COLOPROCTOLOGY 2020

5th to 8th March 2020
Weil Hotel, Ipoh
Perak, Malaysia

Souvenir Programme & Abstract Book
"Wow"

The clinical response most commonly heard when surgeons first experience the new HARMONIC® HD 1000i®.

Designed for complex open and laparoscopic procedures, the new HARMONIC® HD 1000i provides:

**Precision**
Unique shape mimics a mechanical dissector*, reducing the need to use a separate dedicated dissecting instrument†

**Strength**
Unique blade design delivers consistent and reliable hemostasis* and can be used in challenging conditions

**Efficiency**
Increased sealing speed, multi-functionality, and simplified steps for use allowing for optimal efficiency§

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* Design Validation Study with surgeons (n=33) operating in simulated procedures in an animate porcine laboratory model #059590-1600425
† In a design validation study with surgeons (n=33) operating in simulated procedures in an animate porcine laboratory model #059590-1600426
§ In a porcine study comparing sealing times of HARMONIC ACE®-7 and HARMONIC® HD 1000i. HARMONIC® HD 1000i Shears transected vessels faster than HARMONIC ACE®-7, mean vessel transection time of 1.98s vs 1.59s (p=0.01) #059590-1600425
§ In a design validation study with surgeons (n=33) operating in simulated procedures in an animate porcine laboratory model #059590-1600426

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  • 7th March 2020 (Saturday)  
  • 8th March 2020 (Sunday)  

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## Major Sponsors

**Johnson & Johnson**  
**Medtronic**

Further, Together
Malaysian Society of Colorectal Surgeons
Council 2019 - 2021

President  
Immediate Past President  
Vice President  
Hon Secretary  
Hon Treasurer  
Council Members

- Associate Professor Datuk Dr Ismail Sagap
- Dato’ Dr Meheshinder Singh
- Professor Dr April Camilla Roslani
- Dr Jasiah Zakaria
- Dr Luqman Mazlan
- Dato’ Dr Ahmad Shanwani
- Dr Shankar Gunarasa

Coloproctology 2020
Organising Committee

Chairman  
Treasurer  
Scientific Chairman  
Committee Members

- Associate Professor Datuk Dr Ismail Sagap
- Dr Luqman Mazlan
- Dato’ Dr Ahmad Shanwani
- Professor Dr April Camilla Roslani
- Dato’ Dr Meheshinder Singh
- Dr Jasiah Zakaria
- Dr Shankar Gunarasa
- Dr Samuel Tay Kwan Sinn
- Dr M Sarkunnathas
- Dr Foo Chang Lim
- Dr Ravindran M Nardysamy
- Dr Mohd Syafferi Masood
- Puan Mariam Mohd Nasir

- Dr M Sarkunnathas
- Dr Ravindran M Nardysamy
- Dr M Sarkunnathas
- Puan Mariam Mohd Nasir
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- Dr M Sarkunnathas
Welcome Message

I would like to bid you a very warm welcome to Coloproctology 2020 on 5th to 8th March 2020 in the historic city of Ipoh, Perak. This is the first time the conference is held in Ipoh, Perak.

The Organising Committee has prepared an elaborate scientific programme. The conference will start with a pre-congress workshop to be held in Hospital Raja Permaisuri Bainun, Ipoh, Perak. The scientific programme covers a whole array of topics including colorectal carcinoma, infections, minimally invasive surgery, pelvic floor disorders, inflammatory bowel disease and of course we have the How I Do It session and the Professor’s Corner. Separate tracks have also been organised for the allied healthcare professionals and the colorectal cancer survivors’ support group - CORUM.

These two months have been a trying time for the medical profession in Malaysia and worldwide with the COVID-19 epidemic. The Organising Committee has decided to proceed to hold the conference and precautionary measures will be taken at the time and site of the conference.

Ipoh, originally a village, rapidly grew once tin was discovered in the 1800s. Ipoh’s popularity as a tourist destination has been boosted by its British colonial architecture. The city is also well known for its cuisine and natural attractions such as the limestone hills and caves.

Do take this opportunity to explore the sights, sounds and tastes of Ipoh.

Associate Professor Datuk Dr Ismail Sagap
President, Malaysian Society of Colorectal Surgeons & Organising Chairman, Coloproctology 2020
**Faculty**

**Akhtar Qureshi**  
Consultant Colorectal Surgeon  
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Malaysia
# Programme Summary

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**5th March 2020 (Pre-Congress Workshop - Proctology)**

**5th March 2020 (Faculty Dinner - By Invitation Only)**
# Pre-Congress Workshop

**5th March 2020 (Thursday)**

## Proctology

**VENUE**

ACC OT, Level 2, Hospital Raja Permaisuri Bainun, Ipoh, Perak

## Programme

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<td>0730 - 0830</td>
<td>Registration</td>
<td>LOBBY ACC</td>
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<td></td>
<td>Breakfast &amp; Booth</td>
<td>SEMINAR ROOM 2 (Level 4, ACC)</td>
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<tr>
<td>0830 - 1000</td>
<td>Intra-Haemorrhoidal Laser Therapy For Haemorrhoids</td>
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<td><em>April Camilla Roslani</em></td>
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<td>1000 - 1130</td>
<td>Advanced Laser Fistula Ablation For Anal Fistula</td>
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<td><em>April Camilla Roslani</em></td>
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<td>1130 - 1230</td>
<td>Advanced Energy Device Hemorrhoidectomy</td>
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<td><em>Samuel Tay Kwan Sinn</em></td>
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<tr>
<td>1230 - 1400</td>
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<td>1400 - 1500</td>
<td>Stapler Hemorrhoidopexy</td>
<td><em>M Sarkunnathas</em></td>
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<tr>
<td>1500 - 1700</td>
<td>Transanal Minimally Invasive Surgery (TAMIS)</td>
<td><em>Luqman Mazlan</em></td>
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</tbody>
</table>
# Daily Programme

## 6th March 2020 (Friday)

### 0730 - 0830  **REGISTRATION**

### 0800 - 0915  **SYMPOSIUM 1**

**Colorectal Carcinoma In The Elderly**

**Chairpersons:** Jasiah Zakaria / Zaidi Zakaria

**Optimal Surgical Strategies Including Endoscopic And Laparoscopic Resection**

*Khong Tak Loon (Malaysia)*

**Oncological Strategies For Unresectable Colorectal Cancer**

*Mastura Mobd Yusof (Malaysia)*

**Informed Consent In Elderly**

*Esther Ebenezer (Malaysia)*

**Neoadjuvant Chemotherapy For Locally Advanced Colon Cancer**

*Mobd Syabizul Nubairy Mobd Sharial (Malaysia)*

### 0915 - 1000  **PLENARY 1**

**Chairperson:** Meheshinder Singh

**Aligning Colorectal Services To Global Surgery Needs**

*Glenn Guest (Australia)*

### 1000 - 1030  **Coffee / Poster Round**

### 1030 - 1145  **SYMPOSIUM 2**

**Infections Of The Colon And Rectum**

**Chairpersons:** Ismail Sagap / Andee Dzulkarnaen Zakaria

**Gastrointestinal Tuberculosis - To Operate Or Not To Operate**

*Sasbeela a/p Sri La Sri Ponnampalavanar (Malaysia)*

**Clostridium Difficile - Is It A Problem?**

*Andrew Chua Seng Boon (Malaysia)*

**Infective Colitis In A Nutshell**

*The Role Of The Surgeon In HIV And CMV Infection In The Gastrointestinal Tract*

### 0830 - 0900  **CONFERENCE 1**

**Chairperson:** Rozita Mohamad

**AHP Opening Remarks By President, Malaysian Society Of Colorectal Surgeons (MSCRS)**

*Ismail Sagap (Malaysia)*

**Video Presentation And Tribute To The Late Mr Sri Tharan, Past President Of Malaysian Ostomy Association (MOsA)**

*Mubammad Afiq Mobd Azlin (Malaysia)*

### 0900 - 1030  **AHP SYMPOSIUM 1**

**Advancement Of Colorectal Surgery In Malaysia & Worldwide - What Nurses Need To Know**

**Chairperson:** Mariam Mohd Nasir

**Manohar Padmanathan (Malaysia)*

**Resuming A Normal Life: Holistic Care Of The Person With An Ostomy**

**Chairperson:** Rozita Mohamad

**Esther Tng Hui Hui (Singapore)*

**Voices Of ET Nurses: The Importance Of Identification Of Ideal Stoma Siting, How Can I Tell The Surgeon?**

**Chairperson:** Muhammad Afiq Mobd Azlin

**Rozita Mohamad (Malaysia)*

### 1030 - 1100  **Coffee**

### 1100 - 1145  **AHP SYMPOSIUM 2**

**Reaching National Consensus For Standardization Of Ostomy Care Practice Guidelines For Nurses And Doctors**

**Chairperson:** Mariam Mohd Nasir

**April Camilla Roslani (Malaysia)*

### 1145 - 1230  **Lunch Satellite Symposium (Servier)**

**Chairperson:** M Sarkunathan

**Challenges And Advancement In The Management & Haemorrhoidal Disease**

*Akhtar Qureshi (Malaysia)*

**Round Table Discussion On The ASEAN Curriculum (By Invitation Only)**

**Chairperson:** April Camilla Roslani
Daily Programme
6th March 2020 (Friday)

1230 - 1415  Lunch / Friday Prayers

1415 - 1500  PLENARY 2
Chairperson: Samuel Tay Kwan Sinn
Has Minimally Invasive Colorectal Surgery Really Made A Difference In Malaysia?
Yunus Gul (Malaysia) / Akhtar Qureshi (Malaysia)

1500 - 1615  SYMPOSIUM 3
Minimally Invasive Surgery
Chairpersons: Mohd Syaﬀeri Masood / Foo Chang Lim
Prevention Of Ureteric Injury
Khong Tuk Loon (Malaysia)
Laparoscopic Colorectal Surgery In Obese Patients
Luqman Mazlan (Malaysia)
Minimally Invasive Exenterations: Are They Feasible To Do?
David Ong Li Wei (Malaysia)
How To Improve Laparoscopic CME For Right Side Colon Cancer
M Iqbal Rivai (Indonesia)

1630 - 1745  SYMPOSIUM 4
Pelvic Floor Disorders
Chairpersons: Shankar Gunarasa / Azmi Mohd Nor
Bio Feedback For Pelvic Floor Disorder
Nur Afidzillab Abdul Rahman (Malaysia)
Fecal Incontinence: Surgical Perspectives
Colorectal Surgeons’ Perspective On The Essential Investigations For Pelvic Floor Disorder
Azmi Mohd Nor (Malaysia)
The Role Of MRI Defecography In Pelvic Floor Descent

1415 - 1615  AHP SYMPOSIUM 3
Psychosocial Aspect: Body Image And Self Confidence “How Can We Assist The Ostomate?”
Chairperson: Tan Guat Ee
Vinny Nurmalya Megawati (Indonesia)
Paediatric Ostomy: Updates, Challenges And Management Of Complications
Chairperson: Tan Guat Ee
Farah Shakinah Mobd Taib (Malaysia)
Life With A Stoma: How Do Patients Cope Practically And Emotionally
Chairperson: Muhammad Aﬁq Mobd Azlin
Rizki Hidayat (Indonesia)
Issues In Ostomy Care In The Presence Of Surgical Complications
Chairperson: Norazlin Md Nob
Rozita Mohamad (Malaysia)
Counselling: Why It Is A Life-Saving Matter In Preserving Quality Of Life
Chairperson: Rozita Mohamad
Tan Guat Ee (Malaysia)

1615 - 1705  AHP SYMPOSIUM 4
Sharing Our Journey As An Enterostomal Therapist: Facilitating The Development Of Stoma Care Nursing In Our Hospital
Chairperson: Farah Shakinah Mobd Taib
Muhammad Aﬁq Mobd Azlin (Malaysia) / Gan Cheng Geok (Malaysia) / Indah Nursanti (Indonesia) / Norazlin Md Nob (Malaysia)
“Ouch..... Does It Sting?” (Use Of Skin Barrier For Skin Excoriation)
Chairperson: Gan Cheng Geok
Norzilaila Othman (Malaysia)
Stoma Care In Indonesia - Challenges And Advancement
Chairperson: Gan Cheng Geok
Vinny Nurmalya Megawati (Indonesia)

1800 - 1930  MSCRS Annual General Meeting

2000 - 2200  FELLOWSHIP DINNER (By Invitation Only)

YUK SOU HIN RESTAURANT (Level 1)
# Daily Programme
## 7th March 2020 (Saturday)

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<td><strong>MEET-THE-EXPERT</strong></td>
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<td><strong>CONFERENCE 2 (Level 2)</strong></td>
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<td>Glenn Guest (Australia)</td>
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<td>0800 - 0915</td>
<td><strong>SYMPHOSIS 5</strong></td>
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<td>Jasiah Zakaria</td>
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<td>Extended APER And Perineal Reconstruction - Does Patient Position Matter</td>
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<td>Ang Chin Wee (Malaysia)</td>
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<td>J-Pouch Surgery</td>
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<td>Jasiah Zakaria (Malaysia)</td>
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<td>Laparoscopic Lateral Pelvic Lymph Node Dissection For Rectal Cancer</td>
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<td>Tran Duc Huy (Vietnam)</td>
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<td>The Comprehensive Ideas In Anal Stricture Treatment</td>
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<td>Wan Khamizar Wan Khazim (Malaysia)</td>
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<td>Zaidi Zakaria (Malaysia)</td>
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<td>0915 - 1000</td>
<td><strong>PLENARY 3</strong></td>
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<td>April Camilla Roslani</td>
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<td>Diverticulitis In Asians - Is It A Different Disease?</td>
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<td>Armando Crisostomo (Philippines)</td>
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<td>1000 - 1030</td>
<td><strong>Coffee</strong></td>
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<td><strong>SYMPHOSIS 6</strong></td>
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<td>Inflammatory Bowel Disease</td>
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<td>Chairpersons: Poh Keat Seong / Fitzgerald a/Henry</td>
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<td>Perioperative Management Of Pharmacologists</td>
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<td>Andrew Chua Seng Boon (Malaysia)</td>
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<td>IBD Perianal Fistulaes - Is It Always Crohn’s?</td>
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<td>April Camilla Roslani (Malaysia)</td>
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<td>Pouchitis - How To Manage?</td>
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<td>Ida Normiba Hilmi (Malaysia)</td>
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<td>Mobd Rabime Ab Wabab</td>
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<td>Special Consideration In Paediatric Ostomate</td>
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<td>Muhamad Zaki (Indonesia)</td>
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<td>Have Stoma Will Travel: Preparation For Travelling</td>
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<td>Muhamad Afdq Mobd Azlin (Malaysia)</td>
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<td>Availability Of Ostomy Resources In Malaysia And Worldwide</td>
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<td>Chairperson: Mariam Mobd Nasir Tan Guat Ee (Malaysia)</td>
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<td>1100 - 1230</td>
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<td>Clinical Presentation, Diagnosis And Staging Of Colorectal CA</td>
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<td>Surgical Options In Rectal Cancer</td>
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### Daily Programme
7th March 2020 (Saturday)

