Malaysian Society of Colorectal Surgeons
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(Operative Workshop)
Datin Dr Nik Raihan bt Nik Mustapha
(Pathology Workshop)
Welcome Message

Welcome to the Coloproctology 2012, the tenth meeting held annually by the Malaysian Society of Colorectal Surgeons. As always, we have organised this meeting to give regular updates on various topics in coloproctology. Renowned experts from all over the world have been invited to speak at our meetings. We are pleased to receive encouraging support from you, our regular participants. Indeed, the surgical technique has advanced so much that from a simple blade and retractors, it has moved towards laparoscopy and robotic surgery lately.

Similarly, this year, we have arranged experts to come from the United Kingdom, Australia, China, India, Korea, Philippines, Singapore and Thailand, to discuss on various issues on current practice in colorectal surgery. Besides the lectures, there will be workshops, interactive sessions especially during the professor’s corner where management of real complicated cases can be discussed openly. There will also be a post-graduate round arranged with one of our foreign experts for our local surgeons and surgical trainees at Kuching Hospital.

This time, as you can see, Kuching has been chosen as our venue for the conference. We have always had meetings in West Malaysia earlier but due to the tremendous support we obtained from the Sarawak Convention Bureau, we are glad to come to the “Land of the Hornbills”. On top of that, we found that the facilities and space provided by the Pullman Hotel in Kuching are excellent and we are confident that our meeting will be a success. This is not to mention the numerous opportunities provided to our delegates to tour attractive places of interests around Kuching. Therefore, for obvious reasons, we have chosen to hold this meeting during school holidays.

Besides updating ourselves, the meeting is also meant to generate interest among young surgeons especially in East Malaysia. So far, the Malaysian Society of Colorectal Surgeons does not have any member from Sarawak and Sabah. It is hoped that with the exposure provided by our meeting, more will take up colorectal surgery here to provide better service to the people in East Malaysia.

Lastly, I wish you a fruitful meeting here in Kuching, Sarawak. Enjoy yourselves and take the opportunity to visit this exotic and beautiful place.

Dr Wan Khamizar Wan Khazim
President, Malaysian Society of Colorectal Surgeons &
Organising Chairman, Coloproctology 2012
# Programme Summary

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<td><strong>Symposium 6</strong> Colorectal Trauma</td>
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<td><strong>Symposium 3</strong> Infectious Diseases And The Colorectal Surge</td>
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<td>1300 – 1400</td>
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<td><strong>Lunch Satellite Symposium (Ethicon Endo-Surgery)</strong></td>
<td><strong>Symposium 8</strong> Rectal Cancer</td>
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### 8th March 2012 (Thursday)

#### Pre-Congress Workshop 1 • Operative

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#### Pre-Congress Workshop 2 • Pathology

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<td>• Introduction to biopsy interpretation</td>
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<td>• Manuel Salto-Tellez</td>
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<td>• Molecular diagnostics of GIT pathology</td>
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<td>1430</td>
<td>Slide Seminar 2</td>
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<td>• Non-neoplastic pathology</td>
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0830 – 1000
SYMPOSIUM 1 COLOSSEUM 1
Imaging For Colorectal Cancer
Chairpersons: MANOHAR PADMANATHAN / AHMAD SHANWANI

- Endorectal ultrasound for rectal cancer staging – Still the gold standard? [page 13]
  Charles Tsang

- CT vs MRI for rectal cancers [page 14]
  Syazarina Sharis Osman

- PET-CT for staging of colorectal cancer – Does it change management? [page 15]
  April Roslani

1000 – 1030
Tea

1030 – 1115
PLENARY 1 COLOSSEUM 1
Chairperson: YUNUS GUL
Laparoscopic surgery in inflammatory bowel disease [page 18]
Timothy Rockall

1115 – 1245
SYMPOSIUM 3 COLOSSEUM 1
Infectious Diseases And The Colorectal Surgeon
Chairpersons: AZMI MD NOR / M SARKUNNATHAS

- Colorectal surgery in the immunocompromised [page 18-19]
  Parvez Sheikh

- Surgical management of abdominal tuberculosis [page 20-21]
  Shekhar Suradkar

- Sexually transmitted disease affecting the anorectum – The surgeons’ role [page 21-22]
  Parvez Sheikh

- Prevention and management of pseudomembranous colitis
  Jayaram Menon

1245 – 1415
Lunch Satellite Symposium (Ethicon Endo-Surgery)
Chairperson: ISMAIL SAGAP
Science of tissue management advance energy in surgery
Joseph F Amaral
1415 – 1500
PLENARY 2
Chairperson: ISMAIL SAGAP
Laparoscopic surgery for colorectal cancer [page 26] Andrew Bui

1500 – 1630
SYMPOSIUM 5
Colorectal Surgical Training
Chairpersons: MOHAMED AKHTAR QURESHI / JASIAH ZAKARIA
- Colorectal surgical training in Australia [page 27] Andrew Bui
- Colorectal sub-specialty training in a developing country – Necessity or luxury? [page 28] Wan Khamizar Wan Khazim
- Evaluation of residents in colorectal surgery [page 29] Armando Crisostomo
- Colorectal surgery training and certification in the UK [page 30] Timothy Rockall

1630 – 1700
Tea / Poster Judging

1700 – 1800
HOW I DO IT
Chairpersons: PAUL SELVINDOSS / GOOI BOON HUI
- Laparoscopic surgery for rectal prolapse [page 30] Timothy Rockall
- Perineal approach for rectal prolapse Parvez Sheikh
- SILS TEM [page 31] Jirawat Pattana-arun
- Operative techniques for anal sphincter repair Parvez Sheikh
- Intersphincteric approach for anal fistula repair (LIFT technique): How I do it [page 32] Charles Tsang
- Treatment of post-anal abscess Charles Tsang

1800 – 1900
MSCRS AGM

1930 – 2200
GALA DINNER
Daily Programme
10th March 2012, Saturday

0830 – 0930
SYMPOSIUM 6
Colorectal Trauma
Chairpersons: WAN KHAMIZAR WAN KHAZIM / RETNA RASA
- Abdominal trauma for the colorectal surgeon
  Ismail Sagap
- Rectal impalement [page 33]
  Armando Crisostomo
- Sodomy – Clinical evaluation [page 34]
  Andrew Bui
- Sodomy – Forensic aspects [page 35]
  Zahari Noor

0930 – 1015
PLENARY 3
Transanal management of rectal cancer [page 38]
Lee Woo Yong

1015 – 1045
Tea

1045 – 1300
SYMPOSIUM 8
Rectal Cancer
Chairpersons: APRIL ROSLANI / ONG KEE THIAM
- Adjuvant chemotherapy after complete pathological response – Is it necessary?
  Christina Ng
- Histopathological assessment of the rectal cancer resection specimen [page 39]
  Manuel Salto-Tellez
- Surgery for metastatic colorectal cancer – When do we stop?
  Charles Tsang
- Changing surgical strategies after neoadjuvant therapy – Is it safe? [page 40-42]
  Lee Woo Yong

0830 – 1030
SYMPOSIUM 7
Allied Health Professional Session (4)
Chairperson: TAI SEOW BENG
0830 – 0930
Where do we go: Setting up a stoma clinic [page 35]
Mariam Mohd Nasir
0930 – 1000
Attitude and values: Barrier to stoma care? [page 36]
Tai Seow Beng
1000 – 1030
Prevention is better than cure: Role of an enterostomal therapist (ET) [page 37]
Ravathy Ramamurthy

1030 – 1100
Tea

1100 – 1300
SYMPOSIUM 9
Allied Health Professional Session (5)
Chairperson: TAI SEOW BENG
1100 – 1130
Psychological & physical impact of ostomies surgery [page 43]
Ng Yeng Lai
1130 – 1200
Ethical issues and professionalism in enterostomal therapy nursing [page 44]
Mariam Mohd Nasir
1200 – 1230
Counseling issues and problems in stoma care [page 44-45]
Paat Siu Lin
1230 – 1300
Food intake & stoma management: Dispelling the myths [page 46]
Rozita Mohamad
10th March 2012, Saturday [cont’d]

1300 – 1400
Lunch Satellite Symposium (Sanofi-Aventis)  
Chairperson: SAMUEL TAY  
The use and benefit of Seprafilm to prevent post surgery adhesion in open and laparoscopic surgery  
*Francis Seow-Choen*

1400 – 1530
SYMPOSIUM 10  
Diverticular Disease  
Chairpersons: MEHESHINDER SINGH
- Acute diverticulitis  
  *Samuel Tay*
- Diverticular bleeding – Which treatment option is best?  
  *Dean Koh*
- Strictures and fistulas after diverticulitis – Surgical indications and outcomes  
  *Ismail Sagap*
- Controversies in the management of diverticulitis  
  *Timothy Rockall*

1530 – 1600
Tea

1600 – 1700
PROFESSORS’ CORNER  
Moderator: LU PING YAN

1400 – 1630
WORKSHOP 2
Allied Health Professional Session (6)  
Making Life Easier – Optimal Quality of Life for the Modern Ostomate
- Quality of life of temporary ostomates  
  *Ravathy Ramamurthy*
- Preliminary results of QoL survey  
  *Li Ming*
- Holistic care for ostomates from a dignity care perspective  
  *Mariam Nasir*
- Introduction to coloplast’s products  
  *Khaw Wei Ping*

11th March 2012, Sunday

0900 – 1200
POST-GRADUATE ROUND  
*Andrew Bui*
Conference Information

Conference Venue
PULLMAN KUCHING
No.1A, Jalan Mathies, 93100 Kuching, Sarawak, Malaysia
Tel : (6082) 222 888  Fax : (6082) 222 999
Email : H6332-SL2@accor.com / H6332-RE1@accor.com  Website : www.pullmanhotels.com

Registration
The registration hours are:

- 8th March 2012 (Thursday) 1500 to 1900 hrs
- 9th March 2012 (Friday) 0730 to 1800 hrs
- 10th March 2012 (Saturday) 0730 to 1500 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

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 Taj Mahal, Pullman Kuching, and the operating hours are:

- 8th March 2012 (Thursday) 1500 to 1900 hrs
- 9th March 2012 (Friday) 0730 to 1800 hrs
- 10th March 2012 (Saturday) 0730 to 1500 hrs

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

Posters
Posters will be displayed at Ballroom Foyer. The Organising 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 will 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 changes should the need arise.
Function Rooms & Trade Exhibition
Level 2

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The Organising Committee of the Coloproctology 2012
wishes to thank the following for their support and contribution:

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Ethicon Endo-Surgery

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Acknowledgements
ENDORECTAL ULTRASOUND FOR RECTAL CANCER STAGING – STILL THE GOLD STANDARD?

Charles Tsang
University Surgical Cluster, National University Hospital, Singapore
National University Cancer Institute Singapore, Singapore

Endorectal ultrasound is a useful bedside tool for the local staging of early rectal cancer. Detailed resolution of layers of the rectal wall makes it superior to CT and even MRI in defining benign and early T1-T2 lesions. However with the inverse relationship between frequency of US waves and depth of penetration, endorectal ultrasonography pales in comparison to MRI in the evaluation of locally advanced rectal tumors, invasion to adjacent organs e.g. bladder and lateral pelvic wall and presacral space. The most commonly used rigid BK 2050® endoprobe also precludes evaluation of upper rectal lesions beyond 15 cm due to inherent curvature of the presacral space. It is also highly operator dependent and requires a meticulous technique e.g. good bowel preparation, bubble free fluid in the rectal balloon and keeping the probe central within the lumen of bowel during the scan to ensure good focus of the transducer in a 360˚ field. MRI rectal scans however do not offer the same detailed image of the layers and are not good for discerning early lesions. It does however give good imaging of the mesorectal fascia (MRF) and has been used as a tool for predicting CRM involvement. In the era of selecting patients for neoadjuvant chemoradiation, so as to downstage tumors, MRI has emerged as the modality of choice in the local staging of rectal cancer. Endorectal ultrasound however remains useful for evaluation of early rectal lesions, selecting uT0 tumors suitable for local excision. Endorectal ultrasound and MRI thus play complementary roles in the evaluation and staging of rectal cancer. The choice of modality depends on the clinical and endoscopic assessment, availability of both resource and expertise.
CT VERSUS MRI FOR RECTAL CANCER

Syazarina Sharis Osman
Universiti Kebangsaan Malaysia Medical Centre, Kuala Lumpur, Malaysia

Rectal cancer comprises about one third of colorectal cancers. Prognosis depends on the depth of the invasion of the tumor, involvement of the circumferential resection margin/mesorectal fascia as well as number of lymph nodes metastasis. These factors, along with the presence of other organs or distant metastasis will also determine the treatment options of these patients.

Thus imaging plays very important role in the surgical as well as neoadjuvant treatment planning for rectal cancer patients. The imaging options for staging of rectal cancer includes computed tomography (CT), body coil or endorectal coil magnetic resonance imaging (MRI), endorectal ultrasound (ERUS) and positron emission tomography (PET).

Main focus will be on the role of CT and MRI in rectal cancer. Due to the wider availability and accessibility of CT scan in our country, this modality and probably along with ERUS, is more widely used for treatment planning. However, MRI has been shown to be more sensitive than CT for local staging and assessing mesorectal fascia involvement.

In this lecture, the pro and cons of each of the modality will be discussed. The sensitivity and specificity of the imaging techniques will be revealed along with the pitfalls or problems encountered during image interpretation especially for local staging and assessment for nodal involvement.
PET-CT FOR STAGING OF COLORECTAL CANCER
– DOES IT CHANGE MANAGEMENT?

A C Roslani

Department of Surgery, Faculty of Medicine, University of Malaya, Kuala Lumpur, Malaysia

Improvements in colorectal cancer (CRC) outcomes, even in more advanced stages, are often attributed to better therapeutic options in conjunction with more precise staging modalities. 18F-fluorodeoxyglucose (FDG)-Positron Emission Tomography-Computed Tomography (PET-CT), which utilizes the preferential uptake of FDG by cancer cells, combines functional and anatomic imaging techniques to maximize provision of information for clinical decision-making. Current indications for PET-CT in CRC include evaluation of indeterminate lesions in otherwise resectable tumours, potentially resectable metastases or recurrence, and suspected recurrence in the absence of visible lesions on conventional imaging modalities. PET-CT surveillance of response to treatment is increasingly being utilized. There is even evidence that PET-CT predicts KRAS/BRAF mutations in CRC patients, a possible future indication.

Use of PET-CT has escalated in healthcare systems where it is reimbursable. However, there is little data to show that increased utilization for extended indications results in further significant advantageous changes in management; it may, instead, increase the initiation of inappropriate management following false positive and negative results. Additionally, in developing countries, PET-CT is not always readily available, and adds a considerable cost burden. Decision-making for PET-CT utilization should therefore take into account the potential for altering clinically-directed management, bearing in mind patients’ wishes with regards to therapy and financial implications.
ENTEROSTOMAL THERAPIST (E.T.) NURSE: CHALLENGES AND FUTURE OF STOMA CARE NURSING IN MALAYSIA

Tan Tang Peng
TPT Resources Sdn Bhd, Kuala Lumpur, Malaysia

This paper tells about how stomaltherapy nursing, ostomy rehabilitation programs and awareness began in Malaysia in the late 1980s; the challenges faced through the years in terms of resources; and how future stomaltherapy nursing care and education could evolve in Malaysia.

THE STOMA – BASIC PRINCIPLES

Manohar Padmanathan
Pantai Klang Specialist Medical Centre, Klang, Selangor, Malaysia

The creation of intestinal stomas for diversion of enteric contents is an important component of the surgical management of several gastroenterologic disease processes. Despite the frequency with which these procedures are performed, complications of stoma creation remain common, despite extensive measures aimed at reducing them. Early postoperative complications (those seen less than one month postoperatively) can lead to significant cost, both financially and psychologically, and incur significant morbidity. Commonly seen early postoperative stomal complications include improper stoma site selection, vascular compromise, retraction, peristomal skin irritation, peristomal infection/abscess/fistula, acute parastomal herniation and bowel obstruction, and pure technical errors.
A COMPREHENSIVE INITIATIVE FOR REHABILITATION OF THE OSTOMATE

Tai Seow Beng
Clinical Coordinator Cum Lecturer, Segi College Kuala Lumpur, Malaysia

Rehabilitation of a person with a stoma should attempt to maximize a person ability to function, promote independence and self confidence. It should emphasis improving Quality of Life. A person's rehabilitation after ostomy surgery is a continuous process of adaptation and is directed toward returning to a normal way of life.

