

SOUVENIR PROGRAMME



College of Surgeons
Academy of Medicine of Malaysia



Academy of Medicine of Malaysia

3rd MALAYSIAN COLORECTAL WEEKEND

“Overcoming Challenging Problems”

4 – 6 March 2005

The Grand Bahamas, Level 12
Sunway Lagoon Resort Hotel
Petaling Jaya, Selangor

in collaboration with



Universiti Putra Malaysia

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ORGANISING COMMITTEE

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Mr Manohar Padmanathan

Assoc Prof Sukumar Nadesan

Mr Meheshinder Singh

Mr Retna Rasa

Assoc Prof Azmi Md Nor

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MESSAGE



On behalf of the Organizing Committee, it gives us great pleasure in welcoming you to the 3rd Malaysian Colorectal Weekend. The conference on this occasion promises to be particularly special as the academic program has been drawn up to provide a high quality meeting that is bristling with highly interesting topics especially in overcoming challenging problems that surgeons face in colorectal



surgery. It must be emphasized that we have tried our utmost to create a right blend here to benefit both colorectal and general surgeons.

Research in the 21st century continues to be complex and in need of its own interdisciplinary infrastructure that allows it to maintain high quality in the face of increasingly sophisticated methods especially in the field of molecular biology. With that in mind and to emphasise the importance of research in surgical practice, we have included a free paper session in this year's meeting with awards for the three best presentations. We hope that this would stimulate our young surgeons to excel in research-orientated aspects of surgery so that we will not lag behind our counterparts in the more developed nations. Likewise, a one-day workshop has been penciled to provide an extra dimension to the event, which we are certain, will appease the delegates especially those who are still in training.

The social program that has been planned will undoubtedly provide variety offering and fun for accompanying persons taking into consideration the location chosen for this year's event at the Sunway Lagoon Resort Hotel.

In looking forward towards the imminent launch of the Malaysian Society of Colorectal Surgeons (MSCRS), we will now have to continually define our tasks and goals. The needs of the future will no longer be satisfied by merely organizing an annual event in the form of the Colorectal Weekend and to make this its only and most significant achievement. On the contrary, the MSCRS will have to be designed to fit in with its other long-term goals and perspectives especially with regard to credentialing and sub-specialisation in colorectal surgery. It is hoped that through the MSCRS, we will be able to continue promoting a healthy and up to date interest in surgery for colorectal diseases for everyone in this country.

We would like to thank the invited speakers for their commitment and valuable contribution, which we trust will further enhance the science and art of colorectal surgery. We would also like to take this opportunity to thank the medical industry for their valuable and continuous support in realizing the event. Lastly, we hope that you will have an enjoyable stay during the conference and we look forward to your participation in future meetings and events organized by the MSCRS.

YUNUS GUL

Chairman, Organising Committee
3rd Malaysian Colorectal Weekend

SAMUEL TAY KWAN SINN

President, PTC
Malaysian Society of Colorectal Surgeons

PROGRAMME SUMMARY

Date Time	4 MARCH 2005, FRIDAY	5 MARCH 2005, SATURDAY
0800 – 0900	SYMPOSIUM 1 RECTAL CANCER	SYMPOSIUM 4 COLORECTAL CANCER – CONTROVERSIES AND RECOMMENDATIONS
0900 – 1000	OPENING CEREMONY TEA	TEA
1000 – 1100	PLENARY LECTURE 1	PLENARY LECTURE 2
1100 – 1200	SYMPOSIUM 2 CLINICAL DILEMMA	SYMPOSIUM 5 ANORECTAL POT-POURRI
1200 – 1300	LUNCH SYMPOSIUM (SANOFI AVENTIS)	LUNCH SYMPOSIUM (ETHICON ENDO-SURGERY)
1300 – 1400		
1400 – 1500	SYMPOSIUM 3 CONSTIPATION, EVACUATORY DISORDERS & FAECAL INCONTINENCE	VIDEO SESSION 2 HOW I DO IT
1500 – 1600	VIDEO SESSION 1 HOW I DO IT	FREE PAPERS
1600 – 1700	TEA	TEA
1700 – 1800	PRO-TEM COUNCIL MEETING OF MALAYSIAN SOCIETY OF COLORECTAL SURGEONS	CASE DISCUSSIONS
1930 – 2230		COLORECTAL NITE

PRE-CONFERENCE WORKSHOP ON ENDORECTAL ULTRASOUND AND LIVE ANO-RECTAL SURGERY

Paediatric Auditorium, Level 1, Paediatrics Institute, Hospital Kuala Lumpur

3 MARCH 2005, THURSDAY

0730 – 0815 hrs	REGISTRATION
0815 – 0830 hrs	WELCOME ADDRESS <i>Yunus Gul</i>
0830 – 0900 hrs	ENDORECTAL ULTRASOUND – BASIC PRINCIPLES <i>Charles Tsang</i>
0900 – 1200 hrs	ENDORECTAL ULTRASOUND – LIVE DEMONSTRATION <i>Charles Tsang</i>
1000 – 1600 hrs	LIVE SURGERY @ THEATRE 1 & 2 Cases: • Complex Fistula-in-ano • Sphincter Repair • Stapled Haemorrhoidectomy

6 MARCH 2005, SUNDAY

0730 – 0830 hrs	COLORECTAL RUN
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4 MARCH 2005, FRIDAY