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<td><strong>PLENARY 4</strong>&lt;br&gt;Chairperson: <em>Wan Khamizar Wan Khazim</em>&lt;br&gt;The Evolution Of Colorectal Surgical Training In Malaysia&lt;br&gt;<em>Ismail Sagap (Malaysia)</em></td>
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<td>1230 - 1400</td>
<td><strong>Lunch Satellite Symposium (Takeda)</strong>&lt;br&gt;Chairperson: <em>Andrew Chua Seng Boon</em>&lt;br&gt;Optimisation Of Conventional Therapy In The Management Of Ulcerative Colitis&lt;br&gt;<em>April Camilla Rosliani (Malaysia)</em></td>
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<tr>
<td>1400 - 1515</td>
<td><strong>SYMPOSIUM 7</strong>&lt;br&gt;Colorectal Potpourri&lt;br&gt;Chairpersons: <em>M Sarkunathas / David Ong Li Wei</em>&lt;br&gt;Challenges Of Establishing Colorectal Services In Malaysia&lt;br&gt;<em>Fitjerald a/l Henry (Malaysia)</em>&lt;br&gt;The Progress Of CRC Service In Indonesia&lt;br&gt;<em>Zulkifli Zainuddin (Malaysia)</em></td>
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<tr>
<td>1400 - 1530</td>
<td><strong>CONFERENCE 1 (Level 2)</strong>&lt;br&gt;<strong>STOMA CARE WORKSHOPS</strong>&lt;br&gt;1: <strong>HOLLISTER</strong>&lt;br&gt;<em>Farah Shakinah Mohd Taib (Malaysia)</em>&lt;br&gt;2: <strong>CONVATEC</strong>&lt;br&gt;<em>Muhammad Afiq Mohd Azlin (Malaysia)</em>&lt;br&gt;3: <strong>COLOPLAST</strong>&lt;br&gt;<em>Gan Cheng Geok (Malaysia)</em></td>
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<td>1515 - 1615</td>
<td><strong>PROFESSOR’S CORNER</strong>&lt;br&gt;Moderator: <em>Lu Ping Yan</em>&lt;br&gt;Panelists:&lt;br&gt;<em>Armando Crisostomo (Philippines)</em>&lt;br&gt;<em>Samuel Tay Kwan Sinn (Malaysia)</em></td>
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<td>1645 - 1700</td>
<td><strong>1400 - 1700</strong>&lt;br&gt;MUTUAL SHARING SESSION AND ROUND TABLE DISCUSSION</td>
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### Postoperative Surveillance Of Crohn’s
*Andrew Chua Seng Boon (Malaysia)*

### Stoma Care Assessment Tools: Referral Assessment Tool Initiative
Chairperson: *Tan Guat Ee Mariam Mobd Nasir (Malaysia)*

### Challenges Of Establishing Colorectal Services In Malaysia
*Fitjerald a/l Henry (Malaysia)*

### The Progress Of CRC Service In Indonesia
*Zulkifli Zainuddin (Malaysia)*

### Erectile Dysfunction In Post Op / Radiotherapy Patient
*Zulkifli Zainuddin (Malaysia)*

### HIPEC - The Malaysian Experience
*Nora Abdul Aziz (Malaysia)*

### Stoma Care Assessment Tools: Referral Assessment Tool Initiative
Chairperson: *Tan Guat Ee Mariam Mobd Nasir (Malaysia)*
Daily Programme
8th March 2020 (Sunday)

0800 - 0915  SYMPOSIUM 8
CORE TOPICS (1)
Chairpersons: Khong Tak Loon / Mohd Syafferi Masood
Anatomy And Physiology Of Colon, Rectum And Anus: Revisit
Andee Dzulkarnaen Zakaria (Malaysia)

Solitary Rectal Ulcer Syndrome SRUS
Zairul Azwan Mohd Azman (Malaysia)

The Malaysian CPG For Management Of Colorectal Cancer
Nil Amri Mohamed Kamil (Malaysia)

0915 - 1030  SYMPOSIUM 9
CORE TOPICS (2)
Chairpersons: Nora Abdul Aziz / Zairul Azwan Mohd Azman
Managing Difficult Stomas
Ballan Kannan (Malaysia)

Fissures - Primary And Secondary
Poh Keat Seong (Malaysia)

Pilonidal Sinus, Hidradenitis Suppurativa And Pruritus Ani
Wan Khamizar Wan Khazim (Malaysia)

Volvulus
David Ong Li Wei (Malaysia)

1030 - 1100  Coffee

1100 - 1300  COLORECTAL MASTERCLASS
Fitjerald a/l Henry (Malaysia) / Mohd Syafferi Masood (Malaysia)
REGISTRATION
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<td>7th March 2020 (Saturday)</td>
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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:

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

The Organising Committee of the Coloproctology 2020 wishes to thank the following for their support and contribution:

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Malaysia is rapidly aging and in fact Perak is the oldest state in Malaysia. According to the Statistics Department Perak will become an “aged” state in 2020 when its proportion of older population reaches 15%. Prevalence of colorectal cancer increase with age. As the population ages, it will become a common problem often warranting surgical procedures requiring informed consent. Informed consent is integral to medical practice which involves authorization of a procedure based on the understanding of the procedure and not to be control by others. Informed consent is not simply getting the patient’s signature, but a therapeutic communication giving information about the nature, purpose and potential risks and benefits involved with and without the procedure. Allowing a greater patient involvement in the decision making process is fundamental.

Three domains of informed consent are freedom to decide, giving clear information, and decision-making capacity. Many elderly, including those with early dementia retain the capacity to give informed consent but should be sensitive to cultural, ethnic and religious values which vary from person to person. Joint decision-making approaches including friends and family are often recommended. Patients with cognitive impairments have impaired ability to understand treatment options. Evaluating the capacity of patients with cognitive impairment is vital for a valid informed consent. Comprehensive Geriatric Assessment will help in determining the capacity however, these formal tests do not replace clinical history and examination. Patients with cognitive impairment at early stage have the capacity to consent for themselves, while patients with various degrees of cognitive impairment the doctor should facilitate decision-making processes and patients incapable of making decision should the legal guardian take over at the best interest of the patient. Documentation of the informed consent process in medical records is essential, detailing the act on the patient’s best interest.

The history of rectal cancer surgery has shown a continuous evolution of techniques and technologies over the years, with the aim of improving both oncological outcomes and quality of life of the patients. Recent advances in medical technology and new findings of clinical trials, treatment options for colorectal cancer are evolutionally changing, even in the last few years. Therefore, we need to update the treatment options and strategies so that patients can receive optimal and tailored treatment. Although laparoscopic surgery is still considered the most common approach for the treatment of colorectal cancer, new surgical technologies such as transanal total mesorectal excision, robotic surgery, and laparoscopic lateral pelvic lymph node dissection are emerging. However, with the recent evidence, superiority of the laparoscopic approach to the open approach for rectal cancer seems to be controversial. Surgeons should notice the risk of adverse outcomes associated with unfounded and uncontrolled use of these novel techniques. Many promising results are accumulating in preoperative and postoperative treatment including chemotherapy, chemoradiotherapy, and targeted therapy. Development of new biomarkers seems to be essential for further improvement in the treatment outcomes of colorectal cancer patients.

Construction and care of ostomy practices differ significantly between countries of low, middle and high human development index (HDI) status. Surgeons in low HDI countries are more likely to construct end-colostomies following left-sided resections, yet have limited access to enterostomal therapy nursing services. As such, ostomy care practices may vary widely, resulting in significant morbidity for patients, especially those who require life-long stomas. In Malaysia, delivery of ostomy care is shared between surgeons, enterostomal therapists and non-specialist nurses, depending on the resources available. The level of specific ostomy care training received is extremely variable. While there is a cost associated with training sufficient ETNs to cope with the workload, this needs to be balanced against the gains in patient quality of life and prevention of complications. A national consensus is therefore needed to guide ostomy care practice which is evidence-based yet recognizes the practicalities of working with limited resources in the local cultural context.
Laparoscopic colorectal surgery is increasingly being practiced for both benign and malignant diseases of the colon and rectum. The benefits of laparoscopic surgery include accelerated recovery of bowel function, decreased post-operative pain and shorter hospital stays. These advantages could be especially beneficial to high-risk patient groups including those who are obese who may present as technically challenging even for experienced laparoscopic surgeons. This is especially so in our region where many low rectal tumours, occur in men and present late. Albeit the development of newer technologies and surgeries such as the use of robots and trans-anal total mesocolic excision (TaTME), laparoscopic surgery will remain the main alternative to open resections in the near future.

The technical difficulties in performing laparoscopic colorectal surgery in this cohort of patients as well as current evidence for laparoscopy will be presented.

Recognized advantages of laparoscopic surgery include less blood loss, shorter time to recovery, shorter hospital stay and rapid return to work in comparison to open surgery. Since the initial introduction of laparoscopic colectomy in the early 90’s, there has been a plethora of scientific evidence confirming the feasibility and even oncological safety of laparoscopic colorectal surgery in patients with colorectal cancer. For patients with colorectal cancer undergoing laparoscopic surgery, the evidence thus far has not shown significant differences pertaining to cancer related outcomes in comparison to open surgery. The additional benefit of time to commencing oncological related treatment is likewise obvious. It is therefore not surprising that there has been a steady uptake of laparoscopic colorectal surgery in Malaysia in recent years. Factors that are barriers towards its widespread utilization include its technically demanding nature requiring additional skills and experience and its steep learning curve. Cost, training, time related constraints and mentoring are other limiting factors which can however be overcome with better organization and utilization of available resources including structured and supervised training programs.

Laparoscopic colorectal surgery is increasingly being practiced for both benign and malignant diseases of the colon and rectum. The benefits of laparoscopic surgery include accelerated recovery of bowel function, decreased post-operative pain and shorter hospital stays. These advantages could be especially beneficial to high-risk patient groups including those who are obese who may present as technically challenging even for experienced laparoscopic surgeons. This is especially so in our region where many low rectal tumours, occur in men and present late. Albeit the development of newer technologies and surgeries such as the use of robots and trans-anal total mesocolic excision (TaTME), laparoscopic surgery will remain the main alternative to open resections in the near future. The technical difficulties in performing laparoscopic colorectal surgery in this cohort of patients as well as current evidence for laparoscopy will be presented.

The worldwide increase in the incidence of colorectal cancer has lead to an increase in the ostomy creation surgeries. Ostomy has a pervasive impact on every aspect of a patient’s life. The major long term impact is on psychosocial aspect, especially body image and self confidence. Loss a segment of their body and formation of stoma surgery either temporary or permanent will lead to changes in body image. Low self confidence especially because of individuals to perceive themselves in a negative way, to see themselves differently from other, to be ashamed of themselves, to feel rejected by their families and friends, and to limit their social activities. This is period of difficult adaptation for the ostomates in their new life.

The WOC nurses can assist the ostomates to improve body image and self confidence by nursing care process using application Roy Adaptation Models. Roy Adaptation Model has four main conceptual framework, consist of (1) input: stimuli adaptation level (focal, contextual and residual), (2) control process: coping mechanism (regulator and cognator), (3) effectors: physiological function, self concept, role function and interdependence, (4) output: adaptive and ineffective responses.

**Keyword:** Psychosocial, Body image, Self confidence, Ostomates, Roy Adaptation Models
Stoma creation is a surgical operation where the surgeon makes an artificial opening on the abdomen from where the bowel is taken out. It is a radical treatment with permanent physical signs of bodily change. Stoma patients face different losses at the physical and functional as well as at the psychological, emotional and social level. It’s important to remember, emotionally and physically, it may take a while for patient to recover and to get back to feeling like old self again. In order to accelerate the adjustment process to living with stoma, it is very important to know how do Patients Cope Practically and Emotionally. Indonesian stoma care services have been setting up for more than 20 years already since 1993 in Jakarta. There is collaboration between surgeons, stoma nurses and ostomates to promote quality of life and mutual help among stoma patients and health care provider. The new ostomate will be learning and to do new personal life and we believe that only education in personal and between groups by stoma nurses will help them in perfectly. The challenges of stoma care services by clinical nurse specialist in stoma management will help people who undergo stoma surgery and adaptation their stoma in the entire their life. The patients strategies highlighted to be able to cope with their situation were focused on rehabilitation (spiritual-culture) and technical issues regarding self-care (irrigation, diet and food consume, maintain skin integrity, stoma care and hygiene, pouching system and use kind of devices) and other technical aspects to solve problems related to gases and the escape of feces. The nursing professionals play a fundamental role in these patients' self-care In this respect, the stomal therapy nurse, as a model of Advanced Nursing Practice, is an effective alternative to develop both this type of cognitive-behavioral resources and to promote the patients’ autonomy in everything related to care for the stoma.

**Keyword:** stoma, living with stoma, nursing care to a person with stoma

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Ostomy surgery is life altering but it is also life saving. Change in body image and having to get used to the ‘new normal’ way of daily living is a major concern. Psychological well being plays an important role in stoma care and counselling aids in this life changing experience. British Association for Counselling and Psychotherapy states that ‘Counselling is a contracted meeting between a client and a counsellor at a specific time, date and place with the sole focus to the benefit of the client’. The intention and purpose is to bring about change and enhancing the client’s well being. Counsellors guide the client in believing that answers to client’s problems are within client. Ultimately, client learn to face problems and begin to improve and bring positive changes in his or her daily life.
Peristomal moisture- skin damage or Moisture Associated Skin Damage is defined as “inflammation and erosion of the skin caused by prolonged exposure to moisture and its contents, including urine, stool, perspiration, wound exudate, mucous or saliva. Risk of leakage and irritation may cause damage to peristomal skin.

Currently there are various types of products and accessories available in the market and this innovation has helped the patients and caretaker to manage the stoma more effectively and have a better quality of life.

Barrier cream as a physical barrier between the skin and the contaminants that may irritate skin.

Well educated health care provider and caretaker with product and technique of skin treatment may reduce risk of skin damage. Health care provider and caretaker able to do the skin treatment accordingly to the severity of symptom to provide comfort to patient.

No-sting barrier film spray as known as hypoallergenic and able to protect skin from contact with body fluids and to prevent further breakdown.

Skin healing completely with skin barrier cream, no-sting skin barrier film spray and good choice of ostomy pouch.
Ileal pouch created when patient underwent Panproctocolectomy for either FAP of UC. Ileal pouch formed to create a faecal reservoir after whole colon and rectum removed. The ileal pouch anal anastomosis (IPAA) to preserve continuity function bowel with anal sphincter. The common type of pouch created J, S & W. The S and W configuration has been associated with high failure rate 66% however the J configuration is associated with low failure rate 2%.

Ideal Ileal J pouch, both limb length should be 12-15 cm, the pouch naturally dilated with time, efferent limb length greater then 15 cm will allow adequate reservoir. To created adequate length apex of pouch must be 6 cm below symphysis pubis to ensure tension free IPAA. After panproctocolectomy divide terminal ileum flush or 2-3 cm from ceacum. Need to divide all adhesion of small gut mesentery, may need to divide peritoneum of both side of mesentery. If still not adequate length, mobilise terminal ileum mesentery to level of duodenum. If still short need to skeletonize the vessel. To created J pouch need about 25 cm of terminal ileum, anchored both limb in three part then purge ring suture at apex of J pouch then make hole at apex and used linear stapler 2 X 100 mm blue cartridge to created J pouch. Check any bleeding from stapler line. Side to end anastomosis using circular stapler 28/29. Covering ileostomy created and can be closed by 6-12 weeks.

Currently, lithotomy and prone jackknife positions are the two main positions used in performing APER. The lithotomy position, which most colorectal surgeons are more used to, provides adequate access to the rectovaginal septum and allows easy access to the posterior face of the rectum. However, this position is not ergonomic and rather uncomfortable for most surgeons and the assistants, blood tends to accumulate in the operation area, and adequate lighting is often challenging. On the other hand, the prone jackknife position is appropriate for almost all proctological surgeries. This patient position allows an excellent exposure of the posterior and anal perineum and the anterior face of the rectum, provides a more comfortable position for the surgeon and assistants, results in less blood accumulation, and enables better lighting. Here, I present cases of extended APER being performed in prone position along with options of perineal reconstruction. Literature review, evidence and personal views are also presented.
Ostomate’s diary is the best medium for ostomate to express their feedback which is slight inconvenience for them to voice out verbally during follow up. The diary content which records information such as summary of surgery, accessories used, stoma clinic follow up detail and column for them to write up their feedback. It is a tool used to assess and record the patient’s condition such as early symptoms of abnormality, progress of adaptation and to measure their treatment compliance. Recording of Stoma self assessment helps to reduce late complications referral and helps Ostomate to develop their awareness on own stoma conditions. Ostomate’s diary is also a method for Enterostomal Therapist (E.T) or Stoma Nurse to identify how the ostomate adapts their new life with stoma.

Traditionally, during follow up at the clinics, main focus is on disease and medication adjustment. Patients were often discharged from wards with no psychological follow-up or counselling. The benefit of Ostomate diary together with multidisciplinary follow-up clinic has proved in improving patient outcomes especially on physical and psychological health.

