souvenir programme • abstract book

College of Surgeons
Academy of Medicine of Malaysia

Academy of Medicine of Malaysia

2nd MALAYSIAN COLORECTAL WEEKEND

"Back to Basics"

10 - 13 JUNE 2004

Shangri-La's Rasa Sayang Resort
Penang, Malaysia

CONTENTS

MESSAGE FROM THE ORGANISING CHAIRMAN

We are happy and proud to present the Second Malaysian Colorectal Weekend.
The theme for the meeting this year is "Back to Basics". This theme was specifically chosen because the topics covered would be of much interest to general surgeons and colorectal surgeons alike, as well as to surgical trainees and to paramedical staff.

The topics were carefully chosen so that all the common colorectal conditions of daily surgical practice would be covered from the aspects of the basic science behind these conditions together with the principles of management.

There is also a discussion session during which participants can raise questions to a panel of Colorectal experts pertaining to topics such as anal pain, constipation, anorectal trauma, PR bleeding and recurrent perianal fistulae.

The organising committee would like to thank all the invited speakers and Chairpersons who have kindly agreed to share their knowledge and experience with us. We would also like to thank the Academy of Medicine of Malaysia and for their invaluable assistance during all stages of preparation for this meeting. We would also like to thank the sponsors for their support in making this Meeting possible.

The organising committee has worked very hard to make this Meeting relevant and useful to the participants. We sincerely hope you will benefit from this Meeting and at have an enjoyable stay at Pulau Pinang.

Sincerely,

Dr Lu Ping Yan

PROGRAMME SUMMARY

TIME \ DATE	11 JUNE 2004 FRIDAY	12 JUNE 2004 SATURDAY
0800 – 0900 hrs	**SYMPOSIUM 1** PERIANAL PROCEDURES 1	**SYMPOSIUM 3** PERIANAL PROCEDURES 2
0900 – 1000 hrs		
1000 – 1100 hrs	**TEA**	**TEA / TRADE EXHIBITION**
	1ST PLENARY LECTURE	
1100 – 1200 hrs	**SYMPOSIUM 2** ABDOMINAL SURGERY 1	**SYMPOSIUM 4** ABDOMINAL SURGERY 2
1200 – 1300 hrs	**2ND PLENARY LECTURE**	**LUNCH SYMPOSIUM**
	SPECIAL LECTURE	
1300 – 1400 hrs		
1400 – 1500 hrs		**3RD PLENARY LECTURE**
1500 – 1600 hrs	DURIAN FIESTA AT BALIK PULAU *(Please confirm attendance during registration. Places are limited)*	**CASE DISCUSSION**
1600 – 1700 hrs		
1700 – 1800 hrs		
1930 – 2230 hrs		**COLORECTAL NITE DINNER**

10 JUNE 2004 [THURSDAY] 1500 – 1800 hrs	13 JUNE 2004 [SUNDAY] 0730 hrs
ARRIVAL & REGISTRATION	**2ND COLORECTAL RUN**

DAILY PROGRAMME

10 JUNE 2004 [THURSDAY]

1500 – 1800 hrs	ARRIVAL & REGISTRATION

11 JUNE 2004 [FRIDAY]

0800 – 0945 hrs	**SYMPOSIUM 1** ~ PERIANAL PROCEDURES 1 Chairperson: J C Mehta CLINIC PROCTOLOGY *[pg 08]* *Manohar Padmanathan* DIATHERMY HAEMORRHOIDECTOMY: SWIFT AND DRY *[pg 09]* *Lu Ping Yan* STAPLED HAEMORRHOIDECTOMY: TRICKS OF THE TRADE *Ho Yik Hong* LATERAL ANAL SPHINCTEROTOMY: MAKING THE CUT *[pg 10]* *Wong Kutt Sing* Q & A
0945 – 1015 hrs	TEA
1015 – 1045 hrs	**1st PLENARY LECTURE** MODERN HAEMORRHOID SURGERY – WHAT'S THE SCIENCE? *Ho Yik Hong*
1045 – 1200 hrs	**SYMPOSIUM 2** ~ ABDOMINAL SURGERY 1 Chairpersons: Wan Khamizan / Samuel Tay HOW TO CREATE AND CLOSE THAT STOMA *Charles Tsang* BASIC STOMA AND WOUND CARE *Ravathy* MOBILISING THE COLON AND RECTUM: THE EASY WAY *Adrian Leong* ABDOMINOPERINEAL RESECTION *[pg 11]* *Akhtar Qureshi* Q & A
1200 – 1230 hrs	**2nd PLENARY LECTURE** MANAGEMENT OF IDIOPATHIC MEGACOLON / MEGARECTUM *Ho Yik Hong*
1230 – 1300 hrs	**SPECIAL LECTURE** UPDATES IN ADJUVANT TREATMENT FOR COLORECTAL CANCER *Robert Lim*
1300 – 1500 hrs	FREE
1500 – 1800 hrs	DURIAN FIESTA AT BALIK PULAU *(Please confirm attendance during registration. Places are limited)*
1800 hrs onwards	FREE

