastomotic leak. There were 1 mortality from anastomosis leak (4.76%) after elective surgery and 6 patients required ICU admission (28.5%).

CONCLUSIONS
Anastomotic leaks are often diagnosed late in the postoperative period and occasionally after initial hospital discharge, prompting a need for high index of suspicion. CT scan is the preferred diagnostic modality. All anastomotic leaks required re-operation, fecal diversion with significant number requiring ICU admission and in a few cases resulting in mortality.
Anorectal mucosal melanoma accounts for approximately 4% of anal canal tumours and less than 1% of all melanoma. Anal canal is the most frequent site of melanoma after the skin and retina. Anal melanoma is rare and aggressive malignancy. Patients commonly present with advanced, even metastatic disease.

We hereby report a 61 years old male, presented to us with two month history of perianal pain, tenesmus and per rectal bleed following defecation, associated with loss of appetite and unintentional weight loss over a ½ year period. On examination revealed hard anal mass at endocutaneous junction, almost circumferential from 9 o’clock to 6 o’clock position, fixed and easily bleed on touch. A biopsy of the mass confirmed anal malignant melanoma. CT TAP done showed anal carcinoma with possible prostate and seminal vesicle involvement, lymph nodes enlargement at left internal iliac 1.5cm and multiple small lymph nodes in common and para aortic regions. In view of locally advanced disease with lymph nodes involvement, decided not suitable for surgical treatment, thus proceed with diverting trephine tranverse colostomy and subsequently planned for radiotherapy and chemotherapy.

Malignant melanoma of the anal canal is a rare and aggressive disease. Managing anal melanoma remains a major challenge and has overall poor prognosis and a 5-year survival rate of less than 20%. The optimal treatment remains controversial. Historically the treatment of anorectal melanoma has been abdominal perineal resection (APR), but more recently wide local resection (WLE) is recommended, however there is no difference in overall survival. Adjuvant therapy for cutaneous melanoma has been studied extensively, but the efficacy on anorectal melanoma is uncertain.

Stoma is a Greek word meaning ‘mouth’ or ‘opening’. Stoma surgery results in a small opening on the surface of the abdomen being surgically created in order to divert the flow of faeces or urine. There are various reasons why stoma surgery is needed. Since the establishment of Stoma Care Team and Colorectal Unit, Surgical Department of Kuala Lumpur Hospital, constant increment noted in the amount of patients underwent stoma surgery.

Reported here are the statistical data of our local experience on stoma patients and their statistical analysis.

Our data showed that the male patients have higher rates of stoma being created compared to female. While in terms of race the Malay show the highest number in comparison to other ethnic. The main contribution to stoma creation was malignancy 69% followed by benign 23%, infection 5% and trauma 3%. The stoma surgery commonly seen in older patient. In comparison to elective surgery emergency cases contributed most to stoma creation 87%.

In conclusion, our data showed that there is a constant increment in number of stoma surgery performed in our centre and it seen more in older male patient. Early detection of disease and elective surgery is a main key to no stoma surgery. This situation indirectly increases the burden of our limited Enterostomal Therapy Nurse.
Colorectal cancers are among the most common cancers globally and are a major health burden resulting in morbidity and mortality. Historically, as with most cancers, aging has a profound effect on progression of neoplastic lesions. Despite the decrease in numbers of colorectal cancer recently, there has been an increment in its incidence in patients under 40 years of age within these past few decades, which represent about 7-26% of colorectal cancers.

In this case series, we highlight the prevalence of sporadic tumor in comparison to hereditary colorectal tumor in young population, the stage of tumor upon detection, and the outcome of disease compared to older age group in Hospital Kuala Lumpur settings. Also, we discuss the incidence of hereditary germline condition such as Lynch Syndrome, Familial Adenomatous Polyposis and Hereditary Nonpolyposis Colorectal Cancer in this series.

Apart from surgical treatment of these lesions, we elaborate further on the broader aspects of management, namely strategies in detecting the malignancy in younger age group and identifying other members of the family at risk and addressing strategies in preventing the progression to colorectal cancer. We aim to highlight the importance in recognizing the emergence of a younger population of Malaysians that present with signs and symptoms of colorectal cancer as well as the clinical relevance in early genetic team involvement in managing these patients.

**Keywords**

Colorectal cancer, young, Lynch syndrome, FAP, HNPCC

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Haemophilia A is an inherited bleeding disorder that results from a lack or decrease of clotting factor VIII (FVIII). In Malaysia, the prevalence had increased from 5.6 in 1998 to 6.6 per 100000 males in 2006. The severity of haemophilia depends on the percentage of active factor. Many complications due to delayed clotting process can occur however spontaneous intraabdominal bleeding is uncommon especially in mild type. We report a case of a 24-year-old mild hemophiliac male presented to us with sudden onset of left sided abdominal pain for 3 days. There was no other symptom associated to it. He had no history of any form of recent trauma. Patient was pale while the abdomen was tender and guarded on the left side. Blood investigations showed anemia while prothrombin and aPTT were prolonged. Computed tomography scan unveiled large left upper abdomen intraabdominal hematoma with mesenteric hematoma. No contrast extravasation seen. Spontaneous intraabdominal hematoma with mild hemophilia was diagnosed and he was fully managed by conservative treatment with medical therapy. Even though this condition is a rare complication of coagulation disorders, but it should be suspected in cases with internal blood loss. Thorough history and physical examination, combined with CT imaging are necessary to avoid misdiagnosis and further mismanagement of such cases.
BACKGROUND AND AIMS
The incidence of colorectal cancer (CRC) is increasing steadily in Asia Pacific region including Malaysia. The collaborative data collection system enables CRC registration to document details of patients pertaining to CRC cases which should be managed within the context of a multidisciplinary team to improve patient outcomes. This study aims to analyze the clinicopathological features along with treatment modalities received by our CRC patients.

MATERIALS AND METHODS
Medical records of CRC patients were reviewed. Demographics, clinicopathological features along with treatment modalities received by CRC patients were reviewed and analyzed from 1997 to 2017.

RESULTS
A total of 839 CRC cases were reviewed. Majority of patients diagnosed between 50 to 69 years old (56.3%) and 60.3% were males. Chinese patients were highest at 51.5%, followed by Malays at 43.6% and Indians at 3.1%. However, for young patients (<50 years old), Malays predominate at 55.3% and for elderly (>70 years old), Chinese predominate at 59.9%. Most CRC cases were in rectum (34.4%), majority were adenocarcinoma (84.7%) with well-differentiated cells histologically (46.7%). For patients with Duke A: 65.4% had surgery alone and 15.4% had surgery, chemotherapy and radiotherapy. For patients with Duke B (34.1%) and C (39.2%): 40.9% had surgery alone, 26.6% had surgery and chemotherapy and 15.1% had surgery and chemo-radiotherapy. For patients with Duke D: 33.3% had palliative surgery alone and 9.1% had surgery and chemo-radiotherapy. Anterior resections were most frequently performed at 38%.

CONCLUSION
Colorectal cancer in Malaysia is most common among middle-aged and elderly Chinese males whereas young (<50 years old) patients were predominated by Malays patients. Regardless of the ethnicity, majority of CRC diagnosed at the rectum with well-differentiated adenocarcinoma at Duke B and C with most patients received surgery alone and anterior resections were most frequently performed. The synergies from the multidisciplinary team collaborative data highlight the importance of CRC cases registry at a single tertiary care centre and details including stage, chemotherapy regimens and survival rate are still in progress.
SYNCHRONOUS GASTROINTESTINAL STROMAL TUMOR (GIST) OF THE RECTUM AND JEJUNUM: A RARE CASE REPORT

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OBJECTIVE
We aim to report a unique case of simultaneous development of GIST in the rectum and jejunum, to our knowledge this is the first case described as such and reported.

CASE REPORT
We report a 66 year old man who presented with rectal bleeding and altered bowel habit. Colonoscopy revealed submucosal tumor on anterior wall of the rectum. Computerized Tomography (CT) of abdomen and Magnetic Resonance Imaging (MRI) of pelvis demonstrated a mass of approximately 88 AP x 88 W x 89mm CC in size on the anterior wall of the rectum at a distance of 2.3cm from the anal verge, without any invasion to the prostate or evidence of metastasis. Histological examination of the biopsy sample via the rectum showed spindle cell neoplasm suggestive of GIST. An abdominoperineal resection was performed with wedge resection of small bowel lesion who discovered intraoperatively as yellow mass measuring 1.5cm in its diameter extending outwards to the serosa. Histopathological examination of the sample confirmed the diagnosis of GIST of both rectal and small bowel specimen measuring 90x60x55mm and 15x12x9mm respectively with positive CD117 on immunohistochemical assessment. Patient recovered post operatively and planned for initiation of Imatinib.