The convenient and flexibilities of this practice encourage the Ostomate to involve and realize their important roles towards acceptance process. It’s is one of useful communication tool for both patients and health personnel especially Enterostomal Therapists (E.T) to evaluate their treatment plan and practices. This diary benefits not only the patient itself, but useful for the Surgeon, stoma care suppliers, and also the Enterostomal Therapists as an evidence based practice to improve competency based skills in order to improve Ostomate quality of life.

Ostomy surgery saves lives. However, the special and blessed ostomate has to start a ‘new normal’ life in managing the stoma. Coming to terms to living as an ostomate and carer can be traumatic. In the hospital setting, questions and needs that arise can be handled by the doctors and nurses. In the home or public environment, new issues or problems that crop up may cause anxiety and despair. Ostomy resources in Malaysia and worldwide from non-governmental ostomy organisations or associations, support groups and industry representatives provide the much needed assistance to the ostomates. The advancement in technology and media also aid in improving and enhancing ostomates and carers towards a better quality of life.

I shall be relaying how and when Peer Facilitating/Supporting started in CORUM. Mention the original purpose of such a service and its development from infancy stage in 2013 till present. We already have a strong presence in UMMC, HUKM, Hosp. Selayang, Hosp Pantai and very soon in UMSC & Ipoh GH.

- Self-introduction:
  64 yrs, CRC diagnosed in 2016 and survived 6 major surgeries to date plus 40 rounds of chemo.
  - Have been an active Peer Supporter since 2018.
  - Benefitted from several rounds of support sessions from a representative of CORUM when I was initially diagnosed. I firmly believe it will greatly ease the pains and emotional confusion of newly diagnosed CRC patients.

Role of a Peer Facilitator:
- What is a Peer Facilitator?
- Prerequisite of a Peer Facilitator.
- Rules, Regulations & Good Practices.
- What is in it for me as a Peer facilitator.
This is a humble sharing of my experience dealing with colorectal cancer, which will cover the following:
- Self-introduction i.e. my background, medical history, diet habit before the diagnosed of cancer and etc.
- The process of discovering the stage-4 colorectal cancer.
- The emotional shock and impact to me and my family.
- The adjustment of mindset.
- The trust on medical specialist and the quick decision to go for surgery, and the trust on scientific treatment versus traditional medicine.
- The support from family and good friends, before the surgery and during the chemotherapy treatment period.
- The support from CORUM. (Colorectal Cancer Survivorship Malaysia)
- The experience dealing with chemotherapy treatment and the side effect.
- The change of diet and life style.
- The journey continues.

The evolution of Stoma Care training has increased greatly over the past few decades unfortunately, in Malaysia, we are still lacking in this context due to lack of educators and interest among the healthcare providers.

The training was started initially by a group of Doctors in Hospital Kuala Lumpur through a 3-days workshop. Subsequently a group of Nurses in Hospital Kuala Lumpur was sent to Sydney, Australia and one Nurse from University Hospital to Princess Margaret Hospital, Hong Kong to undergo a training of Enterostomal Therapy Nursing Education program a 10 - 12 weeks program encompasses of Stoma, Wound and Continence Care.

The stoma care training was then started by this group of Nurses. Nevertheless, the training then was taken over by University Malaya Medical Centre in collaboration with Malaysian Enterostomal Therapy Nurses Association (METNA), and in 2019 another organization, which is a private training centre, M&T Network Consultancy Services Sdn Bhd was established to also train Nurses in Enterostomal Therapy Nursing till date.

The program is recognized by the World Council of Enterostomal Therapist (WCET)

There are also short courses/workshops for basic stoma care runs by the private centre or organization.

The training is aimed at nurses, health care assistants and care workers that are responsible for delivering stoma care to their clients. Understanding of the digestive system, different types of stoma, diet and the implications needed & side effects that a stoma can cause is vital.

The training will provide theory & practical knowledge on stoma care in order to improve their competency in caring of ostomates and to support the family members. Through lectures and hands-on session, they will learn the indications for stoma, stoma creation, patient preparation and best practices in applying and maintaining of stoma appliances and accessories.
Stoma bag leaks can occur for a variety of reasons. One reason could be that the hole in your stoma bag, which should be a snug fit, is too large. You should re-measure your stoma using a measuring guide. Alternatively, you might be applying your stoma bag incorrectly which could be resulting in creases in the adhesive. Leaks may also be caused by using inappropriate stoma bags for irregular stoma sites. There are stoma bags available which are specifically designed to counteract stoma problems. Accessories are available to prevent leakage. Skin that is too moist can also cause leaks, so make sure your skin is dry before applying the stoma bag. Many ostomates worry about odour. If the stoma bag fits well there should be no smell except when changing it. Certain foods may increase the smell of your stoma output. There is no need to cut out any of these foods but if the smell bothers you, you may want to limit their intake on social occasions or use products to reduce the odour. Stoma products to help prevent odour are available. If you are unsure what might be causing your bag leaks and want to reduced odour, consult your Stoma Care Nurse in the first instance.

Caring for people with intimate healthcare needs such as an ostomy is a great responsibility. Traditionally, ostomy clinicians learn the tricks-of-the-trade from preceptors, mentors, and patients. But as in all of medicine and nursing, as we strive for better out-comes we recognize the need to rely on the scientific method to provide improved, consistent results. Having the right tools makes any job easier. Caring for patients with an ostomy is no exception. - Ann C. Page, 2009. Assessment tools are those instruments (e.g., scales, questionnaires and checklists) that support an assessment, which are used by Nurses around the world and a vital part of the nursing care. It is a data base for comparison and assist Nurses in their documentation. Using a valid and reliable standardized tool to assess a condition has been shown repeatedly to lead to improved outcomes. Stoma care assessment tools also used prevent or detect early complication or issues related to stoma and peristomal skin. Several ostomy assessments tools have been developed over the years, but no single tool has been accepted as a standard. To address this concern, international leaders in ostomy were brought together to develop an ostomy peristomal skin assessment tool that was presented at the World Council of Enterostomal Therapists in 2008. The tool was designed in association with the Coloplast Global Advisory Board, but there are other tools to that can be used by the E.T. Besides DET (physical assessment of discoloration, erosion, and tissue overgrowth the speaker will also discuss brief other tools that available, such as SAC Instruments, and The Ostomy Quality-of-Life Tool (Stoma QoL).

Pelvic surgeries are among the most common causes of organic sexual dysfunction in men. The impact of nerve-sparing surgery on potency has been well documented in radical prostatectomy. However, its impact on potency needs to be evaluated in other pelvic surgeries. Sexual dysfunction is highly prevalent even after multiple technical advances in the field of oncological surgeries. The prevalence varies from 8 to 82%, depending on the type of pelvic surgery. Currently, physicians have several options for the treatment of erectile dysfunction (ED) in men. Since the introduction of oral PDE-5 inhibitors, oral therapy has become the first-line treatment option for ED, irrespective of etiology. Initial reports regarding the role of early rehabilitation are encouraging and may become the part of routine practice in the management of ED after pelvic surgery. This talk will summarize the sexual dysfunction following pelvic surgeries and their management.
Many ostomates have trouble building confidence after their surgery. This is probably due to insufficient pre-operative preparation, denial or unable to accept their life with stoma. Building their confidence is crucial to enable them to accept the stoma and also to continuously care for it since stoma care is self-care. This then will enhance their quality of life after stoma surgery.

According to Vegan Ostomy (2018), a patient that have undergone stoma surgery and receiving home care after his surgery, stated that many of the nurses commented about how well he was handling the situation. They told him that many of their patients refuse to acknowledge their stoma, having a loved-one do appliance changes or empty their bag.

We have heard of several people who hate their stoma, and my heart truly goes out to them - I can’t imagine having such a negative view of yourself, since it saved their life and improved their quality of life 100%, but we know that surgery can come as a shock to many, especially if their stoma was unexpected.

Confidence building is to muster confidence to work toward your goals. With confidence, you’re motivated to put in more time, effort and resource towards your target. Therefore, there are some barriers you need to avoid in order to build confidence for a positive outcome. But as quoted by Henry Ford - “Whether you think you can or whether you think you can’t, you’re right.” According to Ford, your belief in yourself is a determining factor in your success.

The speaker will share some tips on how we can help our patients to building their confidence and it isn’t necessarily an easy road, but you will likely find it more than worth the effort.
An understanding of the anatomy of the colon, rectal and anus is essential to the understanding of the disease processes that occur in this area. Furthermore, unique physiology of the all those organs are very complex, and from the maintenance of peristalsis, act as reservoir and anal continence depends upon a highly integrated series of complicated events upon which there is not uniform agreement. A brief description is made of the various modes of investigation available to establish a diagnosis, provide an objective assessment of function, or identify the anatomic site of a lesion, which has revised our knowledge between normal and disordered physiology, and modified our therapeutic approach.

The term Solitary rectal ulcer syndrome (SRUs) is misnomer and is an uncommon rectal disorder that can present with rectal bleeding, straining during defecation, and a sense of incomplete evacuation. Endoscopic findings in patients with solitary rectal ulcer syndrome can range from mucosal erythema alone to single or multiple ulcers and polyloid / mass lesions. This topic will review the pathogenesis, clinical features, diagnosis, and management of solitary rectal ulcer syndrome.

Pilonidal sinus is a tract that present in the midline in the lower sacral area. It only needs treatment if it becomes chronically infected. Sometimes it may also present as a cyst. The older treatment was to remove the entire tract and leave it to heal with secondary intention. However healing took a long time & recurrence rate is high in the midline. It is thought that midline wound is always subjected to shearing forces of the bilateral right and left gluteal areas. Current concept now is to avoid midline wound and hence several techniques were described. The Bascom procedure, Karyadakis flap or Limberg flap are among the procedures of choice where healing is faster and recurrence rate much lower.

Solitary rectal ulcer syndrome is derived from the Latin word ‘volvere’ which means to ‘to twist’. Volvulus occurs when a part of the mobile gastrointestinal tract twists upon itself along its mesentery. It can occur in the stomach, small intestine and mobile part of the colon. Of interest in the large intestine would be volvulus of the sigmoid colon, caecum (caecal bascule) and less commonly, the transverse colon.

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Volvulus carries a very high risk of recurrence and it is recommended that endoscopic decompression should be followed by bowel resection later. Opponents would argue for a more conservative approach like fixing the bowel to avoid any bowel resection. With regards to volvulus, Chubby Checker got it right when he sang ‘…twist AGAIN’.
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LOCAL RECURRENT RATE FOLLOWING STANDARD SURGERY FOR RECTAL CANCER IN A TERTIARY CENTRE: A 5-YEARS SERIES REVIEW

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BACKGROUND
Large randomized trial showed that the most important risk factor for develop of local recurrence are positive circumferential resection margin (CRM), nodal positivity and advanced T-stage. Implementation of total mesorectal excision (TME) and the subsequent standardization of rectal cancer surgery have led to a significant improvement of survival and decrease of local recurrence rate (LR) from 30% to 10%. But still, a number of patients without evident adverse factors develop LR.

OBJECTIVE
To determine the percentage of local recurrence rate for rectal cancer post-surgery in a tertiary colorectal centre, University Malaya Medical Centre (UMMC).

METHOD
Retrospective cohort study was designed. All patients who diagnosed with rectal cancer subsequently underwent surgery from 2013 till 2017 were retrieved out from operative data folder. Demographic data, tumour localization, pathological reports, TNM stage, Neoadjuvant therapy, postoperative pathological reports and patient’s surveillance up to 2 years were collected from patients records.

RESULTS
A total of 237 patients with rectal adenocarcinoma were treated with definitive surgery. Mean patient age was 67.1. Male patients predominant (53.6%). Chinese had the highest percentage (70.9%). Pre-operative biopsy results were classified: Well differentiated (1.93%), moderate differentiated (93.8%) and poorly differentiated/undifferentiated (4.3%). In these, 121 (46.7%) located at upper rectum, 64 (27.4%) in middle third rectum and 74 (28.6%) in low rectum. 134 patients (51.7%) received neoadjuvant therapy. 1-year local recurrence reported ranging 4-8% whereas 2-year local recurrence ranging 6-10%.

CONCLUSION
Management of LRRC remain a clinical challenge. In our setting, LR ranging 4-10% which is comparable to other literature reviews. However, more appropriate measures should implement to keep our local recurrence rate in a desirable range.

COMPLETE PATHOLOGICAL RESPONSE AFTER NEOADJUVANT THERAPY IN PATIENTS WITH RECTAL ADENOCARCINOMA IN UNIVERSITY MALAYA MEDICAL CENTRE: A 5-YEARS AUDIT

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BACKGROUND
Neoadjuvant chemoradiotherapy has the potential to downsize and downstage the tumours before surgery, decrease local recurrence, and induce a complete sterilisation of tumour cells for middle and low locally advanced rectal cancer. Literature reviews showed that 15-20% of patients are found to have complete pathological response (pCR) to combine multimodal therapy. A watch-and-wait tactic has proposed for patients with clinical complete response.

OBJECTIVE
To determine the percentage of patients with rectal adenocarcinoma with complete pathological response after neoadjuvant therapy.

MATERIALS AND METHOD
All patients diagnosed with rectal cancer underwent treatment from 2013 to 2017 were retrieved retrospectively. Demographic data, tumour localization, pathological reports, TNM stage, neoadjuvant therapy, surgical procedure and postoperative pathological reports were collected from patients records.

RESULTS
A total of 237 patients with rectal adenocarcinoma were treated with definitive surgery. Mean patient age was 67.1 years old. Male patients predominant (53.6%). Chinese had the highest percentage (70.9%) follow by Indian (38.2%) and Malay (29.7%). Pre-operative biopsy results were classified: Well differentiated (1.93%), moderate differentiated (93.8%) and poorly differentiated/undifferentiated (4.3%). In these, 121 cases (46.7%) located at upper rectum, 64 (27.4%) in middle third rectum and 74 (28.6%) in low rectum. 134 patients (56.4%) received neoadjuvant therapy. 12 patients underwent neoadjuvant therapy follow by surgery had a complete pathological response (8.9%).

CONCLUSION
The percentage of pCR in UMMC centre is not similar to that in other literature reports. More evidence and careful patient’s selection needed when adopt watch-and-wait tactic for rectal cancer post neoadjuvant therapy.
BACKGROUND
Selayang hospital is one of the colorectal training and referral centre for those LARC and LRRC in Malaysia. We received referrals from many hospitals mainly from centre and northern regions of Malaysia. Previously, these cancers generally consider incurable and technically inoperable. But its management evolved dramatically over past few decades with the availability of multidisciplinary teams’ services.

OBJECTIVE
To determine our outcome in percentage in term of complete resection, local recurrence rate, 30-days mortality and complications rate.

METHODS
Retrospective cohort data collection was designed for all LARC and LRRC which operated from year 2014 till 2018 in Selayang Hospital. Demographic data, completion of pelvic exenteration, postoperative complication rates, 30-days mortality rate, complete resection and local recurrence were collected from patients’ records.

RESULTS
A total of 51 cases pelvic exenteration were carried out from 2014 till 2018. Male patients predominant (55%) and mostly comprises Malay (52.9%). Out of 51 cases, 17 cases (33.3%) were attempted but failed exenteration as due to either peritoneal metastases or advanced progression disease intraoperatively. Only 34 cases (67.7%) successfully pelvic exenterated after complete workup. From the analysis, we found out that, only 24 cases (47.1%) had pre op MRI/PET-CT done. R0 comprises 23 cases (67.6%), 30-days mortality rate only 2 cases (4%). 23 cases had complications (44.8%) either from anastomotic leak, collection, surgical site infection or cardiac/lung complications. 6-months local recurrence rate was 2 cases (5.8%) and 1-year local recurrence rate was 4 cases (11.7%).

CONCLUSION
Our experience in pelvic exenteration for LARC and LRRC still in toddler stage and need to be improved. Proper MDT discussion and pre op imaging MRI and PET-CT should carry out for every single case to achieve better outcome in future.

INCIDENCE OF SUSPECTED LYNCH SYNDROME BASED ON IMMUNOHISTOCHEMISTRY TESTING IN COLORECTAL PATIENTS UNDERGOING SURGICAL RESECTION
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INTRODUCTION
Lynch syndrome is an autosomal dominant inherited cancer syndrome that predisposes individuals to the development of colorectal and other cancers. Individuals with Lynch syndrome have a germ line mutation in 1 of several genes involved in DNA mismatch repair. The majority of mutations occur in MSH2 and MLH1; however mutations in MSH6 and PMS2 have also been identified.