An excellent surgical technique by the surgeon is advocated for good stoma care (Lagaay & Goozen 2000). When a patient is schedule for ostomy surgery he or she receiving preoperative education and counselling by health professionals can help to relieve some of the psychological feelings contribute to patient's positive recovery and will be able to rehabilitate more quickly. The patient's ability to lead a full and active life will be greatly compromised if stoma is misplaced.

ET nurse's has a vital role in teaching patient to deal with the appliance and care for his stoma. Once competent to carry out the care this will enable him/her to be independent and restore his/her status. It is vital that the ET/nurse continue to provide psychological support, empathy, patient will need reassurance and understanding patient perception towards the new body image. ET/nurse should continue to provide counselling that will be able to assist patient to adapt to alteration of new body image and return to one's previous activities of daily living and life style. A well adjusted stoma patient with a positive thinking will be a successful rehabilitated patient.

A comprehensive and individualised discharge plan is essential will be provided as an integral part of rehabilitating the stoma patient. Prior to discharge ostomate have many concerns about the new stoma which will affect their daily life. Thus advice and information's on following areas :-diet, hygiene, clothing, return to work, where to obtain appliances, travelling, recreational activities, sexual, last of all information regarding welfare aids available for needy ostomate will be provided on the discharge plan. Counselling the family can also be exploited to achieve rehabilitation.

The transition from hospital to home can be a stressful period for the ostomate. The psychological support from community clinic and hospital medical team, person for contact if any problems arise contribute significantly to a successful rehabilitation. Introduction to stoma association will provide advantages in meeting patient's needs to fit and feel part of the group.

CONCLUSION
Having a stoma that receive adequate education pre and post operative time and active informative support is mandatory to obtain some degree of improvement of their QOL and a successful rehabilitate ostomate.
LAPAROSCOPIC SURGERY IN INFLAMMATORY BOWEL DISEASE

Tim Rockall
Royal Surrey County Hospital, United Kingdom

The majority of patients with inflammatory bowel disease requiring surgery can be managed laparoscopically both in the elective and the acute setting. From segmental resection and strictureplasty to proctocolectomy and ileoanalpouch surgery laparoscopic surgery can offer significant advantages to the patient with regards to blood loss, post operative pain and recovery from surgery, especially when combined with an enhanced recovery protocol. In skilled hands laparoscopic surgery can be accomplished quickly and with few complications. Complications relating to wound infection and adhesion formation in particular can be markedly reduced. This is important for this group of patients who often require staged surgical management or multiple operations during their lifetime.

A few scenarios can present particular surgical challenges for the laparoscopic surgeon. In Crohn’s - complex fistulating disease and the large inflammatory mass. In ulcerative colitis, the fulminant colitic with toxic megacolon. In some circumstances laparoscopic surgery will offer no benefit to the patient and open surgery is indicated in order to not jeopardise patient safety.

COLORECTAL SURGERY IN THE IMMUNOCOMPROMISED

Parvez Sheikh
Charak Clinic Nursing Home, Mumbai, India

Colorectal surgery in the immunocompromised patient - there are 2 aspects to consider – first one is the problems faced by the patient due to his/her immunocompromised status, & the second one is the precaution that the surgeon has to take in the immunocompromised patient especially if the immunocompromised status is due to HIV infection. The patient can be immunocompromised either due to an advanced HIV infection or due to suppression by chemotherapeutic drugs commonly used for hepatic & renal transplantation & for treating malignancies or due to prolonged steroid use.

There are some colorectal conditions which have a high incidence of occurrence due to the immunocompromised status of the patient. Immunosuppressed patients are more likely to have extensive AIN III and a greater risk of malignant change (up to 11%) despite AIN surveillance. The frequency of the anal carcinoma has grown in recent years, particularly in HIV+ patients participating in anal sex. Systematic screening and early vaccination should be able to stem this worrying development. However the incidence of metachronous and new polyp formation is similar to people who are not immunocompromised. Pseudomembranous colitis has been reported to be associated with chemotherapy & is a known complication of advanced HIV infection.
Any surgery on an immunocompromised patient can have the following problems – increased risk of infection, delayed wound healing & potential risk of infection for the surgeon & other related personnel, while operating & treating HIV patients. Following the universal precautions minimizes the later risk. The patient should be informed about the delayed wound healing. Post-operative use of antibiotics may be required in these patients.

There is an increased incidence of tuberculosis in immunocompromised patients. In infective colorectal conditions like anal fistula, tuberculosis should be ruled out before surgery. In endemic areas, the incidence of tuberculosis in anal fistulas can be as high as 7% even in non immunocompromised patients. There is also a raised incidence of ileocaecal tuberculosis & tuberculosis in unusual situations; like rectal or colonic tuberculosis.

Abdominal surgery in the immunocompromised patients requires some special care. Any intestinal anastomosis should preferably be drained. This can help if there is a leak or abdominal sepsis even without leak. Low rectal resections should preferably be diverted. Longer use of antibiotics in the peri-operative period can be considered for these patients. There are some GI manifestations unique to advanced HIV infection, like Kaposi’s sarcoma & lymphoma (NHL) of the GI tract which can cause a lower GI bleed. It is also not uncommon to have diarrhea in the immunocompromised patient & uncommonly can be due to cytomegalovirus colitis or cryptosporidium infection.

While doing surgery one should keep in mind the unusual problems of the immunocompromised & act accordingly & one also needs to protect oneself from acquiring infection from these patients by following universal precautions.

Surgical Management of Abdominal Tuberculosis

Shekhar Suradkar
India

Tuberculosis has been declared a global emergency by the World Health Organization and is the most important communicable disease worldwide.

The prevalence of extra-pulmonary tuberculosis seems to be rising, particularly due to increasing prevalence of acquired immunodeficiency syndrome (AIDS).

In patients with extra pulmonary tuberculosis, abdomen is involved in 11% of patients. Though potentially curable, abdominal tuberculosis continues to be a major cause of morbidity and mortality in India.

In the abdomen, tuberculosis may affect the gastrointestinal tract, peritoneum, lymph nodes, and solid viscera.

The disease can mimic various other gastrointestinal disorders, particularly inflammatory bowel disease, colonic malignancy, or other gastrointestinal infections. Because of the non-specific symptoms and signs, its diagnosis is often delayed. A high index of suspicion therefore needs to be maintained for an early diagnosis and timely treatment.

There are three main types, and several less common ones. In India the order of their frequency in adults is:
1. The plastic type, which causes intestinal obstruction.
2. The glandular type, which involves the mesenteric nodes.
3. The type which presents as ascites

In Africa the order of frequency of these types in adults is (3), (1), (2).

In children, the abdominal lymphadenopathy is more common.

The surgical management of GITB is required only when there is a doubt about the diagnosis of TB abdomen & when complications are set in like:
1. Acute on chr intestinal Obstruction
2. Peritonitis with perforation of TB Ulcer
3. Haemorrhage
THE VARIOUS PROCEDURE DESCRIBED ARE

1. Diagnostic laparoscopy (Mini laparatomy – where facilities for laparoscopy is not available)
2. Stricturoplasty / resection anastomosis / Bypass with side to side anastomosis-for ileal strictures causing obstruction
3. Segmental colectomy for ileocaecal mass with obstruction (Ideal)/ Right hemicolecctomy or in adverse condition & inexperienced hands ileo – transverse colostomy. (For lesions causing obstruction only)
4. Adseolysis for bands causing obstruction only.

CONCLUSION

Abdominal Tuberculosis is mainly a medical condition which can be cured by Chemotherapy only. The surgical interventions is required only when there is doubt about the diagnosis or when the complications are set in.

SEXUALLY TRANSMITTED DISEASE AFFECTING THE ANORECTUM – THE SURGEONS’ ROLE

Parvez Sheikh
Charak Clinic Nursing Home, Mumbai, India

The sexually transmitted diseases that can affect the anorectum are usually following anoreceptive sex in males & females although a few can occur due to contiguous spread from genital infection. The common organisms that are responsible are Human papilloma virus, Herpes Simplex Virus, Neisseria gonorrhoeae, Chlamydia trachomatis (in particularly lymphogranuloma venereum) and Treponema pallidum (1). Infected toys used for sexual pleasure can transmit other organisms.

Anal condyloma caused by HPV, is the most common sexually transmitted disease of the anorectum. Since anal condylomas have the potential to lead to anal carcinoma, it is important for the surgeon to regularly follow these patients closely & biopsy any suspicious areas (aceto-whitening). Smaller lesions can be cauterized. Excision of extensive anal condyloma has a known high probability of recurrences, but the risk of developing anal stenosis is low. Careful primary excision of even confluent warts can therefore be safely performed without major primary flap reconstructions (2).

Campylobacter jejuni and other Campylobacter species have been isolated from stool and rectal cultures obtained from homosexual men with proctocolitis (3). Acute infection with C. jejuni may involve the small bowel or the colon and causes a diarrheal illness. Severe cases manifest systemic complaints of myalgias, chills, fever, and abdominal pain. The clinical picture can be similar to appendicitis or inflammatory bowel disease (4). HIV-positive patients tend to have more severe infection of longer duration; are more likely to have bacteremia; and are more likely to manifest extra intestinal disease (cellulitis, pneumonia) (5).
Infection by Chlamydia trachomatis is mostly via anal intercourse, but secondary involvement from genital infection can occur. Infection from non lymphogranuloma venereum (LGV) serovars is frequently asymptomatic but can result in proctitis and common genital infections. LGV serovars (L1, L2, L3) produce a more aggressive infection manifest by perianal, anal, or rectal ulceration with resulting pain and discharge. Anal infection produces abscesses, fistulae, or structuring, which inspection of the rectal mucosa reveals a proctitis that may be indistinguishable from Crohn’s disease. Lymphadenopathy, characterized by large matted nodes and overlying erythema, can occur in iliac, perirectal, inguinal, or femoral nodes.

Chancroid is an ulcerating sexually transmitted disease caused by Haemophilus ducreyi. The transmission of H. ducreyi is facilitated by HIV. The ulcers of chancroid are painful and frequently multiple ulcers are present. They are most commonly located on the genitalia, but perianal abscesses and ulceration may occur.

The primary stage of anorectal syphilis appears within 2 to 10 weeks of exposure via anal intercourse. The anal chancre is a small indurated papule that eventually ulcerates but heals without treatment in 2 to 4 weeks (6) Anal ulcers are located on the perianal skin or in the anal canal; may be single or multiple; are associated with painless but prominent inguinal lymphadenopathy; and in contrast to genital ulcers are frequently painful. Proctitis from syphilis may occur in the absence of anal chancres.

Herpes simplex virus type 2 (HSV-2) is the leading cause of genital ulcer disease in developing countries, including, and is especially prevalent among men who have sex with men (MSM) (7). Prevalent HSV-2 infection is associated with a three-fold increased risk of HIV acquisition among both men and women in the general population, suggesting that, in areas of high HSV-2 prevalence, a high proportion of HIV is attributable to HSV-2 (8).

HIV infection can increase the rate of STI in people who have anoreceptive sex. On the other hand, an anal ulcer caused by STI can increase the chances of acquiring HIV infection during anoreceptive sex.

For a surgeon, it may sometimes be difficult to differentiate between the different types of ulcers & diagnostic tests may be required to confirm the diagnosis. Anal fistulas & solitary rectal ulcers are the common differential diagnosis for the surgeon. Most of the anal STIs caused by bacteria can be easily treated with antibiotics, while the STIs caused by virus may need surgical intervention. The colorectal surgeon has to follow up these patients closely, especially the patients having condylomas, so that an early diagnosis & treatment of anal carcinoma can be done.

DIGESTIVE & URINARY OSTOMY: THE ROLES OF SKIN PROTECTORS

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The skin plays an important role in ostomy care, providing the surface on which the pouching system is adhered. Intact, dry epidermis and a well-fitted pouching system enable a sustained, predictable wear time. When skin integrity is compromised or when drains or an open incision infringe on adhesives, potential for pouch leakage exists. The cyclical pattern of pouch leakage/skin erosion must be broken to enable epidermal resurfacing and restoration of an intact seal. Peristomal skin protection is the cornerstone of ostomy management; treatment of the skin relies on methods to create dry surfaces, fill irregular contours, and treat infections, while an adhesive seal is maintained.

Providing quality care for the person with an abdominal stoma requires attention to clinical care, quality of life issues, and cost. The condition of peristomal skin in this matrix is significant because compromised tissue leads to increased care, health-seeking activities, problems with adjustment, and increased costs. A comprehensive approach to the prevention and management of peristomal skin complications begin preoperatively and continue until the stoma can be closed or for the rest of a person’s life. Access to knowledgeable care providers is key to decreasing complications and minimizing their effect.

THE BAD AND THE UGLY – MANAGING STOMA AND PERISTOMAL SKIN EXCORIATION

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Possible complications faced by patients who have a stoma come into many ways. One of the complications is physical complications. Some complications will require further surgery, while others can be treated with medication and altered techniques in caring for stoma. Complications can be detect by examination or complaint from patient. Nurse should report any suspected complication as soon as possible to the doctor in charge especially after surgery.

Pre and post operative nursing management is most important to prevent any complication such as skin excoriation, stoma prolapse, herniation of the stoma and stenosis. Stoma should treated before complication become worse. Patient should be cautioned about stoma care. A full explanation of the condition and proposed treatment should be given.
SAFE CARE AND SAFE PRACTICE:
STOMACARE BEST PRACTICES GUIDELINES

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Safe care and safe practice are entrenched as key benchmarks for the nation in health services industry. Standards, protocols and guidelines are being made to ensure this. This is vital since it helps to determine the patient’s safety, welfare of patients and right’s to access to the highest standards of care.

We are seeing increasing number of ostomies surgery being done now as compare with before, but we do know too, that we do not have sufficient number of trained Enterostomal Therapists, who are specially trained to care for the stoma patients.

Safe is defined by Dictionary.com as “secure from liability to harm, injury, danger or risk” and we are accountable to ensure this element is instilled in our care and practice. One of the ways to ensure this, is to train more Enterostomal Therapist (E.T.), to care for the stoma patients and for those who do not qualified to carry out the care, practice guidelines is one of the best option.

Precaution is better than cure, and don’t learn safety by accident.
OSTOMY SUPPORT GROUP AND THE ROLE OF STOMACARE SOCIETY OF MALAYSIA (PERSATUAN STOMA CARE MALAYSIA (PSCM))

Mohd Rahime Ab Wahab

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Hons Secretary, Persatuan Stoma Care Malaysia (PSCM)

Stoma care Society of Malaysia or commonly known as “Persatuan Stoma care Malaysia” (PSCM) is a national organization which provides support, information and advocacy to those who have undergone ostomy surgery, or known as ostomates and their caregivers. It is a non profit support groups who are committed to the improvement of the quality of life of people who have, or will have, an ostomy.

The roles of PSCM is very vital for those ostomates and due to that PSCM has been dedicated to the provision of information, advocacy and service to, and for, its affiliated support groups, their members and the ostomy community at large.

Since there are increasing number of ostomy surgery being done now as compare with before, PSCM is focusing on their goals, which is to increase its membership creating a channels for ostomate to exchange their knowledge, experiences and also to built up confident among them, so that they can be united and have a better quality of life. This is being done through Ostomy Support Group, which the speaker will share with all during the conference.

It is not easy to maintain the support group as to ensure it is relevant and able to function effectively, since it involves commitment, dedication and also good financial status. Organizing activities, get together, seminars etc will need a lot of team work and hard work.

Collaboration and support between healthcare providers towards caring of ostomies group is the key to improving and sharing the best care for all of them.
LAPAROSCOPIC SURGERY FOR COLORECTAL CANCER

Andrew Bui

Austin Health and The Northern Hospital, University of Melbourne Teaching Hospitals, Melbourne, Australia

Laparoscopic surgery for colorectal cancer has now been widely accepted as a safe and effective operative treatment for benign and malignant colorectal diseases. The uptake of this technique has been slow initially but in Australia has been steadily increasing over recent years. Up to 30% of the colorectal cancer was being treated laparoscopically in 2007 compared to a mere 5% in the mid 1990s.

This presentation will trace the development of both the concept of laparoscopic surgery and the technological advances in the instrumentation required for this operation.

It will review the evidence supporting the use of this minimally invasive technique in the treatment of colorectal cancer through the various multi-centric trials such as COST, CLASSIC, COLOR and ALCCOS.

It will also compare and contrast the benefits and the complications of this operation from the perspectives of the patients, surgeons and the hospitals.