- 0800 – 0930 hrs **SYMPOSIUM 1** ~ RECTAL CANCER
 Moderators: P Kandasami / Charles Tsang
 PREOPERATIVE STAGING – WHAT’S THE BEST PRACTICE
Sebastian Tong
 NEOADJUVANT RADIATION – A SURGEON’S PERSPECTIVE
Ian G Finlay
 URETERIC INVOLVEMENT – WHAT TO DO? [page 08]
Ding Chek Lang
 TREATMENT OF RECURRENCE – CAN WE AIM FOR CURE? [page 8]
Peter W R Lee
 Q & A
- 0930 – 1030 hrs OPENING CEREMONY & **TEA**
- 1030 – 1100 hrs **PLENARY LECTURE 1**
 Chairperson: Sukumar Nadesan
 LAPAROSCOPIC COLORECTAL SURGERY – AN OVERVIEW AND
 HOW TO GET STARTED [page 09 – 10]
Chucheeep Sahakitrungruang
- 1100 – 1215 hrs **SYMPOSIUM 2** ~ CLINICAL DILEMMA
 Moderators: Lu Ping Yan / R Ragupathy Naidu
 VTE PROPHYLAXIS IN COLORECTAL SURGERY [page 10]
Yunus Gul
 LOWER GASTROINTESTINAL HEMORRHAGE [page 11]
Manohar Padmanathan
 PRESACRAL HAEMORRHAGE: STEMMING THE TIDE [page 12]
Meheshinder Singh
 STOMA COMPLICATIONS – PREVENTION AND TREATMENT [page 12]
Retna Rasa
 Q & A
- 1215 – 1300 hrs **LUNCH SYMPOSIUM (SANOFI AVENTIS)**
 Chairperson: Gurcharan Singh Khera
 NEW CHEMOTHERAPEUTIC AGENTS FOR COLORECTAL CANCER
 – MUCH ADO ABOUT NOTHING?
Kong Hwai Loong
- 1300 – 1430 hrs **LUNCH** / FRIDAY PRAYERS
- 1430 – 1545 hrs **SYMPOSIUM 3** ~ CONSTIPATION, EVACUATORY DISORDERS
 & FAECAL INCONTINENCE
 Moderators: Manjit Singh / Mohamad Ismail Ali
 ENDORECTAL ULTRASOUND – WHAT ARE WE LOOKING AT?
Charles Tsang
 SURGERY FOR CONSTIPATION: INDICATIONS AND RESULTS? [page 13]
M Sarkunna Thas
 SOLITARY RECTAL ULCER SYNDROME [page 13]
Akhtar Qureshi
 RECTOCELES – WHY, WHEN AND WHO? [page 14]
Lu Ping Yan
 Q & A

- 1545 – 1645 hrs **VIDEO SESSION 1** ~ HOW I DO IT
 Moderators: Peter W R Lee / Andrew Gunn
FISTULA SURGERY – INTERACTIVE VIDEO
Ian G Finlay
LAPAROSCOPIC ANTERIOR RESECTION
Chucheeep Sahakitrungruang
SPHINCTEROPLASTY
Charles Tsang
COLONOSCOPY – TRICKS OF THE TRADE IN DEALING WITH CHALLENGING LESIONS
Ryan Ponnudurai
- 1645 – 1700 hrs **TEA**
- 1700 – 1800 hrs **PRO-TEM COUNCIL MEETING OF MALAYSIAN SOCIETY OF COLORECTAL SURGEONS**

5 MARCH 2005, SATURDAY

- 0815 – 0945 hrs **SYMPOSIUM 4** ~ COLORECTAL CANCER – CONTROVERSIES AND RECOMMENDATIONS
 Moderators: Yunus Gul / Abdollah Salleh
 CURRENT RECOMMENDATIONS FOR SURVEILLANCE AND SCREENING OF COLORECTAL CANCERS [page 14]
Sukumar Nadesan
 POSITIVE RESECTION MARGINS – WHAT TO DO? [page 15]
Francis Seow-Choen
 THE DILEMMA OF A MALIGNANT POLYP [page 15]
Arun Rojanasakul
 HEPATIC METASTASES FROM COLORECTAL CANCER [page 16]
Russell W Strong
 Q & A
- 0945 – 1015 hrs **TEA**
- 1015 – 1045 hrs **PLENARY LECTURE 2**
 Chairperson: Samuel Tay
FAECAL INCONTINENCE – DEALING WITH A DIFFICULT PROBLEM
Ian G Finlay
- 1045 – 1200 hrs **SYMPOSIUM 5** ~ ANORECTAL POT-POURRI
 Moderators: Harbahajan Singh / Akhtar Qureshi
 FIBRIN SEALANT FOR FISTULA IN-ANO – DOES IT WORK? [page 16]
Azmi Md Nor
 ANAL STENOSIS – ENLARGING THE VIEW [page 17]
Arun Rojanasakul
 MANAGEMENT OF ANAL FISSURE [page 17]
Samuel Tay
 RECTOVAGINAL FISTULAE – WHAT NEXT?
Ian G Finlay
 Q & A

DAILY PROGRAMME [CONTINUED]

- 1200 – 1400 hrs **LUNCH SYMPOSIUM (ETHICON ENDO-SURGERY)**
Chairperson: Yunus Gul
STAPLED HAEMORRHOIDECTOMY – A DURABLE PROCEDURE? [page 18]
Francis Seow-Choen
- 1400 – 1500 hrs **VIDEO SESSION 2 ~ HOW I DO IT**
Moderators: Sebastian Tong / Wan Khamizar
STAPLED HAEMORRHOIDECTOMY
Yunus Gul
TOTAL MESORECTAL EXCISION [page 18]
Francis Seow-Choen
LAPAROSCOPIC TOTAL PROCTOCOLECTOMY WITH IPAA
Chucheeep Sahakitrungruang
RECTAL PROLAPSE – PERINEAL APPROACH
Ian G Finlay
ILEO-ANAL POUCH [page 18]
Francis Seow-Choen
Panel Discussion / Q & A
- 1500 – 1600 hrs **FREE PAPERS** [page 19 – 24]
Chairpersons: Akhtar Qureshi / Lu Ping Yan
- 1600 – 1615 hrs **TEA**
- 1615 – 1730 hrs **CASE DISCUSSIONS**
Moderators: Yunus Gul / Samuel Tay
- 1930 – 2230 hrs **COLORECTAL NITE**
Poolside, Level 1, Sunway Lagoon Resort Hotel, Petaling Jaya

6 MARCH 2004, SUNDAY

- 0730 – 0830 hrs **COLORECTAL RUN**

FREE PAPERS

- 1500 – 1510 hrs **MUTATIONAL ANALYSIS OF APC GENES IN MUTATION CLUSTER REGION (MCR) IN COLORECTAL CANCER** [page 19]
M F Jabar, K T Oo, H Ithnin, H F Seow, Y A Gul
- 1510 – 1520 hrs **STAPLED HAEMORRHOIDECTOMY IN MALAYSIAN PATIENTS – A PROSPECTIVE EVALUATION** [page 20]
A Fernandez, A Balan, Y A Gul
- 1520 – 1530 hrs **INTRAOPERATIVE SENTINEL LYMPH NODE MAPPING IN COLORECTAL CARCINOMA** [page 21]
Azim I, Sagap I, Ismail A, Sukumar N, Isa R
- 1530 – 1540 hrs **SURVEILLANCE COLONOSCOPY FOR COLORECTAL POLYPS** [page 22]
Nor Azlindah, Teoh C M, Sukumar N, Azmi M T
- 1540 – 1550 hrs **ACUTE HEMORRHAGIC RECTAL ULCERS: THE RECTUM'S VERSION OF STRESS ULCERS?** [page 23]
I A Rizal, K K Chan, A Gunn
- 1550 – 1600 hrs **MANAGEMENT OF HIRSCHSPRUNG'S DISEASE WITH REFERENCE TO ONE-STAGE PULL-THROUGH WITHOUT COLOSTOMY** [page 24]
Yik Y I, T M Ramanujam