OBJECTIVE
To identify the incidence, demographic features and tumor characteristics of suspected Lynch syndrome based on immunohistochemistry testing in colorectal patients undergoing surgical resection.

METHODOLOGY
This study was conducted in Hospital Kuala Lumpur between January till December 2019. Immunohistochemistry (IHC) analysis was conducted on all patients below the age of 60, and all right sided tumours (up to mid transverse colon), who underwent surgical resection for colorectal cancer that fit the inclusion criteria.

RESULTS
A total of 50 cases that fit the inclusion criteria underwent immunohistochemistry testing, out of which 16% (n=8) showed loss of MMR proteins. Out of these, 10% (n=5) cases showed loss of nuclear reactivity to MLH 1 and PMS 2, and 6% (n=3) cases showed loss in both MSH 2 and MSH 6. Further testing with BRAF is required to rule out sporadic cases in those with loss of MLH 1 and PMS 2.

CONCLUSION
Immunohistochemistry testing for a select group of patients will allow us to identify those most likely to have Lynch syndrome and these patients can be counselled for genetic testing. This then allows for counselling about the risk for second cancers and its prevention through close surveillance or prophylactic surgery.
INTRODUCTION

PIPAC is a minimally-invasive procedure for intraperitoneal administration of aerosolized chemotherapy in palliation of peritoneal metastases (PM). It allows high tissue concentration of chemotherapy without the side effects and toxicity of systemic administration. Thus, patients unsuitable for curative Cytoreductive Surgery & Hyperthermic Intraperitoneal Chemotherapy (CRS-HIPEC) may be considered for PIPAC. We describe the implementation challenges of the first PIPAC in Malaysia.

METHODOLOGY

Core personnel, comprising surgeons with prior experience of CRS-HIPEC, underwent accreditation training in a regional PIPAC centre. Prior to performing our first PIPAC, international protocols were reviewed. Multi-disciplinary discussions involving clinical and allied health units, engineering and industrial partners were held to address the procedural, instrumentation and peri-operative safety concerns. Institutional occupational safety health (OSHE) reviews, protocol revisions and assessments were done, including mock operating theatre trial runs. Shortlisted patients were discussed in both internal and external tumour boards before final selection. An experienced proctor was present for the operations.

RESULTS

Procedural safety concerns identified were the potential hazards of using aerosolized chemotherapy in the operating theatre. Procedural protocols and equipment were optimized to ensure a fully closed system. Patient fitness, tumour volume and biology, chemotherapy selection and post-operative care were the main considerations in patient selection. Two patients with peritoneal metastasis from colorectal carcinoma with poor systemic treatment response underwent PIPACs on 15 November 2019 under proctorship and OSHE monitoring. Post-operatively, patients were managed in the ward according to post chemotherapy precautions and discharged 3 days later with no complications.

CONCLUSION

PIPAC is safe and feasible with the right patient selection as long as strict procedural protocol is followed with multi-disciplinary collaboration. We hope that selected patients can achieve symptomatic relief and disease control with this palliative procedure.

A 3-YEAR STUDY OF PREDICTIVE FACTORS FOR POSITIVE AND NEGATIVE APPENDICECTOMIES

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OBJECTIVES

(i) To identify potential predictive factors for positive and negative appendicectomies; and (ii) to analyse the use of ultrasound scans (US) and computed tomography (CT) scans for acute appendicitis.

METHODS

All appendicectomies that took place at Peel Health Campus from 01/01/2013 to 31/12/2015 were retrospectively recorded. Test results of potential predictive factors of acute appendicitis were recorded. These factors included white cell count (WCC), neutrophil count, C-reactive protein (CRP), serum bilirubin, gamma-glutamyl transpeptidase, alkaline phosphatase and alanine transaminase. The imaging (if any) and histopathology reports of every case were also recorded. Statistical analysis was performed using Fisher exact test, logistic regression analysis, sensitivity, specificity, and positive- and negative predictive values calculation.

RESULTS

208 patients were included in this study (110 males, 98 females). 184 (88.5%) patients had histologically-proven acute appendicitis. The other 24 patients had either non-appendicitis pathology or normal appendix. Logistic regression analysis showed statistically significant associations between appendicitis and WCC (p=0.038), neutrophil count (p=0.008), CRP (p=0.044) and bilirubin (p=0.001). Neutrophil count was the test with the highest sensitivity (81.9%) and negative predictive value (22.5%), whereas bilirubin was the test with the highest specificity (95.5%) and positive predictive value (97.2%). US (n=58) and CT (n=52) scans had high sensitivity (100.0% and 97.7%, respectively) and positive predictive value (96.3% and 95.6%, respectively) for diagnosing appendicitis.

CONCLUSIONS

No single test was sufficient to diagnose or exclude acute appendicitis by itself. Combining tests with high sensitivity (abnormal neutrophil count, and US and CT scans) and high specificity (raised bilirubin) may predict acute appendicitis more accurately than can be achieved with single tests.
A REVIEW OF LIFT PROCEDURE FOR FISTULA-IN-ANO: EXPERIENCE FROM A NORTHERN PENINSULA MALAYSIA TERTIARY HOSPITAL

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OBJECTIVES
To evaluate our experience on Ligation of Intersphincteric Fistula Tract (LIFT) procedure for the treatment of fistula in ano in Hospital Sultanah Bahiyah Alor Setar.

METHODS
Retrospective review of patients who underwent LIFT procedure at Hospital Sultanah Bahiyah from January 2017 till December 2019. Parameters measured includes comorbidities, previous fistula in ano, previous perianal abscess, operative details and recurrence rate are presented as descriptive statistics.

RESULTS
39 patients underwent LIFT procedure from January 2017 to December 2019. Median age was 37 years old (range 22-64). 27 patients (69.2%) had previous perianal abscess, in which 15 underwent drainage (38.5%). 15 patients (38.5%) had previous fistula in ano. 24 patients (61.5%) had pre-operative endoanal ultrasound done. Intra-operatively, types of fistula identified were: inter-sphincteric fistula (46.2%, n=18), trans-sphincteric fistula (43.6%, n=17), and complex fistula (10.3%, n=4). 21 patients had recurrence (56.4%). None of our patients had fecal or flatus incontinence at 1 year follow up.

CONCLUSIONS
Ligation of Intersphincteric Fistula Tract for treatment of fistula in ano is a safe technique. Our recurrence rate is higher than reported in literature. In our series, significant number of patients have multiple previous drainage procedures for perianal abscesses. Pre-operative endoanal ultrasound should be offered to all patients. Careful selection of patients and use of pre-operative draining setons may improve outcomes.

RESONATING COMPLEX ANAL FISTULA PATTERNS WITH ARUN ANAL SEPSIS CLASSIFICATION

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OBJECTIVE
This is a pilot study to identify the patterns of the complex anal fistula presentation using the Arun anal sepsis classification system.

 METHODOLOGY
Prospective analysis of all the patients with complex anal fistula who underwent fistula treatment from January 2019 to June 2019 was traced. Socio-demographic data, type of fistula patterns was classified using Arun anal sepsis classification system, procedures and immediate the outcomes include the length of hospital stay were collected. The descriptive analysis was used to summarize the socio-demographic characteristics of the subjects and reported as median (range) and frequency (percentage).

RESULTS
There was a total of 78 cases traced and 51 patients fulfilled the criteria of complex anal fistula. Among this, 22 patients were new cases and 22 recurrent cases. The median age of our cohort was 39 years old (range 18-72). The ratio of male and female were 4:1. The median length of stay was three days (range 3-7). The most common type of anal fistula was type 4, posterior high transphincteric fistula, 19 (37.2%). In the recurrent cases, the most common type of anal fistula was also type 4 with 12 patients (30.0%). The unclassifiable type were accounted only 4 cases (7.8%). The median number of fistula tracts was two (range 1-4). Ligation of intersphincteric tract (LIFT) procedure had a total of 32 procedures and fistulotomy, 19 procedures. Single-type procedures were performed in 37 cases (72.5%) and combined procedures in 14 cases (27.5%).

CONCLUSION
Arun anal sepsis classification system is a reliable classification system to aid planning of surgery. The most common types of complex anal fistula, either new or recurrent cases were type 4 and sphincter-sparing LIFT procedure was still the choice of treatment for these fistulae. Therefore, these patients should be informed regarding a higher possibility of multi-staged surgery.
OBJECTIVE
The use of adjuvant chemotherapy in patients with stage II colon cancer is controversial. Current guidelines recommend adjuvant chemotherapy as an option for colon cancers with high risk features. Chemotherapy is not without its side effects and if its potential benefits are marginal, its role in this group of patients is debatable. Tumour biology affects the progression of disease and since it may differ in a multi-ethnic Asian population, we compared the 5-year overall survival between patients with stage II colon cancer who received adjuvant chemotherapy and those who did not.

METHODS
We evaluated all patients with stage II colon cancer with the accrual time from 1/1/2002 to 31/12/2012 in University Malaya Medical Centre (UMMC). Data on patient demography, clinical staging, surgical procedure, histopathological report and use of adjuvant chemotherapy were recorded. The primary outcome measure was all-cause mortality. Statistical analysis was performed using SPSS Version 20. Kaplan Meier survival curve and log-rank test were used to compare the all-cause survival rates.

RESULTS
There were 189 patients with stage II colon cancer during the period. There were 69 (36.5%) deaths, yielding an overall mortality rate of 6.5 (95% CI: 5.0, 8.6) per 100 person-years. The estimated 5-year survival rate was 61.8% (95% CI: 54.0, 68.6). The median survival for the entire cohort could not be estimated as the cumulative overall survival was still high (>50%). The patients who received adjuvant chemotherapy had higher 5-year survival rates (75.3%; 95% CI: 64.9, 83.0) compared to those who did not (60.2%; 95% CI: 49.8, 69.1) (p=0.025).

CONCLUSION
Adjuvant chemotherapy improved the 5 year survival rate in our cohort of patients. Discussion between clinicians and patients regarding the real and potential risks and benefits of adjuvant chemotherapy in stage II colorectal cancer is vital for decision making.

THE EFFECT OF OBESITY ON PERIOPERATIVE MORBIDITY AND HISTOPATHOLOGICAL OUTCOMES FOLLOWING TOTAL MESORECTAL EXCISION

OBJECTIVE
Obesity is a growing epidemic in Malaysia and is a risk factor for colorectal carcinogenesis. Of late, it is observed that more and more patients at index presentation are obese. It is hypothesized that with increased visceral adiposity, the technical challenge in performing total mesorectal excision is higher therefore compromising intraoperative, perioperative and histopathological outcomes.

METHODS
Retrospective data concerning patients who underwent anterior resection with total mesorectal excision were evaluated. The patients were divided to those who are obese and non-obese. Obesity is defined as having a BMI > 25 kg/m² in keeping with the WHO classification of obesity for the Asian population. Patients demographics, intraoperative details, perioperative complications and oncological outcomes were compared between the two groups.

RESULTS
32 patients who underwent total mesorectal excision for rectal adenocarcinoma were identified. Of this, 11 patients were obese (34%). The two groups were homogenous as there were no significant differences in demographics, comorbidities and oncological status at presentation. Intraoperatively, the obese group had a longer operative time, but this did not achieve statistical significance (p=0.584). The estimated blood loss was significantly higher in the obese group (p=0.004), although post operatively this did not translate to any clinical significance. Both groups had similar complication rates. The length of stay was the same across both groups (p = 0.067). The lymph nodes yield from histopathological examination and negative free margin rates from either group were not statistically significant (p=0.875). The overall survival and disease-free survival were comparable.

CONCLUSION
The risk of perioperative morbidity and histopathological outcomes following total mesorectal excision of rectal adenocarcinoma are not affected by obesity despite being more technically demanding.
OBJECTIVE
We aim to report a rare case of large bowel obstruction due to pancreatic adenocarcinoma.

CASE REPORT
A 58 years old chronic smoker male presented to the emergency room with progressive abdominal distention started 3 weeks prior. It was associated with absolute constipation but no nausea or vomiting. Clinically, the patient appeared cachectic, abdomen was grossly distended, tympanic and tender to palpation. Rectal examination was unremarkable. Computerized Tomography (CT) of abdomen demonstrated diffuse dilatation of large and small bowel with possible transition zone at the splenic flexure area.

The patient underwent an emergency explorative laparotomy, At the operation, there was a mass involving the left colonic flexure, the spleen and pancreatic tail was found. Left hemicolectomy, from the hepatic flexure to the upper sigmoid colon, was performed, with the spleen and the distal half of the pancreas being excised. A double barrel stoma was performed.

The histology showed ductal adenocarcinoma with primary location in the pancreatic tail, invading the colon and metastasis to the spleen. Postoperative period was uneventful except for hospital acquired pneumonia which was managed with antibiotic. He was discharged on day 21 after surgery. Unfortunately, a week after, he succumbed when he presented with recurrent pneumonia with severe sepsis.

CONCLUSION
Although rare for pancreatic adenocarcinoma to have the same presentation as colon cancer, and should therefore be considered in the differential diagnosis of large bowel obstruction.

IMPACT OF ROUTINE HISTOPATHOLOGICAL EXAMINATION OF APPENDECTOMY SPECIMENS ON PATIENT MANAGEMENT: A STUDY OF 4012 APPENDECTOMY SPECIMENS

OBJECTIVE
For a suspected diagnosis of acute appendicitis, appendectomy is one of the most common emergency abdominal operations performed. However, the need for routine histopathological examination (HPE) of all appendectomy specimens has recently been questioned. The aim of this study was to assess whether a routine HPE of appendectomy specimens is needed and whether routine HPE has an impact on further management of patients.

MATERIAL AND METHODS
From January 2009 to June 2017, all histopathology reports of 4012 consecutive appendectomy specimens for a clinical suspicion of acute appendicitis were retrospectively analyzed in two university hospitals.

RESULTS
Out of the 4012 cases, 3530 (88%) patients showed findings consistent with acute appendicitis on HPE. Perforation rate was 5.8% and was significantly higher in male patients (p< 0.001) and higher in the > 30 years age group (p= 0.024). Negative appendectomy rate was 5.6% and was significantly higher in female patients (p< 0.001). There were 256 (6.4%) patients who demonstrated unusual findings in their HPE, which included chronic appendicitis (n= 207; 5.2%) patients, Enterobius vermicularis (n= 14), Schistosoma (n= 8), Crohn’s disease (n= 1), neuroma (n= 10), carcinoid tumour (n= 5) and mucinous cystadenoma (n= 5), mucocele (n= 4) and mucinous cystadenocarcinoma (n= 2).

Conclusion
HPE of the appendix does not only confirm the diagnosis of acute appendicitis, but also detects other unusual diagnoses that may have an impact on a patient's management. A number of patients with unusual histopathological findings require anti-helmentic treatment, colectomy, gastroenterology follow-up or periodic surveillance. Hence, all appendectomy specimens must be submitted for routine HPE.

Keywords
Appendectomy, appendicitis, histopathological examination
ALTEMEIER PROCEDURE (PERINEAL RECTOSIGMOIDECTOMY) FOR INCARCERATED AND RECURRENT RECTAL PROLAPSE

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OBJECTIVE
We describe a rare case of incarcerated, recurred rectal prolapse and was managed successfully with perineal proctosigmoidectomy.

CASE REPORT
A 71 year old woman with hypertension and parkinsonism underwent successful perineal stapled prolapse resection. Two months later she presented with incarcerated recurrent rectal prolapse. On clinical examination, vital signs within normal limits. Her abdomen was not tender and had no signs of peritoneal irritation. Rectal examination revealed 10 cm incarcerated prolapsed rectum with markedly swollen, congested, and showed signs of superficial mucosal erosion and necrosis. Because of patient’s age, comorbidities, failure of external manual reduction and the appearance of established necrosis, we decided to proceed with perineal proctosigmoidectomy. The postoperative recovery was uneventful and the patient discharged on the fourth day. Histopathological examination revealed necrosis of mucosa and submucosa in resected specimen. During subsequent clinic follow-up 3 months later noted no evidence of recurrent rectal prolapse.

