

SOUVENIR PROGRAMME & ABSTRACT BOOK



MALAYSIAN SOCIETY OF COLORECTAL SURGEONS



THE ASIAN SOCIETY OF STOMA REHABILITATION

6th MALAYSIAN COLORECTAL CONFERENCE & 5th CONGRESS OF THE ASIAN SOCIETY OF STOMA REHABILITATION

THEME Topical Issues in Stoma Rehabilitation

DATE 7th & 8th March 2008

VENUE Shangri-La Hotel
Kuala Lumpur, Malaysia



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ORGANISING COMMITTEE

6th Malaysian Colorectal Conference

CHAIRMAN	Dr Mohamed Akhtar Qureshi	
SCIENTIFIC CHAIRMEN	Dr Paul Selvindoss	
	Prof Yunus Gul	
BUSINESS AND TRADE	Dr Retna Rasa	
	Dr Meheshinder Singh	
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COMMITTEE MEMBERS	Dr Jasiah Zakaria	Dr M Sarkunnathas
	Dr Wan Khamizar	Dr Foo Chang Lim
	Assoc Prof Azmi Md Nor	

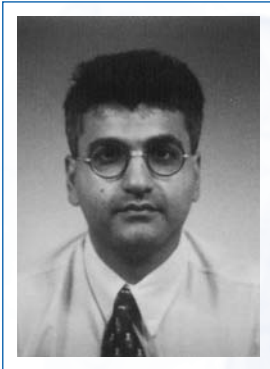
5th Congress of The Asian Society of Stoma Rehabilitation

CHAIRMAN	Prof Yunus Gul	
DEPUTY CHAIRMAN	Ms Ravathy Ramamurthy	
COMMITTEE MEMBERS	Dr Meheshinder Singh	Dr Mohd Faisal Jabar
	Dr Tikfu Gee	Ms Ng Yeng Lai

SPEAKERS

AUSTRALIA	INDONESIA	PHILIPPINES	THAILAND
Julia M Thompson	Dieta Parengkuan	Robert Chang	Pariya Taveechaigam
Keryln Carville	Widasari Sri Gitarja		Uchalee Boontanonda
CANADA	IRELAND	SINGAPORE	UNITED KINGDOM
Louise Forest Lalande	Ronan O'Connell	Azizah Mohd Yunus	Graeme Duthie
CHINA	ITALY	Charles Tsang	Peter Lee
Yang Li-Fang	Carlo Pezcoller	Ong Choo Eng	Nigel R Suggett
INDIA	KOREA	Tan Yew Oo	VIETNAM
Buch Harikesh	Kim Kwan-Ho	SRI LANKA	Hau Van Nguyen
Neeta Sabharwal	Lee Hae-Ok	Kemal Deen	Long Vo Tan
Nishi Chakroborty			
Roy Patankar			
MALAYSIA			
Ahmad Kamal Mohamed	Meheshinder Singh	Paul Selvindoss	Samuel Tay
Mrs Chong Hon Fui	Mohd Akhtar Qureshi	Sanjiv Mahadeva	Wan Khamizar
Looi Lai Meng	Ng Yeng Lai	M Sarkunnathas	Mdm Yew Yock Kee
Matin Mellor	Paat Siu Lin	Tai Seow Beng	Yunus Gul

MESSAGE



The Organising Committee of the 6th Malaysian Colorectal Conference would like to extend a warm welcome to all delegates, speakers, and sponsors. This Conference, in conjunction with the 5th Congress of The Asian Society of Stoma Rehabilitation, has been drawn up to keep the participants updated in the current trends in Colorectal Surgery. The programme has been fine-tuned to meet the expectations of trainees in postgraduate programmes, the General Surgeon as well as the Specialist Colorectal Surgeon.

The Organising Committee has put together an attractive scientific programme which includes plenary sessions, symposia, video sessions, case discussions as well as a pre-congress workshop on live colorectal surgery. The entire meeting has been focussed on bringing you the very latest in the field of colorectal surgery. The Conference should be of interest to healthcare professionals, postgraduate students, general surgeons as well as consultant colorectal surgeons who want an update. We have an impressive list of world renowned speakers invited for the Conference, with a focus on practical points to take home.

Over the years, this meeting has enabled many to meet up with old friends and colleagues as well as spending time with the family. The social programme provides an interesting variety for both the delegates as well as the accompanying persons.

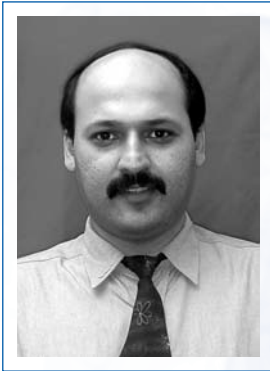
Finally, we would like to thank all the invited speakers, delegates and sponsors for their commitment and time to ensure a successful meeting for all. I would hope that you will find this Conference rewarding both academically as well as socially. I hope that you will have an enjoyable stay.



Dr Mohamed Akhtar Qureshi

*President, Malaysian Society of Colorectal Surgeons &
Chairman, Organising Committee, 6th Malaysian Colorectal Conference*

MESSAGE

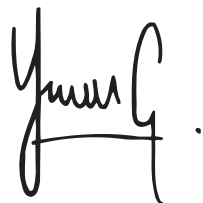


I welcome all of you to the 5th Congress of The Asian Society of Stoma Rehabilitation (ASSR). In line with this year's theme of 'Topical Issues in Stoma Rehabilitation', we have organized an informative and exciting programme with renowned international and local speakers where we hope to provide a forum for discussion on current practices in stoma rehabilitation as well as recommended management of complex wounds. Innovations in stoma appliances and recommended rehabilitative measures in stoma therapy will form the core of the subject matter in the workshop which will be helpful for all grades of ET nurses. The compact but rich programme over the two days will certainly help enrich our knowledge in stoma rehabilitation and complex wound management.

I sincerely hope that this Congress will continue to be a platform for us to help foster closer ties between the multi-national participants, which will hopefully help improve stoma and wound care in Asia. I would like to thank the speakers, members of the Organising Committee, sponsors and all the participants for their role in helping to bring this year's meeting to fruition.

Apart from the main scientific event, lively social programmes have been prepared to help make your stay a pleasant and memorable one. Please feel free to contact any member of the Organising Committee to help you overcome any inconveniences should you encounter any difficulty during your stay in Kuala Lumpur.

Enjoy the meeting and "Selamat Datang".

A handwritten signature in black ink, appearing to read 'Yunus Gul'.

Professor Yunus Gul

*Chairman, Organising Committee
5th Congress of The Asian Society of Stoma Rehabilitation*

PROGRAMME SUMMARY

DATE TIME	7 TH MARCH 2008 FRIDAY		8 TH MARCH 2008 SATURDAY	
SOCIETY	6 TH MCC	5 TH ASSR	6 TH MCC	5 TH ASSR
0800 – 0830	SYMPOSIUM 1	SYMPOSIUM 2	SYMPOSIUM 6	SYMPOSIUM 7
0830 – 0900				
0900 – 0930				
0930 – 1000	OPENING CEREMONY / REFRESHMENTS		PLENARY LECTURE 2	PLENARY LECTURE 3
1000 – 1030			TEA	
1030 – 1100	KEYNOTE ADDRESS		SYMPOSIUM 8	SYMPOSIUM 9
1100 – 1130	SYMPOSIUM 3	SYMPOSIUM 4		
1130 – 1200				
1200 – 1230	LUNCH SYMPOSIUM <i>[Nycomed GmbH]</i>		LUNCH SYMPOSIUM <i>[Alcare Co Ltd]</i>	
1230 – 1300				
1300 – 1330				
1330 – 1400				
1400 – 1430	PLENARY LECTURE 1		SYMPOSIUM 10	FREE PAPERS
1430 – 1500	PROFESSORS' CORNER	SYMPOSIUM 5		
1500 – 1530				
1530 – 1600	TEA SYMPOSIUM <i>[Pfizer]</i> TEA		TEA SYMPOSIUM <i>[Merck Serono]</i> TEA	STOMA WORKSHOP
1600 – 1630				
1630 – 1700				
1700 – 1730	HOW I DO IT (1)	ASSR EXECUTIVE COUNCIL MEETING	HOW I DO IT (2)	
1730 – 1800	MSCRS ANNUAL GENERAL MEETING			
1800 – 1830				
1830 – 1900				
1930 – 2230	ANNUAL DINNER			

6TH MARCH 2008
THURSDAY

PRE-CONGRESS WORKSHOP ON OPEN SURGERY

PRE - CONGRESS WORKSHOP

6TH MARCH 2008 [THURSDAY]

PRE-CONGRESS WORKSHOP ON OPEN SURGERY [*Johnson & Johnson*]

Stargate, UKM

0800 – 0830	REGISTRATION
0830 – 0840	Welcome by Assoc Prof Zulkiflee b Md Zainudin <i>Head of Department of Surgery, Universiti Kebangsaan Malaysia</i>
0840 – 0900	Brief Synopsis by Faculty
0900 – 1230	Live Surgery
1230 – 1430	LUNCH
1430	Q & A with the Faculty Faculty: • Graeme Duthie • Hau Van Nguyen • Charles Tsang • Roy Patankar • Pariya Taveechaigam

DAILY PROGRAMME

7TH MARCH 2008 [FRIDAY]

	6 th Malaysian Colorectal Conference	5 th Congress of The Asian Society of Stoma Rehabilitation
	Sabah Room, Basement II	Selangor Room, Basement II
0800 – 0930	SYMPOSIUM 1 Anal Neoplasms Chairpersons: Lu Ping Yan / R Ragupathy Naidu <ul style="list-style-type: none"> • Pathology of anal tumours [<i>page 15</i>] Looi Lai Meng (Malaysia) • Management of T1 anal squamous carcinoma Graeme Duthie (United Kingdom) • Management of anal melanoma [<i>page 16</i>] Nigel R Suggett (United Kingdom) • Chemoradiation in anal cancers Ahmad Kamal Mohamed (Malaysia) 	SYMPOSIUM 2 Quality of Life Chairpersons: Mohamad Ismail Ali / Ravathy Ramamurthy <ul style="list-style-type: none"> • An ideal QOL scoring system for ostomates [<i>page 17</i>] Paat Siu Lin (Malaysia) • Factors affecting QOL assessment in Asian patients [<i>page 18</i>] Lee Hae-Ok (Korea) • Are we doing enough in assessing the quality of life? [<i>page 19</i>] Nishi Chakroborty (India)
0930 – 1030	OPENING CEREMONY / REFRESHMENTS	
1030 – 1115	KEYNOTE ADDRESS Chairperson: Yunus Gul A Western perspective on stoma rehabilitation [<i>page 20</i>] Ronan O'Connell (Ireland)	

DAILY PROGRAMME [CONTINUED]

7TH MARCH 2008 [FRIDAY]

	6 th Malaysian Colorectal Conference	5 th Congress of The Asian Society of Stoma Rehabilitation
1115 – 1230	<p style="text-align: right;">Sabah Room, Basement II</p> <p>SYMPOSIUM 3 Management of Anorectal Diseases I Chairpersons: Gerald Henry / Peter Lee</p> <ul style="list-style-type: none"> • Obstructed defaecation Kemal Deen (Sri Lanka) • Faecal incontinence [page 21] Ronan O'Connell (Ireland) • Rectal prolapse and pelvic floor disorders Graeme Duthie (United Kingdom) 	<p>SYMPOSIUM 4 Function of Stoma Support Groups – What is the Ideal Model? Chairpersons: Lim Teik Mau / Zainuddin Mohd Tahir</p> <ul style="list-style-type: none"> • Function of Stoma Support Groups – What is the Ideal Model? [page 22-23] Carlo Pezcoller (Italy) • Ng Yeng Lai (Malaysia) • Function of stoma support groups – What is the ideal (Indonesian) model? [page 24-25] Widasari Sri Gitarja (Indonesia) • Ong Choo Eng (Singapore)
1230 – 1400	Sarawak Room, Basement II	
	<p>LUNCH SYMPOSIUM [Nycomed GmbH] Chairperson: Ong Kee Thiam Publishing in an electronic era Ronan O'Connell (Ireland)</p>	
1400 – 1445	Sabah Room, Basement II	
	<p>PLENARY LECTURE 1 Chairperson: Azmi Md Nor Management of complex wounds Kemal Deen (Sri Lanka)</p>	
1445 – 1545	Sabah Room, Basement II	Selangor Room, Basement II
	<p>PROFESSORS' CORNER Chairperson: Samuel Tay Panelists:</p> <ul style="list-style-type: none"> • Graeme Duthie (United Kingdom) • Kemal Deen (Sri Lanka) • Nigel R Suggett (United Kingdom) • Ronan O'Connell (Ireland) 	<p>SYMPOSIUM 5 Case Discussion – Management of Complex Wounds Chairpersons: Jasiah Zakaria / Ng Yeng Lai</p> <ul style="list-style-type: none"> • Keryln Carville (Australia) • Participants from Malaysia
1545 – 1615	Sabah Room, Basement II	
	<p>TEA SYMPOSIUM [Pfizer] New frontiers in the treatment of GIST and advanced colorectal cancer Tan Yew Oo (Singapore)</p>	
1615 – 1645	TEA	

DAILY PROGRAMME [CONTINUED]

7TH MARCH 2008 [FRIDAY]

	6 th Malaysian Colorectal Conference	5 th Congress of The Asian Society of Stoma Rehabilitation
1645 – 1745	<p style="text-align: right;">Sabah Room, Basement II</p> <p>HOW I DO IT (1) Video Session Chairpersons: Meheshinder Singh / Sebastian Tong</p> <ul style="list-style-type: none"> • Anal sphincter repair <i>[page 26]</i> Ronan O'Connell (Ireland) • Sacral Nerve Neuromodulation Graeme Duthie (United Kingdom) • Advancement flap for fistula-in-ano Kemal Deen (Sri Lanka) • Gracilis neo-sphincter Graeme Duthie (United Kingdom) 	<p style="text-align: right;">Selangor Room, Basement II</p> <p>ASSR EXECUTIVE COUNCIL MEETING</p>
1745 – 1845	<p style="text-align: right;">Pahang Room, Lower Lobby</p> <p>MSCRS ANNUAL GENERAL MEETING</p>	
1930 – 2230	<p>ANNUAL DINNER</p> <p style="text-align: right;">Sabah Room, Basement II</p>	