CONCLUSION
Simultaneous development of GISTs in the rectum and jejunum is extremely rare. Resection is the treatment of choice, suspicious lesions discovered during operation should be biopsied or removed as GIST could appear synchronously.

PERIANAL ABSCESS CAUSED BY MELIOIDOSIS

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OBJECTIVE
We aim to report a unique perianal abscess caused by melioidosis.

CASE REPORT
A 58 years old a Malay male with hypertension and poorly controlled Type II diabetes presented to the emergency department with sepsis and diabetic ketoacidosis. The patient had history of passing discharge through his perineal with fever. On arrival to the emergency department, his blood pressure and temperature was normal but he was tachycardic and tachypnic. After drained the abscess the pathological investigations were indicative of perianal melioidosis. Appropriate surgery and antibiotic treatment healed the perianal infection.

CONCLUSIONS
Anorectal infections caused by melioidosis have not been previously reported in the literature. After elimination of other causes of perianal abscess, this rare case of perianal melioidosis should be kept in mind in the differential.
BACKGROUND
Colorectal lymphoma is a rare entity of colorectal malignancy accounting for less than 1% of all colorectal malignancy cases. Patients with colorectal lymphoma can manifest in a variety of different clinical presentations. Thus, different surgical and oncological approaches are needed in the management of these cases.

CASE PRESENTATION
Two cases of colorectal lymphoma are being reported in this case study. Both cases presented and being managed differently. The first case was a 48 years old lady presented to us with altered bowel habit whilst the second case was a 47 years old man presented in impending obstruction. Radical removal of tumor was done for the first case whilst defunctioning colostomy was done for the second case in view of obstruction. The diagnosis of the first case was confirmed postoperatively after histopathological examination of the operative specimen; whilst the second case diagnosis was confirmed preoperatively from the histopathological examination on the biopsy samples. Chemotherapy were commenced for both cases postoperatively. However, the second case was complicated with tumor perforation after commencement of chemotherapy.

CONCLUSION
Primary colorectal lymphoma is a rare disease and can manifest in different clinical presentation. Future case studies and researches are warranted for better understanding of this disease and its treatment approaches.

INTRODUCTION
Acute intestinal obstruction secondary to internal herniation through acquired mesenteric defect is uncommon but an important complication following open bowel resection. Mesenteric defect are generally closed to prevent this complication. However, there are opposing views that advocate such practice may lead to strangulation of the mesenteric blood supply. This case report illustrated the importance of mesenteric defect closure following panproctocolectomy with end ileostomy in preventing internal herniation.

CASE REPORT
We report a case of 60 years old gentlemen who had history of panproctocolectomy with end ileostomy for massive mesenteric arterial thrombosis secondary to underlying infrarenal abdominal aortic aneurysm. He later underwent elective open abdominal aortic aneurysm repair. Unfortunately, he came back with acute intestinal obstruction, a year after the surgeries. Emergency laparotomy was done and found out there was internal herniation of small bowel through the acquired mesenteric defect. Small bowel was viable, with reduction of the hernia and resiting of the end ileostomy done due to concurrent parastoma prolapse. Patient was well seen at six months follow up.

CONCLUSION
Closure of mesenteric defect remain an important surgical technique in preventing internal herniation following bowel resection. This case highlighted the risk of internal herniation when the defect was not adequately closed.
BACKGROUND
Colorectal cancer is the second most common cancer in males and the third most common cancer in females in Malaysia. Preoperative neoadjuvant therapy (chemotherapy and radiotherapy) is the gold standard in the management of rectal cancer before surgical resection. The literature includes reports of absence of neoplastic cells after neoadjuvant therapy.

OBJECTIVES
This study is done to determine the complete pathological rate for patients with rectal adenocarcinoma after neoadjuvant concurrent chemoradiation therapy. All rectal cancer patients requiring neoadjuvant concurrent chemoradiation in Sarawak General Hospital, Kuching, Sarawak between 1st January 2015 until 30th June 2017 were included.

MATERIALS AND METHODS
Data from the prospectively collected Colorectal Cancer Database of this hospital were collected. Demographic data, neoadjuvant therapy received, surgical procedure and postoperative pathological report were studied.

RESULTS
A total number of 207 were recruited for analysis. Median patient age was 61 years old (range of 28-90 years old); 77 were women (37.2%) and 130 men (62.8%). 110 patients received neoadjuvant therapy (31.2%). Complete pathological response was seen in eight patients (7.27%), 18 patients (16.36%) had minimal residual tumor, 11 patients (10%) had partial response to neoadjuvant therapy, three patients (2.72%) had disease progression, one patient (0.91%) had no changes in his tumor and 69 patients (62.73%) had no report on response to chemoradiation in the histopathological report.

CONCLUSIONS
The percentage of patients with a complete pathological response is similar to that in other literature reports. More studies are needed to define good prognosis factors in patients who might not require surgery after neoadjuvant therapy.

TRANSIT STUDY; ROLE IN CONSTIPATION
Constipation is defined as an unsatisfactory defecation characterized by infrequent stools, difficult stool passage or both. By pathophysiology, it’s divided into primary and secondary causes. Primary causes are intrinsic problems of colonic / anorectal function, whereas secondary causes are related to organic / systemic disease or medications. Colonic transit study is used to point area of pathology. Methods using radiopaque markers include the single capsule technique and the multiple capsules technique. The single capsule technique requires ingestion of markers in a single capsule on day one, followed by several abdominal X-rays that are repeated until all markers are defecated or single abdominal X-ray on day 5. The multiple capsules technique requires ingestion of 1 capsule a day for 3 days, followed by abdominal X-rays on day 4 and 7 or only on day 7. Interpretation is based on the identification of markers in 3 regions namely the right, left and rectosigmoid regions. In the single capsule technique with a single abdominal X-ray on day 5, delayed transit is defined as >20% retention of markers. Here we compare 2 patients with 2 different transit study results from Hospital Selayang. Both patients were provided with ryle tube cut into 30 equal pellets and were ordered to ingest the pellets on day 1. The first patient is a 33 year old female, with history of imperforate anus as a child, surgical treatment done, been having on and off constipation. Transit study with AXR done on day 5 showed generally scattered radiopaque markers throughout the colon with more than 20% retained indicating generally slow transit. The second patient is a 20 year old female with history of constipation since the age of 3 years old, with bowel habits once in 2-3 days, worsening till episodes of no bowel output for 3 weeks. CT abdomen/pelvis done showed dilated rectum, colonoscopy and rectal biopsy were insignificant. Transit study with AXR on day 5 showed pooling of radiopaque markers in the rectum >20% suggestive of pathology of anorectal area. In conclusion, colonic transit study provides the best functional appreciation of colonic motility and shows area of pathology. It cannot provide data on colonic motor movement or anatomical abnormalities that are not detected on colonoscopy. Furthermore no literature review shows usage of colonic transit study solely in determining course of treatment for patient. Other means of investigations are still necessary before final decision is made.
Colonic volvulus is more common in Asia, compared to the West. The commonest site of colonic volvulus is at the sigmoid colon (60-75%), caecum (25-40%), transverse colon (1-4%) and splenic flexure (1%).

We discuss a case of an elderly lady who presented with signs and symptoms of intestinal obstruction. She complained of progressive abdominal distension associated with colicky abdominal pain for 3 days duration, without nausea or vomiting. The abdomen was distended but no peritonism. Abdominal X-ray showed grossly dilated loop of bowel with the typical 'coffee bean' sign. Diagnosis of sigmoid volvulus was made and she underwent a diagnostic laparotomy in which we found the sigmoid colon twisted twice, and redundant transverse colon. The bowels were deemed viable, and redundant bowels were resected en bloc and brought out as a double barrel stoma.

Though uncommon, there have been reports of transverse colon volvulus as well in the literature. The appearance of healthy bowels during laparotomy brings us to the question of whether a colopexy is an adequate measure, or how much bowel to resect in order to prevent recurrence. Literature documents up to a 30% risk of recurrence with colopexy, compared to about 10% after bowel resection. In this patient, resection of the redundant loop of bowel from transverse colon up to mid sigmoid was necessary to prevent recurrence. While extensive resection was performed, it has little effect on colonic function as there is adequate residual length, and even if subtotal colectomy was performed, the small bowels are able to adapt by increasing their absorptive capacity for fluids.