CONCLUSION
Our patient successful treatment with perineal proctosigmoidectomy (Altemeier’s procedure), highlights the value of this procedure in debilitated elderly patient with incarcerated recurrent rectal prolapse.

LUPUS ENTERITIS PRESENTED AS LOWER GASTROINTESTINAL BLEEDING: A CASE REPORT

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INTRODUCTION
Systemic lupus erythematosus (SLE) is an autoimmune disorder which can affect multiple organ, therefore the index of suspicion should rise when evaluating patients with multiorgan symptoms.

CASE REPORT
A 25 years old lady who was diagnosed with SLE, presented with passing out melena for 1 week. OGDS done shows erosive gastritis. Subsequently patient had episode of massive lower gastrointestinal bleeding requiring activation of massive transfusion protocol. CT angiogram done shows contrast extravasation at distal ileum. Patient underwent exploratory laparotomy. Intraoperative enteroscopy shows area of ulceration and blood clot at 10cm from ileocaecal junction. Proceed with right hemicolectomy and double barrel stoma. HPE from the hemicolectomy specimen shows area of ulcer with microscopic perforation featuring disruption of the muscularis propria. Some of the blood vessel exhibit variable number of extravasated red blood cells, neutrophils and nuclear debris. Fibrinoid necrosis of the vessel wall is present. Generalised submucosal and vessels congestion. Impression given is ischemic bowel with perforation, features of vasculitis are present.

DISCUSSION
Lupus enteritis is defined as either vasculitis or inflammation of the small bowel, with supportive image and/or biopsy findings. The clinical picture of lupus enteritis is often nonspecific, with mild to severe abdominal pain, diarrhea, and vomiting being the cardinal manifestations. Although considered a form of visceral or serosal vasculitis, it is seldom confirmed on histology, making computerized tomography the gold standard for diagnosis. It is generally steroid-responsive, and the route of administration is based on clinical status and organ involvement, with preference for intravenous route in flares.

CONCLUSION
In patient diagnosed with SLE, presented with gastrointestinal symptoms, further evaluation should be conducted to look for lupus enteritis or vasculitis.
OBJECTIVE
This study is to identify the commonest location of colorectal cancer, their histopathology and total numbers of cases operated in Hospital Melaka (HM) from 2014 until 2018.

METHODS
A total number of 353 patients were selected from colonoscopy result positive of colorectal malignancy from the year 2014 until 2018. This descriptive study included the location of colorectal malignancy, their histopathology and operation done in Hospital Melaka. Demographics and treatment done are analysed from patient’s record and case notes.

RESULTS
Based on the data obtained, we managed to evaluate that the most common site of colorectal cancer among the population is rectal (42.7%), followed by sigmoid (12.8%), and while among the least common sites are transverse colon and anal, 2.8% and 2.2% respectively. Along with that, more than 92% of the colorectal malignancy in Hospital Melaka yielded histopathology results of adenocarcinoma. This was then followed by histopathology of mucinous carcinoma (2.2%). From the analysed data of patients over the 5-year period, about 70.5% of them went through a surgical procedure, with 49.3% patients having it done in Hospital Melaka and about 21.2% underwent procedures outside of HM.

CONCLUSION
Colorectal cancers are quite common in Hospital Melaka. The most typical location of this malignancy is found mainly at the rectum. Surgical procedures are done mostly in Hospital Melaka. The results came back are dominantly adenocarcinoma by histopathology.

A REPORT OF INITIAL OUTCOMES FOR MINIMALLY INVASIVE LASER HAEMORRHOIDOPLASTY SURGERY IN UKMMC

Laser Haemorroidoplasty (LHP) seems to be the latest trend of surgery for haemorrhoids with minimal post-operative complication and good short term outcome. We report our initial experience of LHP and outcomes.

METHODS
Patients with Grade II-IV haemorrhoid were recruited from July 2019 - Dec 2019. All patients underwent colonoscopy to rule out other causes of per rectal bleed or prolapsing tissue. All patients were admitted electively the day before and subjected to spinal anaesthesia. Pain score were assessed with visual analogue Pain Score (VAPS) at day 1, 2 weeks and 6 weeks post-operatively. All patients received regular paracetamol and a COX II inhibitor immediately post op for a week. We also prescribed 3 day oral Metronidazole. The procedure itself is performed by a colorectal surgeon.

RESULTS
Eleven patients were recruited. Half had surprisingly impressive improvement in immediate post-operative appearance. The median age was 53 years old (30-78). Seven patients (63.6%) were male, 36.4% were female (n=4). Three patients (27.3%) had grade 2 haemorrhoids and 8 patients (72.7%) had grade 3 and 4 haemorrhoids. All of the patients were compliant with post-operative procedural protocol. Post-operative VAPS at day 1 was 0 in 36.4% (n=4), 1 in 18.3% (n=2), and in 27.3% (n=3) the VAPS was 2. One patient (9%) (n=1) had a VAPS of 3. At 2 weeks post-operation day a VAPS of 0 was found in 72.7% (n=8), 2 in 18.2% (n=2) and in 9.1% (n=1) it was 3. At 6 weeks post-operation day, the VAPS was 0 in 81.8% (n=9) and in 18.2% (n=2) it was 1. One patient did not require any analgesia as his VAPS was 0 after the operation. There was one incident of acute urinary retention and 1 patient had recurrent intermittent per- rectal bleeding at 6 weeks assessment.

CONCLUSION
Our case series demonstrates promising outcomes from LHP and a good safety profile. Patients who are terrified of surgery tend to find this option more attractive as it does not involve actually cutting of tissues. However, long term outcome with regards to recurrence still needs to be evaluated to make this the preferred standard of management.
Ischiorectal abscess occurs as an extension of suppurative inflammation of the deep anal space. This infection may extend to pararectal space, forming the suprapubic abscess, following the intersphincteric plane, and cause life-threatening medical condition.

We present a rare case of 57 years old HIV-positive male, with bilateral ischiorectal abscess, in which he underwent incision and drainage. After one week of the procedure, the patient presented again with suprapubic and scrotal painful swelling. Computed tomography (CT) of the pelvis revealed multiloculated collections at the bilateral ischioanal and ischiorectal fossa which extends anterolaterally into extraperitoneal fats superior to the urinary bladder and into bilateral inguinal canals and scrotal sacs. The patient underwent wound exploration, debridement of the ischiorectal space and scrotal exploration with multiple corrugated drains insertion. The patient completed several courses of intravenous antibiotics and repeated CT pelvis showed a significant reduction of the collection and patient able to be discharged home.

This condition is an unusual clinical problem that often poses a significant diagnostic and therapeutic challenge due to complex anatomical planes and rarity of such sequelae of this ischiorectal abscess. We discuss the relevant anatomy, literature reviews and approach to the management of this unfamiliar complication of the disease.

Pseudolipomatosis of the large intestine is a rare and benign disease with a reported frequency of the condition ranging from 0.02% to 1.7% among colonoscopy. Histopathologically it is characterized by variable-size cystic spaces within the lamina propria.

We are reporting a case of 58 years old Chinese lady presented with abdominal discomfort and constipation. A colonoscopy was performed and revealed multiple white to yellowish plaque seen at descending colon. Histopathological examination of the biopsy taken from the lesion showed the typical characteristic of pseudolipomatosis coli.

While this unusual condition does not cause any symptoms, it has been associated with pneumatosis intestinalis which has catastrophic complications including bowel necrosis and perforation. We discuss the literature reviews with the emphasis of the etiology, possible causes identified that may be attributed to the disease and subsequent management.

A primary large bowel cancer which occurs at any time after surgical achievement of a ‘clean’ colorectum is termed metachronous. A lifelong risk of developing metachronous colorectal cancer after undergone large bowel resection for malignancy is at 1-3% of patients 3-5 years postoperatively. A propensity for metachronous colorectal cancers with predilection for the proximal colon and development of cancer at an early age are well recognised characteristics of Hereditary non polyposis cancer syndrome.

We present a case report of a 56 years old chinese gentleman presented to us with altered bowel habit and Per rectal bleeding . He had a previous history of left hemicolectomy done for descending colon carcinoma at the age of 33 years old and right hemicolectomy done for ascending colon carcinoma at the age of 39 years old in 2 separate occasion 6 years apart. He subsequently underwent further investigation with a Colonoscopy. Findings were ulcerative growth at the lower rectum. Biopsy of the growth showed a infiltrating moderately differentiated adenocarcinoma. A Contrast enhanced imaging shows rectal growth with no distant metastasis.

His Carcinoembroyin antigen value was raised (17.8). Patient was subjected to concurrent chemotherapy and radiotherapy before proceeding with curative surgery of Abdominal perineal resection, completion proctocolectomy and end ileostomy. Metachronous tutors are features of hereditary non-polyposis colorectal cancer (HNPCC) syndrome which is characterised by a genetic predisposition to colorectal cancer. There have several risk factors are associated with the occurrence of metachronous CRC however different diagnostic intervals on the clinicopathologic features of metachronous CRC remains unclear.

Metachronous colorectal cancers are usually suitable for further curative surgery of extensive resection. However the potential benefits of a radical resection needs to be weighed against a significant morbidity and mortality rate with an individualised approach tailored to suit each patient.
Familial adenomatous polyposis (FAP) is an autosomal dominant disorder, inherited polyposis syndrome which is caused by mutation of the adenomatous polyposis coli (APC) gene on 5q21. Approximately 10-30% of patients will develop FAP spontaneously without a family history.

Our aim was to determine whether the screening of family members of familial adenomatous polyposis (FAP) patients is mandatory which subsequently improves survival.

We review 5 patients with FAP in our centre with different epidemiological data.
There were total of 5 patients, ranging from age 24-41 years old with male to female ratio of 2:3. The distribution of cases between malay and chinese were 3:2. We have 2 patient who had more than 2 family members of 1st degree with FAP, 1 patient with one family member of 1st degree with FAP and the other 2 does not have any family history at all. The patients presented to us with Altered bowel habits and Per rectal bleeding which was diagnosed subsequently with Colonoscopy examination.

The patients underwent prophylactically Panproctocolectomy + ideal pouch anal anastomosis.
The histopathology report shows that most of the polyp size ranging from 0.5 to 1.5 cm and multiple polyposis (>100) was seen.

We have 3 patients which the HPE report as malignant tumour of adenocarcinoma in the background of adenomatous polyposis type and the other 2 patients who has benign tumour of adenomatous polyposis type.

It is important to screen family members of FAP patients. This approach led to decrease to a 55% in the occurrence of colorectal carcinoma and marked improvement in the survival. It is imperative that FAP families be referred for genetic counselling, genetic testing, early diagnosis and clinical management to centres that are aware of the complexity of both surgical intervention and possible implication of molecular findings for individual patients.
PATIENT DELAY FOR COLORECTAL Cancer Patients IN International ISLAMIC University Malaysia Medical centre

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BACKGROUND
Many studies have highlighted the influence of diagnostic and therapeutic delays on the prognosis of patients with colorectal cancer (CRC). There are limited data on patient delays in presentation, diagnosis or treatment from east coast of Malaysia.

OBJECTIVE
The aim of our study to determine the waiting time for patients with CRC in IIUMMC.

METHODS
Between February 2017 to October 2019 data on patients with CRC were reviewed retrospectively. Patient demographic characteristics, day of first symptoms, day first visit to the doctor, day of colonoscopy, day of diagnosis, referral, the date of diagnosis, the stage of the tumor at diagnosis and the date of therapy was retrieved from hospital records. Patient waiting time is the time from first symptom to first consultation. Diagnosis waiting time is the time between seeking medical advice and the date of final diagnosis based on histopathological examination. Treatment waiting time is the time from the first patient-physician consultation until the first day of any form of treatment.

RESULTS
41 patients (56% male) were recruited, the mean age was 60 years, cancer site was 39% in rectum, 36% in left colon and right colon in the remaining 24% of cases. The most commonly reported symptom was altered bowel habit (51%). 49% of patients were referred from Emergency Department. The majority (61%) of the cases were diagnosed as advanced stage (Stages III-IV). Patients who presented to clinic had symptoms for a median of 92 days prior to presentation. The patients waited for median 20 days for a pathologically confirmed diagnosis and median treatment waiting time was 30 days.

CONCLUSION
Patient delay was observed for our CRC patients. Further studies are needed to determine the reasons for these delays and could be reduced by improving information, health education and raising awareness of CRC-related symptoms.

OUR EXPERIENCE WITH THE STAPLED MESH STOMA REINFORCEMENT TECHNIQUE (SMART)

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BACKGROUND
Parastomal hernia is not an uncommon complication in patients after ileal conduit urinary diversion. Mesh repairs provide acceptably low hernia recurrence rates. The Stapled Mesh Stoma Reinforcement Technique (SMART) is one such method.

CASE REPORT
A 59-year-old lady was diagnosed with an incarcerated parastomal hernia of her urinary ileal conduit causing obstruction of her upper urinary tracts. She has a past history of recurrent parastomal hernia with previous open mesh stoma reinforcement repair three years prior. Due to the previous local repair, we performed a laparotomy to reduce the incarcerated loop of ileum within the parastomal hernia and re-site the conduit to the contra-lateral side. A new stoma aperture on the left side of the abdomen was fashioned; a cylinder of skin and fat was excised, and a cruciate incision was made on the anterior rectus sheath. A 25 mm CS Compact™ EA circular stapler was used to secure a ProLite Ultra™ mesh to the staple line on the posterior rectus sheath. The anvil of the stapler was placed in the abdominal cavity and the shaft of the anvil grasped and delivered through the posterior rectus sheath. The stapler trocar was engaged with the anvil shaft and the stapler fired, leaving behind a reinforced stapled stoma consisting of the mesh, posterior rectus sheath and peritoneum. The mesh circumference was secured to the anterior rectus sheath and the ileal conduit passed through the reinforced stoma. The stoma was secured to the skin with undyed 3.0 Vicryl sutures. A standard stoma appliance was applied. There were no perioperative complications and the re-sited stoma remained healthy and functioned normally. She resumed oral intake on Day 2 and was safe for discharge on Day 4. Follow up at 16 weeks showed a normal looking stoma with no evidence of recurrent herniation.
THE ROLE OF HEPARIN IN A WARFARINISED PATIENT WITH MESENTERIC VENOUS THROMBOSIS

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BACKGROUND
Mesenteric venous thrombosis is managed with anticoagulation, whether with or without surgery, depending on the condition of the affected bowel. Anticoagulation-only therapy is only suitable for those with no evidence of bowel infarction or perforation.

CASE REPORT
An 82-year old lady presented with three hours of sudden onset severe epigastric and central abdominal pain associated with nausea and vomiting. She was on warfarin for paroxysmal atrial fibrillation. Upon presentation, she was in severe pain, hypertensive, tachypnoeic, tachycardic and afebrile. Her epigastrium was very tender on palpation with localized guarding. She had a raised serum lactate level of 3.7 mmol/L and international normalized ratio (INR) of 2.9. Her other blood tests were unremarkable. Triphasic CT angiogram of the abdomen then suggested ischemia of 30-40 cm of mid small bowel secondary to MVT with no evidence of bowel perforation.

After discussion with a vascular surgeon and haematologist, medical management was commenced in the Intensive Care Unit with intravenous heparin infusion to keep the activated partial thromboplastin time at 100-120 seconds while keeping the INR levels at a therapeutic range of 2-3 with warfarin. The multi-disciplinary team opted for additional anticoagulation via therapeutic heparin infusion over the alternative of thrombolysis. Her abdominal pain improved over the next few days. Oral intake was re instituted on the second day. She was discharged from the ICU to the ward after four days. The heparin infusion was then replaced with once daily therapeutic-dose subcutaneous enoxaparin and warfarin was ceased. Investigations to find the cause of her prothrombosis were unremarkable. She was discharged home eight days from her original presentation with therapeutic-dose enoxaparin after which she was gradually switched back to long-term warfarin anticoagulation. There was no evidence of significant bleeding during her hospital stay.