Training and credentialing of established surgeons and trainees are important issues in the introduction of any new procedure. I will outline the various aspects of training courses based on animal laboratory workshops, human cadaveric model, computer simulation, practical mentorship program and post fellowship training programs.

I would also like to share my experience of setting up laparoscopic colorectal surgery at the Austin Hospital. The practical aspects of setting up a laparoscopic team will be described; the impact on theatre allocation and hospital finance will also be discussed.

Future developments of SILS, NOTES and Robotic surgery will also be discussed.
In this presentation, I will outline the Australasian Colorectal Surgery Training programme. I will cover the process of selection, some training and educational activities, the process of assessment and what opportunities exist in Australia.

The colorectal surgical training programme in Australia and New Zealand is a 2 year post fellowship programme run by the TBCRS (Training Board in Colon and Rectal Surgery) on behalf of the two colorectal societies, Section of Colon and Rectal Surgery of the RACS and the Colorectal Surgical Society of Australia and New Zealand (CSSANZ).

The Programme is the oldest and most established post fellowship specialty training programme in Australia and NZ. It was initially based on a few centres with a one year term in a local Unit and an overseas term or research. The Programme has now expanded to include 21 accredited training units in Australia and New Zealand.

Application to the Programme can only be made after the candidate had successfully completed the 4 years of the General Surgery Fellowship. Often an additional year of clinical work or research, as well as strong support from mentors are required before most candidate gained entry into the training Unit programme.

The training programme is made up of two one-year rotations in an accredited training unit in Australasia, with provision for a year spent in an approved overseas centre.

Each training unit is inspected by members of the TBCRS every 5 years to ensure that an adequate mix of cases and a significant volume of work are provided for the training.

Trainees are required to undertake an approved research project at the start of the 2 year programme. There is also an annual education weekend at which all trainees are given a topic to present to the group and members of the TBCRS. The presentations are printed and burnt into CD format for circulation to members of the CSSANZ and it also forms the core education material for the exit examination at the end of the 2 year term.

The assessment of the trainees is based on the report of the Unit Training Director, operative logbooks, annual interviews by the TBCRS, and final written examination and completion of research project. A Certificate of Completion is the awarded upon satisfactory completion of the above assessments.

At present, the majority of Fellows are able to find consultant positions upon completion of their training.
Most developing countries usually do have modern healthcare facilities available. However, due to the inadequate facilities and doctors, people have to resort to doing general works. Therefore we have General Physicians, General Surgeons etc who have to cope with the ever increasing workloads in their respective countries. However, the spectrum of diseases would be about the same except with some little variations in some areas.

Colorectal problems would have been one of the most common diseases encountered by these surgeons. Even though some of these diseases could be handled by General Surgeons, there are problems with they seldom encounter and thus lack experience and expertise to solve them. This is especially so in managing the perineal pathologies such as incontinence and constipation.

On top of that, Colorectal Cancer is one of the most common malignancies affecting men & women in most countries. In order to achieve good tumour clearance especially in the rectum, a proper surgical training is imperative for TME. Not only that, the surgeon must also have enough & constant volume of cases to maintain excellent skill in operating this patients. This can only be achieved by someone with special interest in the area who is a Colorectal Surgeon and not by a General Surgeon.

Many studies have shown that the results of surgery would be better if it is done by someone with interest than a generalist. This is not only true for Colorectal Surgery but in other disciplines too whether medical or non-medical. These studies will be discussed during the presentation and it will show that subspecialty training is necessary and not a luxury. After all when it is a matter of well being, survival, life and death, nothing should be considered a luxury but a necessity.
EVALUATION OF RESIDENTS IN COLORECTAL SURGERY

Armando C Crisostomo

College of Medicine-Philippine General Hospital, University of the Philippines Manila, Philippines

Assessment of residents in colorectal surgery begins with a good selection process. This is achieved by having a clear idea of the entering competencies for trainees who enter your program. In the UP-PGH Division of Colorectal Surgery, we pay particular attention to performance in the following criteria in our selection process – cognitive competency and operative experience in general and colorectal surgery, performance during general surgery residency, the candidate's prospective place of practice and performance in a structured interview.

A comprehensive, competency-based assessment plan is generally recommended. The plan is based upon the terminal competencies expected of the graduates of our training programs. Among US programs, the ACGME has mandated the utilization of assessment methods in six competency areas: medical knowledge, patient care, interpersonal skills and communication, professionalism, practice-based learning and improvement, and system-based practice. In the Philippines, we utilize a standardized evaluation system mandated by the Philippine College of Surgeons (PCS) where residents are evaluated on 4 major areas: surgical knowledge, clinical competence, technical skills and attitudinal competencies. Regardless of content, the following principles of clinical evaluation are recommended:

1. Clear purpose of evaluation
2. Clear definitions of competencies to be assessed
3. Appropriate training and preparation of evaluators
4. High quality learning environment
5. Timeliness of the evaluation
6. Reliable processes to collect, summarize and disseminate assessment information
7. Use of a variety of assessment methods
8. Transparency and trainee engagement
9. Efficient management of information
COLORECTAL SURGERY TRAINING AND CERTIFICATION IN THE UK  
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Royal Surrey County Hospital, Guildford, United Kingdom

The first laparoscopic colorectal resections were reported in 1991 and the first UK series in 1993. Since that time there has been a series of developments that has led ultimately to a National Laparoscopic Colorectal Training Programme in the UK which is unique.

As a result of a lack of evidence favouring a laparoscopic approach the UK National Institute of Clinical Excellence (NICE) made a health technology assessment in 1999 which did not support laparoscopic surgery for the treatment of colorectal cancer outside of the context of a clinical trial. The CLASICC trial was actively recruiting in the UK at that time.

In 2004 the Association of Laparoscopic Surgeons and the Association of coloproctology developed its own preceptorship programme to stimulate and allow safe development of laparoscopic colorectal surgery.

In 2006 NICE made a further health technology assessment and on this occasion issued guidance that supported laparoscopic surgery for colorectal cancer in suitable patients with access to suitably trained surgeons. However there was recognition that there were insufficient trained surgeons in the UK to offer this surgery to all patients.

On the back of this guidance the Department of Health invested heavily in the development of a National Training Programme (www.lapco.nhs.uk) for laparoscopic colorectal surgery which aimed to train the consultant body of colorectal surgeons in the UK to a standard of independent safe practice through preceptorship. This programme is still active and runs alongside an educational research programme. Inherent in the programme is a validated mechanism for assessment and feedback and a validated sign off process.

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LAPAROSCOPIC SURGERY FOR RECTAL PROLAPSE  
*Tim Rockall*  
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Rectal prolapse is often seen in conjunction with other elements of a global pelvic floor disorder. Historically full thickness prolapse has been treated broadly with either a perineal approach in the form of Delormes or Altemeier's procedure, or with an abdominal approach by rectopexy with or without mesh and with or without resection.

All procedures have a significant recurrence rate but evidence suggests that perineal procedures have a higher recurrence rate which is a trade off against a potentially more invasive abdominal procedure.

Rectopexy can however be accomplished laparoscopically in nearly all cases. The posterior sutured rectopexy with or without resection is being replaced by an anterior mesh rectopexy. Both these procedures are described.
**PROPOSE**

1. To introduce a new modified technique of transanal endoscopic surgery
2. To apply this technique for limited resource hospital

**INTRODUCTION**

Transanal endoscopic microsurgery (TEM) was described by Gerhard Buess since 1992. At first, this technique is preserved for high-lying early rectal cancer, in which transanal excision (TE) doesn't reach the lesion. Later, the indication has been extended to mid-to-low rectal lesion and showed benefits above TE in terms of free resected margin and lower recurrence. However, TEM is not widely used because of the expensive instruments and the rare fulfill conditions. Recently, Khoo showed the alternative technique of TEM by using single access laparoscopic port and other laparoscopic equipments in the multimedia article, but not enough detail to reproduce. To overcome these problems, we had practiced this technique in soft cadaver till we got the conclusive steps. We would like to share our tips and techniques for succeeding this procedure to surgeons who don't have TEM system in their hospitals.

**TECHNIQUE**

Patient is placed in the position that the lesion is situated at 6 o'clock. The standard single incision laparoscopic surgery (SILS) is applied. We prefer flexible tip camera, because it minimizes hand crossing, chopstick effect and providing unlimited view. Ultrasonic device is used for dissection and V-loc suture (Covedien TM) for wound closure. The important tip is rectal occlusion with microfiber towel plus intermittent insufflation. It helps decrease the volume of insufflated gas, which means reducing risk of subcutaneous emphysema and carbon dioxide retention. The whole-layer dissection is performed with Ultrashear (Covedien TM). We choose this one because it produces less foggy operative field. When complete excision is achieved, sterile water irrigation is applied and the defect is closed with V-lock suture (Covedien TM) continuously. Flexible sigmoidoscopy is routinely scheduled at two weeks.

**CONCLUSION**

SILS-TEM is the new modified technique of transanal endoscopic surgery that may replace the need of TEM in clinical practice.

**REFERENCES**

The Ligation of Intersphincteric Fistula Tract first originated from Thailand by Prof. Arun Rojanasakul from Chulalongkorn University. In an early series of patients in 2007, he reported a success rate of 94%. This sphincter preserving technique was soon popularized by many groups of surgeons worldwide, for its simplicity, easy to learn, quicker wound healing and less pain and most importantly, good success rates between 70-80%. There has been several variations of the technique over the last five years but the fundamental principle remains the same: sphincter preservation, extirpation of the source of sepsis i.e. intersphincteric portion of fistula tract containing the anal gland and good closure of the remnant openings in the sphincter musculature. At NUH, we had reported a long term freedom from failure of 78% over 4 years. In our technique, we use the Lonestar retractor for good exposure of the intersphincteric space, excision of the intersphincteric tract and suture ligation of the remnant openings on the anal sphincters using monofilament absorbable suture. Judicious use of low wattage cautery and preservation of the internal sphincter and anal mucosa (avoid button hole injury) are important factors in ensuring success of the technique. Most importantly, we believe that preoperative imaging using endoanal ultrasound to delineate the fistula tract helps site the operative incision and endure complete eradication of the source of sepsis. A video of our technique is presented.
RECTAL IMPALEMENT

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Impalement is the traumatic penetration of an organism by an elongated foreign object such as a stake, pole or spear, and this usually implies complete perforation of the central mass of the impaled body. Impalement injuries have been documented since the early beginnings of recorded history in ancient Egypt. Throughout the medieval period, rectal impalement was mainly described as means of torture and execution. In Malay Adat law, the traditional punishment for adultery before the modern age was impalement, known in Malay as Hukum sula.

Currently, rectal impalement occurs as an uncommon and unique form of penetrating injury usually thru an accidental fall to a sharp object. After initial resuscitation, management depends on the following factors: the location and severity of the rectal injury and the presence of injuries to other organs and structures. Isolated rectal injuries are managed similarly to the evolving trends in rectal trauma. The traditional use of diverting colostomies and pre-sacral drains is now being replaced by evidence-based approach based upon precise anatomic injury location. As much as possible, involvement of other organs is identified precisely with use of appropriate radiologic studies. Impaled objects should preferably be removed utilizing a multimodality surgical approach in a tertiary care facility under the guidance of surgeons specialized in the particular anatomic regions and systems affected by the impaling objects.

In our center, we encountered only 7 cases of rectal impalement over the past 5 years. Two of these cases however, were patients initially managed with sigmoid diversion and drainage by other hospitals and admitted for closure of their stomas. Two patients had associated bladder and/or urethral injuries managed by cystoscopy with cystorrhaphy and suprapubic tube cystostomy respectively. The latter patient was referred subsequently to the urology service for definitive repair of the urethral injury. One patient underwent primary repair of the rectal injury thru a transanal approach while the other two patients underwent repair and proximal sigmoid diversion and pre-sacral drainage.
SODOMY – CLINICAL EVALUATION
Andrew Bui
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Colorectal trauma following sodomy is an interesting and challenging condition for the clinician. It often attracts extra interest and curiosity from all involved in its management. The condition also requires additional and careful consideration in dealing with the medico-legal aspect of the case if relevant.

This lecture will focus mainly on aspects of the clinical evaluation pertaining to the surgical management of the injury to the ano-rectum.

Clinical evaluation includes history, examination, imaging and special testings.

Relevant history should focus on the following points: circumstances of the event, the relationship between the participants, mechanism of injury, objects used and the involvement of alcohol and drugs use. Specific questions about abdominal or rectal pain, loss of function and rectal bleeding are useful indicators of the effect of injury.

Examination of the patient should be conducted with care and sensitivity. Abdominal examination is performed to rule out local tenderness and pneumoperitoneum. Rectal examination is conducted under good lighting with the patient in a comfortable position to ensure that obscure injuries are not missed. A high index of suspicion for rectal injury is required to avoid missing or delay in the diagnosis of an occult deep seated rectal injury. Examination under anaesthetic may be necessary to ensure thorough assessment and it is often useful in patients with severe pain. The perineum is inspected to look for bruising of the skin, tissue lacerations, laxity of the anal opening. Palpation of the anal sphincter to assess for tenderness, sphincter defect, resting and squeeze pressure, presence of blood or object. Sigmoidoscopy is performed to rule out mucosal injury or presence of foreign body.

Plain abdominal XR is useful to detect retained foreign body and rule out pneumoperitoneum.

Collection of samples from the ano-rectum for special testings is important if there is medico-legal implication.

Further management of ano-rectal injury depends on the site, the extent and severity of the injury. The principles of treatment include: removal of retained foreign body, debridement and repair of major laceration or perforation with or without a diverting stoma. use of appropriate intravenous antibiotics.

A case scenario will be presented to illustrate the above management points.
SODOMY – FORENSIC ASPECTS

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Sodomy is defined as sexual anal intercourse between two persons. In Malaysia according to the Section 377 Penal code, it is illegal whether with consent from the anoreceptive person or not. The offences are classified under the “Offence against person”, where corroborative evidences from medical examination and forensic laboratory analyses are essential for any successful prosecution of the alleged perpetrator. Doctors are trained to examined the anorectal region for clinical and treatment, but not many are trained to look at this area for evidence in the Court. This presentation will focus the Forensic aspects of examination of sodomy victims as well as how to present the evidence in the Court of Law. The two Sodomy cases on Datuk Seri Anwar Ibrahim will be referred for comparison.

KEYWORDS
Sodomy, anal penetration, forensic, evidence

WHERE DO WE GO: SETTING UP A STOMA CLINIC

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Through history, Enterostomal Therapy Nursing started only in year 1987 in Kuala Lumpur, General Hospital, Malaysia, and ostomies surgery have been started earlier even at that time Malaysia do not have any Enterostomal Therapist (E.T.) who can care for these patients.

I could not imagine how were the care given by then and by whom. Most of the Nurses who take care of the patients are only trained through job training by the surgeons. Complications such as skin excoriation are very common and this can lead to problems and depression to the patients.

Ostomies surgery is about adaptation and rehabilitation and a well trained nurse on this field is the most suitable to care for them as to ensure optimal care. Enterostomal Therapy Nursing Education Program up to date have trained approximately 200 nurses to be an E.T. but sadly this does not grant them to practice as E.T. due to many factors such as shortage of nurses and E.T. Nursing does not seems to be important and not life threatening if we do not have any.

Once the patients have been operated, where do they go? It is non ethical or non professional for us to create stoma for them but there is no qualified nurse who can help and assist them once they are being discharge from hospital, so setting up a Stoma Clinic is the best thing we can do for them. At least they have place to go to seek help, advice, support and being follow up.
ATTITUDE AND VALUES: BARRIER TO STOMA CARE?

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Values constitute an important psychological element which can influence attitude as well as an important driver to shape behaviour (Link Wicker 1969).

Ostomy surgery causes a threat to one's self esteem and causes a readjustment of one body image. Trauma after ostomy surgery can affect human basic needs such as need to be valued and have self esteem. Any behaviour or reactions that are interpreted as negative can have ill effect on self esteem, loss of self confidence and loss of competence personality.

According to Triadic Model patient attitude are influence by various elements from nurses, friends family, lack of information and environment. Negative attitude personality can cripple the person and destructive which can alter physical or mental wellbeing. Vicious cycle of life when a patient presented a negative attitude drains patient him/her feel like a failure in life, feel insecure, unproductive, resist gaining independence, reluctant to cooperate with care, develop low self image, unable to absorb knowledge, negative self concept. It strips success in life. It is crucial to correct the causes that can result in negative attitude outcome. Stoma patient require a positive thinking, accepting new body image, self concept to achieve adjustment and adapting the new way of life.