**INTRODUCTION**

Dilatation of the rectum and/or colon, in the absence of demonstrable organic disease, is an uncommon and poorly characterized condition. In patients with constipation, the term megarectum is often used indiscriminately. For some it means a large rectal mass on rectal examination, while for others it means a wide rectum on an abdominal radiograph, the presence of impaired rectal sensation, or the finding of large maximal rectal volumes on anorectal manometry.

**METHODS**

Case report of a patient was studied to portray the manifestation of a patient whom was diagnosed to have megarectum and the management of this patient.

A 19-year-old female presented with difficulty of passing motion since she was 3 years old. Her condition worsened as the years pass as she could not pass motion for 1 month. Tenesmus was presented and she would often require manual evacuation when she was defecating. She had persistent hard stool despite laxatives.

**RESULT AND CONCLUSION**

Chronic constipation is a manifestation of megarectum. Chronic constipation is a common condition in childhood, which is often accompanied or followed by acquired megarectum and soiling. The etiology of this symptom may be well-defined (for instance, absent ganglionic cells, endocrine disorder, anorectal lesion, etc.), but chronic constipation in children is very often of unknown origin. The term megarectum is often used indiscriminately in patients with constipation or fecal impaction but often lacks quantitative measures. There is also scant information about the management of idiopathic megarectum. Patients with isolated megarectum can be treated with either proctectomy and coloanal anastomosis or vertical reduction rectoplasty however studies have shown that the success rate of surgery is not well established.
Anastomotic leaks are devastating complications of bowel surgery and they are truly a surgeon’s nightmare. Clinical presentations of anastomotic leaks are typically abdominal pain, alterations in bowel function and systemic sepsis.

In this case report, we would like to bring up an extremely rare and atypical presentation of anastomotic leak in the form of an ischiorectal abscess.

This is a case of a 55 years old male who was diagnosed with rectosigmoid carcinoma and subsequently underwent laparoscopic anterior resection, who presented to us almost two weeks post operatively with complains of only perianal region swelling and pus discharge and fever. Clinically, the patient was not septic, there was no abdominal symptoms nor peritonism, normal bowel opening and no surgical wound dehiscence. It was only during on table colonoscopy, that we noticed that there was a Grade C anastomotic leak which warranted operative intervention.

We have concluded that anastomotic leaks presenting in this manner are extremely rare and we would like to share our experience with our dear colleagues with this case report.

Lynch syndrome (HNPCC or hereditary non-polyposis colorectal cancer) is an autosomal dominant genetic condition that has a high risk of colon cancer as well as other cancers. This includes endometrial cancer (second most common), ovary, stomach, small intestine (duodenum and jejunum), hepatobiliary tract, upper urinary tract (ureter and renal pelvis), brain (glioblastoma), skin and malignancies of the laryn, pancrease as well as hematopoietic system. Hereby presenting fate of a patient who had four different types of primary tumors at four different sites along different time frame.
Appendiceal mucocele is a very rare disease today. It consists of different pathological entities. Majority of the cases are discovered incidentally and it is vital to achieve a correct diagnosis for the correct surgical treatment for the patient. We present a case of a 44 year old woman, who presented with vague abdominal pain and menorrhagia for 1 month.

She was investigated further at the Obstetrics and Gynecology clinic at our hospital. Clinically, there was superficial tenderness over the right iliac fossa, and a bedside ultrasound revealed a right ovarian cyst measuring 12 x 9cm. She was posted for a diagnostic laparoscopy and ovarian cystectomy. However, a huge, dilated, cystic mass of the appendix measuring 10 x 3cm with a broad base was discovered intraoperatively, and the case was referred to our surgical team. In view of the findings, the case was converted to a laparotomy.

An appendiceal mucocele was suspected and we proceeded with right hemicolectomy. The specimen resected was sent to the laboratory. Histopathological findings later confirmed the specimen to be a mucinous adenoma with low grade dysplasia. The patient eventually recovered and was discharged well.

Anal warts, or condyloma acuminata is an infection around or inside the anus. Most anal warts, 90%, are caused by the human papilloma virus (HPV), a sexually transmitted disease. It first appears as tiny growths, as small as pinheads but can eventually grow into large size. As it typically does not cause pain, most cases go unnoticed and patients commonly present with complaints of itching, bleeding, mucous discharge and a lumpy sensation over the anal region. Although watchful waiting for spontaneous resolution is an acceptable treatment, once symptomatic, most patients will require topical treatment or even surgical resection.

This is a case of a 17 year old gentleman who was referred to our centre for complaints of per rectal bleeding. He was tested positive for HIV in the clinic prior to referral. On further questioning, his spouse was also positive for HIV but denies MSM (male who have sex with male) behavior. He has been having complaints of dyschezia, bleeding with whitish mucous discharge per rectally for about 1 year prior to his visit.

On examination, there were multiple polypoid growths from within the anal canal. He was then subjected to colonoscopy which revealed multiple anal warts. He was counseled for an excision, and was done using a diathermy with the base transfixed. There were 3 anal warts and 1 perianal wart that was excised intra operatively. He was discharged well with clinic follow up dates given.

Condyloma acuminata is a fairly common sexually transmitted disease but with no documented cure. Vaccination is available in controlling the viral load of HPV but surgical excision is still the treatment of choice especially for symptomatic patients as in this case. This patient will need follow up as he may require multiple excisions and the risk of developing cancer is about 10-50% here.
Multiple primary carcinoma, although uncommon, has increasingly been reported owing to better diagnostic techniques. Few tumours have known to occur simultaneously like breast and ovarian tumours due to mutation in BRCA genes. Lynch syndrome is another example where there is an increased risk for colon and endometrial cancer, and MEN syndrome which predispose to endocrine tumours. Nasopharyngeal carcinoma (NPC) is a tumor arising from the epithelial cells of nasopharynx. It commonly metastasize to the bone, viscera, even small bowel and rectum but only 1 reported case to the colon. Sigmoid colon carcinoma, although common, in terms of metastases, has have had an extremely rare case of nasopharyngeal metastases.

Here we report a 67 year old gentleman with sigmoid colon adenocarcinoma and nasopharyngeal carcinoma, presenting at the same time. He was referred for per-rectal bleeding but also noted to have left sided neck swelling associated with hemoptysis. He was subsequently scheduled for an anterior resection followed by adjuvant chemotherapy, and radiotherapy for his NPC. In our literature search, these two tumours occurring simultaneously in on subject has never been reported before.

Treating two primary tumours on one subject proves to be a therapeutic dilemma as to which to treat first. A multidisciplinary approach with exhaustive discussion between colorectal surgeons, ENT surgeons, oncologists, pathologists and radiologists to formulate the treatment plan, not forgetting discussion with the patient and family is imperative to achieve the best possible outcome with timely surgical intervention, chemotherapy and radiotherapy.

The limited knowledge based on the reviewed literature does not allow the mode and sequence of treatment to be determined. This case however, unveils the possibility of such pathology and the need for a more vigilant diagnosis in patients with colorectal carcinomas. This is particularly important, with regards to which of the tumour is to be treated first.

INTRODUCTION

Lipoma of the gastrointestinal (GI) tract are rare and mostly found in the colon. They are the third commonest tumour after adenomatous and hyperplastic polyps of the colon. Lipomas of GI tract are often asymptomatic but can present with abdominal pain, altered bowel habit and rarely, intussusception and intestinal obstruction.

CASE REPORT

We report a 36-year-old gentleman who presented with abdominal pain, altered bowel habit and occasional per rectal bleeding. He also had significant loss of weight and symptoms of dyspepsia. Both oesophagogastroduodenoscopy (OGDS) and colonoscopy was done. OGDS showed hiatus hernia and colonoscopy revealed an intramural lesion, 20cm from anal verge but not obstructing. Biopsy results were inconclusive. Computed tomography (CT) scan showed a non-obstructing intussuscepting sigmoid colon lipoma. A laparoscopic sigmoid colectomy was performed. Patient had an unremarkable recovery post-operatively and was well during follow-up a month later. Histopathological examination showed a 5.5x5x5cm well circumscribed mass confined to the submucosa and confirmed the diagnosis of sigmoid colon submucosal lipoma.