FUNCTION ROOMS & TRADE EXHIBITION



Booth No	Company
1	Avro Medical
2	Roche Malaysia Sdn Bhd
3	M C Endoscopic Sales & Services
4	B H Enterprise Sdn Bhd
5 & 6	Ethicon Endo-Surgery, Inc. – Johnson & Johnson
7	TransCare Healthservices Malaysia Sdn Bhd
8	Endodynamics (M) Sdn Bhd
9	Sanofi Aventis
10	Primed Medical Sdn Bhd
11	Boston Scientific
12 & 13	Malaysian Healthcare Sdn Bhd
14	Lap Tech Medical Sdn Bhd
15	United Italian Trading (M) Sdn Bhd
16	Biomedical SEA Sdn Bhd
17	Pfizer (Malaysia) Sdn Bhd
18	B Braun Medical Supplies Sdn Bhd
19	Convatec Division, Bristol-Myers Squibb Co
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ACKNOWLEDGEMENTS

The Organising Committee of the 3rd Malaysian Colorectal Weekend records its grateful thanks to the following for their support and contributions.

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URETERIC INVOLVEMENT – WHAT TO DO?**Ding Chek Lang***Ipoh Specialist Hospital, Ipoh, Perak, Malaysia*

Ureteric involvement in patients with colorectal carcinoma is uncommon. It is believed that the motility of the ureter and the Denonvilliers fascia are natural protective mechanisms delaying ureteric involvement.

The ureters may be involved by tumour encasement, tumour infiltration, lymph node encasement and iatrogenic damage during surgery or after radiotherapy. Preoperative imaging of the urinary tract is advisable in the presence of locally advanced disease.

Management of the patient needs to be individualized. The patient's performance status, the tumour characteristics, whether it is de novo or recurrent disease, the extent of ureteric involvement and the functional status of the bladder are factors to be taken into consideration before deciding the best mode of treatment for the patient. When circumstances allow, the patient should play an active role in deciding the modality of treatment. Treatment would range from symptomatic treatment to a major reconstruction of the upper and lower urinary tracts. Since most of the patients would have incurable disease, the aim would be to preserve renal function with as simple a procedure as possible, while preserving quality of life.

SYMPOSIUM 1

TREATMENT OF RECURRENCE – CAN WE AIM FOR CURE?**Peter Lee***Penang Medical College, Penang, Malaysia*

Recurrence of rectal cancer is probably best considered separately as isolated distal metastatic disease (liver or lung metastases) and true local pelvic recurrence (LR) – be this anastomotic, involving other pelvic organs or the pelvic wall.

Survival figures for isolated liver and lung metastases are well documented and will probably continue to increase with improved post operative surveillance and multimodality techniques – be this surgery, chemotherapy, immunotherapy or a combination of these.

In recent years considerable effort has been made to reduce the incidence of local recurrence by improved surgical technique (TME) and perioperative adjuvant therapy. In spite of this, data from the literature would suggest the outlook for patients with LR is gloomy: 3 – 30% will develop LR; about 25% of these patients can be resected with curative intent, but overall 80 – 90% of those with LR will die within 5 years¹.

Despite these gloomy statistic there is now data to indicate with appropriate patient selection and multimodality management a significant number of patients with LR can be cured of their disease (table 1)

This presentation will look at the mode of presentation of LR; the preoperative assessment and selection of patients suitable for intended cure and the adjuvant and operative techniques involved in their management. Continuing improvement in surveillance to identify the recurrent disease at a curative stage is emphasized together with the development of multimodality teams, in specialist centres, to provide optimal results and care.

Table 1 : Treatment of Locally Recurrent Rectal Cancer

CLINICS / HOSPITALS	NO. OF OPERATED CASES	OVERALL 5 YEARS SURVIVAL
Mayo Clinic USA (ref 2)	304	25%
National Cancer Centre Chiba, Japan (ref 3)	43	39%
Cleveland Clinic, USA (ref 4)	43	32%
Washington Uni. Hospital USA (ref 5)	14	86%
Leeds Infirmary, UK (ref 6)	57	Median survived 33 months

LAPAROSCOPIC COLORECTAL SURGERY – AN OVERVIEW AND HOW TO GET STARTED

Chucheep Sahakitrungruang

King Chulalongkorn Memorial Hospital, Bangkok, Thailand

Laparoscopic surgery has been successfully introduced in various surgical fields since first laparoscopic cholecystectomy in late 1980's. In colorectal surgery, laparoscopy has been used more than 10 years to treat colorectal diseases. At present, laparoscopy for benign diseases is accepted as an alternative modality of treatment, on the other hand, in malignant diseases, is technically feasible but still oncologically challenging. However recent prospective randomized trials (RCT) of laparoscopic surgery for colorectal cancer are very encouraging not only improving recovery outcome but also long term oncologic outcome.

In this symposium I would like to overview the trend of laparoscopic colorectal surgery considering the above description and I would like to present the aspect of how to learn and develop these techniques in our institute.

Extent of resection by laparoscopic approach

Feasibility describes the ability to perform the same procedure laparoscopically as would be performed via laparotomy. In the oncologic setting, this mandates that the same extent of resection is performed. Adequate resection is judged by proximal and distal margins of the colon, lymphadenectomy as measured by the number of harvested lymph nodes, proximal vascular ligation, and if indicated, en bloc resection of adjacent organs to which the tumor is adherent. Both early retrospective and more recent prospective studies have confirmed that the same extent of resection is possible laparoscopically.

Short term recovery outcomes

The results of several RCT have confirmed the advantage of postoperative outcomes including reduction of pain and narcotic use, faster resolution of postoperative ileus and shorter hospital admission. Given all apparent benefits, the assumption was made that laparoscopic colectomy would result in improving the QOL for the patient which was shown in NIH multicenter trial.