In conclusion definitely attitude plays a vital role in modelling a stoma patient life towards rehabilitation and QOL. The care will be affected if a person's attitude is negative. Patient having positive attitude will definite play an important part in winning a battle against all odds. As quoted by Winston Churchill attitude is a small thing that makes a big difference towards a patient life.
Enterostomal therapy nurses are pathfinders who help guide patients with stomas on their journey to a new life that should lead them towards a better quality of life. However, adapting to a life with a stoma involves a number of physical and psychological challenges and the partnership formed between ostomy patients and the ET nurse is central to making this transition a successful one.

ET nurses play a key role in the rehabilitation process by providing information, education as well as encouragement and counseling for ostomy patients and their carers, all whom have a diverse range of fears, needs and aspirations. In short, an ET nurse is there before a severe damage appears to the ostomy patient. Therefore, she needs a broad knowledge and must be capable of working with the clinical teams that give support to these vulnerable patients.

ET nurses’ role is complex and challenging as well as rewarding. The other key aspects in her role are clinical, education, research, audit and consultancy managers.

The practical and psychological support given by ET nurse both in hospital and at home contributes significantly to an individual making a successful adjustment to life with a stoma.
Transanal endoscopic microsurgery (TEM), as described by Buess, has been suggested as a novel local treatment for rectal tumors for its advantages such as accurate full thickness excision and closure under magnified view, more resection margin and accessibility to upper rectum.

Usually, TEM is performed for the patients who have benign rectal lesion, carcinoma in situ of rectum and low risk early rectal cancer which is defined as T1 carcinomas with 1) well or moderate differentiation 2) without lymphovascular invasion 3) without massive submucosal invasion (invasion depth greater than 200-300 µm from muscularis mucosa). As for T1 high-risk carcinoma and T2 carcinoma, TEM should be considered as a biopsy and should be performed in patients with severe co-morbidity and who refuses radical surgery.

As for oncologic concern we reported the result comparing 74 patients with T1 and T2 rectal cancer who were treated with TEM and 100 patients with T1N0M0 and T2N0M0 rectal cancer treated with radical surgery. Of 74 patients in TEM group, 52 patients were T1 (70.3%) and 22 patients were T2 (29.7%). Of 100 patients in radical surgery group, 17 patients were T1 (17.0%) and 83 patients were T2 (83.0%). Five-year local recurrence rates were 4.1% for T1, 19.5% for T2 after TEM, 0% for T1 and 9.4% for T2 after radical surgery. There was no statistical difference between TEM and radical surgery group for T1 rectal cancer (p=0.95), but in T2 rectal cancer, 5-year local recurrence rate was higher after TEM than after radical surgery (p=0.04). There were no significant statistical difference between two groups in terms of 5-year disease free survival rate and survival rate.

Another concern after TEM is whether salvage treatment is necessary or not if the pathology had risk factors. From 1994 to 2004, 36 patients who received TEM had risk factors. Twelve of 36 patients underwent salvage operation and 24 patients did not due to poor physical condition or refusal of radical operations. One of the 12 patients (8.3%) who underwent salvage operation had systemic recurrence. Five of 24 patients (20.8%), who did not receive surgery, had recurrence. Two had recurrences in 7 patients (28.6%) with lymphovascular invasion, 1 patient (100%) had T3 lesion. And Three out of 17 patients (17.6%) were T2 lesion. So, in high risk patients, TEM followed by radical surgery is most beneficial in preventing recurrence. Radical surgery is strongly recommended if pathologic results shows T3 lesion or lymphovascular invasion.

In conclusion, with accurate preoperative staging and strict selection criteria, TEM can be considered as a first-line therapy for T0 and T1 rectal cancer. If TEM is used for high risk T1 rectal cancer and T2 rectal cancer, further therapy to reduce the local recurrence rate should be considered.
In 1986, Quirke et al noted in a seminal article (Local recurrence of rectal adenocarcinoma due to inadequate surgical resection. Lancet. 1986;2:996-999.) that 27% of patients with cancer of the rectum and rectosigmoid had metastatic cancer extending to the resected lateral mesenteric margin, and 85% of these patients had a local recurrence. Since then, the careful analysis of the proctectomy surgical specimen, and the continuous discussion between colorectal surgeons and histopathologists is the best mechanism to improve therapeutic surgical outcomes.

In this presentation we shall discuss the comprehensive approach to the analysis of proctectomy specimens, paying special attention to the usual planes of resection (muscularis propria, intramesorectal and mesorectal planes). This will include the difficult challenge of the very-low rectal cancer.

At the end of this session, both surgeons and pathologists should have a better understanding of the pathological assessment of rectal cancer and how it can improve the quality of surgery.
CHANGING SURGICAL STRATEGIES AFTER NEOADJUVANT THERAPY
– IS IT SAFE?

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NEOADJUVANT CHEMORADIATION THERAPY

Although, the Total Mesorectal Excision (TME) has been established as the gold standard for rectal cancer treatment, the proper radiation therapy before or after the surgery is one of the key factors which decrease local recurrence of rectal cancer. Swedish rectal cancer trial reported that preoperative short course high dose radiation therapy for seven days decreased local recurrence from 27% to 11%. Dutch TME trial reported a significant decrease in local recurrence rate but there was no difference in long-term survival rate. After the report from Germany (CAO/ARO/AIO-94) successfully demonstrated that neoadjuvant chemoradiation reduced recurrence rate of the locally advanced rectal cancer, this method has been accepted as a standard treatment for locally advanced rectal cancer. Advantages of neoadjuvant chemoradiation therapy includes preservation of rectal sphincter function, increasing the respectability of tumor, reducing radiation injuries of intestinal tract and increasing chemotherapeutic effect due to the intact blood flow to the rectum. However it has disadvantages such as possibility of unnecessary radiation treatment and delayed time of surgery.

RE-EVALUATION AFTER THE TREATMENT

1) Method

Re-evaluation of response after neoadjuvant chemoradiation therapy is crucial for deciding the treatment methods. The recommended methods are digital rectal exam (DRE), evaluation of original cancer site with colonoscopy with endorectal ultra sound (ERUS), CT, MRI, PET-CT. Son et.al performed ERUS to 60 out of 83 patients and CT to 80 patients out of 83 patients. They concluded that two methods were useful in predicting negative predictive value of rectal lymph involvement but unreliable in predicting the status of primary tumor. Chen et.al evaluated MRI before and after the treatment in 50 patients and concluded that accuracy was not high (T-stage 52%, N-stage 68%) and it was due to over-staging. Cho et.al. performed MRI and PET-CT to 30 patients before and after the treatment. They reported accuracy of T, N staging as 67%, 75% and 60%, 71% respectively. They also reported that PET-CT was especially useful in predicting pCR and detecting metastasis.

2) Classification of Response

Dworak classification and TRG classification are two major classification tools for the neoadjuvant cheomoradiation.

Dworak classification is divided into 5 stages;

GR4: no residual tumor cell, only fibrotic mass (total regression), GR3: very few tumor cells, GR2: dominant fibrotic change with few tumor cells, GR1: tumor mass with obvious fibrosis, GR0: no regression.

Mandard et.al. reported usefulness of TRG classification. TRG classification is divided into 5 stages also;

TRG1: complete remission, TRG2: presence of rare residual cancer cells scattered through the fibrosis,
TRG3: increase in the number of residual cancer cells, but fibrosis still predominated, TRG4: residual cancer outgrowing fibrosis, TRG5: absence of regressive change.

Complete remission (CR) or complete response means no evidence of tumor after treatment but does not mean complete cure. CR is also re-classified as cCR (by radiologic evaluation) and pathologic evaluation (by pathologic evaluation)

**TREATMENT OF CCR PATIENTS**

There are many treatment options for cCR patients after neoadjuvant chemoradiation such as radical surgery, local excision, and wait and see. The gold standard is radical surgery and should be recommended to all patients unless a contraindication is present. If the patient refused radical surgery due to the fear of stoma or the patient status is not fit for radical surgery the other options are possible but it should be done carefully and meticulous follow-up is needed.

1) Radical Surgery

Even if the patient is evaluated as cCR, total resection of rectum and rectal mesentery to remove any possible tumor cells and confirming pCR is the aim of the treatment.

Although there are many complications after radical surgery such as anterior resection syndrome, urinary and sexual problem, we should consider the method which increases the cure rate most.

In the paragraph below there are several topics which support the radical surgery:

- **Is cCR equivalent to pCR?**
  As previously mentioned, re-evaluation methods after radiation therapy include ERUS, CT, MRI, and PET-CT. However no imaging can predict 100% remission and most of evaluation reports over-staging rather than under-staging. In conclusion, most accurate method of re-evaluation is pathologic confirmation after resection. Garcia-Aguilla et.al. reported higher pCR rate (43%) in patients who received neoadjuvant chemoradiation therapy before local excision (ASOSOG Z6041) and also reported 85% sensitivity, 67% specificity, 69% positive prediction rate, and 86% negative prediction rate at preliminary report using DRE and other tests. As these authors demonstrated, cCR cannot predict pCR completely.

- **Does pCR of Original Tumor Reflect Sterilization of Mesorectal Lymph Node?**
  Hughes et.al. reported 23 cases of metastasis out of 143 patients who receive neoadjuvant chemoradiation therapy. 4 patients out of these 23 (17%) patients were found to have mesorectal lymph node although they were revealed as cCR before surgery.

- **Rate of Recurrence after pCR**
  Mass et.al. performed meta-analysis of 27 literatures which reported the result of the surgery after neoadjuvant chemoradiation. There are 484 pCR out of 3105 patients. Five-year-survival rate of 484 patients was 83.3% and that of other patients were 65.6%. As in this report, radical surgery is the best method which has lowest recurrence rate.
2) Local Excision

There are several reports which showed local excision had comparable result with radical surgery after neoadjuvant chemoradiation in limited patient population. However, even with advantages such as rectal function preservation, the limitation such as limited resection margin and inability of harvesting mesorectal lymph node this method is not used widely. Lezoche et.al. reported 15 year follow up data in patients with TEM after neoadjuvant chemoradiation in 145 patients who were diagnosed with T2-3 rectal cancer. Cancer-specific survival rate in pT2 and pT3 patients was reported to be 90% and 77% respectively, showing similar result compared to radical surgery. We analyzed 40 cases of uT2-T3N0 patients who received neoadjuvant chemoradiation followed by local excision in 6 hospitals in South Korea. 43% patients demonstrated as pCR and 3-year survival rate was 85.9%. Especially there was no recurrence in pCR patients. Considering this result, it can be concluded that local excision is a good option for selected patients.

3) Wait and See

After Dr. Harb-Gama reported the concept of wait and see for the patient who showed cCR after neoadjuvant chemoradiation in 1998 there were much debate for the validity of this type of treatment. In 2004, she reported the long-term follow up data of 71 patients who took wait and see method. They compared them with 22 patients who underwent radical surgery and confirmed as pCR after the surgery. The stoma creation rate was 30% in patient who received radical surgery. Five-year-survival rate of surgical group was 92.1% and disease-free survival rate was 83%. Five-year-survival rate of wait and see group was 100% and disease free survival rate was 88%. But there are still no other reports which support this report and still there is much debate for the real value of this method.

CONCLUSION

It is obvious that radical surgery is the treatment of surgery for the patients who showed cCR in patients after neoadjuvant chemoradiation. However, the other methods such as local excision and wait and see have a some role in small portion of patients who are not fit surgery or refuse radical surgery.

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PSYCHOLOGICAL & PHYSICAL IMPACT OF OSTOMIES SURGERY

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Patients undergoing stoma formation will face major surgery, loss of bodily function, a distortion of body image and changes in personal hygiene. Such patients will have to make major psychological adaptation and physical changes following stoma surgery.

Patient's concerns creation on an ostomy surgery includes: ability to lead a 'normal' live, have a satisfying sexual relationship, participate socially, employment, relationship with family members, odour, paying for the appliance. Some ostomy patients may experience psychological disorders such as disturbance in body image, low self esteem, denial, phantom rectum, psychosocial problems and psychosexual problem. Therefore the emotional and psychological aspect of care were integrated in the nursing standard care plan in the pre-operative teaching and counselling and post-operative follow up. Pre operatively, enterostomal therapy nurse (ET) nurse participate in teaching, counselling and stoma site selection. The main objective of pre operative teaching is to ensure patient and family members understand the rational of the surgery, the planned procedure, and the creation of an ostomy. The second objective of counselling is to facilitate in adapting life with a stoma. Post-operative ET nurse continue in emotional support, instruction in stoma management, helping in selection of appliances, application and changing of pouch, advice in dietary and fluid adjustment and planning discharge to ensure that patient and family members able to cope as well as master the skill. Research indicate that, patients satisfaction with healthcare received, development of therapeutic relationship with ET nurse and mastering of self care in changing the appliances are the key components in adjusting to living with a stoma and improve quality of life post operatively. Therefore teaching, counseling and good support is crucial in psychological & physical adjustment ostomy patients.
ETHICAL ISSUES AND PROFESSIONALISM IN ENTEROSTOMAL THERAPY NURSING

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Ethic and professionalism are fundamental to clinical work. It guides the moral conduct of professionals, it addresses questions about morality between good and evil, between right and wrong and also discusses about virtue, justice and fairness.

It is about ethical values of Nurses and of nurses’ commitments to person with health care needs and person receiving care. This includes the relationships, responsibilities, behaviour and their decision making since Nursing is a moral activities. As much as professionalism it is also a provision of a caring relationship that facilitates health and healing.

“Ethics is central to the way we care, and to the way we envision ourselves as professionals...”

As health care providers it is our duty of care to provide safe, compassionate, competent and ethical care, promoting health and well-being, promoting and respecting informed decision, preserving dignity, maintaining privacy and confidentiality and promoting justice.

These issues will be discussed further in the presentation.

COUNSELING ISSUES AND PROBLEMS IN STOMA CARE

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Having a stoma for the passage of faeces (permanent / temporary) is a major event for a patient. He/She can become very anxious and depressed. Adequate counseling with good visual aids is vital and mandatory. Introduction of a well rehabilitated ostomate is an effective and valuable method.

ISSUES AND PROBLEMS IN STOMA CARE WILL INCLUDE:

1. Psychological Issue: When patients are been informed of coming ostomy surgeries, they may experience a ‘nervous break down’ due to the surgery and lacking of knowledge of stoma care. Surgeon usually does not have sufficient time to explain in detail regarding stoma care, appliances available in the market and
rehabilitation. Sometimes due language barrier patients are unable to understand the doctor’s explanation. Thus ETs play an important role in imparting knowledge / counseling to assist these patients to cope in changes of body images, self concept, life style, social relationship, role performance, sexuality and caring for the stomas, through the remaining course of their life with a stoma.

2. **Technical Aspects:** Important roles of the ETs are to reinforce of the surgery and stoma construction with pictures, provide information regarding the changes of the amount and consistency of the faeces after ostomy surgery, the various types and cost of the ostomy appliances available in the local market. Demonstration to patients and care taker on caring of the stoma and its appliances. Ensure that they must have return hand-on demonstration before discharge. Peristomal skin irritation may occur if the cutting of the aperture on the flange is too big or prolong time usage. Stoma exit – related problems – this includes bleeding at the stoma mucosa (either due to rough cleaning or recurrent of tumour) prolapsed, narrowing of blockage of the stoma, partial or fully detached mucotaneous function and parastomal hernia which occurs at late year.

3. **Dietary Issue:** There are no important dietary restrictions. However, patients are advice to eat and chew food slowly. Information regarding gas and odour producing food and increase fluid intake is of beneficial.

4. **Social Issue:** Stoma appliances are costly for the low income group of patients which will in turn add-on psychological burden to them. Assisting in referral to any non-government organization for support and supplies of appliances is strongly recommended.

Ostomates can continue with their usual employment. However, if occupations that involve heavy lifting, may require some modification. They can travel as usual but they require preparing extra appliances as hand carry luggage. Should they need to travel on public transport, it is advisable to take a corner seat (more privacy while changing appliances when needed).

The presence of a stoma and appliances will not interfere any physical activity once physically recovered from surgery. However, body contact sports are not recommended because appliances might be dislodged or stoma may be injured due to rough body contact. Ostomates are advised to empty the ostomy appliances before prayer or going to sleep.

5. **Sexual Concerns:** Patients and their partners should be informed about the potential sexual impairment arising from their surgeries by surgeon pre operatively. Assure patients who are concerned about sexual expression that intimacy is not prohibited by surgery and explain that sexual impotency (for male) may recover gradually after surgery. Referral to a sex therapist is of beneficial.