OBJECTIVES
(i) To determine if online learning modules improve student performance in general surgery and urology, and (ii) to determine if previous use of online learning modules promote future utilisation of such modules among students.

METHODS
Web-based learning modules on four topics each in general surgery and urology were delivered as an adjunct to traditional teaching via an online Learning Management System to fourth year medical students at the University of Western Australia in 2009 (urology) and 2010 (general surgery). Different surgical fields were used to avoid the bias of answers being handed down between different batches of students. Each module contained 40 identical pre-module and post-module questions. Rate of participation and change in student performances after delivery of these modules were analysed. The student t-test and Fisher’s exact test were used for statistical analysis.

RESULTS
In 2009 (urology), the pre- and post-module questions were completed by 27.5% (60/218) and 7.3% (16/218) of students. The mean pre-module score was 22.4 (SD 4.3) and the mean post-module score was 33.0 (SD 2.1) (p<0.001). Students who completed all the pre-module and post-module questions had a mean increase of 12.8 score points (SD 3.9). In 2010 (general surgery), the pre- and post-module questions were completed by 42.7% (94/220) and 23.2% (51/220) of students. These levels of participation for both the pre- and post-module questions were significantly higher in the general surgical modules compared to the urology modules from the year prior (p<0.001).

CONCLUSIONS
The introduction of web-based general surgery and urologic learning modules as an adjunct to traditional teaching improved student knowledge, and their use of the teaching facility improved over time.
INTRODUCTION
Malignant Gastrointestinal Neuroectodermal Tumor is an extremely rare form of soft tissue sarcoma which is commonly misdiagnosed as GIST and clear cell carcinoma. It has similar histological features as clear cell carcinomas but lacks the immunohistochemical reactivity for melanocytic markers. GNET tends to have an aggressive clinical behaviour with local recurrence and metastases. Common reported clinical manifestation of GNET were anemia, fatigue and abdominal mass. According to Yang Z et al in 2018 noticed that the incidence of GNETs has increased from 0.31 per 1,000,000 patients in 1975 to 4.85 in 2014.

CASE PRESENTATION
A case of 29 years old male who presented with recurrent severe symptomatic iron deficiency anaemia who required transfusion regularly. He later on developed colicky abdominal pain, intermittent low grade fever, loss of weight, anorexia and a palpable left abdominal mass and was worked up for Gut TB and GIST. Computed tomography revealed a circumferential small bowel thickening and small bowel resection was done. Immunohistochemistry test confirmed malignant GNET.

CONCLUSION
Prompt assessment and further work up in young males with anemia and abdominal mass has to be carried out in order to identify gastrointestinal tumors or especially GNET given its aggressive clinical course and very high recurrence rate. In our case a young male who has no comorbidities and was initially treated as iron deficiency anemia later turned out to have a rare form of gastrointestinal tumor shows that an extreme rare disease can be masked by a common phenotypic manifestation.

BACKGROUND AND OBJECTIVES
Crohn’s Disease (CD) is a burdening, incurable, remitting disease which may affect any part of the gastrointestinal tract. Medical therapies has evolved tremendously within this 30 years, from the use of corticosteroids, immunomodulators and to the latest findings of biologic treatment. Despite that, at some point in life, most of CD patient will undergo surgical intervention. This is due to its nature of transmural process. It can post a wide range of complications which includes serosal adhesions, fistula, stenosis, bleeding and even perforations. This study aims to discuss the diagnosis, types of surgical methods used, findings from each case and complications involved.

METHODS
A descriptive study which involves 3 patients with the same underlying cause but different complications. All 3 patients were operated in the year 2019 and currently still under follow up.

CASE SERIES
It involves 3 patients with age 19, 20, 27 years old presented with varying complaints of fever, abdominal pain, and urinary symptoms. Serial investigations were done for all patients and finally proceeded with exploratory laparotomy, bowel resections for all 3 patients, partial cystectomy for 1 patient and gastric wedge resection for another 1 patient. Stoma were created for all the patients.

CONCLUSION
Most of CD patients will undergo surgical intervention at some point of their lives. It is important to detect possible complications arising from the disease early in order to provide the necessary management.
INTRODUCTION
Extended resection involves resection of 2 or more pelvic organs, or removal of bony structures of the pelvis to achieve R0 resection. We review our experience in extended resection of T4b rectal cancers to determine the demography, outcome and cost effectiveness in embarking on extensive surgery in a public tertiary hospital.

METHODOLOGY
Retrospective review of medical records for 14 patients with T4b rectal or rectosigmoid cancer underwent extended resection from 1st July 2016 - 30th June 2019 (3-year period). Demographics, type of disease and surgery, outcome and cost effectiveness were compiled and presented as descriptive statistics. Survival and disease-free survival were reported at 1 year due to short duration of follow-up.

RESULTS
14 patients underwent extended resections. Types of surgery included: 10 pelvic exenteration (including 1 sacrectomy and 1 total vaginectomy), 2 extra-levator abdomino-perineal excision (ELAPE) with extended vaginectomy and coccygectomy respectively, 2 low anterior resections with radical cystectomy with ileal conduits. Mean age is 57.8 years. 71.4% of patients were unfit to undergo adjuvant chemotherapy. 85.7% developed significant post-op complications within 30 days after surgery. 1-year overall survival was 92.8% and 1-year disease free survival was 78.5%. R0 resection rate was 85.7%. Mean hospital stay is 10.6 days and mean cost per patient is RM 13,999.

CONCLUSION
Despite careful selection, post-operative morbidities remain high, leading to long hospital stay and increased cost of treatment. Majority of patients were unfit for adjuvant chemotherapy due to post-operative morbidities, implicating the role of totally neoadjuvant treatment strategies. Longer follow-up and larger sample size will better determine the cost effectiveness and true survival rates.

SHORT-TERM OUTCOME REVIEW OF A PELVIC EXENTERATION SERIES IN LOCALLY-ADVANCED RECTAL CARCINOMA - A HKL EXPERIENCE
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INTRODUCTION
Pelvic exenteration (PE) is a potentially curative treatment for locally advanced primary or recurrent rectal cancer. Historically reserved as a palliative procedure, nowadays, patients who undergo PE for advanced or recurrent rectal cancer can expect reasonable rates of long-term survival (up to 60% at 5 years) with an acceptable morbidity and quality of life.

OBJECTIVE
A review of a single-centre experience in PE done for patients with locally advanced primary rectal cancer. The perioperative outcomes, histopathological result, mortality and morbidity consequence were reviewed.

MATERIALS AND METHOD
This case series involved retrospective review of PE cases for locally advanced rectal cancer performed in Colorectal Unit, Hospital Kuala Lumpur from 2016 to 2019. Patients with locally advanced primary rectal cancer were given pre-operative chemoradiation and structures such as the urinary bladder and female reproductive organs were resected en-bloc with the lesion where indicated.

RESULTS
PE data were collected of 9 patients with a median age of 61 (range 39 - 83). PE performed included anterior resection/abdominoperineal resection in combination with either radical/partial cystectomy with urinary reconstruction/diversion or hysterosalpingoophorectomy. The rate of major post-operative complications was 20% (n=2), where 1 patient had small bowel obstruction due to early adhesions, another had ureteric injury with urinoma, both requiring relaparotomy for suspected anastomotic leak. Median length-of-stay (LOS) post-operatively is 9 days (range 7 - 25) There were no mortalities in the perioperative period. The histopathology examination (HPE) showed moderately-differentiated adenocarcinoma in 8 of 9 patients, 1 with well-differentiated adenocarcinoma, with 3 out of 9 showing mucinous differentiation in the tumor HPE. 8 patients were operated with curative intent and negative circumferential margins were shown in 6 out of 8 patients (75%).

CONCLUSION
An aggressive surgical approach with PE in patients with locally advanced rectal cancer has an acceptable morbidity profile with proven survival benefit.
Rectovaginal fistulas are abnormal, epithelium-lined communications between the rectum and vagina, accounting for approximately 5% of anorectal fistulas. Recurrent rectovaginal fistulas challenge the patient’s perseverance and the surgeon’s skill in view of difficulties in treatment and oft-repeated failures. In addition, they cause considerable distress to the patient as the symptoms are socially disabling.

We present a case of a 49-year-old lady who is under our follow up since 2014 with initial presentation of painful per rectal bleeding and constipation. Lateral internal sphincterotomy was performed in early 2015 with a diagnosis of anal fissure. A transperineal ultrasonography was done which revealed rectocele and prolapsed posterior vaginal wall. She was then subjected for defecating proctogram with the result of anterior rectocele with pelvic floor weakness before decided for Stapled Transanal Resection of Rectum (STARR) in late 2017. Post-operative diagnosis was perineal descend with rectocoele, cystocele and urethrocele. Three weeks post procedure, she complained of passing flatus and feculent material per vagina. An examination under anaesthesia and advancement flap was done which failed after 48 hours post operation. Again, she underwent excision of rectovaginal fistula tract, posterior colporrhaphy and rectal repair which also failed 72 hours post operation.

After almost 18 months dealing with similar symptoms and discussion among Colorectal and Plastic Surgeon, patient decided for another repair attempt, this time with left gracilis flap. Unfortunately, 36 hours post operation she complained of passing flatus and faeces per vagina. A second look operation with diversion ileostomy was performed.

**A CASE OF RECURRENT RECTOVAGINAL FISTULA REPAIR - HOW WE DO IT**


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**MINIATURE MESH TRANSPERINEAL RECTOCOELE REPAIR (MiniR)**

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**OBJECTIVE**

This is a study designed to establish the efficacy and functional outcome of miniature mesh transperineal rectocoele repair in patients with isolated rectocoele with obstructed defecation syndrome.

**METHODS**

Prospective observational study on the site-specific rectocoele repair with small polypropylene mesh (2 cm²) was performed via the transperineal approach. All the patients with symptomatic rectocoele were included in the study. Those with pelvic floor descent or previous rectocoele repair were excluded from the study. Socio-demographic data, functional outcomes using Watson’s Score Criteria and complications were studied over a 24 months follow-up period.

**RESULTS**

There were 11 women with symptomatic rectocoele were included in this study. Preoperative and postoperative Watson’s criteria score were 6.55±2.73 and 2.27±1.42 respectively (p=0.003). Post repair symptoms of prolonged straining, incomplete evacuation, and digitation were improved significantly. Ten of eleven patients (90.9%) rated their global functional outcome as satisfied or very satisfied postoperatively. Mesh-related complications (Mesh erosion, mesh infection, and perineal pain) were not found. Dyspareunia was not reported among the sexually active patients. Mean follow-up time was 24 months.

**CONCLUSIONS**

Miniature mesh transperineal rectocoele repair is effective and safe. The technique is straightforward, reproducible with promising functional immediate and long-term outcome. However, the patient selection is of paramount importance.
DAY-CARE HAEMORRHOIDECTOMY FROM A DEVELOPING COUNTRY PERSPECTIVE

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OBJECTIVE
This is a prospective study designed to assess the feasibility and safety of LigaSure™ haemorrhoidectomy with regional anaesthesia as a day-care procedure.

METHODOLOGY
All the patients who were diagnosed with third and fourth-degree haemorrhoids at our outpatient clinic from January 2018 to December 2019 were invited to participate in the study. They were screened for eligibility for day-care surgery, and informed consent was taken. All patients underwent spinal anesthesia or saddle block and positioned in a lithotomy position for the procedure. Open excisional haemorrhoidectomy (Milligan Morgan Haemorrhoidectomy) was performed with diathermy and LigaSure™ device. No sutures or anal sponge packing were used post-operatively. The patients were observed until completely recovered from the spinal anesthesia; wound inspection for bleeding, pain score and urinary retention were evaluated upon discharge. The day-care procedure protocol was strictly adhered to.

RESULTS
A total of 264 patients were enrolled in this study. 153 (58%) patients were males and 111 (42%) were females. The median age was 30 years old (range 16-80). The third-degree haemorrhoids was found in 142 patients (54%) while the fourth-degree haemorrhoids was found in 122 patients (46%). The median operating time was 8 minutes (range 4-17) with minimal blood loss of lesser than 10 millilitres. During follow-up, the postoperative complications were one patient (0.3%) with mild anal stenosis, one patient (0.3%) with minimal bleeding, one patient (0.3%) with urine retention and four patients (1.5%) required additional analgesia upon discharge. Four patients (1.5%) developed a post-spinal headache which were detected upon discharged and treated immediately. There were no patients complains of immediate incontinence. Two patients were readmitted within one week for upper gastro-intestinal bleeding which is not related to the procedure.

CONCLUSION
LigaSure™ excisional haemorrhoidectomy under regional anaesthesia is a safe and effective day-care procedure with an acceptable readmission and complication rate.

SPONTANEOUS INTESTINAL PERFORATION IN LYMPHOMA PATIENT

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Intestinal perforation during chemotherapy is a treatment-related complication. Studies have shown that patients who undergone systemic chemotherapy have a higher risk of perforation due tumour necrosis and tumour lysis. Sites of perforation reported mostly at ileum, jejunum, cecum and sigmoid colon. Hospital Ampang as the country’s leading hematology centres received many new cases of lymphoma. We would like to report a case of intestinal perforation on day 6 of chemotherapy. A 45 year old lady with intestinal DLBCL had non specific abdomen pain on day 6 post initiation of chemotherapy. Her cxr suspicious pneumoperitoneum, CT abdomen reported perforated vuscis with gross fecal contamination. Emergency laparotomy revealed multiple perforation at jejunum with ruptured caecum, small bowel resection primary anastamosis with limited right hemicolecctomy double barrel stoma done. Goal directed resuscitation post operative recover her well and able to discharge on day 14. High index of suspiscious, prompt surgical intervention and resuscitation can give good outcome even though in immunocompromised patient with gross fecal peritonitis.
BACKGROUND
Colonoscopy is the most reliable screening, diagnostic and interventional tool for colorectal diseases. General Surgery Department Hospital Sarakei offers colonoscopy service for the population size of 255,800 from central Sarawak.

OBJECTIVES
To present a 42 months review of colonoscopy service in district setting and to study the demographic of patients who underwent colonoscopy and their findings.

METHODS
Retrospective study of all patients who underwent colonoscopy from July 2016 to December 2019. Various parameters including patients’ demographic, indications for colonoscopy and scope findings were analyzed.

RESULTS
A total number of 955 patients underwent colonoscopy over 42 months. Elective colonoscopy (77.59%) was performed more often than the emergency colonoscopy (22.41%). There were more male (55.18%) than female (44.82%). Iban was the predominant race (45.97%) compared to Chinese (31.73%) and Malay (20.94%). Mean age of 57.5 (range of 14-92). The 3 commonest indications for colonoscopy were gastrointestinal bleeding (21.99%), altered bowel habits (18.22%) and abdominal pain for investigation (9.63%). 42.51% of patients had normal colonoscopy finding. The 3 commonest pathology found via colonoscopy were benign perianal diseases (14.14%), diverticular diseases (11.73%), and colonic polyps (11.52%). Colorectal Cancer detection rate was 8.17% over 42 months. The complication rate was 0.1%.

CONCLUSIONS
The colonoscopy service offered managed to detect anomalies in more than half of the patients who underwent it. It had achieved a satisfactory standard despite multiple shortcomings.
Pelvic exenteration has been a surgical option for the treatment of locally advanced rectal cancer or recurrent rectal cancer. In Malaysia, not all centers have the capability of performing this surgery. In recent years, our colorectal team in Pulau Pinang Hospital has embarked into this surgery as part of the management of rectal cancer.

OBJECTIVE
The aim of this study is to share our experience with pelvic exenteration. The notes of the patients were analyzed to look for indication and criteria of patient, duration of surgery and also post-operative complications. Other than that we also analyzed the histopathology report to look for the margin of the resected tumor.

RESULT
4 patients underwent total pelvic exenteration as the treatment for rectal cancer from January till December 2019. Two of them were Malay and the other two were Chinese. All of there had primary rectal cancer with local infiltration. Mean operative time for the surgery was 7 and a half hour. Among the complications that were recorded were ileo-ileostomy site leak, recurrent surgical site infection and acute kidney injury due to dehydration. All patient recovered well. For HPE result, all our patient had pT4b for TNM score and pelvic exenteration clearly justified.