DAILY PROGRAMME

12 JUNE 2004 [SATURDAY]

0800 – 0945 hrs

SYMPOSIUM 3 ~ PERIANAL PROCEDURES 2
Chairpersons: P Kandasami / Peter Lee
FISTULA SURGERY: TO CORE OR LAY OPEN
Charles Tsang
HIGH FISTULAS: WHAT ARE YOUR OPTIONS?
Cheong Wai Kit
DIFFICULT ANORECTAL ABSCESSES *[pg 12]*
Dean Koh Chi Siong
PILONIDAL DISEASE
Meheshinder Singh
Q & A

0945 – 1045 hrs — TEA / TRADE EXHIBITION

1045 – 1200 hrs

SYMPOSIUM 4 ~ ABDOMINAL SURGERY 2
Chairpersons: Harbahajan Singh / Richard Sim
COLORECTAL ANASTOMOSIS: BASIC PRINCIPLES
Yunus Gul
SINGLE STAGE SURGERY FOR OBSTRUCTING LEFT SIDED TUMOURS *[pg 13]*
Dean Koh Chi Siong
COLONIC POUCH SURGERY *[pg 14]*
Tang Choong Leong
INTRAOPERATIVE ASSESSMENT OF LIVER
– WHAT A COLORECTAL SURGEON SHOULD KNOW
Leow Chon Kar
Q & A

1200 – 1400 hrs

LUNCH SYMPOSIUM
(Courtesy of Ethicon Endo-Surgery, Johnson & Johnson Medical Malaysia)
STAPLED HAEMORRHOIDECTOMY…WHAT'S NEW?
Adrian Leong

1400 – 1430 hrs

3rd PLENARY LECTURE
MANAGEMENT OF DIVERTICULAR DISEASE
Ho Yik Hong

1445 – 1645 hrs

CASE DISCUSSION
Chairperson : Cheong Wai Kit
Panelists : Ho Yik Hong / Samuel Tay / Adrian Leong / Charles Tsang / Peter Lee
1. ANAL PAIN
2. CONSTIPATION
3. P R BLEEDING
4. ANORECTAL TRAUMA
5. RECURRENT FISTULAE