DAILY PROGRAMME

8TH MARCH 2008 [SATURDAY]

	6 th Malaysian Colorectal Conference	5 th Congress of The Asian Society of Stoma Rehabilitation
0800 – 0915	<p style="text-align: right;">Sabah Room, Basement II</p> <p>SYMPOSIUM 6 Management of Anorectal Diseases II Chairpersons: Foo Chang Lim / Yan Yang Wai</p> <ul style="list-style-type: none"> Fistula in ano revisited Graeme Duthie (United Kingdom) Management of rectovaginal fistula [page 27] Ronan O'Connell (Ireland) Optimal surgery for haemorrhoids in 2008 Samuel Tay (Malaysia) Local experience of anal sphincter repair [page 28] Mohd Akhtar Qureshi (Malaysia) 	<p style="text-align: right;">Selangor Room, Basement II</p> <p>SYMPOSIUM 7 Patient and Care Giver Sharing Chairpersons: April Roslani / Tai Seow Beng</p> <ul style="list-style-type: none"> Carer and child sharing Mdm Yew Yock Kee (Malaysia) Carer and adult sharing Mrs Chong Hon Fui (Malaysia)
0915 – 1000	<p style="text-align: right;">Sabah Room, Basement II</p> <p>PLENARY LECTURE 2 Chairperson: Mohd Akhtar Qureshi Chronic constipation – Are we there yet? [page 29] Graeme Duthie (United Kingdom)</p>	<p style="text-align: right;">Selangor Room, Basement II</p> <p>PLENARY LECTURE 3 Chairperson: Phang Fook Yoong Ostomy care – Patient or industry driven? [page 30] Keryln Carville (Australia)</p>
1000 – 1030	TEA	
1030 – 1200	<p style="text-align: right;">Sabah Room, Basement II</p> <p>SYMPOSIUM 8 Laparoscopic Colectomy Chairpersons: Ismail Sagap / Wan Khamizar</p> <ul style="list-style-type: none"> Laparoscopic colorectal surgery – Toys for boys? [page 31] Peter Lee (United Kingdom) Complications of laparoscopic colorectal surgery [page 32] Yunus Gul (Malaysia) Laparoscopic rectal mobilization Kemal Deen (Sri Lanka) Laparoscopic right hemicolectomy Paul Selvindoss (Malaysia) 	<p style="text-align: right;">Selangor Room, Basement II</p> <p>SYMPOSIUM 9 Ostomy Care Chairpersons: Colin Ng / Ang Swee Ling</p> <ul style="list-style-type: none"> Management of stoma related problems [page 33] Meheshinder Singh (Malaysia) Ostomy and a healthy sexual relationship – Can both co-exist? [page 34] Neeta Sabharwal (India) Has there been an improvement in stoma appliances? [page 35] Tai Seow Beng (Malaysia)
1200 – 1400	<p style="text-align: right;">Sarawak Room, Basement II</p> <p>LUNCH SYMPOSIUM [Alcare Co Ltd] Chairperson: Katsuhisa Shindo Ostomate education in Indonesia [page 36]</p> <ul style="list-style-type: none"> Unchalee Boontanonda (Thailand) Kim Kwan-Ho (Korea) Yang Li-Fang (China) Paat Siu Lin (Malaysia) Long Vo Tan (Vietnam) Buch Harikesh (India) Dieta Parendkuan (Indonesia) 	

DAILY PROGRAMME [CONTINUED]

8TH MARCH 2008 [SATURDAY]

	6 th Malaysian Colorectal Conference	5 th Congress of The Asian Society of Stoma Rehabilitation
1400 – 1530	<p style="text-align: right;">Sabah Room, Basement II</p> <p>SYMPOSIUM 10 Colorectal Pot-Pouri Chairpersons: P Manohar / Jasiah Zakaria</p> <ul style="list-style-type: none"> • Deep vein thrombosis (venous thromboembolism) [page 37] Nigel R Suggett (United Kingdom) • Anastomotic leaks [page 38] Robert Chang (Philippines) • Management of colorectal trauma in the modern era [page 39] Nigel R Suggett (United Kingdom) • Management of perianal Crohn's Disease [page 40] Ronan O'Connell (Ireland) 	<p style="text-align: right;">Selangor Room, Basement II</p> <p>1400 – 1500 FREE PAPERS [page 44-52] Chairperson: Tikfu Gee</p>
1530 – 1600	<p style="text-align: right;">Sabah Room, Basement II</p> <p>TEA SYMPOSIUM [Merck Serono] Chairperson: Dato' Dr Ibrahim Wahid Role of Erbitux in metastatic colorectal cancer and liver metastatic disease Matin Mellor (Malaysia)</p>	<p style="text-align: right;">Selangor Room, Basement II</p> <p>1500 – 1700 STOMA WORKSHOP Chairperson: Katsuhisa Shindo / Ravathy Ramamurthy</p> <ul style="list-style-type: none"> • Psychological aspects in ostomy care [page 41] Julia M Thompson (Australia) • Stoma rehabilitation: Is it a role for nurses or doctors? [page 42] Wan Khamizar (Malaysia) • Managing difficult stoma [page 43] Tai Seow Beng (Malaysia) • Stoma care in children – Dealing with the patient and their carers Louise Forest Lalande (Canada) • Revolution ahead – Moulding the future Azizah Mohd Yunus (Singapore)
1600 – 1630	<p>TEA</p>	
1630 – 1730	<p style="text-align: right;">Sabah Room, Basement II</p> <p>HOW I DO IT (2) Video Session Chairpersons: N Sukumar / Retna Rasa</p> <ul style="list-style-type: none"> • Intersphincteric resection of low rectal cancer Robert Chang (Philippines) • Rectopexy Kemal Deen (Sri Lanka) • Perineal procedures for rectal prolapse Graeme Duthie (United Kingdom) • PPH in the jack knife position M Sarkunnathas (Malaysia) • EMR for colonic polyps Sanjiv Mahadeva (Malaysia) • Transanal rectocle repair: UMC technique (technique note) Hau Van Nguyen (Vietnam) 	

CONFERENCE INFORMATION

CONFERENCE VENUE

Shangri-La Hotel

11 Jalan Sultan Ismail, 50250 Kuala Lumpur, Malaysia

TELEPHONE (603) 2032 2388

FACSIMILE (603) 2070 8616

EMAIL wendy.soo@shangri-la.com

WEBSITE www.shangri-la.com

REGISTRATION

The operating times are:

6th March 2008, Thursday 1500 to 1800 hrs

7th March 2008, Friday 0730 to 1730 hrs

IDENTITY BADGES

Delegates are kindly requested to wear identity badges during all sessions and functions.

ENTITLEMENTS

Registered delegates will be entitled to the following:

- Admission to the scientific sessions, satellite symposia and trade exhibition
- Conference bag and materials
- Annual Dinner
- Lunches & Coffee/Tea

ANNUAL DINNER (7TH MARCH 2008)

The Annual Dinner will be held on 7th March 2008 at the Sabah Room, Shangri-La Hotel, Kuala Lumpur. This promises to be a night of great fun with good entertainment lined up and lots of lucky prizes to be won.

Please confirm your attendance at the registration counter.

Delegates can bring their families and guests at RM 100 per adult and RM 50 per child (between 6 and 12 years old). Trade personnel are welcomed to join the function at RM 100 per person.

Dress: Smart Casual

SPEAKERS AND PRESENTERS

All speakers and presenters are requested to check into the Speaker Ready Room at least two hours prior to their presentation. There will be helpers on duty to assist with your requirements regarding your presentation. The Speaker Ready Room is located at the Sabah Anteroom, Basement II, Shangri-La Hotel and will be open:

6th March 2008, Thursday 1600 to 1800 hrs

7th March 2008, Friday 0730 to 1700 hrs

8th March 2008, Saturday 0730 to 1500 hrs

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

CONFERENCE INFORMATION [CONTINUED]

POSTERS

Posters will be displayed at Basement II. The Organizing Committee bears no responsibility for the safekeeping of posters. Any posters not collected by the close of the poster session will be discarded.

PHOTOGRAPHY & VIDEOTAPING POLICIES

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

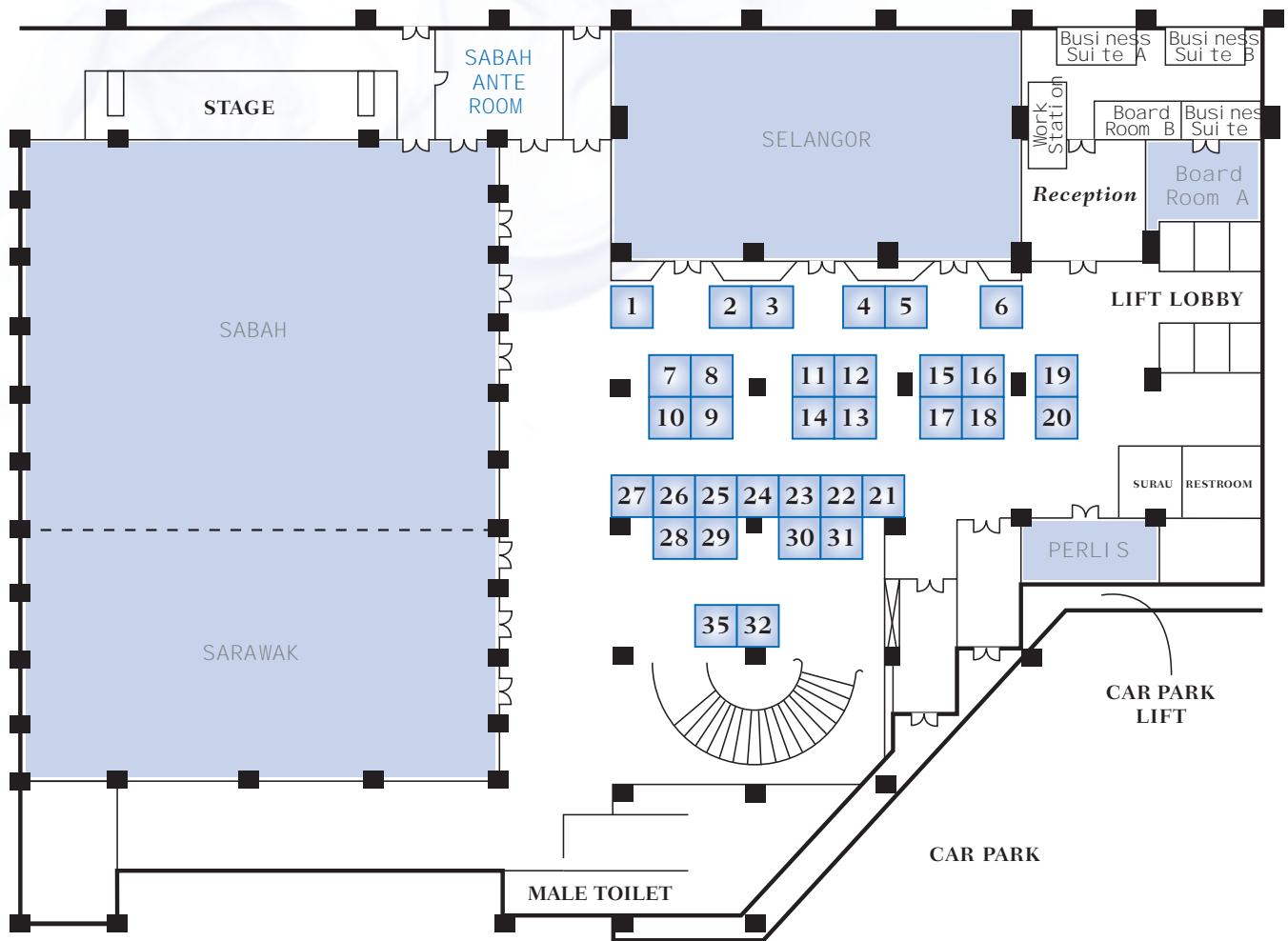
MOBILE PHONES

For the convenience of all delegates, please ensure that your mobile phone is silenced during the conference sessions.