CONCLUSION
In centers that capable of doing pelvic exenteration, it should be offered to patient as one of the surgical treatment for colorectal cancer. Though it can lead to considerable morbidity, in good surgical hand, the outcome is acceptable.

INTRODUCTION
Urinary fistulae are a known complication after rectal surgery. The underlying causes may due to direct injury to the urethral, wound infection, lymphocele, incomplete healing due to irradiation to the tissue. Here we reported a case of urethrocutaneous fistula following abdominal perineal resection for low rectal carcinoma.

CASE REPORT
43yo male diagnosed with low rectal adenocarcinoma (T4bN1cM0). He was subjected to CCRT and subsequently underwent laparoscopic assisted APR. Intraoperatively part of prostate was shaved off and urethral was injured while mobilizing the tumor. The urethral was repaired with Maxon 4/0 and patient was on CBD. Post operatively, there was persistent discharge from perineal region. SPC was inserted and CT done showed fistula communication between prostatic urethral and distal pouch, causing collection. Cystourethroscopy was done showed fistula between prostatic urethral and pelvic cavity. Catheter was inserted through the opening in perineal for drainage, and CBD was inserted. Patient was given appointment OPD for reassessment later.

DISCUSSION / CONCLUSION
Urinary fistula is a distressing condition to patient due to malodourous fluid draining from perineum. Most of these cases are iatrogenic, due to APR, total proctocolectomy, pelvic exenteration etc. Due to creation of dead space after removal of pelvic viscera, the dead space is replaced by blood and lymph, which get infected and developed a path of least resistance for drainage into the perineum. The approach is to divert the urine using catheter or insertion of SPC and with conservative measures such as broad-spectrum antibiotic, instillation of fibrin glue, topical application of metronidazole, use of 0.2% betadine as sclerosant to obliterate the cavity. Open repair also has been described as one of the options.
BACKGROUND
Closure of stoma is a common procedure and some are often considered as minor surgery. Nevertheless, the complications can be devastating if it occurs particularly the risk of anastomotic leakage. Other possible complications that can arise are surgical site infections and intestinal obstruction. This study looks into possible risk factors that may help predict complications after stoma closure using a multivariate analysis.

OBJECTIVE
The aim of this study was to determine the risk factors for complications after stoma closure.

METHODS
Patients who underwent closure of colostomy and/or ileostomy from January 2018 to June 2019 were retrospectively analyzed. All causes for initial stoma creation were incorporated into this study. Multivariate logistic regression was used to determine the potential risk factors on the complications after stoma closure.

RESULTS
A total of 34 patients underwent reversal of stoma. Indications for the initial operation were colorectal cancer (85%), perineal sepsis (5.9%), ischaemic bowel (5.9%) and diverticulitis (2.9%). The incidence of surgical site infection was found to be 5.89%, anastomotic stenosis or adhesion was at a rate 5.8% and anastomotic leak was 2.9%. A total of 9 factors were analyzed comprising of patients pre-operative co-morbidities, pre-operative albumin level, type of stoma, intra-operative contamination and type of skin closure. However, multivariate logistic regression did not show any significant association between complication rate and the risk factor analyzed as the odd ratio was close to or equal to 1.

CONCLUSION
Although interestingly the parameters analysed did not show any significance towards predicting risks, they are well known to be clinically significant parameters to surgeons. Perhaps the numbers can be further increased with a larger sample size to improve study design and accuracy. Patients should also be followed up long term to look into long term complication of stoma closure before a definitive conclusion can be inferred.
The standard management for distal rectal tumour has been Abdominal-perineal excision. However, there are many difficulties encountered when the tumor involves levator muscles and when circumferential margin cannot be properly assessed. Compared with Anterior Resection, Abdominal-perineal resection results in increased rate of circumferential margin (CRM) infiltration, increased iatrogenic tumour perforation and poorer quality of the mesorectum. This may be due to excessive dissection between the distal mesorectum and the levator resulting in a ‘resection waist’ effect in the specimen. Extra-levator Abdominal-perineal excision entails a wider excision of the pelvic floor to provide a ‘cylindrical’ specimen which ideally would reduce the risk of tumour perforation, CRM infiltration and local recurrence. Prior to 2019, in our center, we were doing the standard APR and from retrospective review noted a higher rate of local recurrence. In 2019, to improve the outcome in patients presenting to our department with distal rectal tumour, we advocated ELAPE over standard APR. We hereby present 4 cases that had undergone ELAPE post neoadjuvant chemoradiation. We discuss the technique used, complications and the short term out-come.

**INTRODUCTION**

The incidence of colorectal cancer (CRC) during pregnancy is rare. Hereby we present a case of colorectal cancer diagnosed during 3rd trimester of pregnancy.

**CASE SUMMARY**

She is 36 years old, Para 6+1, presented to obstetric team during 31st week of gestation with complaint of painless rectal bleeding for 1-week, fresh blood and clots mixed with stool. She also had crampy abdominal pain and passed out loose stool with mucous past 1 week. Digital rectal examination revealed presence of mass about 5 cm from anal verge. Sigmoidoscopy revealed fungating mass 5cm from anal verge, friable and bleed on touch. Imaging studies such as ultrasound of liver and endorectal ultrasound and biopsy revealed adenocarcinoma clinical uT4aN2M1 with suspicious liver metastases. After multidisciplinary meeting (MDT), she underwent elective caesarean section at 34th weeks of gestation, followed by neoadjuvant chemotherapy.

**DISCUSSION**

There are challenges managing colorectal cancer in pregnancy. Anorectal bleeding in pregnancy often attributed to engorged hemorrhoid or anal fissure. Gentle flexible sigmoidoscopy can be offered in suspicious case, as complete colonoscopy might compromise the fetus. Colorectal cancer in pregnancy often missed or diagnosed late due to attribution of constitutional and anemic symptoms to pregnancy related. Gestational age and tumor stage are important to determine treatment modality. In this case, cancer treatment can be postponed at the earlier possible date in which the fetus is viable.

**CONCLUSION**

This case demonstrates that colorectal cancer can mimic usual pregnancy complaint and often present at advanced stage in pregnant lady. MDT and good strategy approach needed for this case.
INTRODUCTION
Liver abscess is a known complication of Crohn’s disease. They are rare in patients with Ulcerative Colitis (UC). We discuss an unusual occurrence of liver abscess in a patient with UC.

CASE
A 54-year-old lady with history of UC presents with complaints of fecaluria, dysuria, suprapubic pain and feverish for 1 week. She has biopsy proven UC complicated with stricture at the sigmoid colon and has been on immunosuppressant therapy and monoclonal antibody for one year. Her CRP is raised at >200. CT scan abdomen reveals liver abscess in segment 5 and fistulous communication between urinary bladder and sigmoid colon. Tumor markers are not raised. Cystoscopy shows inflamed and thickened bladder wall posteriorly with presence of feculent debris in bladder. She is managed as complicated UC with colo–vesical fistula and liver abscess. A trephine transverse loop colostomy was done, and intravenous antibiotic therapy was commenced. A follow-up CT abdomen at 6 weeks shows significant resolution of the liver abscess.

DISCUSSION
Liver abscess is a recognized complication of inflammatory bowel disease (IBD), especially Crohn’s disease. There are few reported cases of liver abscess with ulcerative colitis. In this case, she has active exacerbation of UC as evidenced by colovesical fistula. Mucosal barrier disruption by active colitis predisposes to bacterial invasion of the portal venous system and consequently liver abscesses. The ongoing immunosuppressant therapy also renders the patient immunocompromised. Early diagnosis with appropriate antibiotic treatment usually improves clinical outcome.

CONCLUSION
Development of liver abscess is multifactorial in etiology in a patient with underlying ulcerative colitis on immunosuppressant therapy.

INCIDENCE OF COLORECTAL CANCER IN HOSPITAL MELAKA FOR 2014 - 2018
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OBJECTIVE
To reveal the incidence of colorectal cancer (CRC) diagnosed in Hospital Melaka (HM) from 2014 till 2018.

METHODS
The 353 patients are selected by colonoscopy result from 2014 till 2018. We included all cancer from colorectal region, excluding recurrence and small bowel origin. The patient’s demographics were retrieved from their records.

RESULTS
The mean age of patients diagnosed with CRC is 61.9±13.01 (mean ± SD with mostly age between 60-70 (34%). It is common in male (56.9%) compare to female (43.1%). Malay ethnicity was the highest (63.7%) in the population diagnosed compared to Chinese (31.7%) and Indian (3.1%). However, the incidence rate (IR) is higher in Chinese which is 18.9 (2015) but subsequently showed decreasing pattern. 83.6% of the patients did colonoscopy to confirm the diagnosis. In 2015, it is recorded as the highest IR of newly diagnosed CRC by 15.4 with mean number of new cases per year is 70.4. The commonest site of tumour is rectal (42.7%) while the least is anal (2.2%). About 92% of the CRC here yielded adenocarcinoma pathology and 70.5% of them undergone surgical procedure, with 49.3% patients having it done in Hospital Melaka.

CONCLUSION
Colorectal cancer incidence is higher in males than females, with age of diagnosis commonly between 60-70 years old. Chinese ethnicity have the highest IR in the first three years of the study. Year 2015 showed the highest number of CRC diagnosed and more than half patient were diagnosed by colonoscopy. The cancer commonest site is rectum and most surgery are done in Hospital Melaka. The histopathology is dominantly adenocarcinoma.
**Mantle Cell Lymphoma (MCL)** is one of several subtypes of B-cell non-Hodgkin lymphoma (NHL). It is a malignant transformation of a B lymphocyte in the mantle zone causing enlarged lymph nodes. These can enter the lymphatic channels and blood, spreading to other lymph nodes of tissues, such as the marrow, liver and gastrointestinal tract. MCL represents only 6% of all new cases of NHL in the USA. With a predilection to men in their mid-60s, overexpression of cyclinD1 protein within cells is pathognomonic of MCL. Patients usually present with B-symptoms and colonic spread may cause abdominal pain and altered bowel habits.

Reported is a 65 year old Malay gentleman, who had been having per-rectal bleeding and mucous discharge, night sweats, loss of appetite and about 6kg in the duration of 1 month. He was scheduled for a colonoscopy which revealed multiple rectal ulcers and colonic polyps. There was also an ileoocaecal mass which gave an impression of ulcerative colitis (UC) with malignant tumour of the ileoocaecal valve. The histopathology report however, reported atypical lymphoid cells infiltration which expressed strong and diffuse CD20, CD79a, and CyclinD1. This was highly suggestive of Mantle Cell Lymphoma and the patient was then urgently referred to the Haematologist and received R-Maxi CHOP/H Ara-C regime chemotherapy. After completing 6 cycles of chemotherapy, a colonoscopy was repeated and proved to be normal. Repeated CT scans after his chemotherapy showed markedly reduced number and size of nodes.

In a region where colonic malignancies are ubiquitous, the role of colonoscopy is undeniable. However, it pays to remember what appears to look like UC may not always be so. A confirmatory histopathology report is mandatory. To treat this patient as UC on clinical appearance and suspicion alone is of gross injustice as it would delay the correct diagnosis and treatment.

**INTRODUCTION**

Whilst intestinal perforation by foreign bodies are a very uncommon presentation, when it occurs, it is treated as an acute emergency that could lead to severe complications leading to death. We report a peculiar case of sigmoid colon perforation, instigated by an impacted phytobezoar.

**CASE REPORT**

A 73-year-old gentleman presented to the emergency department with complaints of severe lower abdominal pain, which was associated with constipation and fever. Clinically, he appeared dehydrated and tachycardic. Abdominal examination revealed a tender and mildly distended abdomen, particularly over the lower portion. The patient was subjected to a Contrast Enhanced Computed Tomography (CECT) of the abdominopelvic region which showed multiple oval-shaped hyperdense signals in the sigmoid colon with small extraluminal mesenteric air pockets - suggestive of perforation. The patient underwent an exploratory laparotomy, and Hartmann’s procedure. The subsequent histopathological examination revealed perforation of the sigmoid colon and multiple phytobezoar. Thereafter, the patient had an uneventful recovery.

**DISCUSSION**

Statistically, the incidence of obstruction caused by bezoar is rare, accounting for 0.4-4% of all causes of bowel obstruction and should be considered in the initial differential. Given that most patients usually seek medical advice in a timely manner, complications such as perforation is rarely encountered. CT imaging remains the most reliable method to diagnose the presence of phytobezoar in the digestive tract, and surgery remains to be the mainstay of treatment, to effectively tackle it.

**A RARE CASE OF PERINEAL TUMOUR IN A NEUROFIBROMATOSIS PATIENT**

Patients with Neurofibromatosis type 1 (NF 1) have more high chances of developing soft tissue tumors compared to general population. Here we are presenting a case of middle aged women with background of neurofibromitosis, presented with painless and rapidly enlarging perineal swelling for the past 6 months. Patient underwent wide local excision of the perineal swelling after pre-operative and diagnostic imaging work up. Final histopathology examination result revealed a high grade spindle cell sarcoma.
INTRODUCTION
Ventral mesh rectopexy is an established form of surgical option for rectal prolapse. It is also widely performed for patients whom have concomitant defecatory problems and pelvic floor weakness. The procedure requires understanding of the complexity of the pelvic anatomy as well as acquisition of fine generic laparoscopic; in particular dissection and suturing skills. Surgeon’s operating time learning curve is quoted anywhere between 28 to 54 cases. Successful functional outcome on the other hand, is quoted to correlate with higher number of procedures performed (82 to 105). Potential technical pitfalls are avoided by designing the procedure into series of component tasks.

RESULT
The five component tasks for laparoscopic ventral mesh rectopexy includes: 1) Identification of the pelvic anatomy, 2) Lateral dissection - avoiding the TME plane heading towards the tented broad ligament, 3) Division of the recto vaginal septum down into the interspincteric plane (confirmed by DRE), 4) Mesh fixation - avoiding bow stringing and 5) Peritoneal closure over mesh - avoid internal herniation and tenting right ureter.

CONCLUSION
Surgical approach divided into component tasks will ensure a reproducible procedural outcome. This along with an appropriate preceptorship programme will in return be expected to optimize both longterm and shorterm functional outcome.

A RARE CASE REPORT OF ANGIODYSPLASIA IN A NOONAN SYNDROME PATIENT
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Obscure gastrointestinal bleeding (OGIB) is defined as bleeding of unknown origin that persists or recurs after an initial negative endoscopic evaluation [1]. Incidence is 5% in patients presenting with gastrointestinal bleeding which accounts 40-70% of small bowel origin [2]. OGIB is not only challenging but a diagnostic dilemma which may require serial clinical and imaging assessment. We report a case of 30 year old patient with underlying Noonan syndrome who presented with recurrent painless hematochezia associated with symptomatic anemia requiring multiple admission and blood transfusion. In view of negative EGD & colonoscopy, capsule endoscopy was performed which showed few areas of vascular ectasia. Subsequently he underwent exploratory laparotomy and on table enteroscopy which revealed jejunal angiodysplasia. Segmental jejunal resection and anastomosis was done with uneventful recovery. During follow up, patient was well with no evidence of GIB. Histopathology reported evidence of jejunal lymphagestacia with angiodysplasia. Our discussion is tailored to ideal approach in diagnostic and therapeutic intervention for OGIB.

A RARE CASE OF ILEAL PERFORATION SECONDARY TO BILIARY STENT MIGRATION. A CASE REPORT
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Preoperative biliary stenting and drainage is offered to patient with expected delayed surgery or symptomatic jaundice secondary to biliary disease. European Society of Gastrointestinal Endoscopy (ESGE) suggested the use of self-expandable metal stent (SEMS) for preoperative period while awaiting definitive surgery. We reported a rare case of terminal ileum perforation due to plastic stent migration in a lady with a history of abdominal surgery for colon tumour with concomitants biliary stone. This case has been managed with surgical intervention for retrieval of the impacted stent.

Keywords
Biliary stenting, biliary stent migration, metal stents, ileal perforation.
BACKGROUND

Anorectal Mucinous adenocarcinoma arising from complex anorectal-vaginal fistula is very rare, with some related reports in literature. Firstly, a high index of suspicion is required to establish the disease as it may often mimic other benign conditions such as anal fissures and fistula in Ano.