DISCUSSION

Larger colonic lipomas (>2cm) are usually symptomatic and requires intervention. Surgery appears the mainstay of treatment option. However, smaller lesions may be removed endoscopically.
Preoperative chemoradiotherapy has become the standard of care in most T3 and T4 rectal cancers. The German Rectal Cancer trial has shown that those who underwent preoperative chemoradiotherapy shows a local recurrence rate of 4% at 5 years compared to 13% in those who underwent postoperatively. Habr-Gama et al in 2004 demonstrated that 26% of resectable low rectal cancer underwent complete pathological response and was treated by observation alone.

This is a case of a 43 years old Malay gentleman diagnosed with locally advanced low rectal carcinoma involving prostate and bladder. He underwent neoadjuvant CCRT and CT showed no evidence of distant metastasis. He then had abdomino-perineal resection, cystoscopic examination, RPG stenting and bilateral ureteric stenting where the HPE came back as complete histomorphologic regression. He is currently subjected for adjuvant chemotherapy.

Although true incidence of complete pathological response of rectal cancer following chemoradiation in Malaysia is unknown, this case illustrates it too, occurs in our shores. Perhaps we should also embark on this ‘watchful waiting’ in these selected cases. However, the definition of complete clinical response is so varied. The use of MRI has shown high specificity of 90% for T0 rectal tumour. Even after establishing complete clinical response, the next challenge remains in how aggressive should surveillance be done. There however seem to be no consensus in the follow up. Perhaps, it is time to form a working group comprising of colorectal surgeons, oncologists, pathologists and radiologists to draw some recommendations on defining complete clinical response and surveillance in our setting which could reduce the need of surgery and improve quality of life of low rectal cancer patients.

Intestinal MALT lymphoma: A Case Report

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Introduction
Extranodal marginal zone B cell lymphoma or MALT (mucosa associated lymphoid tissue) lymphoma often affected stomach in approximately 80% of gastrointestinal cases. Patient usually presented with dyspepsia, reflux and epigastric discomfort.

Case Presentation
A 48 year old Malay male, presented with sudden onset of abdominal pain over the right iliac fossa and fever for two days duration. His vital sign was normal. On examination of the abdomen reveal tenderness over right iliac fossa region and voluntary guarding. Together with leukocytosis, he was diagnose as acute appendicitis. Patient was brought to theater for appendicectomy. Intraoperatively noted there are two small bowel mass located at 60cm from doudenal-jejunal junction and 170cm from ileocecal valve. Histopathology examination reveals transmural infiltration by atypical lymphoid cell suggestive of MALT Lymphoma.

Conclusion
Malt lymphoma is a subtype of Non-Hodgkin Lymphoma that may develop due to prolonged lymphoid proliferation in response to persistent stimuli such as chronic infection and autoimmune disease.
Gastrointestinal stromal tumors (GISTs) are uncommon and can be a cause of obscure hemorrhage when conventional investigations such as esophagogastroduodenoscopy and colonoscopy fail to detect bleeding lesions. GIST tumors, a rare group of neoplasia of the gastrointestinal tract (GI) and considered to be cause of obscure GI bleeding. The objective of the study is to make sure if we are dealing with GI bleeding, we need to consider GIST. Especially in Small bowel. The case report is a 58 year years old gentleman, presented since 2005 with anemic symptoms secondary to UGIB. Multiple OGDS and Colonoscopy was done in multiple center but no significant findings. We also proceed with First CTA in 2015 and capsule endoscopy but no significant finding seen. The 2nd CTA was done in 2017 showed Extra luminal abnormal vasculature and pseudoaneursym at the jejunal branch of the SMA. Laparoscopic Assisted bowel resection done intra-op finding was small bowel tumor at antimesenteric border.

Final histopathology showed tumor with positive immunochemistry stain for GIST in the spindle cells. Patient was discharge well. In conclusion, GI bleeding in patients can be caused by GISTs tumors. Even if rare, they must be included in the differential diagnosis. Treatment is still complete surgical resection.

While the majority of colonic malignancies represent primary tumors, secondary tumors are not uncommon with lung, breast and ovary being the typical origin. There are only a small number of case reports of secondary colon cancers of endometrial origin, most of which are due to endometriosis rather than metastatic disease. We present a case of 65 year old lady who underwent TAHBSO for cervical cancer stage 3a in October 2014, completed radiotherapy and was on regular surveillance which all yielded negative results till 2017. During one of her oncological followup noted that she had a right upper quadrant mass about 10x15cm which was mobile. She had also been complaining about discomfort however had no altered bowel habit or obstruction symptoms. Colonoscope done was showed no intraluminal mass. CT Abdomen / Pelvis done showed a mass at the right side of the abdomen appears to be arising exophytically adjacent to the ascending colon. An open right hemicolectomy was electively done and final histopathology reported metastatic adenocarcinoma, favours origin from the female genital tract, suspicious of endometrial carcinoma. Secondary tumors of the colon can result either from direct spread or peritoneal seeding. They usually present as serosal implants to the colon. In conclusion immunohistochemistry has an important role here to point out the origin of the tumor as colon and endometrial origin malignancy respond differently to the same staining.
INSIDIOUS: ARE COLORECTAL CANCERS REALLY RARE IN OCTOGENARIANS IN MALAYSIA?

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OBJECTIVE
The purpose of this study is to estimate the demographics and incidence of colorectal cancer patients aiming at the age 80 and above group by sex and ethnicity, with its initial clinical presentation, cancer staging, histopathology findings and course of management during their treatment and follow up in Hospital Pulau Pinang between January 2012 and June 2017.

BACKGROUND
Colorectal cancer in Malaysia is one of the most common cancer found, with an incidence rate of 13.2% (13693 over 103507 in total of all new cases in between 2007 to 2011). It is the most common cancer in males and second commonest in females. Geriatric, or the elderly, poses another challenge to the healthcare treatment; more sensitive and meticulous management is needed for treat this group of patients to recovery. This study is conducted over 5 and 1/2 years in the Surgical Department of Hospital Pulau Pinang (HPP), a tertiary centre in Malaysia.

METHODOLOGY
Date is collected via the hospital records software known as the General Surgery Online (GSO), along with the Histopathology results and radiology imaging and follow up data via the Surgical Outpatient Department records. The data is tabulated with the program Microsoft Excel.

RESULTS
An average of 80 patients is diagnosed yearly (2012 to 2017) in our tertiary centre, of which approximately 5% are of age 80 and above. Within the octogenarian group, approximately 60% of the advance cancers (Stage III and above). Majority of their HPE type are of moderately differentiated adenocarcinoma. Male to female ratio are 2:1, with the highest ethnicity group falling into Chinese, followed by Malay then the Indians.

CONCLUSION
In this advanced age group, colorectal cancers incidence are higher in males, with individuals of Chinese of the highest incidence, and presented with advance cancer (stage III or IV cancer).

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Synchronous colorectal carcinoma is defined as more than one primary colorectal tumours detected in a patient at the time of diagnosis. Synchronous cancer can be detected either pre- or intra-operatively, or in a 6 months period post-operatively. There should be absence of submucosal spread or a satellite lesion of each other and have a distinct separation of at least 4cm (Cunliffe et.al). Most patients has two carcinomas coexist but up to six has been reported in one patient. It accounts for 3 to 5% of colorectal carcinoma cases. Early detection of synchronous tumour are essential as it may alter the extensiveness of surgical procedure and preventing advanced stage presentation, thus increases chances to cure. A pre-operative complete colonoscopy is necessary for exclusion of synchronous tumours, however, it is not always feasible due to presence of constricting distal tumour. Some are diagnosed from CT scan or MRI; or intra-operatively during bowel manipulation. We reported a case of 63-year-old Malay gentleman who presented to us with altered bowel habit, anemic and constitutional symptoms. Colonoscopy done noted a transverse colon adenocarcinoma. Scope was unable to pass beyond the lesion. We proceed with contrast-enhanced commuted tomography for staging, which was done within a week from initial presentation. A synchronous bowel malignancy in the hepatic flexure and distal transverse colon was detected from the scan and patient subsequently underwent total colectomy. Preoperative diagnosis of synchronous colorectal carcinomas has remained difficult despite major improvement in the available modality. Missed lesions can result in additional surgery, higher morbidity and poor prognosis, especially when the prevalence of synchronous tumour is known to be higher in those in the early half of the seventh decade.

**INTRODUCTION**

Intussusception is a process where part of small intestines invaginates into adjacent intestinal lumen. It is an uncommon diagnosis in adult and accounts 1-5% of mechanical bowel obstruction. Adult intussusception is almost always has a demonstrable lead point. We present a case of a18 year old patient with symptoms resembling of an acute appendicitis that turned out to be an ileo-ileo intussusception.