DISCLAIMER

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

FUNCTION ROOMS & TRADE EXHIBITION



BOOTH STAND	COMPANY
1	Laptech Medical Sdn Bhd
2	Nycomed
3	Endodynamics (M) Sdn Bhd
4, 5	Convatec
6	United Malaysian Medical Industries Sdn Bhd
7, 8, 9, 10	Malaysian Healthcare Sdn Bhd
11, 12	Coloplast
13, 14	Pfizer (Malaysia) Sdn Bhd
15	Insan Bakti Sdn Bhd
16	Genzyme Malaysia Sdn Bhd
17	Merck Serono
18	Avro Medical Sdn Bhd
19	Hollister

BOOTH STAND	COMPANY
20	HNS Medical Supply (M) Sdn Bhd
21	Fuji Film (Malaysia) Sdn Bhd
22	MKS Medic Sdn Bhd
23	Yakult (M) Sdn Bhd
24, 25	Sanofi-Aventis/Aventis Farma SA (Malaysia) Sdn Bhd
26, 27	Johnson & Johnson Sdn Bhd
28, 29	Tyco Healthcare Medical Supplies Sdn Bhd
30	B Braun Medical Industries
31	Smith & Nephew Healthcare Sdn Bhd
32	BH Enterprise Sdn Bhd
35	KS Tekno-Med Sdn Bhd

ACKNOWLEDGEMENTS

The Organising Committee of the 6th Malaysian Colorectal Conference & 5th Congress of The Asian Society of Stoma Rehabilitation wish to thank the following for their support and contributions:

MAJOR SPONSORS

Johnson & Johnson Sdn Bhd

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MKS Medic Sdn Bhd

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Pfizer (Malaysia) Sdn Bhd

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Smith & Nephew Healthcare Sdn Bhd

United Malaysian Medical Industries Sdn Bhd

Yakult (M) Sdn Bhd

SYMPOSIUM 1 ❖ Anal Neoplasms

PATHOLOGY OF ANAL TUMOURS

Looi Lai Meng

Department of Pathology, University of Malaya, Kuala Lumpur, Malaysia

When considering the pathology of anal tumours, a fundamental distinction should be made between the skin-like anal margin and the mucosa-lined anal canal. Despite its short length, the anal canal produces a large variety of tumour types due to its complex anatomical and histological structure. This includes squamous, glandular, transitional, and melanocytic tumours, occurring alone or in combination. Although anal canal cancers account for only about 1.5%-4% of digestive tract malignancies, there has been considerable interest in its changing pattern and molecular pathology. Anal squamous cell carcinoma (SCC) typically occurs in the 6th or 7th decade of life with an approximate 2:1 female predominance, but may occur in young adults in the setting of cellular immune incompetence. While haemorrhoids, fissures, fistulae and Crohn's disease were long considered predisposing factors, there is no strong evidence for this. Of interest is the significant increase in anal SCC over the last 50 years and studies supporting a pivotal role of HPV in its pathogenesis. HPV-DNA can be demonstrated in most anal SCC, with higher proportions among women and HIV-infected homosexual men than non-homosexual men. Transplant recipients also have an increased risk. Preinvasive anal intraepithelial neoplasia (AIN) is known to occur concurrently with cervical intraepithelial neoplasia (CIN), vaginal intraepithelial neoplasia (VAIN) and vulval intraepithelial neoplasia (VIN) in multicentric anogenital intraepithelial neoplasia (MIN), a condition that is strongly linked to HPV 16 & 18, with cigarette smoking and benzpyrene as co-factors. Because anogenital epithelia have a common origin from the embryonic cloaca, it is not surprising that they share histogenetic susceptibility to similar aetiological agents. The combination of increased cell proliferation (pRb inactivation) and impaired ability to induce cell cycle arrest or apoptosis following DNA damage (p53 inactivation) are two central mechanisms through which 'high risk' HPV increase the risk of anogenital cancer. The most important prognostic factors in anal canal SCC are tumour stage and nodal status. DNA ploidy status appears to have independent prognostic significance.

Most adenocarcinomas found in the anal canal represent downward spread from rectum adenocarcinoma or arise in colorectal type mucosa above the dentate line. Pagetoid extension of the tumour may pose a diagnostic problem. Most other anal tumours such as basal cell carcinoma, melanoma, skin adnexae tumours and neuroendocrine tumours are essentially regarded as skin cancers.

SYMPOSIUM 1 ❖ Anal Neoplasms

MANAGEMENT OF ANAL MELANOMA

Nigel R Suggett

University Hospital Birmingham, Birmingham, United Kingdom

Anal melanomas account for approximately 4% of anal tumours and 0.3% of melanomas but are the most common site for a primary gastro-intestinal tract melanoma. They frequently present late and are often misdiagnosed as benign disease such as haemorrhoids. Prognosis is very poor with 5 year survivals reported between 0 and 22% although reports of long term survivors exist. Treatment options include wide local excision (WLE) and abdominoperineal excision of the rectum (APER), with or without inguinal lymph node dissection, chemotherapy, radiotherapy and immunotherapy. If possible, surgery seems to carry the best outcome however, since there appears to be no survival advantage to APR and it is associated with increased morbidity and mortality, WLE is considered to be the procedure of choice where negative margins are achievable.

SYMPOSIUM 2 ❖ Quality of Life

AN IDEAL QOL SCORING SYSTEM FOR OSTOMATES

Paat Siu Lin

*Stoma Care Department, University of Medicine and Pharmacy, Hospital Umum Sarawak,
Kuching, Sarawak, Malaysia*

INTRODUCTION

Patients with colorectal cancer have a special need to be provided with appropriate information regarding their disease, surgical intervention which may result in the formation of either a temporary or permanent stoma, because they will be embarked on a journey with physical and functional impairment.

In Malaysia, colorectal cancer patients are referred to the surgeon at the bigger hospitals where ostomy surgeries are performed. Diagnosis is confirmed after colonoscopy & histopathology report available. Then the patients will be informed of their actual diagnosis and option of treatment given. When ostomy surgery is indicated, the patients will be sent to the Enterostomal therapy nurse (ET) / stoma care nurse for further detail information regarding ostomy care.

Educational ostomy care plan for ostomates. Ostomy teaching is a critical component of patient's care for ostomates. An ostomy teaching plan will include aspects of the following:

PREOPERATIVELY

1. The aetiology and pathology of the patient's medical condition that led to ostomy surgery
2. Stomal construction (shown with pictures)
3. Ostomy appliances- various choices, prices, where to obtain supplies.
4. Application, care and removal of ostomy appliances (actual handling and hands-on)
5. Care of stoma and peristomal skin.
6. Activities of daily living.
7. Sexuality
8. Available resources.

The above teachings are done in a quiet place with the patient and family members / care takers. This will enable them to have a clear mind and support. If the patient is still not convinced regarding having a stoma, then a well rehabilitated ostomate will be arranged to have a session with him (i.e.: patient to patient counselling)

POST OPERATIVELY

Patient & family members/ care takers will have assisted hand-on experiences on the application, care and removal of the ostomy appliances. These will be done from time to time till they are competent and confident.

PLANNED DISCHARGE AND FOLLOW-UP CARE

Before discharge from the ward, ostomates and care takers must be able to do a return demonstration of application, care and removal of the ostomy appliances. They are been taught again on recognition of signs and symptoms of stoma complications, if having any other doubts at home, when, where and who to seek for help

As regarding the training program for the ostomy visitors, though IOA has set the program, so far in Malaysia, we do not practise. It is mainly because if the aged ostomates, they need their family members to send them. For those who are working, they can't afford to take time off. Some of them just feel that it is too troublesome to come.

SYMPOSIUM 2 ❖ Quality of Life

FACTORS AFFECTING QOL ASSESSMENT IN ASIAN PATIENTS

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Most people have an idea as to what quality of life is, and yet definitions of the term vary even between those researching the field. It's a very broad concept describing a person's overall feeling of well-being and includes a wide range of both physical and psychological concepts. Health related quality of life is a subset of quality of life, which revolves around four core domains; physical functioning, psychological functioning, social interaction and disease and treatment related symptoms.

Stoma surgery has a profound effect on the mind as well as the body, and a holistic approach to care of patients with a stoma is essential because QOL depends on their physical, psychological, social and sexual adjustment. Common QOL problems included gas, constipation, diarrhea, difficulties in returning to work, leisure difficulties, sexual problems, impact body image, psychosocial phenomena such as depression and self esteem.

Most measures of health status and quality of life have included the three dimensions of health outlined by the World Health Organization: "Health is not only the absence of infirmity and disease, but also a state of physical, mental and social well-being".

One method of assessing the QOL is Cancer Rehabilitation Evaluation System, or CARES, which was developed by Schag and Heinrich in 1988. The CARES is a questionnaire for self reporting designed for the evaluation of treatments and for assessment of the negative or positive impact of treatments on a patient's ability to function and his or her quality of life.

Five summary scales of the quality of life construct: physical health; psychosocial function; medical interactions; and marital interactions. The domain of physical health encompasses the physical changes and disruption of daily activity caused by the disease. The psychosocial domain includes psychological issues and problems in interactions and communications with the medical team.

ET needs to improve QOL, ostomates should seek supportive counseling, increase their sense of worth and meet their esteem needs and education about self-care adherence to treatment and follow-up management.

REFERENCES

1. Vera Lúcia Conceição de Gouvenia Santos et al. Quality of life and coping of persons with temporary and permanent stoma, JWOCN 33(5) 503-509, 2006
2. Sabine HK et al. Pelvic exenteration: Effect of surgery on Quality of life and body image- A prospective longitudinal study, Gynecology Oncology 66: 495-500, 1997
3. Schag CAC, Heinrich RL: Development of a comprehensive quality of life measurement tool: CARES. Oncology 4:135-138,1990

SYMPOSIUM 2 ❖ Quality of Life

ARE WE DOING ENOUGH IN ASSESSING THE QUALITY OF LIFE?

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DEFINITION

Quality of life is individuals' perception of their position in life in the context of the culture and value system in which they live, in relation to their goals, expectations, standards and concerns affecting complex ways by the person's physical health, psychological state, level of independence, social relationships to salient features of their environment.

AIM

To assess quality of life of patients with stomal surgeries.

- To solve psycho-social problems rule out financial problems. Effective pouching system provides confidence and security Help gain confidence, self esteem and sense of social wellbeing. Compare expenditure of equipments for different surgeries.

MATERIAL AND METHOD

Quality of life with Irrigation after APR with irrigation.

- The psychosocial problems. and effect of surgery on physical activities. Expenditure required per year. Quality of life after Urinary Diversion
- Minimize and solve problems, Achieve independence in self care. Management of Abdominal Stomas with Convexity
- Effective pouching system provides comfort and security. Ostomy pouches users Preferences and Economical Evaluation
- Find out financial difficulties. Availability of medical support. Cost effectiveness.

CONCLUSION

Most patients felt stoma surgery gave them life extension to fulfil their responsibilities had difficulty in obtaining stoma products. Convex system solution for frequent leakage. Irrigation reduced psycho-social & financial problem. Research studies showed some problems remained unseen and unattended.

Most stoma patients are left unattended due to:

- Lack of knowledge among the health care professionals
- Distance in rural places -specialized care not available
- Stoma products not introduced, Financial constraints
- Communication problems, Sexuality

In spite of we, the health care professionals, are well trained and well informed from time to time about scientific health care products, management techniques by the experts, we are still trying our level best in assessing and solving the problems. Though we say the world is well connected by information technology, the fact remains; it is limited to urban areas only.

We Together the rehabilitation team can help lead our patients towards better Quality of Life.

KEYNOTE ADDRESS

A WESTERN PERSPECTIVE ON STOMA REHABILITATION

Ronan O'Connell

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Coloproctology has emerged as a subspecialty of general surgery within the past 30 years. With specialization has come the need and latterly the funding for stoma care within the multidisciplinary team that now delivers specialist care for patients with colorectal disease.

Stoma rehabilitation has its origins in self help groups established in the 1940's. The first stoma therapist, Norma Gill, herself an ileostomist, with the encouragement of Dr Turnbull at Cleveland Clinic, established the first training course in stoma care in 1958. Now, stoma care is widely available in hospitals and community stoma care nursing is well established throughout Europe. Ostomy societies, both national and international, provide excellent support by way of information and advice.

As colorectal surgery has developed, one of the major goals has been to preserve continence and stoma avoidance where possible. Advances in surgery for inflammatory bowel disease, rectal cancer, congenital abnormality and continence disorders have meant substantial reduction in the absolute number of permanent stomas. For patients who require a stoma, the range and quality of stoma appliances have greatly improved. Yet 30 to 50 percent experience post-operative stoma complications. In the long term, para-stomal herniation is a significant problem. These are issues of ongoing importance.

Stoma care has become an integral part of specialist practice in coloproctology. As operative outcomes improve, quality of life issues become more important in a more holistic caring environment. With this development, in the West, has come awareness of social, ethnic and religious concerns regarding stoma formation. These are the challenges of the moment.

1. Black PK. *Holistic stoma care*, Bailliere Tindall, London, 2000
2. Fucini C, Grattai, Urena C, Bandettine L, Elbetti C. Quality of life among 5 year survivors after treatment on very low rectal cancer, with or without a permanent stoma. *Ann Surg Oncol*, 2008; Jan 8; [Epub ahead of print] PMID: 18181002
3. Pachler J, Wille-Jorgensen P. Quality of life after rectal resection for cancer, with or without permanent colostomy. *Cochrane Database of Systematic Reviews* 2005, Issue 2. Art No.: CD004323. DOI:10.1002/14651858.CD004323.pub3
4. Kuzu MA, Topcu O, Ucar K et al. Effect of sphincter sacrificing surgery for rectal carcinoma on quality of life in Muslim patients. *Dis Colon Rectum*, 2002; 45:1359-66

SYMPOSIUM 3 ❖ Management of Anorectal Diseases I

FAECAL INCONTINENCE

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Faecal incontinence is a devastating social handicap. The most common cause is childbirth. Approximately 2% of women who deliver vaginally have a recognized third-degree tear, however, evidence of anal sphincter injury can be identified in 30 to 40%^{1, 2}. Use of forceps, primiparous delivery, birth weight greater than 4 kg, and occipito-posterior position are all associated with anal sphincter injury². In addition, injury to the pudendal nerves, levator ani and endopelvic fascia may accompany anal sphincter disruption. Approximately 20% of women experience transient alteration in continence post partum, however the majority recover fully. Those with persistent symptoms may deteriorate after further vaginal delivery and elective caesarean delivery should be considered³.

Investigation of incontinence should exclude underlying malignancy, inflammatory bowel disease and neurological disorders. A careful history and physical examination will distinguish congenital abnormalities, defaecatory disorders, faecal impaction and cognitive impairment as causes. Endoanal ultrasound examination will identify anal sphincter disruption and anal manometry provides useful baseline functional measurement. Pudendal nerve terminal motor latency measurement is unreliable and formal electromyographic assessment is needed if neuropathy is suspected⁴. A continence score and quality of life assessment are important. Dietary manipulation, use of stool bulking agents and pelvic floor physiotherapy are first line interventions. Oral loperamide or diphenoxylate may be helpful.

Surgical intervention is reserved for those with socially disabling incontinence. Large (>1 quadrant) anal sphincter defects may be repaired with reasonable expectation of improvement. Sacral nerve stimulation has replaced most other interventions in other circumstances. Rarely there may be an indication for implantation of an artificial bowel sphincter or construction of a gracillus neosphincter. Colostomy may be the best option in the otherwise infirm or particularly in those with predominantly loose stool, particularly on a background of irritable bowel syndrome⁵.