CASE PRESENTATION

A 34 years old woman presented with perianal swelling for 1 month associated with pus discharge, intermittent fever and pain. Subsequently, patient had per vaginal discharge with abdominal discomfort. Per Abdomen was unremarkable and noted internal opening felt at 7 o’clock position with pus discharging from anus and vagina.

Colonoscopy done shown low rectal fistula with internal opening seen, surrounding fistula necrotic with induration. Other parts of colon are normal. Subsequently, patient underwent examination under anaesthesia (EUA) and Seton insertion. Noted External opening at 7 o’clock + position forming communication with vaginal wall laterally at 8 o’clock with large cavity from vaginal wall opening. Necrotic tissue found in cavity was sent for HPE. HPE results shown mucinous adenocarcinoma, primary colon.

CT thorax, abdomen, and pelvis (TAP) shown complex anorectal-vaginal fistula complicated with right perirenal and perirectal collection. No evidence of metastases. MRI pelvis was done shown locally advanced anorectal pelvic tumour with local infiltration (MRF+) and extension into upper vagina. Right intersphincteric fistulous communication show. Patient is currently undergoing neoadjuvant CCRT is planned for Abdominal Perineal Resection after completion of CCRT.

CONCLUSION

Fistula-associated perianal mucinous adenocarcinoma is an uncommon malignant transformation of complex fistula-in-ano. Histologic diagnosis with EUA procedure must be achieved to confirm the diagnosis. MRI able to establish malignant transformation and allows for superior anatomic delineation.

CASE PRESENTATION

A 15 years-old fit Malay boy presented with generalized abdominal pain associated with diarrhea and vomiting for 1 week. Otherwise no other significant symptoms. On examination, he was haemodynamically stable but there was tenderness over right iliac fossa. Blood investigations and imaging were unremarkable. Patient was posted for emergency diagnostic laparoscopy with the impression of appendicular pathology. Intraoperatively, serous fluid noted throughout the abdominal cavity and was unable to further assessed via laparoscopically. Hence converted to laparotomy, multiple levels of stricturing of small bowel were noted. Also noted about 20 cm of unhealthy and strictured small bowel 15 cm from ileocaecal valve causing proximal small bowel dilatation, thus decision for small bowel resection and double barrel ileostomy were made. Otherwise, Appendix and other parts of bowels were normal. Resected bowels and abdominal serous fluid sent for further evaluation and histopathological examination (HPE) came back as chronic active colitis with ulcerations. Furthermore Polymerase Chain Reaction (PCR) of abdominal serous fluid detected Mycobacterium Tuberculosis DNA.

DISCUSSION

Abdominal Tuberculosis (TB) is divided into 4 types: gastrointestinal, peritoneal, visceral and tubercular lymphadenopathy. Common sites for gastrointestinal tuberculosis are ileocaecal region, jejunum and colon. Ileocaecal region mostly comprises of 64% of gastrointestinal tuberculosis cases. This is because of increased physiological stasis, presence of abundant lymphoid tissues and increased absorption rate. Isolated jejunal involvement is rare, if presence, may mimic Crohn’s disease. Clinical presentation are non-specific. The diagnosis of abdominal TB may be definitively established by demonstration of Mycobacterium Tuberculosis in peritoneal fluid. Recommended treatment for abdominal TB is anti-Tuberculosis therapy for minimum of 6 months.

CONCLUSION

Astute clinical suspicion especially in uncommon presentation of abdominal tuberculosis is needed.
Intussusception is a common cause of acute abdominal emergencies among children but not in adults. It is uncommon with incidence of only 5% in adult and 1% - 5% of all cases of bowel obstruction. An elderly lady presented with rectal bleed with mass passing through her anus. Examination revealed prolapsing rectal polyp with long stalk from anus. Colonoscopy showed bleeding large polyoidal mass prolapsing 5 cm from anal verge. Urgent CT abdomen revealed long segment intussusception within sigmoid and rectum with presence of suspicious malignant looking enhancing lesion at the tip of intussusception. She underwent emergency laparotomy with Hartmann’s procedure. Intraoperatively, the mucosa of intussuscipied sigmoid into rectum was ischemic with large polyp at sigmoid colon as the lead point. The final histopathology reported hamartomatous polyp with high grade dysplasia.

Intussusception is rare in adult population characterized by no definite classical symptoms. Due to the nonspecific nature of these symptoms, the diagnosis is usually delayed. CT scan is the diagnostic test of choice for intussusception in adults as it can also identify the etiologies of obstruction. Given the high incidence of underlying malignancy in adult intussusception, many advocate for routine resection. In cases of colocolonic intussusception, as in our case, it is necessary to do en bloc resection of the segment with an oncologic purpose and without prior reduction to prevent bowel injury causing perforation with intraluminal seeding, cancer cell dissemination and venous embolization.

Intussusception in adults are highly associated with malignancy. It should be kept in mind in treating surgeons whenever dealing with intestinal obstruction. Although the main treatment is resection, it is important to not perform reduction prior resection to avoid cancer cell dissemination.

‘HOME-MADE STOMA’: A CASE REPORT OF SPONTANEOUS UMBILICAL ENTERO-ATMOSPHERIC FISTULA RESULTING FROM STRANGLATED RICHTER’S HERNIA

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BACKGROUND
Strangulated Richter’s hernia is an abdominal hernia in which part of the circumference of bowel entrapped in the hernial sac and is a high-risk ischaemic gastrointestinal disorder that is typically diagnosed in a delayed manner due to a lack of obvious symptoms. Entero-atmospheric fistula (EAF) is defined as communication between gastrointestinal (GI) tract and the atmosphere. Spontaneous umbilical entero atmospheric/cutaneous fistula (EAF/ECF) resulting from an incarcerated Richter’s hernia is extremely rare. In fact, our literature review did not yield any such reported cases of EAF.

CASE PRESENTATION
We present a case of 78 years old lady who had never underwent any abdominal surgery before, developed an entero-atmospheric fistula with excoriation and granulation of the abdomen for the past two years. It posed as a diagnostic dilemma with few possible postulations on how an EAF happened in this patient. Nevertheless, the most important things are, prevention, treatment of sepsis and healing of the EAF. Unfortunately, the management of patient with EAF is very challenging. Adhering to principles of classic enterocutaneous fistula which is to control enteric spillage, attempt to seal the fistula, as well as managing the wound surrounding the fistula opening. As for our case, we applied negative pressure wound therapy (NPWT) as an adjunct to heal the wound around the EAF. Later, aiming for a permanent closure of the fistula once condition is more favourable.

CONCLUSION
Strangulated umbilical Richter’s hernia is a rare clinical entity and the formation of EAF from this is never been reported before. Management of such case should be holistic and tailored to individual patient applying the right surgical principles.
INTRODUCTION
Among the most common lower gastrointestinal anastomosis complications are leakage and dehiscence, strictures, fistulas and bleeding. While risk factors for leakage and dehiscence, strictures and fistulas are widely reported, risk factors for anastomatic bleeding are not as well known. Most cases of postoperative anastomotic bleeding are self-limiting and are not commonly reported by surgeons, however major anastomotic bleeding can be life-threatening if not treated promptly. The reported incidence rates for anastomotic bleeding range from 5 to 4.2%. Severe lower gastrointestinal bleeding can be difficult to locate, making the diagnostic and therapeutic maneuvers challenging. Conservative approaches have been successful in some cases, though only a handful have been reported in the literature. Surgical techniques have evolved quickly, with newer generations of innovative medical and surgical materials being currently employed. Given the scarce evidence in the published literature on the risk factors associated with major anastomotic bleeding, this case report aimed at assessing the incidence of postoperative lower gastrointestinal intra-luminal bleeding and identifying its potential risk factors.

CASE REPORT: CLOSTRIDIUM DIFFICILE CAUSING MASSIVE LOWER GASTROINTESTINAL BLEED

Clotstridium difficile is a common cause of healthcare associated infection with significant morbidity and mortality. The common clinical presentation is watery diarrhea. We report a 45 year old lady with metastatic ovarian cancer whom presented with fresh per rectal bleeding and hypovolemic shock. She was recently admitted for neutropenic sepsis managed with intravenous antibiotics. The patient underwent laparatomy and total colectomy and primary end to end anastomosis, adhesiolysis and omentectomy and excision of tumour deposits with bilateral ureterolysis for a large ovarian carcinoma with invasion into the transverse and sigmoid colon one year ago followed by chemotherapy and radiotherapy. Baseline blood investigations showed anemia with haemoglobin of 5.6g/dL and patient was stabilised with intravenous fluids, blood products. Subsequently patient underwent sigmoidoscopy which showed an ulcerative lesion at 15cm from anal verge near anastomatic site but no bleeding from the lesion, bleeding was proximal to this. A computed tomography angiogram abdomen was done which then showed no evidence of active bleed at the time. Stool culture taken demonstrated clostridium difficile antigen positive. Patient was started on intravenous metronidazole and subsequently no further episodes of gastrointestinal bleeding were observed during the admission. The presence of a metastatic ovarian malignant teratoma with carcinosarcoma which posed a diagnostic challenge as the patient presented with an uncommon clinical picture for clotstridium difficile infection. This case report highlights the importance of considering other causes of gastrointestinal bleed in the presence of a more obvious pathology masking the diagnosis of pseudomembranous colitis which may delay definitive diagnosis and management.

A RARE CAUSE OF ABDOMINAL PAIN: ISCHIOANAL ABSCESS WITH INTRAPERITONEAL EXTENSION

Ischioanal abscess accounts for 30% of all anorectal abscesses. Superior extension into the supravelvator space is rare and associated with a high mortality.

CASE REPORT
25 year old obese man presented with lower abdominal pain for 1 day, preceded by perianal pain and swelling 2 days prior to presentation. Patient was in septic shock. Physical examination revealed a tender lower abdomen with 2 external perianal openings at 9 & 11 o’clock position. Blood parameters showed marked systemic inflammation. Patient pushed for examination under anesthesia, which revealed internal opening at 12 o’clock with a multiloculated ischioanal abscess, tracking beyond the supravelvator space, reaching the anterior pre-peritoneal space. There were 200cc of pus mixed with necrotic debris intraperitoneally mainly at the pelvic and bilateral iliac fossae with minimal small bowel interloop slough. Corrugated drains were placed for adequate drainage.

DISCUSSION
Ischioanal space is a triangular shaped fat filled space bounded superomedially by levator ani muscle posteriorly & external anal sphincter anteriorly. Its lateral boundaries include the obturator internus & ischial tuberosities. Organisms found responsible for these abscesses include B. fragilis, Clostridium, Staph aureus, Streptococcus, & E. coli. Once the collection forms, it can spread along the path of least resistance but rarely above supralevator space and into the peritoneal space. Treatment involves resuscitation with ICU stabilisation if indicated, before venturing into an examination under anesthesia and appropriate drainage procedure. Lack of fluctuance should not delay treatment as it will progress into a life-threatening generalized systemic infection. The occult nature of this condition with subtle presentation of abdominal symptoms, compounded with vague gluteal signs, often delay the diagnosis. Therefore, a high index of suspicion is prudent as intraperitoneal extension is associated with higher morbidity & mortality.
A caecal volvulus is a malrotation of a mobile cecum and ascending colon. Bascule subtype accounting for <10% of all cases of caecal volvulus. Although volvulus can occur at other sites of the gastrointestinal tract, such as stomach, gallbladder, and small bowel, they most commonly occur in the colon in which commonest site for volvulus is sigmoid colon followed by the caecum.

**Clinical Case**

We present a case of a 58 years old gentleman who presented with multiple episodes of subacute intestinal obstruction since 2018. A diagnosis of caecal bascule was made after a CT scan showed distended caecum with dilated small bowel with an incidental finding of a fundal polyp. A laparotomy was performed confirming a caecal bascule around an adhesion band and a stomach tumour at fundus measuring 4cm x 3cm. A right hemicolectomy, wedge resection of stomach GIST, roux en y creation was done.

**Discussion**

Caecal bascule is an infrequent type of caecal volvulus. It appears when the caecum folds upon itself, causing an intestinal obstruction and is usually diagnosed using imaging techniques or intra-operatively. An incidental finding of a stomach GIST is a separate entity and not associated with development of caecal bascule.

**Conclusion**

A caecal volvulus or bascule presents a challenge in diagnosis. Mainstay of treatment is a right hemicolectomy whilst other treatment modalities such as decompressive tube cecostomy, simple detorsion, and cecopexy have been used. Management of a stomach GIST is separate entity and targeted therapy should be initiated upon confirmation.
SAFETY AND EARLY SURVIVAL OUTCOME IN PATIENTS MORE THAN 65 YEARS FOLLOWING ELECTIVE COLORECTAL CANCER SURGERY

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BACKGROUND
Advancing age is considered an important and independent risk factors for post-operative morbidity and mortality in major abdominal surgery. In the last 2 years, our center experienced increasing number of patients aged 65 years and above, subjected to curative surgery for colorectal cancer. We investigate the impact of age on short-term outcomes in terms of 30-day post-operative morbidity and mortality and their early survival outcome after colorectal cancer surgery.

METHODS
105 patients diagnosed with colorectal carcinoma were subjected to elective oncological resection at Hospital Tuanku Ja’afar Seremban between July 2018 and December 2019. Clinical, operative and follow up data were retrospectively retrieved from hospital records. Patients were divided into 2 groups; age less than 65 years old and 65 years and above. Number of perioperative severe complications (CTCAE grade 3 to 5) and mortality for both groups were statistically compared using Chi-square test. Survival analysis for both groups was performed by Kaplan-Meier method with log-rank test and tested with other variables in multivariate analysis using Cox proportional hazard regression model.

RESULTS
The overall postoperative mortality and major morbidity CTCAE grade 3-5 in this study is 3.9% and 16.7% respectively. No difference in mortality (1.8% versus 6.5%, p=0.325) and severe post-operative morbidity (14.9% versus 9.6%, p=0.114) were observed in patients age less than 65 years compared to patients aged 65 years and above. The 1-year OS and DFS for both groups showed no statistical difference in univariate analysis. Multivariate analysis for DFS retained tumour stage IV as significant risk factor (p= <0.001, HR=0.137, CI=0.046-0.411).

CONCLUSIONS
Post-operative outcome and early survival following curative colorectal cancer surgery did not differ between patients aged 65 years and above with those younger than 65 years old.

METASTATIC ANGIOSARCOMA TO THE DIGESTIVE TRACT: A CASE AND LITERATURE REVIEW

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OBJECTIVES
To review and identify learning points in the management of a patient presented with a very rare cause of severe GI bleed with evidence-based approach

METHODS
Retrospective case note review, and literature search using PubMed with keywords ‘angiosarcoma’ and ‘gastrointestinal tract’ followed by manual backward chaining hand search of the references from the articles obtained.

RESULTS
An 83-year-old who previously treated for scalp angiosarcoma, presented with severe GI bleed. The OGD to D2 was normal and colonoscopy showed blood clots in the right colon with no obvious lesion seen, though subsequent CT angiogram confirmed active contrast extravasation in the ascending colon. A further colonoscopy revealed a small bleeding sessile lesion which was clipped. This failed to control the bleeding and therefore, right hemicolectomy was performed. The histology confirmed angiosarcoma, likely a metastasis given his past medical history. He re-represented two weeks later with severe GI bleed again. Small bowel balloon enteroscopy was performed and showed 2 further metastatic lesions in the D4 and mid jejunum. Given poor prognosis and general deterioration, he passed away at 33 days following the readmission.

Several case reports and series were found from the literature search, which were mostly primary angiosarcoma of GI tract. There were 13 cases reported as multifocal angiosarcoma in the digestive tract of metastatic occurrences which often pose diagnostic and management dilemma, as in our case. Surgery followed by chemotherapy offer the best outcome but in patients with metastatic disease, the outcome is very poor, with <20% 5-year survival rate.

CONCLUSIONS
Patients with a background history of angiosarcoma presented with gastrointestinal bleed may have multiple metastatic angiosarcoma in the digestive tract as the cause for the bleed. Local treatment to the bleeding lesion is futile. Surgery may not be appropriate if there are several metastatic lesions in the digestive tract.
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