**CASE PRESENTATION**

A 18 year old healthy male came to the Emergency Department with complain of generalized abdominal pain, vomiting and loss of appetite. Abdominal examination reveals tenderness at the right iliac fossa. Diagnostic laparascopic revealed segments of gangrenous small bowel near the ileocaecal region with ileo-ileo intussusception. Conversion to midline laparotomy and limited right hemicolectomy with primary anastomosis was performed. No attempts were made in reducing the intussusception. No lead point was demonstrated in the histopathology examination. Patient recovered well post-operatively.

**CONCLUSION**

Adult intussusception is a rare entity which is distinct from paediatric cases in incidence, aetiology, and management. It is often caused by lead point thus necessitating resection and histopathology examination. A high index of suspicion is needed to avoid any delay in surgical intervention.
OBJECTIVE
Emergency surgery for colorectal malignancy carries higher morbidity and mortality than elective setting due to various reasons. This study is to evaluate the outcome and complication of emergency colorectal surgery in our centre.

MATERIAL AND METHODS
Patients who had emergency surgery for colorectal malignancies were extracted from the prospectively collected Colorectal Cancer Database of Sarawak General Hospital from 2015 to 2017.

RESULTS
A total number of 161 patients underwent emergency colorectal surgeries were included. There were 91 male patients (56.5%) and 70 female patients (43.5%). Median age was 65 years old (range: 21-90 years old). Only 29 of cases (18.0%) were performed by consultants. Majority of patients were in ASA class II (61 patients or 37.9%). Intestinal obstruction was the most common presenting symptom (118 patients or 73.3%) followed by colonic perforation (23 patients or 14.3%) and massive per rectal bleeding (5 patients or 3.1%). Majority of obstruction was at sigmoid colon (49 patients or 30.4%), followed by rectum (26 patients or 16.1%). The commonest surgery done was hartmann’s procedure (49 patients or 43.3%). Main complications were surgical site infection (57 patients or 35.4%). 16 patients (10%) required ICU admission, while 9 patients (5%) had re-operation. Overall 30-days postoperative mortality was 18% (29 patients).

CONCLUSION
Emergency colorectal surgeries are associated with significant morbidities and mortalities. Multiple factors such as patient’s preoperative condition, surgeon’s experience and postoperative nursing care play a major role in the outcome of patient’s underwent emergency colorectal surgeries.

INTRODUCTION
Entero-cutaneous fistulae (ECF) are defined by their sites of origin, communication and flow. We evaluate the treatment of complex patients with ECF in Hospital Sultanah Bahiyah from January 2016 to December 2017.

MATERIALS AND METHODS
Retrospective case note review of four patients (three males and one female) treated at our centre for ECF from January 2016 to December 2017. Management strategy involved early drainage of sepsis and nutritional support prior to elective ECF repair.

RESULTS
All fistulae were resulted from previous surgery for Crohn’s Disease (25%), Superior Mesentric Artery Thrombosis (25%), and adhesion causing Intestinal Obstruction (50%). Median age of patients involved were 34 years old. While the most common site of presentation was jejunum (75%) and ileum (25%). Median fistula output was 1200 ml/day (range 800-2500ml/day) with the mean time for onset of ECF 22.5 days and elective time of definitive surgical management was 401 days. Among the four cases surgery was successful in 75% of cases while mortality rate was nil.

CONCLUSIONS
Early recognition and control of sepsis, management of fluid and electrolyte imbalances, meticulous wound care and nutritional support appear to reduce the mortality rate. After optimization of nutritional status surgery with en bloc resection of fistula offers best results.
Adrenal incidentaloma in patients without history of malignancy are rarely metastatic. The incidence of adrenal metastasis from colorectal carcinoma ranges from 1.9% to 17.4% as it usually associated with liver or lungs metastasis, and the incidence of solitary adrenal gland metastasis is extremely rare.

We reported a case of a 65 years old lady with locally advance rectosigmoid adenocarcinoma with solitary left adrenal gland incidentaloma. She underwent emergency Hartmann’s procedure for obstructed rectosigmoid cancer. We discussed diagnostic dilemma in managing locally advance rectosigmoid cancer with solitary adrenal incidentaloma.

Colonic obstruction (CO) is most commonly due to malignancy, volvulus, hernia, diverticular disease and inflammatory bowel disease. CO due to adhesions is unusual and most commonly is associated with small bowel obstruction. A literature review was conducted which revealed that only a few such cases have been reported. Adhesions, which are fibrous bands between two or more adjacent anatomic structures, are a common cause of small bowel obstruction but a very rare cause of large bowel obstruction.

We would like to present a case of CO due to volvulus caused by the adhesion band following Tenkchoff catheter insertion in a 33 years old patient with end stage renal failure (ESRF).
OBJECTIVE OF THE STUDY
To acknowledge the difference in presentation of adult intussusception and its etiology behind these three cases. The aimed was to recognize and be more cautious that at any setting of adult’s acute abdomen, abdominal obstruction or any abdominal symptoms, the adult intussusception cannot be rule out. Current evidence available literature is discussed.

METHODOLOGY
This is a case series of 3 patients with a surgical rare condition in adulthood; “intussusception” at a district hospital setting; Bintulu Hospital over the year of 2016. These 3 patents were diagnosed with adult intussusception by the aid of imaging modalities that are available at Bintulu Hospital; i.e. xray, US and CT scan. There were no exclusion criteria for the study.

SUMMARY OF RESULTS OBTAINED
A total of 3 cases of adult intussusception in Bintulu Hospital over the year of 2016 were diagnosed. One out of 3 cases was incidental finding with no abdominal symptom and the other 2 cases came with abdominal symptoms. One of which was idiopathic and the rest were due to tumor pathologies. The diagnosis were made mostly by the aid of imaging as well as the clinical symptoms.

CONCLUSION
Most of Adult intussusception have an underlying tumor pathology but there are still cases of idiopathic etiology in Adult intussusception. They may present with abdominal symptom but some may present with no symptom, thus making it difficult in making the diagnosis. Adult intussusception are rare condition but should not just being ignore from making the differential diagnoses in adult patient with abdominal symptom.

INTRODUCTION
Intussusception is a process of intestine invaginates into the adjoining intestinal lumen, which rarely occurs in adult. In contrast to pediatric intussusceptions, which are managed non-operatively with air contrast enemas, treatment in adults is exploratory laparotomy for surgical reduction or resection.

CASE REPORT
A 41-year-old lady with no underlying comorbid presented to Emergency Department with sudden onset of colicky periumbilical pain which associated with non bloody emesis. Further history noted she had similar problem since past one year with multiple casualty visits, with the impression of gastritis. On examination, the patient was in discomfort. Her abdomen was soft and non-distended. She had mild tenderness on palpation in the right lower quadrant with vague mass at right iliac fossa region. Blood investigations were unremarkable with normal arterial blood gases result. Urgent computed tomography of abdomen was performed, which revealed long segment ileoileal intussusceptions (24cm) with possible intestinal lipoma as the leading point. She was then taken to the operating room for exploratory laparotomy. Intraoperatively, noted there was a long segment of ileocolic intussusceptions. Thus limited right hemicolectomy was performed. Gross specimen showed small bowel polyp in the ascending colon. Histopathological examination confirmed intussusception with the leading point formed by a polypoidal mass of ectopic gastric tissue. She is currently recovered well with symptom free.

CONCLUSION
Although intussusception is a rare cause of abdominal pain in adults, it is an important diagnosis to consider in patients with recurrent abdominal pain. Management is often surgical, and delays in diagnosis can lead to complications such as bowel obstruction, ischemia, or undiagnosed malignancy.
INTRODUCTION
The involvement of the CRM by tumour in rectal cancer is a predictor of poorer prognosis (tumour ≤1mm from CRM). CRM involvement increases local recurrence risk and decreases overall survival rate in comparison to patients who have clear margins. However, the question of whether clinically abnormal lymph nodes at the CRM are as significant as encroachment by the primary tumour remains unanswered. The aim of our study is to determine whether clinically abnormal lymph nodes threatening the CRM are a predictor of survival in rectal cancer patients.

METHODS
This is a retrospective review of patients who underwent surgery for primary rectal cancer between January 2009 and August 2015. Patients with metastatic disease, no MRI scan, CRM threatened tumour, previous history of pelvic malignancy, previous recurrence from colorectal cancer and synchronous cancer were excluded. All staging MRI scans were re-reviewed by an independent radiologist with gastrointestinal interest. Threatened CRM was defined as: presence of suspicious lymph node (size ≥10mm on short axis, or heterogeneous appearance, or irregular border) ≤1mm from the CRM on MRI. Disease free survival (DFS) and overall survival (OS) were analysed with Kaplan Meier analysis.