1. Sultan AH, Kamm MA, Hudson CN, Thomas JM, Bartram CI. A prospective study of anal sphincter disruption during vaginal delivery. *N Engl J Med* 1993; 329: 1905-11.
2. Donnelly VS, Fynes M, Campbell DM, Johnson H, O'Connell PR, O'Herlihy C. Obstetric events leading to anal sphincter damage *Obstet Gynaecol*, 1998; 92: 955-61.
3. Fynes M, Donnelly V, Behan M, O'Connell PR, O'Herlihy C. Effect of second vaginal delivery on anorectal physiology and faecal continence: a prospective study. *Lancet*. 1999;354:983-6.
4. Fitzpatrick M, O'Brien C, O'Connell PR, O'Herlihy C. Patterns of abnormal pudendal nerve function that are associated with postpartum fecal incontinence. *Am J Obstet Gynecol*. 2003;189:730-5.
5. Tjandra JJ, Dykes SL, Kumar RR et al. Practice parameters for the treatment of fecal incontinence. *Dis Colon Rectum*. 2007;50:1497-507

**SYMPOSIUM 4 ❖ Function of Stoma Support Groups
– What is the Ideal Model?**

**FUNCTION OF STOMA SUPPORT GROUPS –
WHAT IS THE IDEAL MODEL?**

Carlo Pezcoller

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Modena, Italy*

- 1) It's very difficult to rank all various types of disability, as only the people who experience this situation first person can give voice to his/her own inner trouble.
- 2) The ostomy represents a very serious handicap both from the physical point of view and from the psychological impact.
- 3) The ostomate is a survivor who lives his or her own drama completely alone.
- 4) The ostomate tends to live apart and to withdraw into him/herself.
- 5) Ostomates are rarely able to gather in active groups or associations.
- 6) Ostomates need help, mainly from the "Stoma Support Groups".
- 7) But how? Is there an ideal model?
- 8) Models could be different and they must take into account the cultural background of every single Country.
- 9) In order to provide a better support to ostomates in Italy, FAIS association is composed of four components: ostomate patients, doctors, nurses, supporters
- 10) Ostomates, possibly, are in charge of the association appointments, in particular the Presidency.
- 11) Sometimes it is quite difficult to find the right people.
- 12) It is very important the involvement of the other three components of the association: doctors, nurses, supporters, all acting as "Stoma Support groups".
- 13) Doctors and nurses play two important roles since they are in contact both with the old and with the new ostomates.
- 14) In Italy these two roles are believed to be represented inside the association.
- 15) Doctors and nurses (ET) are the professional men and women who practically run the rehabilitation centres.
- 16) Doctors and E.T. can encourage Ostomates to found association to help themselves.
- 17) They can provide the information of the existing rehabilitation centres as well as the ostomate association.
- 18) Doctors and E.T. take part in the association life and they are very close to the patients' needs.
- 19) Doctors and ET are technically able to carry on the research to improve the ostomates' quality of life.
- 20) The ostomates' voice does not always get to the health authorities.

**SYMPOSIUM 4 ❖ Function of Stoma Support Groups
– What is the Ideal Model?**

- 21) Their problems are often disregarded as they involve a suffering minority group that is not properly listened to.
 - 22) It is useful involving other supporting elements such as the "Club Services".
 - 23) There are several "Club Services": Lions, Rotary, Round Table, Soroptimist,...
 - 24) The aim of these clubs is to carrying out humanitarian projects all over the world, free from any constraints due to nation, race, culture and religion.
 - 25) Sensitive people adhere to these clubs so that they can help the disabled to be more listened to by the responsible authorities.
 - 26) But how?
 - 27) Contacts with the central government
Contacts with the local administrations
Contacts with town hall administrations
Contacts with hospital managements
Campaigns of information
Campaigns of fund raising
 - 28) Thanks to this organization, the following results have been attained in Italy
 - 29) In Italy we have 500 full ET, 2000 nurses expert in Stoma therapy. All the products for ostomates in Italy are free:
 - 30) 1 piece:
Ileostomy drainable bags: 90 x month
Colostomy: 60 x month
Urostomy: 30 x month
Same quantity for convex products
 - 31) 2 pieces:
Ileostomy - 15 flanges x month
- drainable bags: 90 x month
Colostomy - 10 flanges x month
- bags: 60 x month (or 30 mini bags)
Urostomy - 20 flanges x month
- bags: 30 x month
Same quantity for convex products
- 1 irrigation set every 6 months
30 irrigation bags x month

**SYMPOSIUM 4 ❖ Function of Stoma Support Groups
– What is the Ideal Model?**

**FUNCTION OF STOMA SUPPORT GROUPS – WHAT IS THE IDEAL
(INDONESIAN) MODEL?**

Widasari Sri Gitarja

Indonesia

INTRODUCTION

Administrative division of Indonesia is 32 provinces, with two extraordinary regions and one capital city. Religions: Muslim (88%), Protestant (5%), Oman Catholic (3%), Hindu (2%), Buddhist (1%), other (1%). Ethnic groups are Javanese (45%), Sundanese (14%), Madurese (7.5%), coastal Malays (7.5%), other.

In 1994, there are 8580 people suffers from cancer disease who came to Dharmais Cancer Hospital (location at capital city, Jakarta). Around 468 people were suffering the colorectal cancer, which describe into 16 people had an esophagus, 25 gaster, 45 pancreas, and 372 colon cancer. Most of colon cancer happen at the rectum are 191 person. (Dukut Respati, 2007. Dharmais Hospital)

Stoma support group is one of ETs responsibility by improving the quality of life for ostomy patients. Actually, all the patients are physically and psychologically stressed by their illness and having a stoma. In 1997, at 'Dharmais' Cancer Hospital in Indonesia, ETs and ostomates gathered to start a stoma support group. They are offers counseling and role models to patient and their families, before and during their rehabilitation process after stoma surgery. They help them to understand what is happpeneing, answering and dealing with the non medical problems, support them when they have the operation and follow up after. They called 'Dharmais Ostomate'.

ACTIVITIES AND OUTCOMES

Stoma support group was a unique group, with different cultures, religions and social-economics status. The reason behind it was that there were a feeling of stigmatization from public and afraid of revealing themselves as ostomate to other people. They were really aware, this situation will be improved if the public understands more about ostomates, but it was not easy.

We were tried for creating education and guideline for nurses and ostomate to be knowledgeable and skillful to look after stoma patients. Every year, there's many event in national or local scale of seminars and ostomate gathering for introducing ostomate to public which sponsored by hospital and product.

In 2000, when Indonesia still has a monetary crisis, and number of ostomates support group were increased, they have problems in finding bags for them. FOW (Friend of Ostomy Worldwide) - Project SHARE -USA, and FOW-Project SHARE - Canada gave a charity bags to YKI for ostomates. 'Dharmais Ostomate' with other ostomate from other hospital and YKI (cancer foundation), come together to solve this situation, and The InOA (Indonesian Ostomy Association) was established for the first national ostomate support group in Indonesia.

SYMPOSIUM 4 ❖ Function of Stoma Support Groups – What is the Ideal Model?

InOA members against stigmatization were always became a big issues, followed by financial difficulty, and medical problems. All members and professional board of InOA helps ostomates to find brightness in the darkest time of their life. Support them and their families to get through the traumatize situation of what is happening to them and their body.

Further details of aims that stoma support groups try to reach are follows:

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

CONCLUSION

1. The stoma support group is very important and the best solution for ostomates, especially for new ostomate.
2. This organization also important for any medical doctors, ETs and others for creating and developing a operational standard procedure to help patients with stoma.
3. Stoma center will be the next issues in Indonesia for answering the QOL for Ostomate.

HOW I DO IT (1) ❖ Video Session

ANAL SPHINCTER REPAIR

Ronan O'Connell

St Vincent's Hospital and University College, Dublin, Ireland

Primary anal sphincter repair may be required for obstetric or non-obstetric anorectal trauma that results in anal sphincter disruption. Adequate wound toilet, debridement and correct anatomical apposition are essential. A recent metanalysis of 3 trials of direct versus overlapping repair failed to show superior results for one technique¹. Penetrating injury to the rectum may require faecal decontamination, repair of the rectal wall, a defunctioning stoma and drainage of the presacral space. Faecal diversion is rarely required for isolated anal sphincter injury.

Delayed surgical repair is required in symptomatic patients in whom a primary repair has failed or the original tear has been missed. It is usually performed in the lithotomy position through an inverted 'V' perineal incision. A posterior fourchette incision may be used except where there is complete disruption of the perineum with a cloacal defect.

Identification and exposure of the external anal sphincter is crucial. It is uncertain whether the internal anal sphincter should be separately repaired. An overlapping sphincteroplasty is usually performed. The author regularly performs an anterior levatorplasty. A recent metanalysis has failed to show superiority of any one technique². A satisfactory outcome can be expected in approximately 80% of patients, however results deteriorate with time and menopause^{3, 4}. Sacral nerve stimulation may prove superior to sphincteroplasty in patients with sphincter defects less than one third anal circumference⁵.

1. Fernando R, Sultan AH, Kettle C, Thakar R, Radley S. Methods of repair for obstetric anal sphincter injury. *Cochrane Database of Systematic Reviews* 2006, Issue 3. Art. No.: CD002866. DOI: 10.1002/14651858.CD002866.pub2
2. Brown SR, Nelson RL. Surgery for faecal incontinence in adults. *Cochrane Database of Systematic Reviews* 2000, Issue 1. Art. No.: CD001757. DOI: 10.1002/14651858.CD001757.pub2
3. Baig MK, Wexner SD. Factors predictive of outcome after surgery for faecal incontinence. *Br J Surg* 2000; 87: 1316-30.
4. Malouf AJ, Norton CS, Engel AF, Nicholls RJ, Kamm MA. Long-term results of overlapping anal-sphincter repair for obstetric trauma. *Lancet* 2000; 355: 260-5.
5. Melenhorst J, Koch SM, Uludag O, van Gemert WG, Baeten CG. Is a morphologically intact anal sphincter necessary for success with sacral nerve modulation in patients with faecal incontinence? *Colorectal Dis.* 2007 Oct 19; [Epub ahead of print] PMID: 17949447

SYMPOSIUM 6 ❖ Management of Anorectal Diseases II

MANAGEMENT OF RECTOVAGINAL FISTULA

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Obstetric injury is the most common cause of rectovaginal fistula and may result from failed recognition of a 4th degree or from breakdown following repair of a recognized tear. In the absence of adequate obstetric care, obstructed labour may lead to pressure necrosis of the rectovaginal septum with fistula formation. In such situations, the defect may be extensive.

Inflammatory bowel disease, particularly Crohn's Disease may lead to vaginal fistula, however this is more commonly ano-vaginal rather than rectovaginal. Low fistulas may occur following restorative proctocolectomy for ulcerative colitis or colo-anal anastomosis for cancer. Both are challenging to deal with and may require anastomotic revision or excision. Radiotherapy used in the treatment of gynaecological malignancy can result in radiation necrosis and particularly complex fistulas¹.

The treatment depends on the level, complexity and etiology of the fistula. Rectovaginal fistulas in the upper third of the vault generally require laparotomy for repair, whereas fistulas in the lower and middle thirds can usually be treated by a trans-anal, trans-perineal or transvaginal approach. Perineotomy converts the fistula to a 4th degree tear that is then repaired including sphincteroplasty. The transanal approach is suited for with low fistulas and an intact anal sphincter. The transvaginal approach provides better access, however leads to scarring that can cause dysparunia. The transperineal approach allows anterior levatorplasty to be incorporated².

Irrespective of the technique of repair, recurrence rates are high because of infection, poor tissue quality or technical deficiency. Secondary repair holds a reasonable prospect of success, but augmentation with a Martius flap or gracillus muscle interposition may be helpful. There is no convincing evidence that faecal diversion is necessary in primary repair, however it may be considered in secondary repair^{2, 3, 4}.

1. Saclarides TJ Rectovaginal fistula *Surg Clin N Am* 2002; 82: 1261-72
2. Watson SJ, Phillips RK *Non-inflammatory rectovaginal fistula*. *Br J Surg* 1995; 82: 1641-43
3. Songe K, Scotte M, Lubrano J et al Treatment of anovaginal or rectovaginal fistulas with modified Martius graft. *Colorectal Dis* 2007; 9: 653-656
4. Lowry AC, Thorson AG, Rothenberger DA, Goldberg SM Repair of simple rectovaginal fistulas: influence of previous repairs. *Dis Colon Rectum* 1988; 31:676-8

SYMPOSIUM 6 ❖ Management of Anorectal Diseases II

LOCAL EXPERIENCE OF ANAL SPHINCTER REPAIR

Akhtar Qureshi

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Anal incontinence is frequently seen in Malaysia following perineal trauma. At present treatment is expectant, with a covering loop colostomy being the surgical management of choice in cases of significant anal incontinence. At this center, all cases of anal incontinence are offered primary anal sphincter repair as the initial surgical treatment.

Following clinical assessment, the degree of anal incontinence is documented with the clinical site of sphincter injury confirmed by the use of an endoanal ultrasound. The severity of anal incontinence is graded by the Miller score where a score of greater than 12 is considered as significant incontinence requiring surgical intervention. The primary surgical procedure performed is an overlapping repair of the sphincter injury with elongation of the anal canal. Most patients referred, have already been given a covering stoma prior to referral. We do not routinely use a covering stoma.

A total of 27 patients with anal sphincter injuries have been surgically treated with a primary overlapping sphincter repair. The causes of sphincter injury include road traffic accidents (n = 14), Obstetric (n = 10) and iatrogenic (n = 3). Male to female ratio was 5:4. The mean age was 32.6 years with an age range of 15 – 62 years. A total of 26 patients were available for complete analysis, as any covering stoma had been closed. All patients with an anterior sphincter defect had significant improvement while three patients with a lateral sphincter injury with extensive scarring had a poor outcome.