6. **Spiritual / Culture Issue:** Encourage patient to have spiritual prayers as it allow them to recognize their personal perception of the meaning of life, disease, suffering that contributed to their self knowledge and strengthening feeling of worth and acceptance.
FOOD INTAKE & STOMA MANAGEMENT: DISPELLING THE MYTHS

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Good nutrition plays an essential role in gaining and maintaining health and vitality. Patients and family members generally have many questions about diet and nutrition following ostomy surgery. Below are listed guidelines that can assist you in maintaining good nutrition and enable your body to adapt as easily as possible to its new anatomy and digestive system.

Please keep in mind that each individual responds to surgery and the recovery process differently and therefore will need to find a diet approach that works best for them. For example, a food that causes a problem to one person may not cause a problem for another. There is quite a bit of trial and error that takes place during these months. Try to be patient and assure yourselves that eventually you will find a diet that works for you!

Many ostomates experience a variety of side effects from various foods. Knowing which foods to avoid or increase will help the patient manage side effects, thereby improving the nutritional quality of the diet. Many times patients are overly restrictive due to fear of side effects but this is not always necessary if the cause of the problem can be pinpointed to a few foods. Healthcare practitioners should reassure patients with an ostomy that side effects often can be managed with some simple dietary changes. Patients should be encouraged to notice how they react to various foods and to keep a food diary for several weeks to highlight patterns.

ACUTE DIVERTICULITIS

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50 % of 50 year olds can have diverticulosis in the western population. 20% of these can develop acute diverticulitis. Another 20% of these may require hospitalisation for treatment of its complications. Hinchey Classification for Acute Diverticulitis has been modified. Stage I-Uncomplicated Diverticulitis; Stage Ia-phlegmon; Stage Ib-pericolic abscess; Stage II-Intraabdominal abscess; Stage III-purulent peritonitis; Stage IV-fecal peritonitis. Recently CT Classification by Ambrosetti has been useful, accurate and has prognostic value. Moderate Diverticulitis – colonic wall 5 mm, pericolonic fat inflammation. Severe Diverticulitis – abscess, extraluminal air and contrast extravasation. Treatment for Hinchey I and Ia is conservative. Treatment for Hinchey III/IV is surgical. Treatment for Hinchey Ib and II is not so straightforward. Currently percutaneous drainage has been employed successfully for this group. However, there are still questions that need answers. Is there a need for subsequent resection? Should it be done immediately or delayed. Operative treatment usually is in the form of resection and toilet. Should the resection be ?one stage, ?two stage, ?two stage Hartmann's type, ?two stage ileostomy-anastomosis, ?open or laparoscopic or hand assisted laparoscopic. Can laparoscopic lavage alone be sufficient? Experience, Judgement and Expertise is the key to successful management of Complicated Acute Diverticulitis.
DIVERTICULAR BLEEDING – WHICH TREATMENT OPTION IS BEST?

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Diverticular disease is a condition that became more widespread in the last 2 centuries. However, it was first described as far back as the late 1700s. The term was first coined by in 1815 by Fleishman and its link to constipation was described in 1869. The prevalence of diverticular disease remains high in the western population although right sided disease is more common in Asia. There is a link between urbanization and the increase in rates of disease.

Lower gastrointestinal bleeding (LGIB) remains a common presentation of diverticulosis. About 70% of cases spontaneously resolve with about 25-30% of these patients experiencing additional bleeding episodes. All patients who present with suspected bleeding from diverticulosis need to be evaluated accurately to confirm the etiology. Key to the management of diverticular LGIB is site localization, failing which the surgeon will remain handicapped in his ability to effectively gain control of the situation. Well established modalities for this include nuclear scintigraphy, angiography (both catheter and more recently, CT reconstruction) and colonoscopy.

Embolization of the bleeding vessels have now become mainstay in many tertiary institutions providing the full range of medical services. The modern microcatheters allow the skilled interventional radiologist to cannulate the most distal branches of the arterioles that are responsible for the hemorrhage. The advent of new thrombotic agents have served to increase the efficacy of embolization and at the same time, decrease the risks of bowel infarction.

Endoscopic techniques have also benefited from the technological advances. From the traditional epinephrine injection to the modern day hemoclips, endoscopic therapy can achieve results approaching that of superselective embolization in the hands of a skilled endoscopist.

Surgery remains an integral option in the colorectal surgeon's armamentarium. The most common indication for this will be the presence of continued episodes of bleeding requiring transfusions of 6 or more units of packed cells with or without episodes of hemodynamic instability. Preoperative localization will serve to reduce the morbidity and mortality rates of the procedure.
DIVERTICULITIS, predominantly affecting the sigmoid colon is a common problem, although there is some geographical variation in the incidence and the location of the disease as well as wide variation in management.

Controversy exists around when surgical intervention is required, both in the elective and the emergency setting.

In the acute setting, when to operate and which operation to perform is a crucial decision and in particular whether resection is necessary or lavage is all that is required. Is a stoma necessary after resection? Should a primary anastomosis be performed? Are drains necessary? What is the role of laparoscopy?

In the elective setting what are the indications for resection? In the absence of a specific complication such as stricture or fistula, how many acute attacks warrant elective surgical resection?
| PO 1 | Analysis Of Low Rectal Cancer Regression In Response To Neoadjuvant Long Course Chemoradiation  
*Khan Wei Chan*¹, *Sagap Ismail*², *Hussin Fatimah*³, *Daren C Y Teoh*¹  
¹Queen Elizabeth Hospital, Kota Kinabalu, Sabah, Malaysia  
²Universiti Kebangsaan Malaysia Medical Centre, Kuala Lumpur, Malaysia |
| PO 2 | Does Radio-Frequency Ablation Improve Survival In Patients With Unresectable Primary And Metastatic Liver Cancer?  
¹Department of Surgery, University Malaya Medical Centre, Kuala Lumpur, Malaysia  
²Department of Surgery, Hospital Permaisuri Raja Bainun, Ipoh, Perak, Malaysia  
³Department of Surgery, Universiti Teknologi MARA, Shah Alam, Selangor, Malaysia |
| PO 3 | Cost-Effectiveness Analysis Of Elective Colectomy In Universiti Kebangsaan Malaysia Medical Centre Kuala Lumpur: Open Versus Laparoscopic  
*Noorharisman Ideris*¹, *Rizal Manaf*², *Holdan Ibrahim Al sheikh*², *Ismail Sagap*¹  
¹Colorectal Unit, Department of Surgery, Universiti Kebangsaan Malaysia Medical Centre, Kuala Lumpur, Malaysia  
²Department of Community Health, Universiti Kebangsaan Malaysia Medical Centre, Kuala Lumpur, Malaysia |
| PO 4 | Ultrasonographic Internal Sphincter Thickness Is Predictive Of Clinically Significant Faecal Incontinence Following Instrumental Delivery  
*Lam Ruey Shyang*¹, *April Camilla Roslani*², *Wan Khamizar*²  
¹University Malaya Medical Centre, Kuala Lumpur, Malaysia  
²Sultanah Bahiyah Hospital, Alor Setar, Kedah, Malaysia |
| PO 5 | Gene Expression Signatures For Early And Advanced Stage CRC  
*Tze Pheng Lau*¹, *April Camilla Roslani*², *Lay Hoong Lian*¹, *Kek Heng Chua*¹  
¹Department of Molecular Medicine, Faculty of Medicine, University of Malaya, Kuala Lumpur, Malaysia  
²Department of Surgery, Faculty of Medicine, University of Malaya, Kuala Lumpur, Malaysia |
| PO 6 | Colorectal Cancer Survivors’ Knowledge Of Their Diagnosis And Treatment  
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²Department of Surgery, University Malaya Medical Centre, Kuala Lumpur, Malaysia |
| PO 7 | Long Term Efficacy Of Biofeedback Training Among Patient With Pelvic Floor Dysynnergy–Type Constipation  
*Noor Ezmas Mahno, Hanim Yati Hussin, Aziwani Yusof, Razali Ibrahim, Azmi Md Nor, Mohd Zailani Mat Hassan*  
Colorectal Unit, Department of Surgery, Faculty of Medicine, International Islamic University Malaysia, Kuantan, Pahang, Malaysia |
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| PO 8          | Comparison Of Enhanced Recovery After Surgery Program Versus Conventional Care On Quality Of Life In Colorectal Surgery Patients | Normah Ismail¹, Chan Koon Khee¹, Ismail Sagap²                                                   | ¹Hospital Sultanah Aminah, Johor Bahru, Malaysia  
²Universiti Kebangsaan Malaysia, Kuala Lumpur, Malaysia                                              |
| PO 9          | Vascular Anatomy Of Colorectal Anastomosis: An Analysis Using 3D-CT Angiography | Wong M W¹, Syazarina S², Ismail S², Jasiah Z¹                                                   | ¹Hospital Tuanku Ja’afar, Negeri Sembilan, Malaysia  
²Universiti Kebangsaan Malaysia Medical Centre, Kuala Lumpur, Malaysia                              |
| PO 10         | Colorectal Cancer in Sarawak General Hospital: A Demographic Review   | Aisah M W, Nadiah A A, Phung Shehab C W, Nik Azim N A                                            | Surgical Department, Hospital Umum Sarawak, Kuching, Sarawak, Malaysia                           |
| PO 11         | Retrospective Study Of The Relationship Between Presenting Symptoms Of Colorectal Cancer To The Location Of The Tumour In HUSM | D Z Andee, M A S Zaid, Z Zaidi, S Hassan                                                      | Department of Surgery, Hospital Universiti Sains Malaysia, Kubang Kerian, Kelantan, Malaysia       |
| PO 12         | Synchronous Colorectal Neoplasm: Series Of Case Studies               | Atifah A, Hasslinda H, Umasangar R                                                               | Hospital Taiping, Taiping, Perak, Malaysia                                                       |
| PO 13         | Rhabdomyosarcoma Of The Perineum In Pregnancy                         | T H Chieng, AC Roslani, Sandip K, Thurein K M, C W Law                                         | Colorectal Unit, Department of Surgery, University Malaya Medical Centre, Kuala Lumpur, Malaysia |
| PO 14         | Feasibility And Short Term Outcomes Of Single-Incision Laparoscopic Colorectal Surgery For Colorectal Cancer | T H Chieng, A C Roslani, Sandip K, Thurein K M, C W Law  
Colorectal Unit, Department of Surgery, University Malaya Medical Centre, Kuala Lumpur, Malaysia |
| PO 15         | Isolated Pancreatic Metastasis From Colon Cancer                      | A D Azzyati, A R Hashimah, S Febra, N A Nik Azim                                                | Department of Surgery, Sarawak General Hospital, Kuching, Sarawak, Malaysia                      |
**Poster Presentations [cont’d]**

**PO 16**
A Retrospective Analysis Of Laparoscopic Colectomy Outcomes For Rectal Carcinoma In A Single Malaysian Tertiary Referral Centre  
H Amin Tai¹, MG Khairul Asri², M G Norazura², M F Jabar¹, T F Gee¹, R B H Raja Zezeman Shah¹, N C Liew¹, Y A Gul¹  
¹Department of Surgery, Faculty of Medicine and Health Science, Universiti Putra Malaysia, Kuala Lumpur, Malaysia  
²Centre of Statistical Studies, Faculty of Communication and Media Studies, Universiti Teknologi MARA (UITM), Shah Alam, Selangor, Malaysia

**PO 17**
Extramammary Paget's Disease : A Forbidden Malignancy  
K Kharlina¹, C S Tee¹, I Sagap²  
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²Department of Surgery, University Kebangsaan Malaysia Medical Centre, Kuala Lumpur, Malaysia

**PO 18**
Lymph Node Yield From Rectal Cancers At A Colorectal Unit In Malaysia: A Five Year Experience  
Kishen R, R Prabhu, Buvanesvaran T M, Wan K  
Hospital Sultanah Bahiyah, Alor Setar, Kedah, Malaysia

**PO 19**
Obstetric Perianal Injury – Outcome Of Two Different Types Of Repair In Hospital Taiping  
Ee Shuan Lim, Umasangar Ramasamy  
Department of Surgery, Hospital Taiping, Perak, Malaysia

**PO 20**
Manometric And Endosonographic Evaluation Of Internal Anal Sphincter In Patients With Constipation  
M Luqman, I Sagap  
Universiti Kebangsaan Malaysia Medical Centre, Kuala Lumpur, Malaysia

**PO 21**
K-Ras Mutation In A Local Malaysian Population : A Pilot Study  
M Nursharmizam Baharudin¹, Azmi M Nor², Zailani M Hassan¹, Norlelawati A Talib²  
¹Colorectal Unit, Surgical Department Kuliyyah of Medicine, International Islamic University Malaysia, Kuantan, Pahang, Malaysia  
²Molecular Laboratory, Kuliyyah of Medicine, International Islamic University Malaysia, Kuantan, Pahang, Malaysia

**PO 22**
Correlation Between Clinical Outcomes And Anorectal Manometry Findings In Patients With Third And Fourth Degree Obstetric Perineal Injury: A Preliminary Result  
Mohd Yusof Sainal, Azmi Md Nor  
International Islamic University Malaysia, Kuantan, Pahang, Malaysia
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*N H Zubaidah, Tikfu Gee, K W Ong, M O Myint*
Department of Surgery, Universiti Putra Malaysia, Hospital Kuala Lumpur, Kuala Lumpur, Malaysia

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*K W Ong, Tikfu Gee, M O Myint, N H Zubaidah*
Department of Surgery, Universiti Putra Malaysia, Hospital Kuala Lumpur, Malaysia

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*Wong Sze Ming, Gerald Henry*
Department of General and Colorectal Surgery, Selayang Hospital, Selangor, Malaysia

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*F J Ruhi, M A Zairul, I Sagap*
Colorectal Unit, Department of Surgery, Universiti Kebangsaan Malaysia Medical Centre, Kuala Lumpur, Malaysia

PO 44  Acute Aortic Thrombosis Post Anterior Resection: A Rare Case Report

*M I Ismail, W K W Khazim, H Y Chong, P Ramasamy*
Department of Surgery, Hospital Sultanah Bahiyah, Alor Setar, Kedah, Malaysia
ANALYSIS OF LOW RECTAL CANCER REGRESSION IN RESPONSE TO NEOADJUVANT LONG COURSE CHEMORADIATION

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¹Queen Elizabeth Hospital, Kota Kinabalu, Sabah, Malaysia
²Universiti Kebangsaan Malaysia Medical Centre, Kuala Lumpur, Malaysia

INTRODUCTION
Neoadjuvant long course chemoradiation for T3 and T4 rectal cancer has been proven to increase local control and survival benefit. Tumour shrinkage with increase distance from anal verge to perform sphincter preserving surgery is inconclusive.

OBJECTIVES
This study was conducted to assess the low rectal cancer degree of regression after neoadjuvant long course chemoradiation by magnetic resonance imaging (MRI) and sigmoidoscopy.

METHODOLOGY
This is a prospective observational experimental pilot study over a period of 12 months. Patients planned for neoadjuvant long course chemoradiation had MRI and sigmoidoscopy done before and 6-8 weeks after the therapy. Measurements were compared to assess tumour regression. Surgery done was compared to surgery proposed. Resected specimens were examined for pathological tumour response.

RESULTS
23 patients were recruited but 7 patients dropped out and 6 had not completed the study. 10 patients completed full treatment and assessment by MRI showed significant vertical regression in 80% of patients (p=0.0046, mean 2.152 ± 2.063 cm), mainly contributed by downward vertical regression (p=0.0197, mean 1.102 ± 1.447 cm) rather than upward regression (p=0.0309, mean 1.05 ± 0.492), and horizontal regression in all patients (p=0.0012, mean 0.753 ± 0.180). Sigmoidoscopy examination was not significant to detect change in tumour distance from anal verge (p=0.207, mean 0.35 ± 0.409). Neoadjuvant therapy did not increase rate of sphincter preserving surgery. Only one patient had complete pathological tumour response.

CONCLUSION
In conclusion, neoadjuvant long course chemoradiation has tumour shrinkage capability mainly contributed by downward regression rather than upward regression. Tumour shrinkage and upward regression did not promote sphincter preserving surgery.
INTRODUCTION

Overall five-year survivals for unresectable hepatocellular carcinoma (HCC) and stage IV colorectal cancer (CRC) are 4% and 11% respectively. Radio-frequency ablation (RFA) is the treatment of choice for patients with early, localized HCC when surgical resection or liver transplantation is not suitable options. In addition, RFA is also emerging as an alternative treatment for metastatic liver disease especially from CRC in patients who are contraindicated for liver resection. Currently, the long-term results of RFA are limited and randomized controlled trials of RFA are lacking. RFA has been offered to cancer patients on an individualized basis in UMMC since 2003. The aim of this study is to determine the survival of patients with unresectable primary HCC or colorectal cancer with metastatic liver disease treated with RFA in our institution.