RESULTS
202 of the 358 rectal cancer patients identified were included in the study. 18 patients (8.9%) were found to have threatened CRM by lymph node while 184 patients (91.9%) had unthreatened CRM. 33 patients (17.9%) with unthreatened CRM and 3 patients (16.7%) with threatened CRM by lymph node developed disease recurrence. However, the difference in DFS was not significant (P=0.847). The OS rate in patients with unthreatened CRM and threatened CRM by lymph node was 18.5% and 16.7% respectively (P=0.866).

CONCLUSION
Rectal cancer patients with unthreatened CRM have no significant difference in their DFS and OS rates than patients with threatened CRM by lymph node. This finding needs to be validated in a larger dataset.

REFERENCE
INTRODUCTION

Total mesorectal excision is recognised as the current gold standard for oncological surgical resection of rectal cancer.\(^1\)\(^2\) A significant number of patients with mid and low rectal cancer also have abnormal PSW lymph nodes, and there is debate about whether these should also be included as part of a curative surgical resection, or whether neoadjuvant radiation is sufficient treatment. The aim of this study is to investigate the rate of disease recurrence and overall survival in rectal cancer patients with suspicious PSW nodes on MRI after neoadjuvant chemoradiotherapy without resection.

METHODS

This is a retrospective review of patients who underwent surgery for primary rectal cancer between January 2009 and August 2015. Patients with metastatic disease, no MRI scan, previous history of pelvic malignancy, previous recurrence from colorectal cancer and synchronous cancer were excluded. All staging MRI scans were re-reviewed by an independent radiologist with gastrointestinal interest. Clinically abnormal PSW nodes were defined on pre-treatment MRI as: nodes ≥7mm on short axis and/or morphological changes either with irregular border or heterogenicity. Disease free survival (DFS) rate and overall survival (OS) rate were analysed with Kaplan Meier analysis.

RESULTS

In total, 230 of the 358 rectal cancer patients identified were included in the study. Of these, 16 patients (7.0\%) had clinically abnormal PSW nodes, all of whom received long course chemoradiotherapy. Significantly worse DFS was noted in patients with suspicious PSW nodes versus patients without suspicious PSW nodes (37.5\% vs 17.8\%, P=0.026). There was no significant difference in OS between groups (31.2\% vs 18.7\%, P=0.192). Of patients in the PSW who recurred, 2 patients (12.5\%) developed local recurrence and distant metastasis while 4 patients (25\%) developed distant metastasis only.

CONCLUSION

Rectal cancer patients with clinically abnormal PSW nodes has a higher DFS rate despite neoadjuvant long course chemoradiotherapy.

REFERENCE

INTRODUCTION
Colorectal cancer (CRC) is a major health problem in our population and surgery is often the only definitive management. The purpose of this study is to evaluate postoperative morbidity and mortality and its risk factors after elective CRC surgery.

METHODS
Data for patients who had elective surgery for colorectal cancer were retrieved from the prospective collected Colorectal Cancer Database of this hospital between 2015 and 2017 and analysed using SPSS version 21. Those patients with inoperable tumor, internal bypass, surgery for recurrences and defunctioning stoma were excluded.

RESULTS
A total of 246 patients were included in the analysis. There were 147 male and 99 female patients (M:F ratio:3:2). The median age was 63 years old (range 26-90 years). The majority of patients were in ASA Class ll (169 patients, 68.7%). 64.2% of the surgeries were attempted laparoscopically with conversion rate of 29.1%. Median operative time was 3 hours (Range: 0.75–7.25 hours) and median length of stay was 9.5 days (range:4-55 days). Median estimated blood loss was 200mls (range:0-4000mls), with 49 patients (19.9%) required peri-operative blood transfusion. 17 patients (6.9%) required post-operative ICU admissions. Overall complications rate was 45.8% with 19.9% of surgical site infection, 5.3% of post operation ileus and 16 patients with anastomotic leak (7.7%, n=207). There were 26 reoperations (10.6%), 11 readmissions (4.5%) and 6 mortalities (2.4%) within the 30 day perioperative period. Having any complication was strongly correlated with longer operative times (p<0.001).

CONCLUSION
Surgery for CRC does carry a significant morbidity and mortality and the operating surgeon(s) need to audit his/her outcome, identify underlying cause(s) or risk factor(s) and take necessary action to improve the quality.

INTRODUCTION
Inflammatory myofibroblast tumour (IMT) is a tumour of myofibroblasts spindle cells admixed with plasma cells, lymphocytes, and eosinophils. IMT is a rare tumour can occur in almost any part of the body. They are commonly found at lungs, orbit, peritoneum, and mesentery.

CASE PRESENTATION
We are presenting a case of a 60-year-old Indian gentleman presented to us with intestinal obstruction. He had a CT abdomen showing dilated loops of small bowels and segmental sigmoid colon thickening. He underwent exploratory laparotomy for obstructed sigmoid colon tumor. Intraoperative findings showed a cocoon abdomen with dense adhesions between the small bowels and multiple peritoneal nodules seen. The intraoperative diagnosis was peritoneal tuberculosis and hence, anti-tuberculosis therapy regime has been initiated with minimal effect. The peritoneal nodules histopathological examination shows weakly stained ALK-1 which is suggestive of intermediate/borderline myofibroblastic tumour. The anti-tuberculosis regime was halted as all the biopsy specimens show negative for tuberculosis and he was started on anti-inflammatory agents.

CONCLUSION
The IMT is rare and they have a wide diverse imaging finding; this includes the presence of soft tissue mass with or without infiltration accompanied by the different gradient of inflammation, hence, making its diagnosis and management a challenge to the clinician.
INTRODUCTION
Obstructed Defaecation Syndrome (ODS) is a form of constipation whereby the patient experience immense difficulty in defaecation with the sensation of tenesmus, incomplete evacuation, urgency and need for manual self-digital evacuation. It is both functional and mechanical disorder. It is commonly affecting women. It was reported that twenty percent of these patients would require the corrective surgical procedure. Non-operative treatment such as biofeedback, transanal electrostimulation, and psychotherapy require utmost commitment and compliance from the patient to follow the strict regime to achieve the desired outcome. We are reporting on our experience in managing obstructing defaecation syndrome at Universiti Kebangsaan Malaysia Medical Centre.

METHODOLOGY
Data were collected from the Radiology department for all the patient who has undergone Defaecation Proctogram from January 2016 to January 2018. Demographic data were collected and the number of patients undergoing different types of operative procedure was recorded.

RESULTS
There is a total of 239 defaecation proctogram performed during the study period. Majority of the patients are female. Ten patients (4%) agreed and undergone surgical procedure for their disorder - Stapled Transanal Rectal Resection (STARR) Procedure (n=8, 80%) and Laparoscopic Resection Rectopexy (n=2, 20%). The rest of the non-operated patients were subjected for biofeedback and psychotherapy with the varying outcome.

CONCLUSION
Obstructed Defaecation Syndrome is a complex dysfunction disorder which can be managed by multi-modality treatment. The non-operative treatments are more favourable among the patients. However, when the non-operative measures have depleted, surgery should be advised to improve quality of life.
OBJECTIVE
World Health Organization (WHO) predicts the number of world population expected to live beyond the age of 70 (septuagenarian) will double in the year 2050. This trend poses a dilemma amongst surgeons in predicting the surgical outcomes when operating on these group of people and thus identifying factors that need to be address in ensuring favourable outcomes. We reviewed our institutional data on septuagenarian patients who underwent surgical operations under our unit from year 2011 until 2017.

METHOD
We retrospectively reviewed the records of all our colorectal patients who underwent surgery (elective or emergency) from January 2011 till December 2017. Based on this record, we analysed the data of patient aged 70 and above (septuagenarian) based on the demographics, diagnosis, type of surgery (elective or emergency) and morbidities associated.

RESULTS
Overall, we operated on 552 patients aged 70 and above throughout the 6 years period. 61.2% of patients (338/552) presented as emergency while 38.8% of patients were operated under elective list. In total, 9.6% of patients (53/552) developed post-operative morbidities (Clavien-Dindo Grade I-V), with large majority occurring in those patients presented as emergency cases (77.4%).

CONCLUSION
Septuagenarians who underwent surgical operations are at higher risk of developing post operative complications, especially in those who presented under emergency situation. Other contributing factors are due to increasing age, frailty and pre-existing co-morbidities.