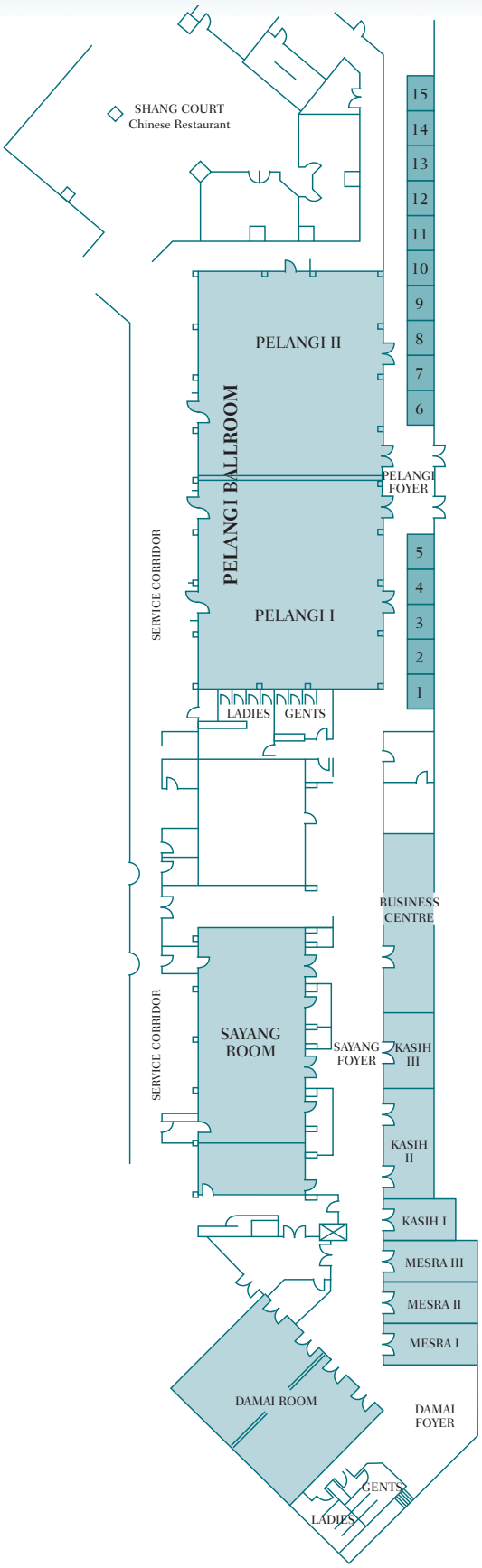
1930 – 2230 hrs — **COLORECTAL NITE DINNER**

13 JUNE 2004 [SUNDAY]

0730 hrs — **2nd COLORECTAL RUN**

FUNCTION ROOMS & TRADE EXHIBITION

BOOTH NO	COMPANY
1 & 2	B Braun Medical Industries Sdn Bhd
3 & 4	Convatec
5	Tyco Healthcare Medical Supplies Sdn Bhd
6 & 7	Johnson & Johnson Medical Malaysia
8	Endodynamics (M) Sdn Bhd
9	Pfizer (Malaysia) Sdn Bhd
10	United Malaysian Medical Industries Sdn Bhd
11	Lab Tech Medical Sdn Bhd
12	Delta Medisains (M) Sdn Bhd
13	Primed Medical Sdn Bhd
14	Malaysian Healthcare Sdn Bhd



THANK YOU

The Organising Committee of the 2nd Malaysian Colorectal Weekend records its grateful thanks to the following for their support and contribution:

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ABSTRACTS

Clinic Proctology

Dr P Manohar
Department of General/Colorectal Surgery, Hospital Selayang, Selangor, Malaysia

The Clinic is an imporant place for a Colorectal practice, as it is the first place the Surgeon makes contact and establishes a rapport with the patient. Eliciting a good and detailed history, very often points to a diagnosis. Majority of patients with anorectal diseases present with a limited number of symptoms eg. bleeding, pain, anal discharge, pruritis. Both diagnostic and therapeutic procedures can be carried out in the clinic. A complete physical examination should be done, which includes digital rectal examination, proctoscopy, rigid sigmoidoscopy, endo anal ultrasound. Common clinic procedures which can be done are rubber banding & injection sclerotherapy for haemoirrhoids, evacuation of perianal haematoma, incision & drainage for perianal abscess, excision of anal warts & skin tags, biopsies for anal ulcers, tumours.

Diathermy Haermorrhoidectomy: Swift And Dry

Dr Lu Ping Yan

Department of Surgery, Hospital Selayang, Selangor, Malaysia

Haemorrhoids are prolapsed anal cushions. Only symptomatic haemorrhoids require treatment. Haemorrhoidectomy (whether open or closed) is indicated for symptomatic third and fourth degree piles.

The operation for diathermy haemorrhoidectomy is described in the lecture. A short video clip of the actual procedure will also be shown. The need to preserve a bridge of anoderm of at least 1 cm between excised piles is emphasied. The haemorrhoide mass is excised off the underlying internal sphincter.