Long term oncologic outcomes

1. Port site recurrence

It is now believed not a specific complication of laparoscopic surgery but universal pattern of tumor recurrence in advanced cancer is more related to poor technical manipulation of tumor.

2. Overall survival

Besides advantages of early recovery in laparoscopic group, several large scaled prospective clinical trials, some of them are done and others are ongoing, showed at least equal short or long term survival rate and complication rate between laparoscopic and open group. One distinguished Spanish trial by Lacy et al. reported unexpected better survival in stage III colon cancer. This result is ironically very strong encouraging extending indications of laparoscopy not only for early colorectal cancer, but also for more advanced cancer. More recently COST study group concluded that laparoscopic colectomy for colon cancer is an acceptable alternative to open surgery. Because all laparoscopic resections reported in these studies were performed by the experienced surgeons, the important message is not just that the laparoscopic is better, but that it can be better in experienced laparoscopic hands.

Technical aspects

Many reports revealed steep learning curve in laparoscopic colorectal surgery. Even surgeons with some experiences of laparoscopic surgery such as LC, laparoscopic colorectal surgery seems to be more difficult because it needs multi-quadrants approach, more tedious vascular division, anatomically close to critical structure and reconstruction of bowel continuity in most cases.

How can we reduce learning curve?

1. Systematized approach and experience of laparoscopic surgery
2. Enough experience of open surgery and comprehensive knowledge of anatomy
3. Understanding of disease pathophysiology
4. Good patient selection and proper preoperative evaluation
5. Learning from previous laparoscopic surgery (positive feedback)
6. Learning from good model

SYMPOSIUM 2

VTE PROPHYLAXIS IN COLORECTAL SURGERY

Yunus Gul

*Department of Surgery, Faculty of Medicine, Universiti Putra Malaysia,
Kuala Lumpur, Malaysia*

Venous thromboembolism (VTE) is a common complication of surgical procedures and patients undergoing elective and emergency colorectal surgery often fall into the upper echelon risk groups for the development of VTE. In fact, patients undergoing surgery for rectal cancer are frequently categorized in the highest risk group as these patients have several other well-recognized VTE risk factors, including advanced age, medical comorbidities and treatment with antineoplastic agents in the adjuvant or neoadjuvant setting. Even though there is a wide variation in the reported incidence of VTE in the Asian population, the condition is increasingly recognized as a significant postoperative complication in Asian hospitals thereby confirming objective evidence that VTE related events in Asian patients is not a rare entity. Prophylaxis in patients undergoing colorectal surgery with either unfractionated or low-molecular-weight heparin is currently recommended for patients classified as highest-risk while mechanical prophylaxis with perioperative sequential compression devices remains a viable option. A number of issues related to prophylaxis of VTE after surgery deserve further clarification, including the role of screening for asymptomatic deep vein thrombosis, the best timing for initiation of pharmacological prophylaxis, and the optimal duration of prophylaxis in high-risk patients.

LOWER GASTROINTESTINAL HAEMORRHAGE

P Manohar

Pantai Klang Specialist Medical Centre, Selangor, Malaysia

Lower Gastrointestinal Haemorrhage (LGIH) continues to be a frequent cause of hospital admissions and is a factor in hospital morbidity & mortality. Mortality rates are reportedly between 10 – 20% and are dependent on age, multiorgan system disease, transfusion requirements, need for operation and recent stress.

LGIH is defined as haemorrhage in the gastrointestinal tract distal to the Ligament of Trietz. LGIH can be due to numerous conditions eg. diverticular disease, anorectal diseases, carcinomas, Inflammatory Bowel Disease, angiodysplasias.

Management of LGIH includes relevant history, physical examination, initial fluid resuscitation, investigations and definitive treatment. Lab Investigations include Full Blood Count, Coagulation Profile, Liver Function Test, Renal Profile. Investigation modalities include inserting a nasogastric tube to rule out an upper gastrointestinal source of bleeding, colonoscopy and imaging studies such as mesenteric angiography & nuclear scinigraphy.

The priority in definitive treatment is to treat the shock. Colonoscopy is the procedure of choice for evaluation of LGIH. Ideally prior bowel preparation should be done. It is a versatile tool as it allows diagnosis to be made as well as therapeutic procedures such as endoscopic coagulation, adrenaline injection & hemoclip application to be done.

Mesenteric angiography allows precise localization of bleeding sites and can be used for therapeutic intervention such as selective arterial infusion of vasopressin, superselective embolization with gelfoam, polyvinyl alcohol, microcoils.

Surgery is indicated when a precise site of bleeding has been located and does not respond to conservative measures. Segmental resection is appropriate in this situation.

Emergency surgery is indicated when patients require > 1500ml of blood transfusion for initial resuscitation with ongoing bleeding, requirement of 6 or more units of blood, ongoing bleeding for 72 hours or rebleeding within 1 week of initial cessation of bleeding. Intraoperative diagnostic methods used to identify bleeding include intraoperative colonoscopy, oesophago gastroduodenoscopy and enteroscopy. A blind segmental colectomy is reserved as a last resort but is associated with a high rebleeding rate.

PRESACRAL HAEMORRHAGE: STEMMING THE TIDE**Meheshinder Singh***Pantai Cheras Medical Centre, Kuala Lumpur, Malaysia*

Presacral haemorrhage is a potentially life threatening complication of pelvic operations. Although uncommon, it can occur during the course of rectal mobilization.

Hemostases in a presacral haemorrhage can be difficult to achieve because of the complex interlacing of the presacral venous network. Conventional methods like suture ligation, electrocautery, use of hemoclips or application of hemostatic sponges should be used with caution as it can aggravate the condition. Various strategies like use of thumbtacks, muscle tamponade, muscle fragment welding, use of endoscopic helical tackers or even inflatable balloon devices have shown promising results.

Although there are multitude of strategies in controlling a presacral haemorrhage, it is imperative to consider the stability of the patient when using potentially time consuming techniques. Due consideration must be given towards a damage control approach if necessary. Damage control refers to an immediate pelvic packing to prevent further deterioration and a subsequent exploration at 24 – 48 hours or once patient is stable.

There are several measures which minimize the risks of a presacral haemorrhage amongst which meticulous sharp dissection within proper tissue planes cannot be overemphasized. However, this requires a clear understanding of the anatomy of the rectum and its surrounding fascial planes.