While the numbers of patients are small, anal sphincter injury resulting in anal incontinence can be surgically corrected by an overlapping repair of the sphincter and elongation of the anal canal, with acceptable results.

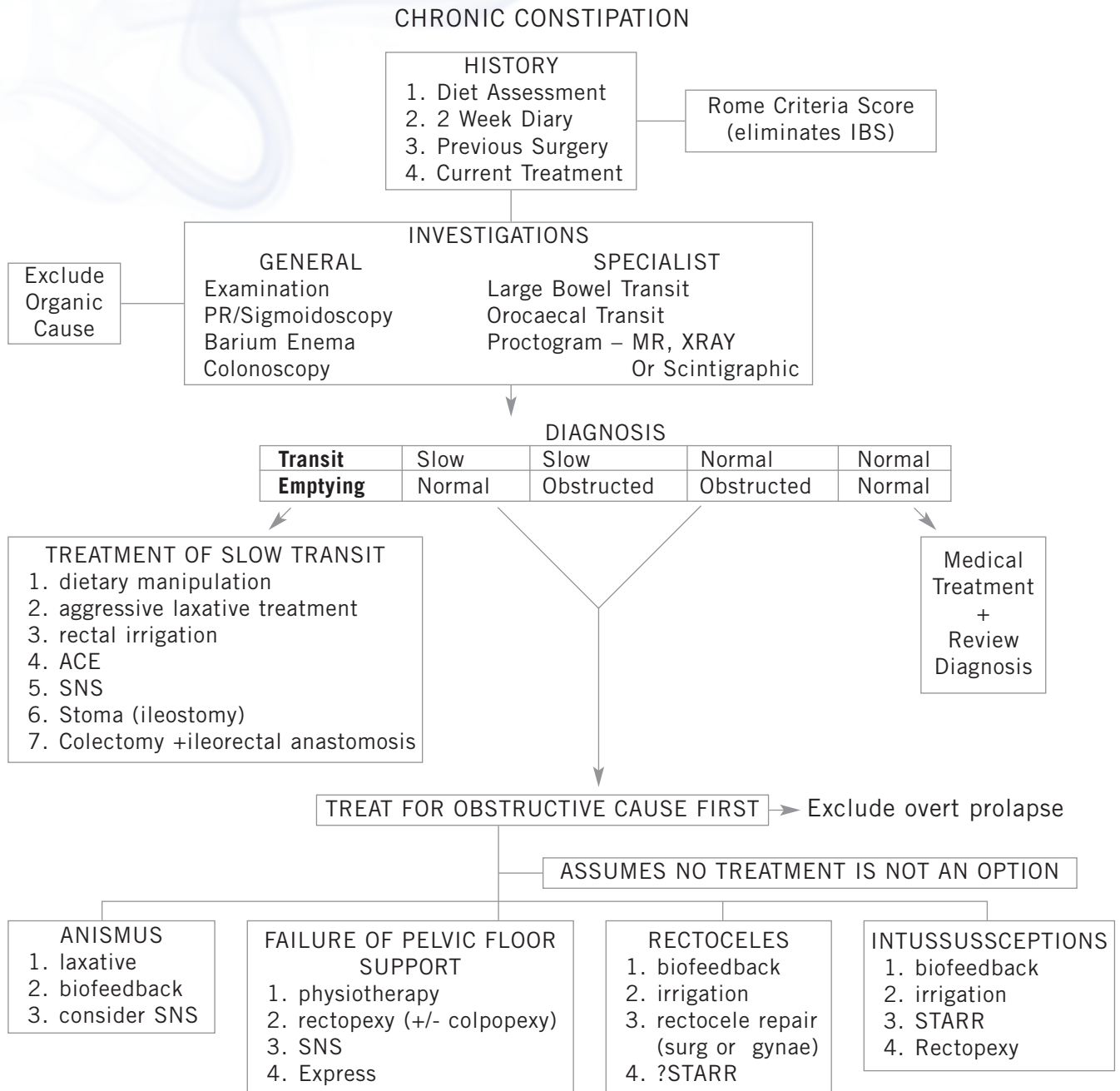
PLENARY LECTURE 2

CHRONIC CONSTIPATION – ARE WE THERE YET?

Graeme S Duthie

Academic Surgery, Castle Hill Hospital, England, United Kingdom

CHRONIC CONSTIPATION HISTORY + INVESTIGATION + CURRENT TREATMENT OPTIONS



1. Treat based on quality of life issues
2. Treat based on minimal successful therapy
3. Stomas often fail symptomatically in obstructed defecation
4. Consider psychological support if required
5. Reassess transit after treating obstruction
6. For surgery option in STC -: anal USS and physiology required pre op

PLENARY LECTURE 3

OSTOMY CARE – PATIENT OR INDUSTRY DRIVEN

Keryln Carville

Silver Chain Nursing Association and Curtin University of Technology, Australia

We in the Association plod on waiting for the lead which must one day come from those in authority in the medical world. Until then it is our duty to accept the responsibilities demanded of us and to carry them out to the best of our ability (Kingston, 1971).

The quality of life for a person with stoma prior to the surgical advances of Bricker (1950) and Brooke (1952) was very poor and frequently intolerable. At that time, the dearth of appliances and ostomates care experiences taught them that the health profession's sympathy was a hollow offering, when informed assistance and efficient means of containing effluent were not available. Such a lack of professional and industrial assistance resulted in the evolution of ostomy 'clubs' which had their genesis in the USA during the late 1940s and early 1950s. The concept of such groups quickly spread to other countries and these support groups were founded on established friendships formed during long periods of hospitalisation and a united need to 'find a better way' to manage. The ostomy associations that emerged became united organised groups that did much to promote the welfare of their members via initiating stomal therapy care and lobbying for access to efficient appliances. History reveals that the specialities of colo-rectal surgery and stomal therapy nursing largely came to be because of the early activities of the lay ostomy groups. Advances in appliance technology and the evolution of a world-wide industry had similar origins. However, in 2008 the roles have been reversed as a result of advances within the profession and industrial competitiveness. The role industry plays in some countries is that of pseudo stomal therapist. This paper will outline the historical journey and current role of patients and industry in determining ostomy care outcomes.

SYMPOSIUM 8 ❖ Laparoscopic Colectomy

LAPAROSCOPIC COLORECTAL SURGERY – TOYS FOR BOYS?

Peter Lee

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The first descriptions of the laparoscopic approach to colon resection appeared in the literature in 1991; now some sixteen years later the call has come out for this mode of treatment to be acknowledged as the 'gold standard'.

This is an appropriate time and place to review the 'evidenced based' standing of laparoscopic surgery. Data is available to substantiate that, at least in the field of colon cancer, laparoscopic resection is

- a. feasible
- b. oncologically acceptable
- c. short term outcomes are comparable to open surgery
- d. complications are comparable or even less
- e. may offer advantages to the patient in terms of cosmesis, post operative pain, length of hospital stay and immunological response

What, however, is the current evidence based situation with respect to:

- a. the longer term survival end points?
- b. the applicability in the more difficult situation e.g. low anterior resection?
- c. patient suitability and case selection?
- d. the learning curve?
- e. conversion figures and outcomes?
- f. quality of life and health economics?
- g. the use of laparoscopy in benign disease?

Laparoscopic colon and rectal surgery has come a long way from being an attractive, technically challenging, novel surgical 'experience' for both patient and surgeon. Are we now, however, at the stage where its use in the armamentarium of the 'average' colon and rectal specialist should become mandatory? The data in this presentation would suggest that a little more time and evaluation is still required and must be waited for. If the data remains favourable, as would seem likely, then the practical consequences on training and 'who should carry out' the surgery may be even more challenging than learning the laparoscopic techniques!

SYMPOSIUM 8 ❖ Laparoscopic Colectomy

COMPLICATIONS OF LAPAROSCOPIC COLORECTAL SURGERY

Yunus Gul

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Laparoscopic colon resections are being performed with increasing frequency even though its use has somewhat lagged behind application of laparoscopic surgery in other surgical fields. A great deal of controversy has surrounded its utilization since the first laparoscopic colectomy was described in 1991 especially pertaining to the management of colorectal cancer and issues related to port site metastasis. Several important studies have since demonstrated the benefits and safety of laparoscopic colorectal surgery, making it now the preferred approach in the surgical management of many colorectal diseases. Nevertheless, complications are still reported in the literature varying from minor to major, in particular during the so called 'learning curve' period. The practicing laparoscopic surgeon has to be aware of potential complications and avoid these mishaps, most of which are related to inexperience and lack of awareness. The use of minimally invasive approaches in the surgical management of colorectal diseases will only be considered as the acceptable norm or continue to gain popularity if complications are kept to a minimum in comparison to open surgery. This lecture will focus on the common reported complications and ways of avoiding or minimizing these in laparoscopic colectomy.

SYMPOSIUM 9 ❖ Ostomy Care

MANAGEMENT OF STOMA RELATED PROBLEMS

Meheshinder Singh

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Intestinal stomas play a key part in both elective and emergency surgery. They are often necessary to prevent potentially devastating complications. However, stomas themselves are associated with a significant short and long term complications that can make their management difficult.

Most patients who receive stoma have colorectal cancer. Apart from coping with cancer, they have to adjust to life with a stoma which becomes even more challenging particularly so when complications arise. The various complications and its management is discussed.

SYMPOSIUM 9 ❖ Ostomy Care

OSTOMY AND A HEALTHY SEXUAL RELATIONSHIP – CAN BOTH CO-EXIST?"

Neeta Sabharwal

Sir Ganga Ram Hospital, New Delhi, India

Our experience suggests that initially after the stoma is constructed, nearly all the patients have great apprehensions and fear about their sexual life. The situation is made worse by the cultural & social inhibitions, which make the patients hesitate to ask the concerned medical personnel about these issues.

One of the primary duties of the stoma therapist is to gain patients confidence which allows the patient to ask questions & clarify any misconceptions. In our experience, apart from directly counseling the patient, allowing the patient to interact with other patients gives a gateway in facilitating sexually oriented questions.

One of the primary concerns that the patients have confided to us is the fear of an altered body image, which might be repulsive to the partner.

The other common fear remains chances of damage to the stoma or accidentally slipping of ostomy devices.

We feel essentially it is a question of making the patient realize that having a stoma does not in any way effect the sexual lifestyle.

There are few tips we can suggest

- Love yourself and have faith in yourself
- Have an open talk with your partner
- Empty and apply the fresh pouch before intimacy
- Minicaps /stomal plugs can be used
- Fancy pouch covers can be used
- Can have dim light in the room
- Use of lubricants if required
- Having stoma does not make you less beautiful
- Can use an implant if required

Sexual health of our patients is as important as their physical wellbeing.

SYMPOSIUM 9 ❖ Ostomy Care

HAS THERE BEEN AN IMPROVEMENT IN STOMA APPLIANCES?

Tai Seow Beng

Nurse Coordinator, Segi College, Kuala Lumpur

The era of using tins, leather bags and rubber pouch that smell, over leaking, didn't accommodate gas episodes and patients faced periods of despair is over now. There is tremendous advancement in ostomy products with improved features to fulfill the highest expectations of patients.

Advance in ostomy management was the introduction of stomahesive wafers as skin barrier in 1972 where in the past karaya based. Currently the new ranges of skin barrier incorporate different constituents' skin barrier and backing materials each stressing their unique adhesive features, extended wear time, degree of flexibility which contributes greatly to improve patient QOL Innovative moldable skin barrier offer desired stoma size without cutting necessary.

Technology and research featuring new generation of coupling designed to "stick it on and go" without hard locked rings and floating flange which make the absence of uncomfortable sensation during fitting and can be used for delicate post-op abdomen. Ergonomic shapes pouches where it adapts to the groin and soft woven materials pouch providing more comfort and discreet. The solution of horror and distress associated with clip coming off during wear with new concept where patients can control stool flow with an integrated soft clamp. Laminar filter was design to increase capacity to dedorise and adjustable filter system to evacuate gases.

Leaking problem of flush or retracted stoma can be resolved with available built in convex pouch Stoma caps are available for those who require something more discreet during swimming or intimate activities. There are also two pouches described as 'toilet disposable' that have revolutionized stoma care These allow the patient to flush either the pouch or liner down the toilet.

A cycle of innovation of ostomy pouching systems appeared in the marketplace, literally transforming the life of the ostomy patient towards a better QOL.

LUNCH SYMPOSIUM [Alcare Co Ltd]

OSTOMATE EDUCATION IN INDONESIA

Dieta Parengkuan

Coordinator of Indonesian Ostomy Association (InOA), Indonesian Cancer Foundation, Indonesia

Ostomate education is an activity of giving information and teaching ostomates about their stoma. The objective is to equip them with a knowledge about stoma, so with their experiences as an ostomate who had undergo a stoma surgery, they can help a new patient who refuse a stoma surgery or afraid for having a surgery, with a right information.

From the beginning, ostomate education in Indonesia was done by doctor, stoma / ET nurse and is a part of activities in the hospital or stoma clinic. The materials for education could be a picture, video / CD. When ostomate come to a clinic or hospital and seek for information about how to take care of their stoma, a doctor of a stoma / ET nurse will help and teach them the right procedure. One day, if they (ostomate survivor) meet with a new ostomate (a patient), they will share and teach them with the right procedure to take care of their stoma. Sometimes ostomate survivor also visits the patients at home for sharing and educating them and their family.

Since the InOA established in 2000, an ostomate gathering is held every year by the board of InOA. This event is also used as a class for educating ostomates (new patients or survivors) because the board always brings forward speakers from many disciplines with many topics to educate ostomates and their families. Besides, sharing with ostomate survivor also play an important role in educating the new patients.

A Visitor Training Guideline from the International Ostomy Association in Indonesian language was received by the InOA last July. This guideline is very helpful for the ostomate. The content is very clear to be learned by ostomate survivor and it help them for explaining to the new patients.

The first training by using this guideline will be held on 2nd February 2008. It will help doctors and nurses in giving the right information and education to the ostomate survivor with a simple language to be understood.