METHODS

Records of patients undergoing RFA from March 2003 to November 2007 were retrospectively reviewed. The survival data was obtained from the National Registry of Births and Deaths. The Kaplan Meier method was applied for survival analysis. Statistical analysis was performed using SPSS v 15.0. P values of <0.05 were considered statistically significant.

RESULTS

Out of 92 evaluable patients, 75 patients (81.5%) were diagnosed with primary HCC and 17 patients (18.5%) were diagnosed with CRC with liver metastases. Median survival of patients with primary HCC was 18 months compared to 33 months in patients with metastatic CRC. The 2-year overall survival in the primary HCC group was 41.5% compared to 58.8% in the CRC with liver metastases while the 5-year overall survival were 18.5% and 16.8% respectively. Only 2 patients (2.1%) developed bleeding post RFA.

CONCLUSION

RFA is an effective alternative for patients with unresectable primary HCC and colorectal cancer with secondary liver metastases.
COST-EFFECTIVENESS ANALYSIS OF ELECTIVE COLECTOMY IN UNIVERSITI KEBANGSAAN MALAYSIA MEDICAL CENTRE, KUALA LUMPUR: OPEN VERSUS LAPAROSCOPIC

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AIM
In an advanced Colorectal Unit especially in UKMMC, Kuala Lumpur, increasing usage of laparoscopic procedure and high costs further restrict the usage of laparoscopy in colorectal surgery. In this study, we compared the short term results and the cost analysis of laparoscopic colectomies with the open technique.

METHODS
We conducted a retrospective cross-sectional study between July 2007 and October 2010. 27 elective laparoscopic colon resections were performed in Universiti Kebangsaan Malaysia Medical Centre (UKMMC), Kuala Lumpur, Malaysia. Each laparoscopic case was matched for age, gender, pre-operative ASA score, co-morbidities and the histopathology site of the lesion with control patients undergoing the equivalent open procedure in the same period. Operation times, length of hospital stay, post-operative complications, re-admission within 30 days, post-operation mortality and cost-effectiveness analysis were compared between these two groups.

RESULTS
Mean hospitalization period was 4.5 +/- 1.0 days in the laparoscopic group and 6.3 +/- 1.9 days in the open group. There was significant difference found between post-operative complication 3(11.1%) vs 8(30.7%) (p=0.005) in laparoscopic group and open group respectively. There were no difference in terms of duration of operation, mortality and re-admission rate within 30 days. Cost analysis, between the laparoscopic and the open groups were RM6008 vs RM7068 respectively with incremental cost for reducing one patient with complication(s) was RM7068.9 (RM7068/1) in open group compared to RM1001 (RM6008/6) in laparoscopic group.

CONCLUSION
It is concluded, on condition that using the laparoscopic procedure as alternative of colectomy operation, it is safe, feasible and cost effective to perform in UKMMC with the current pricing policy.

KEY WORDS
Laparoscopy, colectomy, cost-effectiveness, UKMMC
ULTRASONOGRAPHIC INTERNAL SPHINCTER THICKNESS IS PREDICTIVE OF CLINICALLY SIGNIFICANT FAECAL INCONTINENCE FOLLOWING INSTRUMENTAL DELIVERY

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1University Malaya Medical Centre, Kuala Lumpur, Malaysia
2Sultanah Bahiyah Hospital, Alor Setar, Kedah, Malaysia

BACKGROUND
Instrumental delivery is a recognized cause of faecal incontinence but the correlation of anatomical abnormalities, as determined by ultrasound, to clinically significant incontinence is unknown. We sought to determine the sonographic severity of anal sphincter injury, and its relation to symptoms of faecal incontinence and the mode of instrumental delivery.

METHOD
We prospectively recruited 97 consecutive patients undergoing instrumental delivery from August 2010 until January 2011 in Sultanah Bahiyah Hospital, Alor Setar. Clinical severity of faecal incontinence (Wexner Fecal Incontinence Score, WFIS) and demography were recorded, and anal endosonography was performed 4-6 weeks post-partum. Using SPSS for Windows software (version 15; SPSS Inc, Chicago, IL), we compared WFIS scores and sonographic abnormalities in the group of patients with sphincter defects to the group of patients with intact sphincters by Kolmogorov-Smirnov test, and Student's t-tests. In the group of patients with identified defects, we used Spearman correlation coefficients to determine relationships between the sizes of defects on EAUS to the WFIS.

RESULT
A total of 13 out of 97 women (13.7%), who underwent instrumental delivery, had sonographic evidence of anal sphincter injury. Vacuum delivery accounted for all cases of anal sphincter injury. Eleven of 73 primiparous women (15%) and 2 of 24 multiparous women (8%) sustained anal sphincter injury. Thirteen patients with anal sphincter injury had a significantly increased mean WFIS (0.66 vs 3.08, p=0.002). Perineal body thickness was also significantly reduced in these patients (12.94 vs 10.95, p=0.018). WFIS correlated well with mean and maximum internal sphincter thickness of patients with anal sphincter injury (p=0.031 and 0.036 respectively).

CONCLUSION
Instrumental delivery is commonly associated with occult anal sphincter injury. Internal sphincter thickness is significantly predictive of clinical faecal incontinence.
GENE EXPRESSION SIGNATURES FOR EARLY AND ADVANCED STAGE CRC

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²Department of Surgery, Faculty of Medicine, University of Malaya, Kuala Lumpur, Malaysia

BACKGROUND
Colorectal Cancer (CRC) is one of the most frequent cancer types worldwide. In Malaysia, it is ranked as the second most frequent cancer in men, and third in women. CRC is the fourth most common cause of global cancer death and has accounted for approximately 8% of cancer mortalities worldwide. Currently, the clinicopathological parameters used are insufficient for accurate cancer staging, individual prognostic prediction and therapeutic intervention, owing to the great biologic and genetic heterogeneity of this disease. Hence, a new classification scheme based on molecular biomarkers is needed to improve management of CRC.

METHODOLOGY
A combination of ACP-based PCR and RT-qPCR was used to identify differentially expressed genes (DEGs) associated with early and advanced stage sporadic CRC. Initially, early stage CRC patients (Stage I - II) were recruited for the preliminary differential expression study. Subsequently, the confirmatory test via RT-qPCR was performed with a total of 27 paired samples, ranging from CRC Stages I – IV.

RESULTS
We have successfully identified distinctive gene expression signatures based on cancer stage and site of tumours. The RPL35, RPS23 and TIMP1 genes were found to be over-expressed in both early and advanced stage CRC (p < 0.05). It is noteworthy that the ARPC2 gene was under-expressed in early stage CRC tumours while the C6orf173 gene was over-expressed in late stage CRC tumours only (p < 0.05). On the other hand, the C6orf173, RPL35 and TIMP1 genes were over-expressed in both right- and left-sided CRC tumours (p < 0.05). Remarkably, the left-sided CRC tumours have an additional over-expressed gene (p < 0.05), i.e., RPS23 gene.

CONCLUSION
It is anticipated that these distinctive molecular signatures might complement current histopathological and biochemical parameters in aiding CRC staging. This might then promise a more accurate prognosis prediction and effective therapeutic intervention in future.
COLORECTAL CANCER SURVIVORS’ KNOWLEDGE OF THEIR DIAGNOSIS AND TREATMENT

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¹Faculty of Medicine, University of Malaya, Kuala Lumpur, Malaysia
²Department of Surgery, University Malaya Medical Centre, Kuala Lumpur, Malaysia

BACKGROUND
Colorectal cancer is the second most common cancer in Malaysia. However, compliance of cancer survivors to treatment and follow up is still not optimum. The objective of this study was to evaluate colorectal cancer survivors’ knowledge of their own disease and the treatment they had received, in order to ascertain if knowledge gap was potentially a reason for poor compliance.

METHOD
One hundred colorectal cancer survivors, who were diagnosed between the years of 2006 to 2010, were interviewed. An open-ended questionnaire comprising patients’ demographics and knowledge of their disease and treatment was used. Patients’ responses would then be compared with the medical records for accuracy of their knowledge.

RESULTS
In spite of previously documented pre-operative counselling sessions, 60% of colorectal cancer survivors were unable to identify the stage of their disease. Seventy two percent knew the location of their cancer specifically and the remaining 28% only knew their cancers were arising from the large intestine. All the patients interviewed had surgery performed. However, three percent did not know what type of surgery they had undergone, 32% knew that the surgery was confined to the large intestine, and 65% knew which part of the intestine was removed specified to left/right colon. Seventy one patients underwent chemotherapy, but surprisingly, 39.5% of them did not know the benefits of chemotherapy. Twenty three patients underwent neoadjuvant or adjuvant radiotherapy, but 39.1% of them did not know the benefits of radiotherapy. The importance of follow up was not known in 16% of survivors, but 93% thought follow up is necessary. Sixty two percent did not know any symptoms suggestive of cancer recurrence.

CONCLUSION
The knowledge of the colorectal cancer survivors is evidently poor but this does not appear to affect their compliance to therapeutic protocols. Further study is required to show if improving knowledge transfer leads to better compliance to surveillance protocols.
LONG TERM EFFICACY OF BIOFEEDBACK TRAINING AMONG PATIENT WITH PELVIC FLOOR DYSSYNERYGIA–TYPE CONSTIPATION
Noor Ezmas Mahno, Hanim Yati Hussin, Azniwani Yusof, Razali Ibrahim, Azmi Md Nor, Mohd Zailani Mat Hassan
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BACKGROUND AND OBJECTIVE
Pelvic floor dyssynergia is the most common cause of functional constipation. It is described as paradoxical contraction of pelvic floor during attempts of defecation. Biofeedback training has been recommended as behavioural therapy for this problem. The aim of this study is to evaluate a long term efficacy of biofeedback training in patient with pelvic floor dyssynergia.

METHOD
This is a prospective study done since April 2006 till January 2012. All patients who were diagnosed with pelvic floor dyssynergias were included in the study. Wexner constipation scoring system was used to determine the severity of constipation before and after the biofeedback training program. Data were analyzed using PASW 18.0.

RESULTS
Seventy patients (17 males and 53 females) were included in this study. The mean (SD) age was 39.1 years (17.0). Most of the patients were females (75.7%) and Malay (87.1%). Repeated measure ANOVA determine that mean score differed statistically and significantly over times (F=6.018(2, 24), p=0.015). Post hoc test using Bonferroni correction revealed that biofeedback training has improved in constipation after the training (pre-training versus post training constipation score; 13.31±4.72 vs. 7.31±3.66). However, there is no significant difference in mean score between pre-training score and post-training score and between post-training score and latest score.

CONCLUSION
Biofeedback training has some clinical benefit for the patients with pelvic floor dyssynergia-type constipation but not in the long term. Further study need to be done to evaluate factors that contribute to the effect of biofeedback therapy in pelvic floor dyssynergia.
ERAS program is a global package of perioperative care and it has been implemented in an attempt to modify the psychological stress of major surgery, enhance recovery; reduced morbidity thereby reduced hospital stay and ultimately reduced cost. Many literatures focusing on clinical outcome but not many studies have examined the impact of ERAS program on the patient's quality of life, which is also an important aspect of the disease treatment. This study aims to evaluate the impact of ERAS program on quality of life when compared to conventional care in colorectal surgery for colorectal cancer using SF-36v2 questionnaire. A prospective randomized trial was conducted on 40 colorectal cancer patients aged 18 to 75 years old who underwent elective colorectal surgery in General Surgical Department Hospital Sultanah Aminah, Johor Bahru, from April to November 2011. The patients were randomly assigned into ERAS group (21 cases) and conventional group (19 cases), the SF-36 quality of life score were evaluated at preoperative, post operative 1 week and 1 month as well as morbidity and mortality rate. ERAS program for colorectal surgery patients showed positive trend in terms of improving quality of life, reducing morbidity and mortality even though statistically no significant different. Patients undergoing colorectal resection with ERAS program showed no deterioration in quality of life with no increased morbidity and mortality rate.
VASCULAR ANATOMY OF COLORECTAL ANASTOMOSIS: AN ANALYSIS USING 3D-CT ANGIOGRAPHY

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²Universiti Kebangsaan Malaysia Medical Centre, Kuala Lumpur, Malaysia

BACKGROUND
Resection for rectal carcinoma with restorative colorectal anastomosis is the most commonly performed procedure in many surgical centers. A good blood supply has been recognized as the major factor in ensuring integrity of the anastomosis. Helical computed tomographic angiography has been hailed as a novel imaging technique in evaluation of abdominal vasculature. A detailed analysis of the blood supply of colorectal anastomosis would enable further understanding of anastomotic healing process. This would provide possibilities in improvising surgical techniques to prevent anastomotic leak.

OBJECTIVE
To describe the anatomy of the main blood supply and collaterals to the colorectal anastomosis.

METHODS AND MATERIAL
We performed CT angiography for patients diagnosed with rectal cancer prior to surgery and 7 to 10 days after the surgery.

RESULTS
24 patients had initial CT angiography done from November 2010 to May 2011. Preoperative CT angiogram showed four patients had the main branches of IMA sharing a common trunk. Seven of the 24 patients had the left colic artery and sigmoidal artery sharing a common trunk. 17 patients had the superior rectal artery running posteriorly and divide into 2 terminal branches at the upper rectum. Anterior resection performed in 13 patients; 4 patients were excluded because of total colectomy with ileorectal anastomosis and Hartmann’s procedure. When high ligation of IMA performed the marginal artery becomes more prominent and enlarges in size to supply to the proximal limb of anastomosis. The middle rectal artery was also prominent, reaching until anastomotic ring and gave rise to collaterals at the distal limb of anastomosis.

CONCLUSION
The marginal artery increased in size after high ligation of IMA, providing vasa recta until the anastomotic ring. This blood supply to the anastomosis was reinforced by collaterals formed by the middle rectal artery to the distal limb of anastomosis.

KEYWORDS
Colorectal anastomosis, 3D – CT angiography, vascular anatomy, arterial anatomy, blood supply.
COLORECTAL CANCER IN SARAWAK GENERAL HOSPITAL: A DEMOGRAPHIC REVIEW

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OBJECTIVE
The aim of this paper is to determine the basic demographic features of patients with colorectal cancer that presented to SGH as well as to identify the anatomic distribution of the tumour.

METHODS
The data collected are from review of consecutive patients that were diagnosed with colorectal cancer by histopathological examination that presented to Sarawak General Hospital (SGH) from May 2008 to December 2011.

SUMMARY
A total of 275 patients were diagnosed with colorectal cancer from May 2008 to December 2011. It is noted that majority of patients in SGH presented with colorectal cancer in the 5th and 6th decades of life. It occurs more frequently in males and Chinese patient compared to other ethnic group. The data obtained also showed that the tumours predominantly occur in the rectosigmoid region with no differences in anatomic location were seen between gender, races or age groups.

CONCLUSION
In conclusion, the demographic reviews are in correlation with the other published paper in the region.
RETROSPECTIVE STUDY OF THE RELATIONSHIP BETWEEN PRESENTING SYMPTOMS OF COLORECTAL CANCER TO THE LOCATION OF THE TUMOUR IN HUSM

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AIM
Study the relationship of colorectal cancer presenting symptoms to the location of the tumour.

METHODOLOGY
Retrospective record review of data in Hospital Universiti Sains Malaysia was made. A total of 212 patients data who was diagnosed with colorectal cancer over a fourteen years period from 1996 to 2009 in Hospital Universiti Sains Malaysia were collected and analyzed. We studied the relationship of presenting symptoms to the location of the tumour beside the demographic data and epidemiology for data analysis.

RESULTS
Most of the patients with colorectal cancer are more than 50 years old, and there is male predominance when compared with the female group in this study. However, there is no significant relationship between age and sex to the anatomical location of the tumour (p value > 0.05), while there is a strong relationship between the presenting symptoms and the location of the colorectal cancer (p value < 0.001). However abdominal pain does not follow this role as it is mostly associated with other presenting symptoms like intestinal obstruction or abdominal mass rather than be mono symptomatic for colon cancer. Relatively, this symptom has no significant relation to the anatomical location of the tumour (p value > 0.05).