STOMA COMPLICATIONS – PREVENTION AND TREATMENT**Retna Rasa***Pantai Cheras Medical Centre, Kuala Lumpur, Malaysia*

The creation and infliction of a stoma on a patient is one of the most profound changes a surgeon can do to a patients' psyche. Not only is the surgeon redirecting the normal flow of effluent from an anatomical area the patient has been accustomed to all his life, he is also changing the patients self image and self esteem. In the long run, this may prove more important in the management of the stoma. Thus, the axiom, "Do it once and do it right the first time" is all the more true here as in other surgeries. The creation of emergent stomas should be avoided. All patients should have some form of preoperative counseling on what to expect with his stoma and how he should be able to carry out his normal daily activities. A patient should be intelligent enough to care for their own stomas' or should have a care giver familiar in the art. It is heartening to note the increasing availability of trained enterostomal nurses in most hospitals. However all surgeons should have some rudimentary knowledge of the wide range of appliances and products in the art of stoma management. In the creation of stomas', as in all surgeries, strict adherence to proper surgical technique will produce a sound functioning stoma. Complications should be addressed quickly by a trained surgeon to facilitate a normal functioning stoma. Surgeons should be aware that the stoma is not the patient and patients should be treated holistically and individually. We should constantly be aware of any changes in the patient's psychological outlook. We should be, always, on the lookout for newer and better products for our patients as the field of stoma care is rapidly expanding.

SURGERY FOR CONSTIPATION: INDICATIONS AND RESULTS?**M Sarkunna Thas***Hospital Pantai Putri, Ipoh, Perak, Malaysia*

Severe constipation can be a distressing to the patient and pose a significant challenge to the physician in terms of medical as well as surgical management.

Surgical intervention for intractable disease is rarely necessary. Generally only patients with intractable symptoms and are refractory to medical management are subjected to surgical therapy.

Various surgical options are available. Subtotal colectomy with IRA seems to offer the best results. In a highly select group of patients ileo-anal pouch procedures might be indicated.

Careful preoperative evaluation and patient selection is important to ensure a satisfactory result.

Conclusion: Careful patient selection is vital in offering surgery for intractable constipation. Majority get good relief of their symptoms. However, it is associated with a considerable morbidity and some symptoms such as abdominal cramps and bloatedness may not be resolved completely.

SOLITARY RECTAL ULCER SYNDROME**Akhtar Qureshi***Sunway Medical Centre, Petaling Jaya, Selangor, Malaysia*

Solitary rectal ulcer syndrome is an uncommon condition characterized by rectal lesions that may be solitary or multiple and the lesions may be ulcerated or not. The typical features of this condition include the passage of blood and mucus associated with tenesmus, evidence of rectal prolapse on defecation proctography, endoscopic appearance of single or multiple lesions usually on the anterior wall of the mid rectum. The lesions may be ulcerated or indurated and are usually polypoidal. The histological appearances show evidence of fibrous obliteration of the lamina propria.

The pathogenesis is uncertain with possible role of recurrent digital trauma, straining and neuromuscular pathology. The diagnosis is made by the clinical appearances together with the histopathological appearances.

The management of this condition has to be tailored to the patient with local surgical procedures for the control of symptoms, to major abdominal surgery for any associated prolapse. More recently, biofeedback behavioral therapy has become an integral part in the management of these patients.

RECTOCELES – WHY, WHEN AND WHO?**Lu Ping Yan***Department of Surgery, Selayang Hospital, Selangor, Malaysia*

In this talk, the pathogenesis, investigations as well as the indications of surgical management of a patient with a rectocele will be covered. It is emphasized that although rectoceles are a fairly common finding in women who complain of chronic constipation, in only a very small proportion of these women are the rectoceles the cause of their symptoms. It is prudent, therefore, to properly assess these patients and to exercise care before offering surgery as an option to these patients. The various surgical approaches to the management of rectoceles will be briefly discussed.

CURRENT RECOMMENDATIONS FOR SURVEILLANCE AND SCREENING OF COLORECTAL CANCERS**Sukumar Nadesan***Department of Surgery, Universiti Kebangsaan Malaysia, Kuala Lumpur, Malaysia*

Screening for colorectal cancer reduces cancer related mortality. Optimal screening test should be highly sensitive, noninvasive, with minimal risks, cost effective and easily implemented. Available screening tools are faecal occult blood (FOBT), sigmoidoscopy, colonoscopy and barium anaema. Newer screening tools that are still being looked into are faecal DNA, virtual colonoscopy, magnetic resonance colonography and genetic screening. FOBT is simple, noninvasive and reduces cancer mortality. The immunochemical FOBT is more specific for human haemoglobin. Sigmoidoscopy combined with FOBT is effective (76% positive) to detect cancers. This has been the cornerstone of CRC screening. Faecal DNA is sensitive and specific (more than 90%), but is expensive and tedious. Stool decay accelerating factor seems promising, as it has been reported to be sensitive and specific. Colonoscopy is the most sensitive and specific. Virtual colonoscopy can detect polyps larger than 10mm with a sensitivity of 90% but there are limitations. Magnetic colonography has similar sensitivity and specificity to virtual colonoscopy but artifacts are a problem. Problems with screening include false positive, false negative results, complications, cost, clinical burden and compliance.

At the moment, there is no one best screening method. It depends on the doctor, patient, facilities and protocol. Suggestions are to screen all people above 50 years old (some 40 years) with FOBT annually, sigmoidoscopy 5 yearly or colonoscopy 5 – 10 yearly.

There is little evidence of improvement in survival with surveillance but some report intensive follow up after curative resection does improve survival. Most patients do not develop intramural recurrence and hence colonoscopy seems inadequate. There is insufficient evidence for routine LFT, blood counts, CXR, CT scans though some reported routine CT scans and CEA reduced mortality significantly. Suggestions of follow up of post resection patients are physical examination up to 3 years, CEA and colonoscopy (3 – 5 yearly) which is most indicated in patients with multiple polyps, advance polyps, synchronous & metachronous cancers. There seems a role for CT scans in selected patients.