The advantages of diathermy haemorrhoidectomy are that haemosatsis is good thereby making the the operation easier and quicker. The complications following diathermy include post operative pain, urinary retension, haemorrhage (reactionary and secondary), incontinence and anal stenosis. The treatment of piles in patients with immunodeficiency as well as in pregnancy is mentioned.

Lateral Anal Sphincterotomy: Making The Cut

Dr Wong Kutt Sing
Colorectal Surgery Unit, Digestive Disease Centre, Tan Tock Seng Hospital, Singapore

Lateral internal anal sphincterotomy (LIS) is the surgical procedure of choice for the treatment of anal fissures after conservative measures have failed. An anal fissure is a split in the anoderm. Idiopathic anal fissures occur in the midline distal to the dentate line. Multiple anal fissures or fissures occurring off the midline should lead one to suspect underlying causes such as Crohn's, sexually transmitted diseases, tuberculosis or malignancies.

Anal sphincter hypertonia is a consistent finding in patients with anal fissures. A high anal resting pressure is thought to result in relative anodermal ischemia, especially in the posterior midline of the anoderm. Disruption of the internal anal sphincter (IAS) has been shown to result in decreased anal resting pressure and increased anodermal blood flow.

Medical management of anal fissures include avoidance of hard stool, warm sitz baths and pharmacological agents such as topical nitric oxide donors, botulinum toxin injection and topical calcium channel blockers.

Open LIS was first proposed by Eisenhammer in 1959. An incision made in the perianal skin allows identification of the IAS which is dissected from the external sphincter & anal submucosa and divided under direct vision. **Closed LIS** involves passing a scalpel in the intersphincteric plane, parallel to the IAS, and then turning the blade 90 degrees and advanced towards the anal mucosa, thereby disrupting the fibres of the IAS.

Recurrence rates in both open and closed LIS are similar, about 10%. Incontinence rates after LIS depend on whether it was done open or closed and the level of division of the sphincter (up to dentate line or to uppermost level of fissure).

Recent literature suggests that medical therapy may be applied to acute fissures with a chance of cure marginally better than for placebo. For chronic fissures, surgery is more effective than medical therapy.

Abdominoperineal Resection

Dr Akhtar Qureshi
Sunway Medical Centre, Petaling Jaya, Malaysia

A review of the literature would suggest that local excision for T1 and T2 rectal cancers is associated with recurrence rates that are higher than those reported for radical surgery. Postoperative adjuvant therapy does not appear to be reliable in preventing local tumor recurrence, and surgical salvage of recurrent cancers has a low cure rate.

Improved techniques of coloanal anastomosis combined with the rapid development of stapling devices as well as the acceptance of total mesorectal excision (TME) has significantly improved the rate of anal sphincter preservation and reduced local recurrence rates following treatment for rectal cancer. However, there remains a group of patients in whom sphincter-preserving surgery is not possible. Abdominoperineal resection (APR) is required in this group.

Three large recent studies from Europe and the United States report APR rates ranging from 18 to 27 percent. The ratio of APR to anterior resection for adenocarcinoma of the low rectum remains high, even among surgeons with an aggressive policy of sphincter preservation, and varies in accordance with referral patterns.

While preservation of the sphincters is the goal of every colorectal surgeon, this is not always in the best interest of the patient. APR is able to achieve excellent local control and remains an important technique for the optimal treatment of a small group of patients with rectal cancer.

Difficult Anorectal Abscesses

Dr Dean Chi-Siong Koh
Colorectal Unit, Department of General Surgery, Tan Tock Seng Hospital, Singapore

Anorectal infections form the cornerstone of any colorectal practice. Anal gland suppuration as the origin of most of these infections is now well accepted. Non-cryptoglandular sources include Crohn's disease, atypical infections (eg tuberculosis), malignancy or trauma.

In addition to proper well-performed clinical examination, colonoscopic evaluation of the proximal colon may be indicated in suspected non-cryptoglandular aetiologies. The use of endoanal and endorectal ultrasonography has been shown to be a useful adjunct in localization of the abscess collections in relation to the sphincter complex and accurately delineates fistulous tracts if present.