RECTAL LYMPHOMA: A RARE SITE OF PRIMARY LYMPHOMA

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Gastrointestinal lymphoma is usually in the form of secondary deposit in widespread nodal lymphoma. Primary gastrointestinal lymphoma is rare, in particular colorectal lymphoma, which constitutes 6-12% of all primary gastrointestinal lymphoma, and only 0.2% of all colorectal malignancies. Here we present a case of primary rectal lymphoma and the clinical course of the disease.

This is a 61 year old gentleman who had renal transplant 35 years ago on lifelong Prednisolone, presented with abdominal pain, mass and constitutional symptoms. Colonoscopy revealed a cavitary lesion. Biopsy taken was not conclusive of malignancy. He underwent non-restorative anterior resection. Histopathological report of the resected specimen revealed diffused large B cell lymphoma (DLBCL). Postoperatively the rectal stump dehisced and subsequently complicated with enterovesico-rectal stump fistula with a few bouts of septicaemia. This was treated non-operatively as there was no peritonitis. He later developed expressive aphasia and CT brain showed left temporal lobe lesion, which was likely to be a brain metastasis. Chemotherapy was planned but he was deemed unfit to tolerate its toxicity. He eventually deteriorated, and patient and family member opted for comfort care. He finally succumbed after he was discharged home at own will.
PELVIC EXENTERATION: EARLY EXPERIENCE AND THE SAFETY OF A RADICAL PROCEDURE FOR THE LOCALLY ADVANCEDRECTAL CARCINOMA

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BACKGROUND
Pelvic exenteration (PE) is a morbid procedure. Ours is a tertiary colorectal surgery center and PE is performed by trained colorectal surgeons for the locally advanced rectal cancers since 2013. This audit is to evaluate safety of this radical procedure and early recurrence rate for all patients undergoing PE at our center.

METHODS
This is a retrospective audit of all patients who underwent PE at the Hospital Universiti Kebangsaan Malaysia from March 2013 till December 2017. The severity of post operative morbidity was retrospectively assigned according to Clavien-Dindo classification. Chi square test was done to identify factors affecting grade III and IV morbidity.

RESULTS
21 patients were identified, with the median age of 60 years old (38-85 years old). Anterior, axial, posterior and combined pelvic exenterations were performed in 10 (47.6%), 5 (23.8%), 2 (9.5%), and 4 (19.0%) patients respectively. The median time for surgery was 7 hours (3.5 - 12.0 hours). The median blood loss was 1500mls (300-4500mls). Clavien-Dindo grade III-IV was seen in 7 patients (33.3%). 30-day mortality rate for this study is 0%. Recurrence within first year following R0 resection is seen in 4 patients (28.6%).

CONCLUSIONS
PE related Clavien-Dindo Grade III-IV morbidity in our series is high (33.3%) but with no 30-day mortality. PE provides an opportunity for long-term survival and good local control for patients with locally advanced rectal cancer.

INTRODUCTION
Laser haemorrhoidoplasty (LHP) is an alternative minimally invasive surgical procedure to treat hemorrhoids. Stapled haemorrhoidopexy (SH) has been preferred to conventional haemorrhoidectomy as it is less painful, but is associated with significant post-operative bleeding. There are no studies comparing LHP and SH. Our primary objective is to compare the post-operative bleeding rate between LHP and SH.

METHODOLOGY
Patients with grade II and III haemorrhoids who underwent LHP and SH from January 2012 till August 2016 in Hospital Selayang and University Malaya Medical Centre were recruited. Follow-up was for 6 months. Data analysis was done using SPSS version 21.0. Chi-square test was used to analyse the categorical data. Statistical significance was set at p value <0.05 with a 95% Confidence Interval (CI). Logistic regression analysis was used to determine the relationship with significant complications.

RESULTS
176 patients, 88 in each arm, were analyzed. The post-operative bleeding rate was lower in LHP compared SH (3.4% vs. 12.5%, p-value 0.026). Severity of post-operative pain was lower in LHP (LHP 19.3%, SH 33.0%, p-value 0.040). On multivariate analysis, LHP was independently associated with lower post-operative bleeding (OR: 0.19; 95% CI of 0.051 - 0.727) and pain (OR: 0.41; 95% CI of 0.205 - 0.836). There was a trend to lower rates of other post-operative complications with LHP (anal fissure: 2.3% vs. 5.7%; fistula in ano: 1.1% vs. 3.4%; anal stenosis: 0% vs. 4.5% and abscess 1.1% vs. 2.3%), although these did not reach statistical significance. The recovery rate after both procedures was almost equal (overall resolution at 6 months: LHP 87.5%, SH 83.0%).

CONCLUSION
LHP is associated with less bleeding and pain compared to SH in the short term. However, a randomized control trial with longer follow-up is needed to establish its role in the management of haemorrhoids.
INTRODUCTION

Pseudomyxoma peritonei (PMP) is a rare clinical condition that is usually caused by a ruptured mucinous tumour of the appendix. HIPEC has been reported to improve overall and disease free survival in these cases. However, it requires surgical proficiency in terms of technicality and equipments, cost feasibility as well as multidisciplinary expertises. We present the first PMP treated with cytoreductive surgery and HIPEC in Malaysia.

CASE PRESENTATION

A 39 years old Chinese female presented with 3 days history of right sided abdominal pain and vomiting. Open appendicectomy was performed with the impression of perforated appendicitis. Intraoperatively, jelly like material were discovered over the right paracolic gutter and pelvis. Appendicectomy and omental biopsy was performed. Histopathology revealed perforated mucinous adenocarcinoma and pseudomyxoma peritonei with positive margins on appendix. Post-operative imaging showed soft tissue densities encasing terminal ileum and cecum.

Multidisciplinary discussion resulted in cared decision for cytoreductive surgery and HIPEC. Right hemicolectomy, hysterectomy with salphingooporectomy, peritonectomy, liver stripping and omentectomy was performed successfully. Subsequently hyperthermic intraoperative mitomycin was given for 1 hour. Abdominal cavity washed with 10 liters of saline after infusion of chemotherapy and stapler ileocolic anastomoses performed. Patient recovered well and was discharged postoperative day.

DISCUSSION

Most cases of PMP are caused by ruptured appendiceal tumors with dissemination of mucin-producing epithelial cells into the peritoneal cavity. Recent trials have proposed surgical cytoreduction of the primary tumour, peritonectomy and intraperitoneal hyperthermic chemotherapy (HIPEC) as the standard treatment for PMP due to promising study results. The rationale of this treatment, after macroscopic disease removal, is to obtain an elevated and persistent chemotherapy concentration in the peritoneal cavity white reducing the systemic effects of conventional chemotherapy.

CONCLUSION

Cytoreductive surgery with HIPEC is feasible in Malaysian tertiary centre. However, this service requires a centralized care unit with multidisciplinary expert services to ensure better patient outcome.
OBJECTIVES
To determine if subspecialized delivery of colorectal cancer management is an independent factor for better five-year overall survival (OS) and disease specific survival (DSS).

METHODS
All patients diagnosed with adenocarcinoma of the colon and rectum between 2002 and 2012 in University Malaya Medical Centre (UMMC) were retrospectively reviewed. Patient demographics were extracted from the medical case records. Patients were followed-up until death or censored at the end of the study (31st December 2012). To determine survival rates and to control for confounding factors, multivariate analysis was performed using the Cox model.

RESULTS
The study included 1303 patients out of which 678 (52%) were managed by general surgeons (GS), while 625 (48%) were managed by colorectal surgeons (CR). OS for all patients was 49.3% (GS 48.8%, CR 49.8%) while DSS for all patients was 53.8% (GS 53.0%, CR 54.7%) (p value <0.0005). OS of stage I, II, III and IV were 72.35%, 61.95%, 43.85% and 10.3% respectively. DSS of stage I, II, III and IV were 82.5%, 73.05%, 52.25% and 12.15% respectively. For stages II, III and IV, CR surgeons had a better OS and DSS as compared to GS surgeons with a p value <0.005. On multivariate analysis for OS, decreased survival rates was independently associated with patients managed by GS surgeons (HR 1.5, p<0.001). Stage (p<0.001) and adjuvant therapy (p<0.001) were other factors affecting OS. Similarly, for DSS, reduced survival rates were observed when managed by GS surgeons (HR 1.4, p<0.001). Stage (p<0.001), adjuvant therapy (p<0.001) and tumour differentiation (p<0.05) were other factors affecting DSS. Possible reasons for improved survival included better surgical outcomes, higher likelihood of multi-disciplinary management, and higher likelihood of extended resections, including metastasectomy in Stage IV disease.