KEYWORDS

Ostomate survivor, education

SYMPOSIUM 10 ❖ Colorectal Pot-Pouri

DEEP VEIN THROMBOSIS (VENOUS THROMBOEMBOLISM)

Nigel R Suggett

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Venous thrombo-embolism (VTE) is a major source of in-hospital morbidity and mortality. The annual incidence of hospital acquired fatal Pulmonary Emboli (PE) in the European Union is over 250,000 per year of which 25% will be post-operative¹. This is a particular problem for cancer patients with a seven-fold increase in this group relative to patients without cancer. Since most post-operative cases of VTE are undetected, these numbers represent only the tip of the iceberg since even asymptomatic VTEs can lead to significant post-thrombotic syndrome². There is good evidence for the benefits of both elastic compression stockings and unfractionated and low molecular weight heparins in reducing the risks of VTE³. Reported bleeding and other side effects from these modalities are low. Despite this, the uptake of adequate thromboprophylaxis is far from universal and studies show many patients receiving sub-optimal treatment⁴. In the U.K. the National Institute of Clinical Excellence (NICE) has recently produced guidelines on VTE assessment and information. We hope that increased education and the use of printed or computer-based risk assessment systems may increase the uptake in our institutions.

REFERENCE

1. Cohen AT et al, VITAE study ISTH 2007
2. Wille-Jorgensen et al, Thromb Haem 2005;93:236-41
3. Kakar W et al. Lancet 1975;2:45-51
4. Friedman R, et al. Blood. 2003; 11:abstract 574

SYMPOSIUM 10 ❖ Colorectal Pot-Pouri

ANASTOMOTIC LEAKS

Robert L Chang

Jose R Reyes Memorial Medical Centre, Manila, Philippines

Anastomotic leak is a major cause of post-operative morbidity and mortality. There is recent evidence to suggest that when a leak occurs after resection for colorectal cancer, it has a negative impact on overall and cancer-specific survival. Proposed mechanisms include extra-luminal implantation of viable cancer cells that upstages the disease, and enhanced tumor spread and metastasis secondary to the inflammatory response to anastomotic breakdown.

Various factors have been associated with increased risk for anastomotic leak. This information is essential in planning for surgery. This presentation will touch on the following issues:

- Pre-operative identification of the “at risk” patient
- Intra-operative testing of the anastomosis
- Post-operative diagnosis of the patient who is “not doing well”

Finally, our results of leaks after intestinal anastomosis will be presented.

SYMPOSIUM 10 ❖ Colorectal Pot-Pouri

MANAGEMENT OF COLORECTAL TRAUMA IN THE MODERN ERA

Nigel R Suggett

University Hospital Birmingham, Birmingham, United Kingdom

While colorectal traumatic injuries are relatively rare, they remain a source of high morbidity and mortality both in the civilian and military populations. Many studies suggest that primary repair is the optimal management however the formation of a diverting stoma remains common practice particularly in those patients with destructive injuries that require resection or those with perceived high risk factors such as shock, delayed surgery, blood loss or severe faecal contamination. The decision may also be affected by the increasing use of damage control laparotomies (DCL) where patients are initially left in colonic discontinuity. Evidence suggests that those patients with high risk features will have complications regardless of whether they have a diverting stoma or a primary repair and the increased morbidity and mortality of a second operation to close a stoma should encourage us to perform a primary repair when possible. It remains likely, however, that, with the exception of major trauma centres, actual practice will deviate somewhat from this ideal.

SYMPOSIUM 10 ❖ Colorectal Pot-Pouri

MANAGEMENT OF PERIANAL CROHN'S DISEASE

Ronan O'Connell

St Vincent's Hospital and University College, Dublin, Ireland

The most common manifestation of perineal Crohn's Disease is perianal sepsis leading to fistula formation. The basic principles of managing perianal sepsis apply: drain the sepsis, preserve the sphincters. Perioperative antibiotics are used, metronidazole and ciprofloxacin are the most common. Both maybe continued orally for some weeks and may have anti-inflammatory effects separate to the anti-microbial properties. The extent of perianal sepsis may be complex, and particularly if recurrent, a pre-operative MRI scan is useful in guiding surgical drainage.

When a fistula is identified in the presence of sepsis, it is wise to insert a loose seton. This will promote drainage of sepsis and facilitate later definitive treatment. In the presence of extensive sepsis, often associated with incontinence and systemic upset, a defunctioning stoma may be considered. The type of stoma used depends on the extent and distribution of disease.

Definitive surgery for Crohn's associated fistula is associated with relatively high failure and recurrence rates (30 to 50%). Low fistulae may be laid open, however more complex high fistulae may be best managed with a long term draining seton¹. Endorectal flap advancement may be useful, but risks a more extensive non healing wound. Targeted biological therapy (anti TNF_) may dramatically down-stage perianal disease and allow seton removal. Long term biologic treatment is problematic and recurrence is common when stopped. Long term outcomes of use of fibrin glue or collagen plugs to close tracts are awaited.

Chronic perianal inflammation can lead to anal stenosis, often in the presence of painful fissure/ ulceration. Conservative measures, including balloon dilatation of strictures may temporize, however proctectomy may be required. Careful patient preparation including assessment of the extent of both small and large bowel disease is important. Approximately 25% of patients will experience delayed perineal wound healing. A transverse rectus abdominis or gracillus myocutaneous flap may be used to augment perineal closure².

1. Thornton M, Solomon MJ. Long-term indwelling seton for complex anal fistulas in Crohn's Disease. *Dis Colon Rectum* 2005; 48:459-63
2. Sing B, George BD, Mortensen NJ. Surgical therapy of perianal Crohn's Disease. *Dig Liver Dis* 2007; 39:988-992

STOMA WORKSHOP

PSYCHOLOGICAL ASPECTS IN OSTOMY CARE

Julia M Thompson

St Vincent's Private Hospital, Sydney, Australia

Having a stoma can be psychologically distressing and responses vary according to the individual's particular blend of: age, culture, religion, personality, past and current experiences, and pre-existing / co-existing psychological or psychiatric conditions. Added to this, people use a variety of coping mechanisms.

Whilst it is important not to stereotype people, a general knowledge and understanding of the above factors in relation to ostomy surgery assists us to be aware of different viewpoints. The most useful information comes from careful questioning of the individual.

Research has revealed the main psychological concerns of ostomy patients and routine aspects of stoma nursing care are oriented towards their prevention. These strategies include: preoperative education and counselling; assessment of risk for psychological problems; promotion of stoma self-care; assessing satisfaction with information; monitoring psychological symptoms at outpatients appointments; informing colleagues/others of risk for psychological problems.

The main symptoms of psychologic disorders can be identified with certain screening questions, and it is helpful when stoma nurses are familiar with the symptoms and the questions. When psychological concerns are identified, management strategies include: listening, counselling, strategies to review and respond to negative thinking, consultation with mental health specialists and referral to other specialist support services when appropriate.

This paper will review current knowledge of these aspects.

STOMA WORKSHOP

STOMA REHABILITATION: IS IT A ROLE FOR NURSES OR DOCTORS?

Wan Khamizar

Department of Surgery, Hospital Sultanah Bahiyah, Alor Setar, Kedah, Malaysia

A creation of a stoma of any kind is almost always a near catastrophe for most patients. This is quite obvious when the stoma is of permanent nature. The feeling of hopelessness, suffering from a kind of incurable disease brings a tremendous pressure on the affected patient. The feeling that he is no more a complete person, a handicapped human being causes self isolation. This is further compounded by the fear of possible leak which leads to unthinkable embarrassment in public. At first glance, it is only fair to say that the surgeons who created the stoma must be responsible to take care of it. They should be giving all the necessary help to get patients back into the community. But then, looking at the nature of work involved which is often time-consuming, a paramedic specialized in the area could do an equally good job. They can assist the doctors in that way and therefore allow doctors to spend more time in trying to treat and cure diseases. If the physiotherapists, occupational therapists or speech therapists can help doctors to rehabilitate patients in other disciplines then, the nurses are equally as good for stoma rehabilitation. In fact they do it better as we can see them playing a very important role in stoma rehabilitation worldwide nowadays.

STOMA WORKSHOP

MANAGING DIFFICULT STOMA

Tai Seow Beng

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When application of pouching system in the usual ways is a problem due to:

- i. poor siting
- ii. stoma proper
- iii. peri intestinal area
- iv. mucocutaneous junction and iatrogenic stoma.

Difficult stoma there is a change in stoma shape, profile, abdominal contour and peristomal skin surface. Managing difficult stoma often required modification in pouching including the use of convexity, abdominal support and adhesive products. The main objectives are to ensure proper pouching system to contain effluents, odour proof, prevent skin excoriation, cost effective and protect the stoma. Pictures of difficult stomas and treatments.

FREE PAPERS

8TH MARCH 2008 [SATURDAY] 1400 – 1500 hrs

VENUE: *Selangor Room, Basement II*

CHAIRPERSON: *Yunus Gul*

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Rene Michael², Pam Roberts²*
¹Silver Chain Nursing Association, Western Australia
²Curtin University of Technology, Western Australia
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FP 1

THE STAR SKIN TEAR CLASSIFICATION SYSTEM

Keryln Carville^{1,2}, Gill Lewin¹, Nelly Newall¹, Nick Santamaria², Rene Michael², Pam Roberts²

¹*Silver Chain Nursing Association, Western Australia*

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BACKGROUND

Skin tears are common wounds amongst the frail aged or disabled and associated health costs are significant. However, the Payne and Martin Skin Tear Classification System remains poorly utilised in Australia.

OBJECTIVES

The objectives were:

1. To gain agreement from Australian nurse experts in wound management on a classification system for skin tears.
2. To test the reliability of the resulting classification system.

METHODS

A library of skin tear photographs was established and a nominal group technique was used for consensus development on skin tear definition and classification. A State Development Group of 9 expert Western Australia nurses achieved a consensus for definition and a classification system. The proposed tool was then referred to a National Expert Panel of 14 nurses from each state and territory, for review. Both groups identified critical sources of confusion between the Payne-Martin Skin Tear Classification System categories and this led to a consensus that modifications to this classification were necessary. Reliability testing of the modified tool amongst 26 nurses from all settings failed to demonstrate a consensus when analysed using Cohen's Kappa statistic. To eliminate potential experiential bias, reliability testing was then conducted on a group of non-health professionals and this too failed. The Development Group and National Expert Panel were reconvened until they reached a consensus on 'simple' descriptions for each category of skin tear.

RESULTS

The reliability of the STAR Classification was tested amongst 36 nurses employed across all settings. The results were again analysed using Cohen's Kappa Statistic and a significant level of agreement was achieved. The STAR Classification proved its effectiveness when used in a state-wide wound prevalence survey in Western Australia.

CONCLUSION

The Skin Tear Audit Research (STAR) study is a collaborative Australian project that resulted in the development and testing of the STAR Skin Tear Classification System.

FP 2

SUCCESSFUL MANAGEMENT OF INTESTINAL AND PANCREATIC FISTULAE: A CHALLENGE FOR THE ENTEROSTOMAL THERAPIST

G Rathnayaka, C A H Liyanage, S Abeygunawardana, K I Deen
Department of Surgery, Faculty of Medicine, University of Kelaniya, Sri Lanka

INTRODUCTION

Management of intestinal fistulae is challenging to the enterostomal therapist. At the Department of Surgery, University of Kelaniya, Sri Lanka, we have successfully managed fistulae. In patients with attention to wound care, nutrition and microbiological aspects.

OBJECTIVES

1. To audit the current management of fistulae both enterocutaneous (ECF) and pancreatic (PF)
2. To evaluate the outcome of novel methods of managing such fistulae.

METHODS

All patients with ECF and PF who sought treatment in our unit were retrospectively analyzed for the type, cause of the fistulae, extent, method of treatment, need for defunctioning stomas, skin care, surgical procedures, nutritional management and complications.

RESULTS

Total of 15 patients (M-09, F-06, age range 12-63 years, mean age 42 years) were treated for ECF and PF. The types included colo-cutaneous 09 (60%), small bowel fistulae 05 (33%) pancreatic fistulae 1 (7%). The causes for the fistulae were iatrogenic 14, trauma 01.

06 (40%) were high output fistulae all of which were from the small intestine.

09 (60%) were colo-cutaneous and had a low out put. Pancreatic fistulae were complex and had a high output. 04 patients required defunctioning stomas. 06 were conservatively managed with complete healing in 30 days, 07 underwent surgery with 06 completely healing in 14 days.

Conservative management was by using two piece stoma care bags and wound care drainable bags and nutritional support. 9 Patients who did not respond to conservative management were offered surgery. Post operative complication included 1 stitch abscess and 3 recurrences (02 transient). 30 day mortality was zero. One patient with a pancreatic fistula died at 6 months.

CONCLUSIONS

ECF and PF can be managed successfully both conservatively as well as surgically. Use of novel stoma appliances and wound care appliances with attention to detail on skin care, nutrition and metabolic derangements will improve the rate of healing.

FP 3

LIONS FOR STOMA CARE AROUND THE WORLD

Carlo Pezcoller

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Modena, Italy*

At one time, medical professionals focused exclusively on removing the disease giving no thought as to how the patient was to live with a stoma and live a responsible full life. Today, we cannot be satisfied with having resolved the problem of the removal of disease by creating a survivor, a bearer of such a serious handicap, especially if they are children, forced to live aside, without any possibility of attending schools or playing with friends! All because there is no ostomy equipment available and no one to give advice on how to live with a stoma. In the West, patients' associations, rehabilitation centres, and volunteer groups have been founded to help these patients, but in a large part of the world none of these organisations exists. In 1999 I decided, as surgeon, I needed to help ostomates not only in Italy but ostomates in other countries.

HOW TO DO THIS?

I approached my Lions Club "Modena Wiligelmo" with my project called LIONS FOR STOMA CARE (LFSC) and it was accepted and they financed it. LFSC has been a service of District 108 Tb - Italy for the year 2002-03 and continues to be financed by the Lions Clubs of the province of Modena and by Lions Club International Foundation (LCIF) for the years 2007 and 2008.