Anorectal abscesses can be divided into perianal, ischioanal, intersphincteric and supralevator in location. There is little role for antibiotics except in the immunocompromised patients or those who have prosthetic cardiac valves. Adequate surgical drainage is the treatment of choice. Depending on the size and location, this can be performed under local or general anaesthesia. The role of primary fistulotomy in acute abscesses is controversial. Treatment of intersphincteric abscesses include drainage and division of the fibres of the internal sphincter up to the level of the dentate line. Supralevator abscesses are difficult to diagnose and these should be drained through 1) the rectal lumen, 2) the ischioanal fossa or 3) the abdominal wall. Hanley's technique is an effective means of treating horeshoe abscesses.

Recurrent anorectal abscesses should first be adequately evaluated for a fistulous tract and if present, this must be addressed appropriately in addition to surgical drainage of the abscess.

Single Stage Surgery For Obstructing Left Sided Tumours

Dr Dean Chi-Siong Koh

Colorectal Unit, Department of General Surgery, Tan Tock Seng Hospital, Singapore

Colorectal cancers account for the majority of patients presenting with mechanical large bowel obstruction. About 30% of colorectal cancers will present as obstructive symptoms and of these 15% will have complete obstruction. This presentation aims to evaluate the strategies involved in the surgical management of tumour-related left sided colonic obstruction and emphasis is placed on the option of single-stage surgery in these instances.

Early, accurate diagnosis of this condition is essential in ensuring ideal outcomes. Plain radiographs, contrast enemas and computer tomography scans are all effective, when used singly or in combination, in confirming the diagnosis of bowel obstuction. Concurrent resuscitation and optimization for surgery must be performed judiciously.

Treatment options available to the colorectal surgeon depends on the clinical state of the patient, the stage of the disease and the modalities available at hand. Palliative options include endoluminal stenting, Nd:YAG laser ablation and surgical procedures such as a diverting stoma, a bypass procedure or primary resection with or without anastomosis. Definitive surgical treatment should abide by the principles of resection with gross clear margins, oncologic resection of draining mesenteric lymphatics and re-establishment of intestinal continuity. The option should depend on whether the lesion can be safely resected and if removed, whether anastomosis is achievable. Traditionally, lesions of the left colon, sigmoid or the rectum are managed by a Hartmann's procedure. Evidence exists today that a one stage primary resection, with or without on-table lavage, with primary anastomosis in selected circumstances is acceptable and appropriate.

Endoluminal stenting has now emerged as a suitable alternative by providing temporary relief of obstruction and subsequent semi-elective stoma-avoiding surgery. A reduction in morbidity and mortality can be expected in such selected instances.

Colonic Pouch Surgery

Dr Tang Choong Leong
Department of Colorectal Surgery, Singapore General Hospital, Singapore

Surgical treatment of low and mid rectal cancers with enbloc excision of the mesorectal fat pad (total mesorectal excision or TME) followed by colo-anal anastomosis reconstruction is a widely practiced procedure. This procedure has been proven to be associated with a low local recurrence rate in the hands of experienced surgeons. Technically, this is greatly facilitated by the widespread use of anastomotic stapling devices. Sphincter-saving rates without compromising cure has increased. A straight colo-anal anastomosis often suffers from increased incidence of anastomotic dehiscence as well as increased stool frequency and faecal incontinence in the early postoperative period for up to 1 or more years. This is a distressing problem and may negate the benefits of palliative resections when the life expectancy is short. It may also commit the patient to long-term anti-diarrhoeal medications. Extrapolating from the experience of the ileoanal pouch after total proctocolectomy, the construction of a colonic pouch has been shown to improve these defaecatory problems resulting in a much shorter period of recovery time. Simplistically, it aims to restore the storage function of the rectum but does not restore the evacuatory and sensory roles that are lost after the initial surgery. The colonic J-pouch is the widely used configuration, and until recently, a coloplasty, has been described. Although the large pouch of up to 10 cm was popular initially, this has led to severe evacuatory problems requiring irrigation and severe fragmentation of defaecation. The use of the sigmoid colon is no different from the use of the descending colon in function and outcome. Trials evaluating pouch function is still short-coming and future multicentred randomized trials should be considered.