POSITIVE RESECTION MARGINS – WHAT TO DO?**Francis Seow-Choen***Seow-Choen Colorectal Centre Pte Ltd, Mount Elizabeth Medical Centre, Singapore*

There are several situations where a positive resection margin may be present. Only potentially curative cases are considered. The first is during colonoscopy and polypectomy. The second is during a limited local resection. The third as part of a major laparotomy and resection. Nonetheless in all three situations, the surgeon should strive to obtain tumor free margins. However, if this was not obtained, the next step varies according to the situation. Following colonoscopy, a repeat scope should be undertaken and the area further treated by mucosal resection or repeat polypectomy if possible. Presuming that the cancer is in an early stage, CT scan of the liver and CEA to confirm the stage is needed. Transcolonic ultrasonography is of limited value. If a potentially curative local excision had been performed with a positive margin, then I would advise either repeat resection and radiochemotherapy if patient is willing. Full radical resection and possibly radiochemotherapy depending on the local tumour situation.

If the resection margin was not complete at a major resection, the patient's prognosis is then very bad. There is always a risk of recurrence with this sort of cases with repeat surgery. Completion surgery with added radiochemotherapy is the only way to go.

SYMPOSIUM 4

THE DILEMMA OF A MALIGNANT POLYP**Arun Rojanasakul***Division of Colorectal Surgery, Department of Surgery,
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A malignant polyp is a polyp in which cancer has invaded by direct continuity through the muscularis mucosa into the submucosa. The difficult problem occurs when the pathologist reports that the polypectomy specimen contains invasive cancer. The decision has to be made whether further surgery is beneficial or just close surveillance is enough.

At present, poor risk factors that favor surgical resection are depth of invasion by cancer to deeper submucosa (SM3), status of the resected margin (2 mm free margin), poorly differentiated adenocarcinoma (G3) especially at the invasive margin, and lymphatic invasion. In practice, the individual patient with a histologically unfavorable malignant polyp has either a 10% chance of cancer-specific treatment failure, after polypectomy only or a 3 – 5% risk of postoperative death. The dilemma as to which course of action, either therapeutic polypectomy alone or surgical resection can be best resolved by a team approach, taking the patient's condition and also their preference into account.

In future we need more reliable systems to accurately predict which patients require further operation – may be biomarkers.

HEPATIC METASTASES FROM COLORECTAL CANCER**Russell W Strong***Hospital Selayang, Selangor, Malaysia*

Over the past several decades, the widespread application of surgery for colorectal cancer that has metastasized to the liver has been largely due to the effectiveness and safety with which liver resection can be accomplished. But the management of liver metastases has become more complex, with multimodality treatment being frequently employed. In addition to resection, systemic chemotherapy, hepatic artery infusion chemotherapy, cryotherapy or radiofrequency ablation may be used, either alone or in combination. Despite the number of therapeutic options now available, resection of the liver remains the most effective therapy in selected patients and is potentially curative. Endeavours continue to better delineate patients who will benefit from resection and distinguish them from patients with disease that is likely to recur, even after curative resection. Clinical-risk scores for recurrence have been developed with the aim of identifying such patients. While there is no strong evidence that adjuvant chemotherapy improves survival after a curative resection, the use of neoadjuvant therapy may have a place in converting unresectable to resectable patients using an oxaliplatin based regimen and recent randomised trials may answer the question of whether this should be used routinely in all patients undergoing resection.

SYMPOSIUM 5

FIBRIN SEALANT FOR FISTULA IN-ANO – DOES IT WORK?**Azmi Md Nor***Faculty of Medicine, International Islamic University, Kuantan, Pahang, Malaysia*

Fistula in-ano is a common perianal problem. Majority of fistulae developed as a result of infection of the anal gland. Other diseases associated with fistula in-ano include Crohn's disease, tuberculosis, pilonidal sinus and hidradenitis suppurativa.

The incidence is more common in male. Fistula in-ano is classified as high or low fistula in relation to location of the internal opening from the anal verge. It is also classified according to the anatomical location of the fistula in relation to the anal sphincter.

Endoanal ultrasound and magnetic resonance imaging (MRI) have been used to delineate the type of fistula involved.

Low fistulae are relatively easy to manage and complications are rare. Fistulotomy, draining and cutting setons and advancement flaps have been used to treat this condition. However surgical treatments of high fistulae are associated with complications such as incontinence.

Fibrin sealant or fibrin glue has been used in other surgical fields such as cardiothoracic surgery and neurosurgery to control bleeding and CSF leaks.

The use of fibrin glue to treat fistula in-ano is a novel and ideal especially for high anal fistula.

ANAL STENOSIS – ENLARGING THE VIEW**Arun Rojanasakul***Division of Colorectal Surgery, Department of Surgery,
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Anal stenosis is an uncommon, but disabling condition. In literature the most common cause of anal stenosis is overselous hemorrhoidectomy. Numerous surgical techniques were described for the correction of anal stenosis, and may be classified in three groups-advancement flap, island flap and rotation flap. In Thailand, the two most common causes of severe anal stenosis are chemical injection for the treatment of hemorrhoid by non-medical personnel, and hemorrhoidectomy performed by unskillful surgeon. The surgical technique for correction of severe anal stenosis in King Chulalongkorn Memorial Hospital is unilateral or bilateral large island perianal cutaneous flap. During 1997 – 2002, we successfully repair anal stenosis by island flap in 11 patients. The technique is perceived as a complex procedure but in fact it is a straightforward procedure, easy to learn, practice and teach to young surgeons.

In our unit we never had anal stricture after hemorrhoidectomy because the liberally use of large Fansler's anal retractor. However we do have experience of correction of anal stricture after hemorrhoidectomy performed elsewhere. The prevention of anal stenosis is more desired. Surgeons had to learn the good techniques of hemorrhoidectomy. Another action to prevent anal stenosis in Thailand is to inform the correct approach to hemorrhoid diseases to the public.

MANAGEMENT OF ANAL FISSURE**Samuel Tay***Sunway Medical Centre, Petaling Jaya, Selangor, Malaysia*

Anal fissure is a tear of the squamous epithelium between anal verge and the dentate line. Various modalities of treatment are available for chronic fissures. Medical treatment includes i) conservative methods, ii) chemical sphincterotomy using nitric oxide donors and calcium channel blockers, and iii) neurotoxins. Surgical treatment includes i) internal anal sphincterotomy with its variations and ii) advancement flaps. Medical treatment has variable healing rates of fissure from 50 % to 90% without risk of incontinence. Tailored surgical sphincterotomy heal 90% to 100% of instances. Minor anal incontinence rates range from 0% to 40% in studies. Advancement flaps are advocated for fissures with low or normal anal resting pressures. The choice of treatment modality is dependent on i) availability of method, ii) treatment history of fissure, iii) patient variables.