CONCLUSION
There is strong relationship between most of the presented symptoms and the location of the colorectal cancer.
SYNCHRONOUS COLORECTAL NEOPLASM: SERIES OF CASE STUDIES

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Patients with colorectal cancer have an increased risk of developing either synchronous or metachronous neoplasm. Synchronous colorectal neoplasm, defined by concomitant adenoma or carcinoma within 6 months of previous initial diagnosis accounts for about 30% of patients with colorectal cancer with 9% corresponding data for carcinoma. We reported a series of 3 case studies diagnosed and managed in our hospital within the year of 2011 itself. It has a noteworthy clinical implication, with respect to preventive strategies to acknowledge and identify these subgroup of patients who have tendency to develop tumor multicentricity.
Rhabdomyosarcoma (RMS) is a rare soft tissue sarcoma in adults, accounting for less than 2% of all sarcomas. It is extremely rare in the perineum or anus, and even more rarely complicates pregnancy.

HISTORY
Mdm. TSN, a 40-year old female, presented with a perineal mass during pregnancy, which underwent rapid growth acceleration in the final trimester. Two weeks post-partum, the mass ulcerated and a new lesion lateral to her left labia majora appeared, associated with bleeding and pain.

EXAMINATION
A fungating posterior perineal mass measuring 15 x 12 cm with several satellite nodules anteriorly and inguinal lympadenopathy could be seen.

DIAGNOSIS AND STAGING
Biopsy of the fungating mass showed solid sheets of rhabdomyoblastic cells with focal areas of “strap cells”, and characteristic immunohistochemistry. A diagnosis of solid alveolar type RMS of the perineum was made. Staging CT scan showed locally infiltrating perianal malignancy with nodal involvement and liver metastases.

TREATMENT
A defunctioning colostomy was constructed, and palliative chemotherapy commenced (RMS protocol, very high risk group, combining vincristine, actinomycin, doxorubicin, ifosfamide and mesna).

DISCUSSION
RMS is a highly aggressive tumor and disseminates early as seen in this case. Tissue diagnosis and immunohistochemical staining is the cornerstone in the diagnosis and prognostication RMS. This patient’s age, tumour size (> 5 cm), alveolar subtype, perineal location, locoregional nodal involvement and liver metastasis at diagnosis, all point toward poor clinical outcome (long term survival and response to chemotherapy). Curative treatment of patients with RMS is multi-modal (surgery, radiotherapy and multiagent chemotherapy). Unfortunately, due to her advanced disease, she could only be given palliative chemotherapy.

CONCLUSION
Perineal lesions detected during pregnancy should be adequately evaluated before being dismissed as benign, as aggressive curative treatment for malignancies is more feasible in the earliest trimester.
FEASIBILITY AND SHORT TERM OUTCOMES OF SINGLE-INCISION LAPAROSCOPIC COLORECTAL SURGERY FOR COLORECTAL CANCER

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BACKGROUND

Technological advances have enabled the evolution of abdominal access techniques from conventional open laparotomy to multi-port laparoscopic, and most recently, single-incision laparoscopic (SIL), approaches, the latter potentially further reducing incisional trauma, post-operative pain and wound complications. However, the multi-quadrant dissection and oncologic clearance required in colorectal cancer resections may pose significant challenges to using the SIL approach, which could negate its benefits. The objective of this study was to evaluate the feasibility and short term outcomes of SIL colorectal cancer resections (SILC) in UMMC.

METHODS

All patients who had SILC between October and November 2011 were prospectively included, and followed up for 30 days. Data collected included demographics, BMI, type of procedure, operative time, conversion rates, post-operative pain score, post-operative length of hospital stay, tumour stage, operative complications and mortality.

RESULTS

Three patients underwent SILC between October 2011 and November 2011. All were sigmoid colon cancers, one with liver metastases. BMI ranged from 19.3 to 26.0, while tumour diameter ranged from 2.5 cm to 4.4 cm. Operative time was three to four hours, with minimal blood loss and no conversions. Pain scores at 24 hours were moderate, and post-operative length of stay was three to four days. One patient developed pressure necrosis of the umbilical skin, but no major complications were recorded. There were no re-operations, re-admissions nor operative mortalities. Oncologic clearance was obtained in all cases.

CONCLUSIONS

SILC is feasible and safe in the short term when performed by experienced surgeons on selected patients. Further follow up and study is required to determine the long term outcomes and cost effectiveness of this procedure.
ISOLATED PANCREATIC METASTASIS FROM COLON CANCER
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INTRODUCTION
Pancreas is a rare site for colon cancer metastasis, less than 2% of metastasis to pancreas originates from colon cancer. Isolated pancreatic metastasis from colon cancer is even rarer, thus there is no clearly defined consensus on the surgical management of isolated pancreatic metastasis in the absence of widely metastatic disease.

CASE REPORT
A 47-year old lady underwent left hemicolectomy for colon cancer in 2009. Histopathological examination revealed mucinous adenocarcinoma of the colon. The disease was staged as T4N1M0 and she underwent adjuvant chemotherapy. During the initial 2-year follow up period, the patient remained asymptomatic with normal level of carcinoembryonic antigen. However, computed tomography scan of the abdomen post adjuvant chemotherapy revealed a mass at the pancreatic tail. Distal pancreatectomy and splenectomy was done, intraoperatively there was a hard 2 cm x 3 cm pancreatic tail mass. Histopathological examination confirmed a metastatic mucinous adenocarcinoma of the colon to the pancreas. The operation was complicated by pancreatic fistula that resolved spontaneously 2 months later.

CONCLUSION
A newly diagnosed mass in the pancreas in patients with a history of malignant tumour should raise the suspicion of metastatic disease, despite treatment several years earlier. In the absence of widely metastatic disease, surgical resection of pancreas may offer good outcome.
A RETROSPECTIVE ANALYSIS OF LAPAROSCOPIC COLECTOMY OUTCOMES FOR RECTAL CARCINOMA IN A SINGLE MALAYSIAN TERTIARY REFERRAL CENTRE

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Colorectal cancer is one of the most common malignancies affecting the Malaysian population. This study is a retrospective analysis of the outcomes of elective laparoscopic colectomies performed by University Putra Malaysia surgical department from May 2009 to October 2010 for rectal carcinoma on 100 patients.

All operations were done in Kuala Lumpur General Hospital and performed by 3 senior surgeons. Operative time, conversion rate, intraoperative complications and postoperative outcomes were recorded. The surgical margins status and lymph node yield from the colectomy specimens were analysed.

In our patients cohort (52 males, 48 females – mean age 61 ± 10.4 years and mean BMI 25.4 ± 2.8 kg/m²), 89 underwent laparoscopic anterior resection (LAR) and 11 went through laparoscopic abdomino-perineal resection (LAPR). The average operative time was 287 minutes. 11 were converted to open colectomy. 15 patients developed complications within 30 days of surgery. The most common complication was anastomotic leak (6 patients) followed by adhesive obstruction (3 patients) and deep vein thrombosis (3 patients). 2 patients had superficial surgical site infection and 1 LAPR patient developed an infection to the perineal wound. The patients resumed oral intake within 4.6 days (±1.5 days) and discharged within 13.5 days (±7.3 days). There were neither late post operative complications (>30 days) nor port site metastasis recorded in our group of patients.

99 patients were diagnosed with adenocarcinoma tumour and 1 had a mucinous carcinoma tumour. The average distal margin, circumferential resection margin and lymph node yield were 29 mm (± 11 mm), 26 mm (± 13 mm) and 13 nodes (± 6 nodes) respectively.

Our results were comparable to other published reports regarding laparoscopic colorectal resections and showed the benefits of shorter hospital stay and reduced surgical site infection rates. They also reflect that laparoscopic resections do not compromise on tumour clearance.
Extramammary perianal Paget’s disease is a rare cutaneous carcinoma which usually presented as an anogenital lesion. It is thought to be a cutaneous extension of an underlying adenocarcinoma, although an associated tumor cannot always be demonstrated. Little is known about its prognostic factors and optimal treatment due to the rarity of the disease. We present a case of a 46 years old man with an anal growth of 1 year duration which revealing Paget’s disease of anus and subsequently underwent excisional biopsy with histopathological examination reported as suspicious adenocarcinoma with dysplasia of the squamous epithelium. Clinicopathological features, dilemma in management and treatment options were discussed.

KEYWORDS
Extramammary Paget’s disease, perianal Paget’s disease, intraepithelial adenocarcinoma
LYMPH NODE YIELD FROM RECTAL CANCERS AT A COLORECTAL UNIT IN MALAYSIA: A FIVE YEAR EXPERIENCE

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INTRODUCTION
Lymph node harvest from rectal cancer specimens are an important prognosticator of outcomes in rectal cancers. It reflects the radicality of the surgery and the adequacy of pathological examination\(^1\). Current literature recommends more than 12 lymph nodes to adequately stage a patient\(^1\).

OBJECTIVE
The aim of this study was to examine the adequacy of lymph node yield from rectal surgery for carcinoma of rectum at a dedicated Colorectal Unit, over a period 5 years, beginning in 2006.

METHODS
This is a retrospectively gathered data of patients who underwent surgery for rectal cancers from 1st January 2006 – 31st December 2010, at Hospital Sultanah Bahiyah. The patients were divided into 2 groups, those with less than 12 or more than 12 lymph nodes. End point of this study was to look at the adequacy of lymph nodes yield at this centre.

RESULTS
A total of 72 patients with rectal cancers who underwent curative surgery were recruited. Male to female ratio was 1:1.67. 85% of our patients were above the age of 50 years. Malays, Chinese and Indians constituted 75%, 18% and 2.8% of the study population respectively. Majority of these rectal tumours were T3, which comprised 65%. The lymph node yield from this cohort ranged between 2 to 37 lymph nodes. 52.7% of our patients had less than 12 lymph nodes recovered. Mod of the yield was 11 and mean was 13.5.

CONCLUSION
This results may reflect on radicality of surgery and inadequacy of lymph nodes sampling. However, even data obtained from Malaysian National Colorectal Cancer Registry\(^3\) suggests rates of lymph nodes harvest more than 12 only around 50%. Further prospective studies are required to assess completeness of TME resection and adequacy of lymph node sampling.

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4. Lymph node harvest and survival in rectal cancer - J Clin Oncol 26: 2008 (May 20 suppl; abstr 4048)
OBSTETRIC PERIANAL INJURY – OUTCOME OF TWO DIFFERENT TYPES OF REPAIR IN HOSPITAL TAIPING

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ABSTRACT: Perianal injury in obstetric is rare but it can happened. A retrospective study conducted with the objective of finding out overlapping anal sphincter repair or interrupted anal sphincter repair shows lower risk of faecal incontinence. 17 cases reviewed in 2011, out of which most are type 3 and repair done within 3 hours of injury. Two methods used, 9 patients with overlapping repair of anal sphincter and 8 patients with simple interrupted repair of sphincter. All patients reviewed at six weeks post repair with endo-anal ultrasound done and reassessed with Wexner incontinence score two months post repair. Result shows four patients having problems, one severe with Wexner score 8/20 and three are mild with Wexner score 1/20. In conclusion there is no significant different in the outcome either with overlapping or interrupted repair. However this is a short term study in our results nevertheless long term follow up needed.
MANOMETRIC AND ENDOSONOGRAPHIC EVALUATION OF INTERNAL ANAL SPHINCTER IN PATIENTS WITH CONSTIPATION

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BACKGROUND AND OBJECTIVE
Anorectal monometry can be used to diagnose any abnormalities in resting pressure of the internal anal sphincter (IAS) in patients with constipation. In addition, ultrasonography can be used to detect any abnormality in sphincter morphology. The objective of the study is to observe resting anal pressure and IAS diameter in a cohort of patients with constipation.

MATERIAL AND METHODS
This is a retrospective observational study. All patients diagnosed with constipation according to the Rome III criteria for functional constipation from January 2010 to January 2012 who underwent both anorectal manometry and endoanal ultrasonography were included.

RESULTS
Sixteen patients (9 women) were included. Mean age was 51 years (22-78). The mean resting anal pressure was 152 mmHg with 4 (25%) patients showing hypertonia of the IAS (more than 80 mmHg). The mean IAS diameter was 2.18 mm. After adjustment by age, only 3 (19%) of these patients showed an abnormally thick IAS (more than 2.5 mm in patients under 50 years old and more than 3 mm in those over 50 years old). In patients who showed an increase in IAS pressure, only 1 patient showed a corresponding increase in IAS diameter (resting anal pressure of 87.8 mmHg and IAS diameter of 2.8 mm.)

CONCLUSION
Only a small proportion of patients with constipation show an increase in resting anal pressure or a thickened IAS diameter. However, a larger patient population is needed to statistically analyze the association between IAS function and morphology to better understand the mechanisms of functional constipation.
K-RAS MUTATION IN A LOCAL MALAYSIAN POPULATION: A PILOT STUDY

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OBJECTIVES
Colorectal cancer (CRC) account the 3rd most common cancer worldwide. It is the most common cancer in male and the 3rd common in female in this country. Previous reports elsewhere found that the prevalence of K-ras mutation in CRC patients was around 30-40%. The aim of the current study is to evaluate the prevalence of K-ras mutation in local multiracial Malaysian CRC that has never been documented before.

METHOD
Thirty fresh CRC specimens were investigated in this study. DNA was extracted using standard protocol. Polymerase chain reaction amplification of Exon 2 of K-ras gene was performed using specific primer sequence. The purified amplified products were cycle sequenced and analyzed on 3130 Genetic Analyzer (Applied Biosystem).

RESULT
K-ras mutation was detected in 4 out of 30 CRC samples, comprising about 13% in which it is much lower than expected percentage. Age, sex and race have no influenced over K-ras Mutation which is in accordance with previous study at other region. Out of the 4 positive cases, 2 are positive for K-ras mutation.

CONCLUSION
The incidence of K-ras in Malaysian population in this pilot study is lower in comparison to other study. However larger scale study is needed to ascertain the current findings.
CORRELATION BETWEEN CLINICAL OUTCOMES AND ANORECTAL MANOMETRY FINDINGS IN PATIENTS WITH THIRD AND FOURTH DEGREE OBSTETRIC PERINEAL INJURY: A PRELIMINARY RESULT

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OBJECTIVE
The study is conducted to obtain a local data on the incidence of 3rd and 4th degree obstetric perineal injury (OPI) and the Correlation between Clinical Outcomes and Anorectal Manometry findings

METHODS
Patients with 3rd and 4th degree OPI between November 2010 and November 2011 from Hospital Tengku Ampuan Afzan Kuantan Pahang were recruited for this study. The patients were followed-up at 6 weeks and 3 months. Wexner’s Continence Score is used to assess patients’ anal continence and followed by anorectal manometry.

RESULTS
14 patients (12 Malays, 1 Orang Asli and 1 Vietnamese) had been recruited from November 2010 until November 2011 with mean age of 26.6 years (range from 19-34 years). Three patients were dropped from the study because they did not turn up for subsequent follow-up. Out of 11 patients, only 2 patients did not complete the follow-up at 3 months. Hence, only 9 patients were eligible to be analysed.

One patient (11%) has a fourth degree perineal tear and the majority have third degree perineal tear (89%). One patient had Wexner’s Continence score of 2 at 3 months. During the first visit at 6 weeks, the resting pressure was normal in both types of injuries. The squeeze pressure however was reduced in 3 patients (33%) with third degree perineal injury. The squeeze pressure was reduced in one patient (11%) during the second visit at 3 months in patients with third degree perineal injury.

CONCLUSION
There were no changes in the clinical outcomes and anal manometry findings in patients with third and forth degree obstetric perineal injury.
INDICATION FOR SURGERY IN CLOSTRIDIUM DIFFICILE INFECTION

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A 44 years old lady presented with acute cholecystitis secondary to cholelithiasis underwent emergency open cholecystectomy. On the day 3 of post operation, patient developed severe sepsis secondary to bile leak from the liver bed. During her stay in ICU, multiple broad spectrum antibiotics and antifungal treatment was started for her treatment of sepsis and nosocomial infection. Patient subsequently developed severe Clostridium difficile colitis. Initial treatment with intrarectal and oral vancomycin/metronidazole failed to respond as patient developed toxic megacolon with septic shock and ileus. Patient then had an emergency colectomy. Despite effectiveness of oral therapy, surgical therapy is occasionally rarely indicated for the treatment of severe pseudomembranous colitis. Surgical intervention should be considered when the patient's symptoms continue to worsened/not resolving especially continued increase in WBC count, hypotensive and the need for vasopressor support, if the functionality of the GIT tract is affected (as in patients with ileus or toxic megacolon), signs of organ failure, a worsening CT scan and when the patients has signs of peritonitis. A high clinical suspicion and careful patient selection for colectomy is imperative to improve postoperative survival.
SUCCESSFUL NON-OBSTETRIC LAPAROSCOPIC SURGERY IN PREGNANCY: A REPORT OF FOUR CASES

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Non-obstetric surgery occurs at 1-2% of pregnant women. Special considerations need to be addressed for the life of two individuals at risk associated with the surgery. These risks include problems arising with anaesthetic choices and physiological as well as metabolic changes in pregnancy. It is therefore imperative that a multidisciplinary approach is adopted when dealing with surgical emergencies in pregnant ladies.