WHY THE LIONS CLUB?

"WE SERVE" is the official motto of the Lions Club International, founded in 1917, which has always been committed to carrying out humanitarian projects all over the world free from any constraints due to nation, race, culture and religion. Lions wants to give support and help to anyone who needs it. Thanks to its 1.500.000 members, joined in 50.000 clubs of 192 countries, the Lions Club International is the most far-reaching socio-humanitarian organization in the world. Lions' purpose is to protect, support and promote the principles of solidarity, the protection of an individual's rights and freedom all over the world.

WHAT DOES THE SERVICE "LIONS FOR STOMA CARE" PROPOSE?

The intent of the service is not to collect funds in order to distribute goods free of charge. It proposes to promote a cultural/formative activity through "International Traveling Teaching Teams (ITTT)" that go to the various countries to train locally personnel who will then be able to function autonomously.

WE CAN DEFINE THE PROJECT IN FOUR PHASES:

- 1° Phase: Train, at the Policlinico Unversitario of Modena, selected and motivated doctors from needy parts of the world.
- 2° Phase: Urge local Lions to collaborate in the training of additional doctors and nurses, with the involvement of doctors trained in Modena and of the ITTT.

FP 3

- 3° Phase: Urge the Health Authorities to create rehabilitation centers, utilizing personnel already trained.
- 4° Phase: Unite ostomates in associations able to influence Health Authorities to deal with the problem and involve companies which manufacture ostomy products. Through 2007, training for doctors from the following countries has been funded at the “Policlinico Universitario” of Modena – Italy : Argentina, Bangladesh, Bolivia, Indonesia, Iran, Laos, Mongolia, Myanmar, Nepal, Pakistan, Paraguay, Sri Lanka and Vietnam.

Following this first stage, we have organized, together with doctors trained in Modena and the ITTT, other courses for doctors and nurses in the following countries: China (Lanzhou), India (Belgaum, Hubli, Dharwad, Munmbai) Indonesia, Iran, Mongolia and Vietnam, with the involvement, whenever possible, of the local Lions, as was the case in India.

The realization of the project “Lions for Stoma Care” has been facilitated by collaboration with I.O.A. (International Ostomy Association), A.O.A. (Asian Ostomy Association) and F.A.I.S - Italy Associazioni Incontinenti Stomizzati).

Much has been done thanks to the enthusiasm and generosity of the Lions Clubs of District 108 Tb – Italy and LCIF, but there is still so much to do !

FP 4

QUALITY OF LIFE FOR PATIENTS WITH STOMA IN KEDAH

Dinker Pai, Wan Khamizar, Teh Swee Ping, Kishen Raj

AIMST University and Hospital Sultanah Bahiyah, Alor Setar, Kedah, Malaysia

OBJECTIVES

The study was conducted to determine the quality of care given to patient with stoma; physical difficulties and social problems faced by stoma patients.

METHODS

The study was conducted as a student Special Study Module in Hospital Sultanah Bahiyah, Alor Star. 30 consenting adult patients with enteral stoma for at least 6 months were recruited for the study. A self-designed questionnaire was used to record the details of stoma information and training given. A Likert scale of 0 to 4 was used to grade physical difficulties faced by patients and their social problems.

RESULTS

73% of the surgeries were done electively and the rest emergently. 60% of the elective patients and none of the emergency patients had pre-operative stoma siting. Only 76% of the elective cases were given stoma care advice but all the emergency patients received post-operative stoma care advice. 4 patients received neither siting, nor stoma care advice. 92% of the patients were facing social problems, with work, bathing, and dressing being the worst affected. Patients found family and friends to be supportive with mean Likert scores of 3.2 and 2.7 respectively. Mean expense related to stoma was RM145. There was no difference in mean expenses between patients who received stoma training and those who did not.

CONCLUSIONS

Stoma siting was not done for any emergency patients and for 40% of elective patients. Even when done, siting was not done as per guidelines. Patients found it difficult to perform several activities of daily living. The mean expense for stoma maintenance was high relative to the per capita income. Stoma training did not help to reduce the cost of stoma care indicating its ineffectiveness. The decision to arrange for free appliances was done arbitrarily. Family and friends support was helpful in coping with the stoma.

FP 5

SMART PHONES – A SMART INNOVATION IN WOUND CARE

Keryln Carville

Silver Chain Nursing Association and Curtin University of Technology, Western Australia

Advances in communication and data storage technology, have resulted in two exciting innovations that will promote best practice and optimal outcomes in wound management in Western Australian.

Silver Chain is the largest domiciliary nursing agency in Western Australia and wound care comprises a large component of nursing time. As such there was an organisational need to: 'admit' every wound, track assessment and healing outcomes, benchmark practice outcomes, provide nurses with relevant education and provide and monitor medical consumables used in the provision of care. Silver Chain developed and uses an enterprise wide community and residential patient management system called ComCare. ComCare Mobile is an application that front-ends ComCare in the field and is designed to run on the current generation of 'smart phones', Windows based laptops or tablets. Connectivity between ComCare Mobile and the ComCare database is achieved using industry standard encrypted channels through the internet. ComCare Mobile was expanded to allow nurses to admit and monitor every wound on every community patient. Information recorded on the smart phones includes client demographics, co-morbidities, wound assessment parameters and treatments. Wound locations are plotted on a human outline on the smart phone screens and exception reporting pro-actively identifies areas that need attention. Additional functionality is being included that will facilitate quick and easy wound image transfer from the point of care to a Clinical Consultant who can then provide real-time advice on treatment. ComCare Mobile will allow Silver Chain to benchmark practice and healing outcomes within and outside the organisation. This technology was also used to conduct a prevalence survey of all patients in all 85 public hospitals in Western Australia as a component of the WoundsWest project. This innovative 3 year initiative of the WA Department of Health includes state wide surveys, clinical IT technology for assessment and management of wounds and remote consultation and the role out of evidence based education and guidelines. Comprehensive wound data bases will result from ComCare Mobile and WoundsWest, and these innovations will provide valuable data for benchmarking healing outcomes and other research projects.

FP 6

THE DEVELOPMENT OF STOMA CARE IN SRI LANKA

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BACK GROUND

In South Asia there is an increasing need for stoma care.

With improved survival the quality of life of patients after creation of a stoma is important. In Sri Lanka stoma care is now considered a specialized nursing service .At the department of surgery, university of Kelaniya, we have developed special interest in training stoma nurses.

OBJECTIVES

To evaluate the need for stoma care.

To audit the development of stoma care in Sri Lanka and the training services offered by the University of Kelaniya.

RESULTS

From 1996 to 2007 in our unit alone we have created more than 275 stomas. Which emphasizes the need for specialized care. In 2007 the GI surgical unit of University of Kelaniya trained the first qualified Sri Lankan stoma therapist in Malaysia, with the approval of the ministry of health in Malaysia.

We published a hand book for patients and a health care worker in 2003.The first training programme was launched in 2004 which trained 16 nurses in stoma care and counseling. Upto 2007 we have trained 28 nurses in government hospital.

The training was extended to train nurses from private surgical institutions in 2007.

In addition undergraduate and post graduate doctors have been educated on management of stomas.

CONCLUSION

Special stoma care is now the accepted standard worldwide. A training programme to train stoma nursing is vital in south Asia and should be directed to train at least one stoma nurse in each surgical hospital.

FP 7

CREATION OF STOMAS WITH LAPAROSCOPIC TECHNIQUE

Kimihito Fujii, Shigeaki Moriura, Ichiro Kobayashi, Takatoshi Matsumoto

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Laparoscopic creation of stoma is considered to produce better outcome than conventional open procedure. We report our experience of these two methods in 18 patients. From June 2002 to October 2007, laparoscopic formations of stoma were performed for 9 patients and the open procedures for the rest 9 patients, including one loop ileostomy, 11 loop colostomies and 6 end colostomies. The indications for operations were obstructed ileus for advanced colorectal cancer or recurrent gastric cancer (10 patients), recto-vaginal fistula (2 patients), fecal ileus (1 patient), anastomosis leakage (1 patient), Crohn's disease (1 patient), ulcerative colitis (1 patient) and the others (2 patients). The median age of the patients was 60 y/o for laparoscopic operation and 71 y/o for open procedure. The average time of surgery were 105.8 minutes for laparoscopic operation and 121.5 minutes for open procedure ($p=0.35$) and the mean blood loss during the operations were 38.1 ml and 132.8 ml, respectively ($p=0.06$).

Laparoscopic creation of stoma may be preferable to the conventional open method. Especially in the cases of obstructed ileus with advanced colorectal cancer, laparoscopic fecal diversion is a good indication. Meticulous assessment of the abdominal cavity can be performed with minimal invasion prior to the following resective treatment of the main tumor. And, as the surgical wound around the stoma is small, postoperative management of the stoma may be easy.

In this report, we describe the difference of these two procedures and indications with review of literatures.

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- PO 9** **Developing An Algorithm For The Selection Of Ostomy Appliances** 62
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POSTER 1

EFFECTIVE INTESTINAL FISTULA MANAGEMENT WITH FISTULA DRAINAGE POUCH

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PURPOSE

We found the effectiveness of using a fistula drainage bag for intestinal fistula management.

CASE HISTORY

The patient was a 62-year-old man who underwent Miles operation for rectal cancer, in the terminal phase of the disease, in 1999. After 6 years, fever, pain and redness was appeared at the suture site and intestinal fistula was appeared. The amount of discharge was 2000~3000 ml/day and watery stool. The size of intestinal fistula was 2.2x1.2cm, and it was managed by gauze dressing methods. Due to contact with stool, the surrounding skin became painful and there was a smell issue.

METHODS

We performed the pouch drainage method at the intestinal fistula and used WELLCARE DRAIN and suction.

The features of WELLCARE DRAIN

The skin barrier : With high pH buffering action. it can be cut to fit the shape of the fistula because it does not have a starter hole.

The outlet : Because of its "cap shape," it can be easily connected with a suction tube.

Closing the outlet minimizes restriction of activities.

RESULTS

Stool leakage stopped. The interval of time to change of appliances was extended. Erosion and pain disappeared. The size of intestinal the fistula became smaller (1x0.8cm). When the outlet was closed, the patient was able to move with a wheelchair and there was less activity restrictions.

CONCLUSION

By using the fistula drainage pouch, the intestinal fistula management was carried out effectively, and reduced the burden of taking care of the patient.

POSTER 2

COMPARISON OF QUALITY OF LIFE FOLLOWING CURATIVE LAPAROSCOPIC ANTERIOR RESECTION VERSUS LAPAROSCOPIC ABDOMINOPERINEAL RESECTION AMONG HONG KONG CHINESE PATIENTS WITH RECTAL CANCER

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AIM

Avoiding a permanent stoma following rectal cancer surgery is generally believed to lead to a better quality of life, but evidence from Asian studies is scarce. This study aimed to compare the quality of life (QoL) following curative laparoscopic anterior resection (AR) versus laparoscopic abdominoperineal resection (APR) among Hong Kong Chinese patients with rectal cancer.

METHODS

Consecutive patients with rectal cancer undergoing curative laparoscopic surgery between September 2005 and December 2007 were recruited into this prospective study. Patients with temporary covering stoma were excluded. Their QoL was assessed using the validated Chinese version of two specific questionnaires (QLQ-C30 and QLQ-CR38) developed by the European Organisation for Research and Treatment of Cancer; these were completed before surgery and at 4, 8, and 12 months after surgery. The QoL scores of patients undergoing laparoscopic AR and APR were compared.

RESULTS

Seventy-one patients (43 male) were recruited during the study period, of whom 24 patients underwent APR. There were no significant differences in age, gender, education level, and proportion of patients receiving adjuvant therapy between the 2 groups. Although patients undergoing APR had lower global QoL scores at 4, 8, and 12 months after surgery when compared with patients undergoing AR, the differences were not statistically significant. The physical functioning ($P=0.027$) and social functioning ($P=0.025$) were significantly worse among patients undergoing APR at 8 months after surgery, but there were no significant differences in these 2 domains at 12 months after surgery. Patients undergoing APR also experienced more financial problems at 4 ($P=0.002$), 8 ($P<0.001$), and 12 ($P=0.006$) months after surgery. However, the presence of a permanent stoma did not affect the sexual and urinary functions after curative laparoscopic rectal cancer surgery.

CONCLUSIONS

The overall quality of life as well as sexual and urinary functions following curative laparoscopic APR and AR are comparable among Hong Kong Chinese patients with rectal cancer.

POSTER 3

PSEUDOMEMBRANEOUS ENTERITIS OF SMALL BOWEL: A CASE REPORT

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BACKGROUND

Pseudomembraneous enteritis of the small bowel is extremely rare clinical event. Literature review showed only less than a dozen of similar cases have been reported. We present a case of a 16 year-old girl with end stage renal failure developing features resembling “pseudomembraneous colitis” involving the jejunum.

CASE REPORT

A 16 year-old girl; a case of nephrotic syndrome with chronic renal failure requiring intermittent peritoneal dialysis (PD) presented with 1 week history of dyspnoea, fever, abdominal pain and vomiting. Provisional diagnosis of PD related peritonitis was made and she was treated with intravenous antibiotics. However, her abdominal signs worsen. She was in septicaemic shock and her clinical condition deteriorated. A CT scan of the abdomen and pelvis showed dilated fluid filled small bowel. After adequate resuscitation, emergency laparotomy was done and revealed a segment of jejunum ischemia which was resected. Subsequently peritoneal lavage and feeding jejunostomy were done. Histopathological examination revealed features of “pseudomembraneous colitis”. Her condition improved and she was treated with Metronidazole.

DISCUSSION

Pseudomembraneous colitis is relatively a common condition after prolonged exposure to antibiotics. However, pseudomembraneous enteritis involving the small bowel is extremely rare with high mortality rate being reported.