STAPLED HAEMORRHOIDECTOMY – A DURABLE PROCEDURE**Francis Seow-Choen***Seow-Choen Colorectal Centre Pte Ltd, Mount Elizabeth Medical Centre, Singapore*

Stapled haemorrhoidectomy is fast becoming the procedure of choice for 3rd and 4th degree haemorrhoids across the world. The procedure has to be done well to be durable. A complete reduction of all prolapse before firing the gun is essential. Residual prolapse at the end of the surgery must be dealt with by muosectomy if good cure rates are to be achieved.

VIDEO SESSION 2

TOTAL MESORECTAL EXCISION**Francis Seow-Choen***Seow-Choen Colorectal Centre Pte Ltd, Mount Elizabeth Medical Centre, Singapore*

Total mesorectal excision is a much discussed but difficult technique to master. There are two pelvis planes which I will show in the video. The first plane follows the outside of the fascia propria of the rectum down to the levator ani and the junction of the coccyx and sacrum. The second follows the levator ani upwards towards the anorectal junction. Inability to appreciate this is the major cause of pelvic failure in rectal cancer surgery.

VIDEO SESSION 2

ILEO-ANAL POUCH**Francis Seow-Choen***Seow-Choen Colorectal Centre Pte Ltd, Mount Elizabeth Medical Centre, Singapore*

Ileo-anal Pouch had been said to be the hallmark of the true colorectal surgeon. In this video, I will show how by doing surgery one step at a time, the surgeon can do an ileoanal pouch via a small suprapubic incision.

MUTATIONAL ANALYSIS OF APC GENES IN MUTATION CLUSTER REGION (MCR) IN COLORECTAL CANCER

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Introduction

The adenomatous polyposis coli (APC) gene is the main tumor suppressor gene implicated in the development of CRC. Previous published data have shown that mutations of APC occurred in 80% of all CRCs. The vast majority of these mutations are insertions, deletions, and nonsense mutations that lead to frameshifts and/or premature stop codons in the resulting transcript. This results in a stable truncated APC protein without the carboxyl-terminus. A mutation cluster region exists within the 5' end of exon 15, between nucleotides 3000 and 4800 and represents approximately 60% of reported somatic mutations.

Methods

As the incidence rate of APC mutations in CRC's in Malaysia have yet to be determined, we examined 11 pairs of CRC tissues with apparently normal adjacent tissues for APC mutations in its mutation cluster region (MCR) from nt 3801 to nt 4576 [geneBankTM accession number: NM_000038]. Genomic DNA was isolated from CRC tissues, PCR performed followed by direct sequencing of PCR products.

Results

APC mutations were found in 4 out of 11 CRC tissues examined. Four out of 5 mutations were point mutation at nt 3999 (4 cases), 4043 (4 cases), 4069 (4 cases), 4047 (3 cases), 4065 (3 cases), and 4074 (3 cases). The point mutation that occurred at 4096 in the other 4 samples generated a stop codon UGA. No APC gene mutations were observed in the remaining 6 CRC tissues. The results from APC gene analysis at the mutation cluster region were in accordance with immunohistochemical staining which showed that truncated APC was present in 23 /47 (49.9%) of CRC tissues.

Conclusion

Inactivating mutations of APC may play a causative role in colorectal carcinogenesis in Malaysia and further analysis with larger sample size will be required to support this finding.

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STAPLED HAEMORRHOIDECTOMY IN MALAYSIAN PATIENTS – A PROSPECTIVE EVALUATION

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BACKGROUND

Stapled haemorrhoidectomy has been cited as a breakthrough procedure for the treatment of prolapsed piles especially pertaining to its potential in resulting in less postoperative pain in comparison to excisional haemorrhoidectomy. There has been no prior formal assessment of stapled haemorrhoidectomy in Malaysia and we decided to prospectively evaluate its short and medium-term outcome to confirm the benefits and safe application of this procedure.

METHODS

Forty-seven consecutive patients with circumferential piles underwent stapled haemorrhoidectomy under general or spinal anaesthesia. Criteria for selecting patients for the procedure included absence of skin tags or significant external haemorrhoidal components that circumvented reduction of the pile mass to enable effective stapling to be performed. All the patients received standardized postoperative analgesia and laxative regimens. A linear analogue pain chart (scores: low 0 – 3, moderate 4 – 6, severe > 6) was used to assess postoperative pain scores. Assessment of pain and other symptomatology was continued immediately following discharge using telephone interviews and thereafter outpatient review in the colorectal clinic up to 8 months following surgery.

RESULTS

Of the 47 patients (age range 25 – 70 years), 36 (77%) had third degree haemorrhoids while 11 (23%) had fourth degree haemorrhoids. Postoperative pain score was graded as low by 37 (79%), moderate by 7 (15%) and severe by 3 (6%) patients respectively. Majority of the patients (72%) were discharged one day following surgery while 15% were discharged on the second postoperative day. Immediate postoperative complications recorded included urinary retention (8.5%), bleeding not requiring surgical intervention (4.2%) and severe pain (4.2%). All but one of the complications recorded occurred during performance of the first 20 cases. At a median follow-up period of 6 months, 1 patient (2.1%) developed a low fistula-in-ano while another patient had suboptimal results that required excisional haemorrhoidectomy.

CONCLUSIONS

In our experience, stapled haemorrhoidectomy is a procedure associated with low or tolerable pain and minimal morbidity with acceptable short and medium term results. Patient selection and surgical experience are important factors that help avoid significant complications including the necessity for repeat surgical intervention.

INTRAOPERATIVE SENTINEL LYMPH NODE MAPPING IN COLORECTAL CARCINOMA

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Background

The sentinel lymph node (SLN), is the first potential node to contain metastases and accurately predicts nodal status. The conventional method of LN examination in colorectal cancer (CRC) resection specimens may not be adequate. Almost one third "node-negative" patients develop systemic disease. The aim of this study was to assess the feasibility of lymphatic mapping (LM) and SLN biopsy in CRC.

Methods

Intra-operatively, injection of at least 1 ml of Lymphazurin 1% around the tumour was attempted. The first four blue LNs identified were considered the SLNs. A standard oncological resection of the bowel was performed. If in vivo LM failed to identify SLN, then ex vivo LM was employed. Multilevel sectioning and immunohistochemical staining of the SLNs were performed. The rest of the specimens were examined via the conventional method.