CONCLUSION
Sub-specialization improved the OS and DSS of colorectal cancer patients in UMMC.
OBJECTIVES
Endo-SPONGE (B-Braun Medical), a minimally-invasive endoluminal vacuum system, is an alternative in the treatment of early colorectal anastomotic leakage, and may avoid the necessity for emergency re-laparotomy. There is limited literature on its indications and effectiveness, with none from the Asian population. We reported the efficacy of early intervention with Endo-SPONGE in avoiding re-laparotomy, with the extended indication of pelvic sepsis after colorectal surgery.

METHOD
Patients who developed pelvic sepsis post-surgery, between December 2016 and December 2017, were offered Endo-SPONGE as an alternative to percutaneous or surgical drainage. The insertion was performed under conscious sedation or general anaesthesia, with endoscopic guidance. The system was changed every three to four days until drainage was minimal and the cavity reduced in size.

RESULT
Five patients underwent this procedure during the study period. The median age was 62 years (range 53 - 68 years). Patients presented with pelvic sepsis at a median of 14 days post-surgery (range 5 - 21 days). Three patients had undergone neoadjuvant concurrent chemoradiotherapy for Stage III low rectal cancer. One had advanced sigmoid cancer, complicated by enterovaginal fistula, where Endo-SPONGE was inserted as a controlled fistula. The final patient underwent non-restorative anterior resection for a perforated rectal mass due to B cell post-transplant lymphoproliferative disorder (PTLD). The rectal stump dehisced post-operatively, leading to continued pelvic sepsis. The latter two patients eventually died due to disease progression but had improved symptom control. Two patients had a re-laparotomy prior to Endo-SPONGE insertion. None of the patients underwent re-laparotomy after insertion of Endo-SPONGE. The mean number of Endo-SPONGE systems used per patient was four. The median length of hospital stay was 21.5 days (range 21-22).

CONCLUSION
Endo-SPONGE may be useful for avoiding re-laparotomy in pelvic sepsis following colorectal surgery, particularly in the palliative situation. Further evaluation is needed to determine its precise role.
INTRODUCTION
Internal herniation is uncommon, accounts for <1% of all hernia incidence worldwide. Primary type is rare and its paravesical subtype is even rarer. Bowel obstruction of Richter type is a partial obstruction which occurred when antimesenteric wall of a bowel loop protruded through a rigid orifice in the abdominal wall (primary or acquired). It lacks typical symptoms of bowel obstruction. Preoperative diagnosis is difficult and role of imaging is limited. Most of the diagnosis is only made and confirmed during laparotomy. The only treatment available is surgical repair.

CASE REPORT
A 64 years old gentleman presented with constipation and RIF pain which persisted after enema from local clinic. He denied any history of vomiting, fever, symptoms of bowel malignancy or abdominal surgery. Clinically, he was dehydrated. Abdomen was tender at RIF but no signs of bowel obstruction. Blood investigations shows leukocytosis (18,000) and prominent small bowel were noted at abdominal xray. He was treated for Diverticulitis and was managed conservatively. However within 24 hours of admission he developed progressive abdominal distension and bout of vomiting. Faecal material was noted upon ryles tube insertion. Exploratory laparotomy revealed gross small bowel dilatation proximal to a herniated portion of ileum (270cm from DJ junction) at its antimesenteric border through a right paravesical space. It was oedematous but viable. The defect (2.0cm) was repaired with nonabsorbable interrupted suture. Post operatively the patient was recuperating well and was discharged at D7 post operation.

CONCLUSION
Richter’s hernia is rare and only 10% presented with symptoms / signs of obstruction. It should always be considered as one of the differential diagnosis especially in patient with persisted vague abdominal pain and virgin abdomen or had history of previous laparoscopic procedure. Early surgical treatment is mandatory as it can rapidly progressed to strangulation / gangrene.

THE MISTY MESENTERY IN ACUTE ABDOMINAL PAIN

Mesenteric panniculitis (MP) is a benign, chronic fibrosing inflammatory disease of mesenteric adipose tissue of the small intestine and colon. Mean age of presentation lies in the seventh decade, predominantly in Caucasian men.

We present a 44 year-old Malay lady who complained of central abdominal pain for 2 days with no other bowel symptoms. Past medical history included hypertension and dyslipidaemia. Her abdomen was tender at the periumbilical region. Laboratory profile and abdominal x-ray was normal. CT abdomen revealed increased attenuation of the mesentery in the left iliac fossa, accompanied by multiple subcentimeter lymph nodes. There was fat streakiness of the subcutaneous abdominal fat at the periumbilical region. Adjacent bowels and appendix were normal. Her symptoms resolved with expectant non-operative management.

MP occurs autonomously or in association with an array of conditions: vasculitis, granulomatous or autoimmune disorders, malignancies, pancreatitis, bowel ischemia, abdominal trauma or surgeries. It belongs to a continuum of idiopathic mesenteric disorders known as “sclerosing mesenteritis”, divided into three pathological stages: mesenteric lipodystrophy, mesenteric panniculitis and retractile mesenteritis.

Frequently asymptomatic and incidental, majority are diagnosed by CT. MP results in a well-demarcated, ill-defined mesenteric “mass effect” on neighbouring structures with increased fat attenuation termed “misty mesentery”. Other features include presence of lymph nodes with short axis <10mm, surrounded by a hypoattenuated “fat-ring / fatty-halo sign” and a hyperattenuating “tumoral pseudocapsule”.

Most symptoms in MP resolve spontaneously. There is no standardized treatment. Anti-inflammatory or immunosuppressive agents are options and surgical resection is attempted for definitive therapy and complications.

Mesenteric panniculitis is a rare clinical entity. Its nonspecific presentation of abdominal pain remains a diagnostic challenge to surgeons, gastroenterologists, radiologists, and pathologists. Diagnosis of MP is determined without biopsy, as CT features are exclusive for this disorder.
MALIGNANT EXTRARENAL RHABDOID TUMOUR: A RARE OCCURRENCE IN SMALL BOWEL

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INTRODUCTION
Malignant small bowel tumours are rare, presenting with protean signs and symptoms. Malignant extrarenal rhabdoid tumour (MERT) of the small bowel is even rarer, mostly presenting with aggressive features and metastasis, associated with poor prognosis. We highlight a case which presented acutely, where the diagnosis was only made following emergent surgery.

CASE PRESENTATION
A 59 year-old gentleman presented acutely with four days of absolute obstipation, and no other preceding history such as weight loss, anorexia or surgery. Contrast-enhanced computed tomography showed ileal-ileal intussusception with small bowel obstruction due to a heterogeneously enhancing mass at the terminal ileum, and a right lung upper lobe mass. Intra-operatively, the lead point was found to be a 5x12cm mesenteric tumour. A CT-guided biopsy of the lung mass was performed subsequently. Histopathology report showed MERT of small bowel origin with metastasis to the lung.

DISCUSSION
A literature search showed less than 20 reported cases of small bowel MERT, with none reported in Malaysia. Its rarity, highly aggressive behavior, and non-specific symptomatology present a challenge to the treating physician in diagnosis and proper treatment. Histology examination with immunohistochemistry provides confirmatory diagnosis. Our case showed tumour cells of rhabdoid appearance with positive vimentin and EMA, which is consistent with all previous reported cases. More than 50% of patients survived less than 5 years due to the aggressiveness of the tumour with a preponderance for metastasis. Complete surgical resection may result in better outcome but overall median survival is still less than 11 months. Due to its rarity, an optimal management is difficult to formulate and treatment is individualized.

CONCLUSION
MERT of small bowel is extremely rare, with non-specific symptoms, late presentations and poor prognosis. The best treatment of MERT is complete surgical resection, but palliative resections may be required in acute presentations.
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ECHelon Flex™
GST System

** Benchtop testing in porcine stomach tissue. Mean peak load required to pull tissue from the clamped jaws of ECHelon Flex Powered Plus Stapler (PSE660A) and ECHelon Relaid with GST vs ENDO GIA Ultra Handi (EIGAUSTHD) and Endo GIA Relaid with TriStaple Technology (IGSTK05 6.0/90°/16 & GST1607 7.79/90° vs EQG16AMXT 1325°/6 & EQG16AMXT 1325°/6, all p<0.001.

Constantly innovating, since 1887

From the first sterile suture for surgery in multitudes to needles made from bend-resistant alloy used in aviation industry, we continue to innovate for providing best patient care solutions.