POSTER 4

**CASE REPORT: PERFORATED MECKEL'S DIVERTICULUM
IN A NEONATE**

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It is rare to find perforation of Meckel's diverticulum in the neonatal period. This is a case of spontaneous perforation of a Meckel's diverticulum in a 3-day-old child.

CASE

This 3-day old child was readmitted to the Neonatal Ward for poor feeding associated with abdominal distension less than 12 hours after being sent home from an uneventful delivery via emergency Caesarean Section for maternal severe pre-eclampsia at 36 weeks and 2 days. This child was clinically well except for abdominal distension and pneumoperitoneum seen on the abdominal x-ray. Upon referral to the Surgical team on day 4 of life, the child was promptly resuscitated and sent for an emergency laparotomy. A perforated Meckel's diverticulum with localized contamination was found. Wedge resection of diverticulum was performed with peritoneal lavage. The child recovered well post-operatively and was subsequently discharged 1 week later.

CONCLUSION

Spontaneous perforation of Meckel's diverticulum in the neonatal period is very rare but serious if undetected. Therefore, Meckel's diverticulum should be considered in a neonate with unexplained acute abdomen.

KEYWORDS

Neonate, pneumoperitoneum, perforated Meckel's diverticulum

POSTER 5

**INCIDENCE OF COLORECTAL MALIGNANCY IN HOSPITAL TELUK
INTAN FROM 2003 TO 2007**

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This is a retrospective analysis of incidence of colorectal malignancy in Hospital Teluk Intan from 2003 to 2007 with brief literature review.

POSTER 6

**RETROSPECTIVE REVIEW OF COLONOSCOPY PROCEDURES DONE
IN HOSPITAL TELUK INTAN FROM 2006 TO 2007**

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This is a retrospective analysis of colonoscopy procedure done at Hospital Teluk Intan from 2006 to 2007 with brief review of their indications and complications.

POSTER 7

INCIDENCE OF PUDENDAL NERVE NEUROPATHY IN CHRONIC CONSTIPATION

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INTRODUCTION

Constipation is one of the common symptoms that bring patients to hospital. Definitions of constipation are variable and inconsistent. A panel of expert was convened in Rome, Italy and coined the Rome criteria of constipation.

Defecation is a complex mechanism governed by an intact neuromuscular functions are necessary for the formation of formed. Evaluation of constipation includes a number of investigations which examine every aspect of potential causes of constipation. Detail history and physical examination cannot overemphasized that will navigate appropriate investigations.

The use of Pudendal Nerve Terminal Motor Latency (PNTML) test in the investigation of chronic constipation was introduced by Kiff and Swash in 1984. It reflects the conduction velocity of the fastest conducting motor nerve fibres innervating the muscle and the neuromuscular synapse. It has been postulated that in chronic constipation, chronic straining leads to perineal descent and stretch injury to the pudendal nerve.

Aim Analyze the incidence of pudendal neuropathy among patients with chronic constipation.

METHOD

Patients presented to Surgical Outpatient Department (SOPD), Hospital Tengku Ampuan Afzan (HTAA) with symptoms of chronic constipation and fulfilled the Rome criteria were included in the study. Patient biodata, gynaecological history and past medical were recorded. St Mark's pudendal electrode was used in the study. It allows combined stimulation of the pudendal nerve and recording of anal sphincter electromyography. Pudendal neuropathy is defined when latency > 2.2 mS.

RESULT

Seven patients (4 females and 3 males) were included in the study. Mean average of age is 36 years. All patients showed a significantly prolonged latency period with an average of 25ms.

CONCLUSION

There is a significant association of Pudendal neuropathy in patient with chronic constipation.

POSTER 8

**A RARE MUCINOUS COLORECTAL ADENOCARCINOMA IN A
YOUNG PATIENT : A CASE REPORT**

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Colorectal cancer is the third commonest cancer. It occurs >80% in patient aged more than 60 years old. The incidence of colortectal cancer in the young patient is increasing. There is study showed that the incidence of colorectal cancer in young patient of up to 10%. They usually presented at advanced stage at operation. The location of the tumour is similar with the older patients but it has a higher incidence of mucinous tumour. They also have a poorer prognosis.

We reported a case of 17 years old boy who presented with anaemia and right illiac fossa mass. He was diagnosed to have colorectal carcinoma with synchronous lesion. He was subjected for hemicolectomy and sigmoid colostomy. He was scheduled for closure of colostomy but it was deferred due to recurrent of tumour. Repeated CT scan also showed metastasis to the lymph nodes, lungs and liver. He later underwent laparatomy and internal bypass for transverse colon obstruction.

POSTER 9

DEVELOPING AN ALGORITHM FOR THE SELECTION OF OSTOMY APPLIANCES

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INTRODUCTION

Appropriate selection of ostomy appliances is important in order to improve the quality of life of ostomy patients.

However, it is very difficult for general nurses who have not received WOC (wound, ostomy, continence) education to select appropriate ostomy appliances. A number of studies have been published on factors that should be considered when selecting ostomy appliances, as well as algorithms for the selection of appropriate appliances; however, few studies are based on evidence.

The purpose of this presentation paper is to develop an algorithm for the selection of ostomy appliances based on the results of prior studies.

METHODS & RESULTS

Kaitani and our group reported that we identified 20 stoma related factors which should be taken into consideration when selecting ostomy appliances for 172 ostomates in WOCN

(Wound, Ostomy, and Continence Nurses Society) in 2001

Subsequently, we developed an algorithm for the selection of ostomy appliances based on the results of this study in 2004.

When developing the algorithm for ostomy appliances, we focused on four important factors that should be considered when selecting appliances: Type of stoma, Wrinkle or concave defect in peristomal skin area around the stoma (1 cm from mucocutaneous junction) Height of the stoma, and Description of excreta. As a result of data analysis, we added two factors to make the selection for appropriate ostomy appliances easier; whether the location of the stoma is close to bone prominence and whether a 2-3cm flat area from the mucocutaneous junction existed.

The algorithm was tested by 67 nurses using photographs of stomas. A concordance rate of 86% was obtained. The cause of the 14% discordance was failure to understand the mucocutaneous junction and concave defect within a 1 cm area from the mucocutaneous junction.

In order to manage this problem, we added a cautionary remark to the algorithm to consider when examining areas around the stoma, since the abdominal circumference may change depending upon the position.

CONCLUSION

We developed the algorithm for the selection of ostomy appliances according to the result of our prior study.

We tested this algorithm using photographs by general nurses. As a result, it was necessary to add a cautionary remark to the algorithm to consider when examining areas around the stoma, since the abdominal circumference may change depending upon the position.

We will test this algorithm in clinical practice as our next step.

POSTER 10

A CASE REPORT RECTAL PROLAPSE IN A TODDLER

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Spontaneous prolapse of the rectum is relatively common in toddlers and preschool – age groups (1). A peak incidence occurs at or near the time of toilet training. This report discusses the case of a 5 years old boy who presented with rectal prolapse.

POSTER 11

COLODUODENAL FISTULIZATION IN INFLAMMATORY BOWEL DISEASE: CASE REPORT AND REVIEW OF LITERATURE

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Inflammatory bowel disease occasionally presents in an unusual manner. Although internal fistulization is a common complication of Crohn's disease, coloduodenal fistulas are rare in inflammatory bowel disease. Up to 2005, only 52 cases of primary coloduodenal fistula secondary to Crohn's had been reported. In Malaysia, while the incidence of inflammatory bowel disease is low, coloduodenal fistulas infrequently occur secondary to intestinal tuberculosis. We herein report a case of primary coloduodenal fistula secondary to ulcerative colitis. The literature related to this unusual case and its management is reviewed.

POSTER 12

EARLY EXPERIENCE OF ENDOANAL ULTRASOUND TO DETERMINE PRE-OPERATIVE ANATOMY OF PERIANAL FISTULA

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PURPOSE

The aim of the study was to assess the accuracy of endoanal ultrasound with hydrogen peroxide (H₂O₂) enhancement(EAH) to determine the pre-operative anatomy of perianal fistula in comparison to examination under anaesthesia (EUA) as gold standard.

METHOD

From March to December 2007, patients who were referred to Colorectal Clinic, Hospital Sultanah Bahiyah, Alor Star, Kedah for primary or recurrent perianal fistulas were recruited into this study. Excluded were those who had a seton inserted and those without external opening identified during clinical examination. Patients were then given a date for examination under anaesthesia (EUA) and admitted one day prior to surgery for EAH using 2D diagnostic ultrasound system (BK Medical, Herley, Denmark). Subsequently, all patients were subjected to EUA. Each fistula was described according to Parks classification (intersphincteric, transphincteric, extrasphincteric and suprasphincteric), location of the internal opening, presence or absence of secondary track. EAH was compared to EUA to determine its accuracy.

RESULTS

There were a total of 14 patients (11 males and 3 females) recruited into this study. Their age varied from 21 to 74 years old with a mean of 43.5. There were 7 intersphincteric, 6 transphincteric and 1 suprasphincteric fistulas identified by EUA. EAH correctly identified all the intersphincteric and 5 transphincteric tracks. We failed to identify one internal opening for a transphincteric fistula and misinterpreted the only suprasphincteric track as transphincteric track using EAH (accuracy 85.7%). EAH agreed with EUA with regards to all the position of internal opening except the only transphincteric track that we missed (92.8% agreement rate).

CONCLUSION

Endoanal ultrasound with H₂O₂ enhancement has high accuracy even in our early experience.

POSTER 13

A CASE REPORT OF A PATIENT WITH FECAL INCONTINENCE

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AIM

The aim of this case report is to review the process to solve problem of fecal incontinence after a closure of temporary ileostomy and to discuss ideal support for patients with fecal incontinence.

CASE

A 56 year-old man, who suffered from malignant lymphoma since 1999, was diagnosed rectal cancer in 2005 and was performed low anterior resection, left hemi-colectomy and diverting ileostomy. He continued to come and see stomal out-patient clinic due to complicated stoma care. Frequent defecation and perineal skin problem had continued since his closure of the temporary ileostomy two months later. During this period, we advised him about perineal skin care and bowel control. One year later he consulted his primary surgeon about re-preparation of stoma, but was suggested to stay with only defecation control by opioid. We recommend him to have a second opinion in other hospital, because of the failure to share his problem with the doctor. The other doctor listened to his discontent and recommended to be examined his primary disease. Colonoscopy revealed simple rectal ulcer which might be relative to his complaints. The second opinion that announced him a possibility to have stoma whenever he wanted soothed his anxiety and discontent. As a result, he gradually had tolerable bowel habit and his attitude of facing all challenges against fecal incontinence or disease was changed positively.

DISCUSSION

We generally assess QOL of stomal patients and offer an appropriate care. However, in this case, a lack of consideration of his primary problem was reflected on. As we see the difference of recognition about fecal incontinence between primary surgeon and the patient, we need early development of a team work of medical stuff to provide appropriate care for patients with fecal incontinence. We believe that WOC Nurses are able to play a role of it.

POSTER 14

IMPORTANT POINTS OF CONSULTATION FOR THE FISTULA MANAGEMENT

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INTRODUCTION

Since the excretion without making contact with the skin around a fistula is a fundamental rule of skin care during fistula management, the pouching method may fit this purpose. However, fistula management is difficult in most cases because of poor local skin conditions. There are many care consultations, in wound and stoma fields to our department from a various institution such as a hospital.

In this study, we evaluated important points of consultation about difficult fistula management method.

The subjects were 60 cases that consulted at our department as difficulties in fistula management by direct visit, by telephone, or by letter enclosing photographs between October 1998 and October 2007. The conditions of appliances attached to the fistula and the skin around it after introducing pouching were evaluated by direct visit to the respective patients, by telephone interview by nurses in charge, or by letter enclosing photographs.

CONCLUSION

We introduce the fistula management procedure which we made to nursing staff to overcome the difficulties of fistula management. Applying pouching method is available procedure for a complex fistula management, and enhance the patient's Quality of Life.

POSTER 15

IATROGENIC COLON PERFORATION AND LAPAROSCOPIC COLONIC REPAIR: CASE REPORT

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INTRODUCTION

Colon perforation during colonoscopy is a known complication that usually requires operative intervention. Current practice is laparotomy and repair or resection. With advanced of laparoscopic technique, laparoscopic repair can be consider as option of treatment.

METHOD

We report 2 cases with iatrogenic perforation during elective colonoscopy, then undergone emergency laparoscopic colonic repair within 12 hours.

RESULT

Case 1: A 68 yrs old lady with chronic constipation undergone colonoscopy, noted perforation at sigmoid colon during the procedure.

Case 2: A 49 yrs old man with bone metastasis undergone colonoscopy to look for primary, complicated with perforation at rectosigmoid junction.

Both patients undergone emergency laparoscopic repair of the perforation within 12 hours. Post operatively was uneventful, which patients were allowed orally on post surgery day 1 and discharge on day 2 after operation

CONCLUSION

Laparoscopic repair of colon is a feasible technique to manage iatrogenic perforation of colon in elective colonoscopy.

KEYWORD

iatrogenic, colon, perforation, colonoscopy, laparoscopic, repair

POSTER 16

**CASE REPORT: DEVELOPMENT OF POLYPS AT THE ILEAL
POUCH-ANAL ANASTOMOSIS IN PATIENT WITH
FAMILIAL ADENOMATOUS POLYPOSIS**

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Restorative Proctocolectomy and Ileal Pouch-Anal anastomosis(IPAA) is the surgical treatment of choice for patients with Familial Adenomatous Polyposis(FAP).

This procedure is thought to abolish the risk of adenoma and hence cancer. There have been an increasing number of case reports reporting the development of adenoma or malignancy at the anastomotic site.

We report on a patient with FAP who had IPAA 3 years ago, developed adenomatous polyps at the ileoanal anastomotic site.

We emphasize the need for long term surveillance for patients who had Restorative Proctocolectomy and Ileal Pouch-Anal anastomosis (IPAA).

KEY WORDS

Ileal Pouch-Anal Anastomosis, Familial Adenomatous Polyposis, Adenomatous polyps.