Results

One or more SLNs were found in 88 percent of patient (23/26). In vivo LM alone has a success rate of 29 percent (5/17). However, ex vivo LM can increase the rate by 95 percent (18/19). Seven patients had lymph node metastases. In six patients, the SLNs correctly represented the nodal status (sensitivity of 86%). In one patient, the SLN was tumor-free whereas non-SLN harboured metastases (false negative rate of 14%). Isolated tumour cells were detected exclusively by immunohistochemistry in 6 patients (25%). SLN mapping accurately predicted the lymphatic basin by 95% and the negative predictive value is 93%.

Conclusion

SLN biopsy is feasible provided that ex vivo LM is utilized in addition to in vivo technique, as this will significantly improve the identification rate of SLN. A focused pathologic examination of the SLN may upstage 25% of the 'node negative' patients. Further studies are necessary to elucidate the clinical relevance of these micrometastases.

SURVEILLANCE COLONOSCOPY FOR COLORECTAL POLYPS

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Aim

To compare the recurrence rate detected during the first colonoscopic surveillance after polypectomy for each histological types of adenomas and to identify the suitable interval between polypectomy and the interval of colonoscopic surveillance.

Method

A total of 182 individuals participating in our surveillance programme during 1998 – 2002 were retrospectively evaluated. All patients who had neoplastic polyps during colonoscopy in surgical endoscopy unit of Hospital University Kebangsaan Malaysia were included.

Results

A total of 182 patients were involved in this study and the majority of patients were males 57.1% (104 patients). The most frequent age group in males being in sixties and in females being in the fifties. The incidence of polyps is highest in Chinese 54.9% (100 patients). Recurrence is highest in villous adenomas 90.9% (10 patients) and in cases of multiple polyps, 59.3% (16 patients), and both of them is statistically significant (p value = <0.0005). The mean age of detection of the recurrence is 66.38 year-old and for the non recurrent, the mean age is 58.31 year-old, which is about 8.07 years different, and the difference is significant statistically. The earliest period for recurrence in tubular, tubulovillous, and villous adenoma is 1288 days, 1209 days, and 619 days respectively, which suggests surveillance for neoplastic polyps is 928 days for villous, 1909 days for tubulovillous, and no specific time for tubular adenoma as the number of recurrent cases is very small and the interval is very long.

Conclusion

In the follow up during the 2 years, we observed a clear relationship between the degree of the villous content adenomas, and numbers of the adenomatous polyps during the first colonoscopy and the recurrence of the polyps. This clearly demonstrates the necessity for colonoscopic surveillance especially for villous adenoma, which is 2.54 years, as we observed 5 cases of carcinoma in-situ diagnosed in recurrent cases for villous adenoma.

ACUTE HEMORRHAGIC RECTAL ULCERS: THE RECTUM'S VERSION OF STRESS ULCERS?

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Introduction

Acute hemorrhagic rectal ulcers have no known "Western" counterpart in current literature. It occurs suddenly, painlessly and massively in very ill or debilitated patients. Published reports of acute hemorrhagic rectal ulcer with life threatening bleed are scant.. The exact pathophysiology is not known. Here, we report a series of ten cases.

Methods

Between Jan 2002 until January 2005, ten patients in our hospital were diagnosed with per rectal bleeding characteristic of acute hemorrhagic rectal ulcers. The diagnosis of acute rectal ulcer were made mainly on clinical grounds supported by examination under anesthesia. Case records were analyzed retrospectively.

Results

Of the ten patients 4 were males with a mean age of 55 years (range 43 to 70 years) and 6 females with a mean age of 57.6 years (range 41 to 70 years). Seven of our patients required admission to the Intensive Care Unit for problems related to their initial presenting illnesses, requiring both mechanical ventilation and inotropic support. Five patients had documented sepsis at some point during their hospital stay. Seven patients had significant preexisting medical illnesses. Four patients were admitted due to trauma and the rest were due to medical causes. Mean onset of bleeding was 14.9 days (range; 2 to 30 days) from admission with a mean of 2.5 episodes of bleeding (range; 1 to 4). A mean of 2.3 surgical interventions were performed (range; 1 to 4). The position of the ulcers were consistently at or not exceeding 1 centimeter from the dentate line. Seven out ten patients died in hospital, two died due to exsanguinations, while the rest succumbed due to their original illnesses. Biopsies were taken in 6 patients with identical histopathologic features.

Suggestions

Acute hemorrhagic rectal ulcers are a specific entity afflicting mainly severely ill patients with multiple medical or surgical problems. An increased awareness of this condition as a specific entity is in order to ensure unnecessary death through exsanguinations.

MANAGEMENT OF HIRSCHSPRUNG'S DISEASE WITH REFERENCE TO ONE-STAGE PULL-THROUGH WITHOUT COLOSTOMY

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Background and purpose

We evaluated the safety and benefits of one-stage pull-through in comparison with staged repair of Hirschsprung's disease in our institution over a 14-year period under circumstances prevailing in a developing country.

Patients and methods

Eighty-five patients were treated for Hirschsprung's disease during a 14-year period between January 1991 and June 2004 at our institution, which is a tertiary referral center. Fourteen patients were excluded from the study, and the medical records of the remaining 71 patients were reviewed.

Results

Thirty-nine patients including 12 neonates underwent one-stage pull-through, and 32 patients underwent staged correction. There was no mortality for patients undergoing one-stage treatment, but there was 1 death caused by anastomotic leak after 2 stage repair. There was no substantial difference in the incidence of complications (29.7% v 42.9 %) and the need for additional surgical procedures (24.3% v 47.6%) between the 2 groups. 83.8% after one-stage treatment and 80.9% after staged treatment had a satisfactory functional result, and the incidence of incontinence was 8.1% and 9.5% respectively. Overall, the incidence of postoperative enterocolitis was low (8.3%).

Conclusion

One-stage correction of Hirschsprung's disease is a safe procedure in all age groups. It offers economical and social advantages to families in developing countries. Benefits of one-stage treatment include avoidance of multiple operations, elimination of complications associated with a colostomy, shorter duration of hospital stay, and completion of treatment at an earlier age. It is advisable to continue postoperative anal dilatation for a minimum period of 6 months to 1 year to reduce the incidence of enterocolitis.