Laparoscopic surgery offers better operative outcome for patients especially in producing less pain and hence requiring less analgesia. The wound complication is also reportedly much lower than open abdominal surgery. It is thus sensible to regard that these advantages would benefit both maternal recovery and foetal safety should an emergency abdominal surgery is required in pregnant ladies. However, the teratogenicity and abortion risk in laparoscopic surgery has yet to be confirmed. The optimum time for non-obstetric surgery in pregnant ladies is during the second trimester where risks mentioned above are minimal. This timing could be similarly applied to laparoscopic surgery.

The anticipated difficulty of performing laparoscopic surgery is of its technicality. For example the placement of multiple trocars during the performance of laparoscopic surgery may not be an easy task with a gravid uterus occupying the abdominal cavity. In addition, carbon dioxide insufflation may be harmful to the foetus. Nevertheless, in emergency situations, one would be compelled to offer laparoscopic surgery whenever possible for the reasons mentioned above. We report a series of inevitable emergency non-obstetric laparoscopic surgery performed on 4 women during their pregnancy.
Colorectal cancer is one of the most common malignancies diagnosed and the third leading cause of cancer mortality. About 30% of patients will have synchronous metastases at the time of diagnosis with liver being the most common site followed by metastases to the lung. Up to 7% of these are isolated, however on the whole only 1%-2% are resectable.

Isolated lung metastases are twice commoner in rectal cancer compared to colon cancer and pulmonary metastasectomy offers reasonable survival benefits with acceptable morbidity and mortality. Several prognostic indicators have been outlined to select candidates for surgical resection of metastases for optimal outcome.

We report demographic and clinical data on isolated pulmonary metastases in colorectal cancer from a single tertiary referral institution.

There were 120 primary colorectal cancer operations for the year 2011. Six patients (5%) had isolated pulmonary metastases, diagnosed with computed tomography (CT) scan. The gender distribution was equal for both male and female. The age distribution was from 50-81 years with a mean of 66 years. The female patients seem to be older in comparison to male. Three were moderately differentiated, 2 were well differentiated and 1 patient had anal squamous cell carcinoma. Pre-operative carcinoembryonic (CEA) levels were raised (>5ng/ml) in half the patients with 1 patient having carcinomatosis peritonei intra-operatively. The patients with low CEA levels underwent uneventful primary tumour resection. Most patients with pulmonary metastases are asymptomatic, however if they do have symptoms it is usually of dyspnoea and unexplained cough which is reflected in our patients where none had chest related symptoms.

We conclude that there are no unique clinical or histological features in primary colorectal carcinoma with isolated pulmonary metastases. Pulmonary metastases are amenable to resection in selected patients with reasonable morbidity, and therefore should be considered.
SHORT-TERM OUTCOMES OF MULTIVISCERAL RESECTIONS FOR LOCALLY ADVANCED COLORECTAL CARCINOMA IN UNIVERSITY MALAYA MEDICAL CENTRE (UMMC)

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INTRODUCTION
Multivisceral resections (MVR) are associated with higher morbidity in the short term. When considered for resection of locally advanced tumours, overall and disease free survival should justify the high morbidity rate. MVR with curative intent has been shown to improve overall survival with acceptable morbidity for locally advanced and resectable colorectal carcinoma in developed nations. There is no published data regarding these outcomes in developing countries such as Malaysia, where there may be limitations in terms of expertise and facilities.

METHOD
Records of all patients undergoing MVR for locally advanced colorectal carcinoma in the UMMC from 2007 – 2010 were retrospectively reviewed. Data extracted included demography and operative mortality and morbidity, including anastomotic leak, wound healing and other organ-specific complications.

RESULTS
Of twenty-six evaluable cases, twelve involved primaries in the colon, while fourteen were rectal. Twenty cases were performed electively, while six cases were emergencies. Non-colorectal organs involved included small bowel, genitourinary tract, pancreas and adrenals.

Nine patients (35%) developed 14 operative morbidities, while operative mortality was 3.8% (1 patient). Complications included anastomotic leak, ileal conduit leak, surgical site infection and perineal wound breakdown. 36% of complications were of Clavien grade III and above. Emergencies were not associated with increased morbidity.

CONCLUSION
MVR for locally advanced colorectal carcinoma can be performed in UMMC with short-term outcomes comparable to those in developed nations. Further studies are required to evaluate long-term outcomes.
INTUBATED CAECOILEOSTOMY AN ALTERNATIVE TO LOOP ILEOSTOMY FOR FAECAL DIVERSION FOLLOWING LOW ANTERIOR RESECTION. A SINGLE CENTRE EXPERIENCE

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OBJECTIVES
Loop ileostomies are still constructed to divert fecal stream from at risk distal anastamosis. These stomas are associated with high complication rates and inconvenience to the patient. Intubated caecoileostomy, a novel technique of proximal catheter ileostomy was studied for its feasibility as an alternative to loop ileostomy.

METHODS
This study is a retrospective review of all patients who underwent an intubated caecoileostomy for proximal fecal diversion after a conventional low anterior resection at a tertiary care hospital over a period of six years from June 2006 to July 2011.

RESULTS
There were 13 patients included into this study. There were 8 males and 5 females with a mean age of 52.4 years. Peri- catheter leak was reported in 2 patients (15.4%). There was no catheter blockage observed amongst the patients. One patient had an anastamotic leak (7.7%) and a female patient presented on the twenty second post operative day with a rectovaginal fistula. There were no deaths in this cohort. The average hospital stay was 13.5 days. 11 patients (84.6%) had the catheter tubes deflated on the 5th day. The catheter was removed between the 10th to 15th post operative days (average 12 days) in twelve patients. Spontaneous closure of catheter site was seen within 4 to 9 days (average 6 days). There was no reported intra-peritoneal leak from the catheter insertion site.

CONCLUSIONS
Intubated caecoileostomy is a feasible method for temporary fecal diversion for distal anastamosis. It is easily constructed, with minimal complication and effectively diverts bowel content. It negates the need for a second surgery.
Intussusception is a rare abdominal emergency in adults. Though it shares the same definition as its childhood variant, it is a different entity in adults where the presentations, etiology and treatment is dissimilar. Due to its non-specific and intermittent presentation, diagnosis is usually delayed. Though the presentation may vary among individuals, the use of computed tomogram as a diagnostic tool proves to be accurate and reliable where there is a dilemma in diagnosis. Unlike childhood intussusceptions where reduction is the first line of management, the same is discouraged for adult cases in view of its contrasting etiology. Surgical resection is a safe and preferred modality of treatment for adult intussusceptions. We report 2 cases of adult intussusceptions who presented with large bowel pathology.
ADULT TYPHLITIS IN A RENAL TRANSPLANT RECIPIENT

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BACKGROUND

Typhlitis, also known as neutropenic enterocolitis, is characterised by inflammation of the caecum and ascending colon in an immunosuppressed patient. It has mostly been reported in paediatric oncology patients. However, it has recently been described in adults not only with haematological malignancies, but those with solid tumours, HIV/AIDS and medication-induced neutropenia. Diagnosing typhlitis is challenging, and often a diagnosis of exclusion. We describe a case of typhlitis in an adult renal transplant recipient.

CASE REPORT

A 56 year old male, who had a cadaveric renal transplant 7 years ago, presented with an acute abdomen. In addition to immunosuppressants for his transplanted kidney, he had been on treatment for pulmonary TB for the past year. Computed tomography (CT) scans showed a long segment of terminal ileum thickening with surrounding mesenteric stranding. Exploratory laparotomy revealed thickened, fibrotic and inflamed terminal ileum and caecum. Ileo-caecoctomy was performed and a double-barelled stoma fashioned. Histopathological examination showed non-specific superficial ulceration with inflamed granulation tissue formation. There were an increased number of mast cells, which indicates underlying immunodeficiency. There was however, no histological evidence of tuberculosis.

CONCLUSION

Given the current widespread use of chemotherapeutic and immunosuppressive agents for a variety of indications, typhlitis should be considered as a differential diagnosis in adults who present with an acute abdomen. Further research is needed to determine whether optimum management protocols are similar to those in paediatric cases.
POOR OUTCOMES FOR COLORECTAL CANCER IN PREGNANCY: DIAGNOSTIC, THERAPEUTIC AND COMPLIANCE ISSUES

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BACKGROUND
Colorectal cancer carcinogenesis and its relation to pregnancy are not well understood. It is rare, but is associated with poor outcome even after correcting for stage at presentation. Early diagnosis and treatment are important, but can be challenging due to overlapping signs and symptoms, as well as relative contraindications to some diagnostic and therapeutic modalities. A multidisciplinary team approach is required. Management is individualized and dependent on various factors that include maternal age, patient’s desire for future fertility, gestational age at diagnosis, and cancer stage. We evaluated the outcomes of such patients in our institution, and attempted to identify influencing factors.

METHODS
A retrospective analysis was performed on our database of colorectal cancer between 2007 and 2011. From a total of 684 cases, three were documented as having colorectal cancer during pregnancy.

RESULTS
The mean age was 34.7 years. One of the patients had a background of familial adenomatous polyposis (FAP). Two of the patients had locally advanced colorectal cancer at diagnosis, despite having had regular antenatal reviews and reporting symptoms. However, both of these patients refused surgical resection due to personal belief. The third patient was diagnosed intra-operatively during emergency Caesarean section, defaulted subsequent treatment, progressed to metastatic disease and died after undergoing emergency palliative surgery for colonic obstruction.

CONCLUSION
Improvement in prognosis for this high-risk patient population should focus on earlier detection, multidisciplinary management and increasing patient compliance.
The term indeterminate colitis describes surgical specimens of putative inflammatory bowel disease in which the histological appearances are characteristic neither of ulcerative colitis nor Crohn’s disease. A diagnosis of indeterminate colitis is based on endoscopic, histological, and radiologic findings when the criteria for either both disorders cannot be definitively established. This distinction is of considerable practical importance because of the markedly different prognostic and therapeutic implications of these disorders.

CASE REPORT
A 29 year-old lady presented acutely to a private center in October 2010 with severe abdominal pain and constipation for two weeks. Emergency laparotomy and appendicectomy were performed, but unfortunately, were complicated by an enterocutaneous fistula, for further management of which she was subsequently referred to UMMC. Colonoscopy in February 2011 revealed multiple colonic and terminal ileum ulcers, strictures and skip lesions with inflammed mucosa and cobbled stone appearance throughout the colon, with rectal sparing. Colonoscopy was complicated by iatrogenic perforation and emergency resection was performed. Histopathological examination showed non-specific colitis, but she was treated as Crohn’s disease based on the clinical presentation, commencing Azathioprine and a tapered dose of prednisolone. Despite this, she continued to develop Crohns’-like complications requiring multiple surgeries in the subsequent year. PCR analysis ruled out tuberculosis as a possible differential diagnosis. She currently remains hospitalized for fistula and wound care management.

CONCLUSION
Indeterminate colitis is a diagnostic and therapeutic challenge. Further research should be targeted at the aetiology in order to better define therapeutic options.
LOCALLY ADVANCED DOUBLE-SEGMENTAL GASTROINTESTINAL CARCINOMA – A DIAGNOSTIC AND THERAPEUTIC DILEMMA

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BACKGROUND
Locally advanced gastrointestinal tract carcinomas, which involve more than one segment of the gastrointestinal tract, can pose dilemmas in diagnosis and treatment. The usual scenario is of a primary colorectal carcinoma invading other structures such as the bladder, gynaecological organs, stomach, or rarely, the duodenum. On the other hand, primary duodenal carcinomas are rare, and differ vastly from colorectal carcinomas, both therapeutically and prognostically.

CASE REPORT
A 45 year old female presented with iron-deficiency anaemia, epigastric pain, and significant weight loss, with no change in bowel habit and a palpable mass at the right lower quadrant. Oesophagogastroduodenoscopy revealed a fungating duodenal tumour and colonoscopy showed a large caecal tumour, assumed to be infiltrating into the duodenum. Biopsies from both tumours confirmed a moderately differentiated adenocarcinoma. Staging CT showed a large caecal tumour with infiltration to surrounding structures (right kidney, duodenum and terminal ileum) with pelvic and abdominal lymphadenopathy, and no distant metastasis.

During surgery, lymphadenopathy was noted mainly along the superior mesenteric artery, with no significant lymphadenopathy around the coeliac axis. Furthermore, the larger portion of the tumor was within the colon. The working diagnosis therefore, was of a locally advanced right-sided colonic tumour.

She underwent en-bloc resection with right hemicolecctomy, right nephrectomy, partial duodenectomy of D1 and D2 with primary repair, gastrojejunostomy and ileo-colic anastomosis.

Histopathology revealed an ulcerated tumour 10x7cm, arising from the duodenal mucosa with full thickness invasion and infiltrating into the adjacent caecal wall and renal capsule, confirming a primary duodenal adenocarcinoma.

CONCLUSION
The preferred treatment for a resectable primary duodenal carcinoma would have been pancreaticoduodenectomy with en bloc resection of adjacent tissues, including regional lymph nodes, but this carries a considerably higher morbidity and mortality rate. Chemotherapeutic options are also significantly different to that for primary colorectal carcinomas, and overall survival is worse. This case highlights the difficulties of establishing clinical diagnosis and planning therapeutic options in double-segmental gastrointestinal carcinomas.
COMBINED LAPAROSCOPIC LEFT ADRENALECTOMY AND ULTRALOW ANTERIOR RESECTION FOR LEFT ADRENOCORTICAL TUMOUR AND LOW RECTAL CARCINOMA

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OBJECTIVE
In recent years, minimally invasive surgery has been the gold standard for treatment of rectal and adrenal tumours. We present a case of combined laparoscopic left adrenalectomy and ultralow anterior resection to illustrate the technical aspects of performing two combined procedures in one setting.

METHOD
A 72-year-old Chinese lady presented with synchronous low rectal carcinoma and left adrenocortical tumour requiring resection. Preoperative workout showed a posteriorly located low rectal carcinoma 4 cm from anal verge and an incidental finding of left adrenal mass on computed tomography scan which proved to be a non-functioning tumour after endocrine investigation. Patient was first placed in a right lateral position for the procedure of left adrenalectomy and later changed to Lloyd-Davis modified position for anterior resection. The ports’ position for anterior resection was adjusted according to ports’ position for left adrenalectomy.

RESULTS
Patient made an uneventful postoperative recovery except for high ileostomy output during the initial few days. She passed flatus at second postoperative day and was taking soft diet at 3rd postoperative day. She was discharged from the ward at 7th postoperative day. Histopathological examination confirmed a moderately differentiated adenocarcinoma, T3N0Mx and left adrenocortical adenoma.

CONCLUSION
Combined laparoscopic surgery is feasible and confers the advantages of simultaneous management of two different coexisting pathologies without significant addition in postoperative morbidity and stay.
**LAPAROSCOPIC ULTRALOW ANTERIOR RESECTION – THE FINER POINTS IN TECHNIQUE**

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**OBJECTIVES**
The benefit of magnification and improved visualization has greatly improved the quality of dissection with preservation of finer structures normally not easily seen during open surgery. Such advantages are particularly apparent when performing laparoscopic rectal surgery especially when performing ultralow anterior resection. However, due to the steep learning curve and perceived additional cost the adoption of laparoscopic approach as a gold standard remains slow. A standardized technique would prevent pitfalls due to common errors and promote the adoption of this technique among junior surgeons.

**METHODS**
Laparoscopic ultralow anterior resection for mid and low rectal cancers is performed at our center using a standardized technique following a step by step approach. Issues with regards to standing position between surgeon and assistant which best provides freedom of movement, trocar placement, choice of dissecting instruments, choice of stapler, the technical difficulties associated with the circular stapler and positioning of the proximal colon. Common pitfalls are discussed.

**RESULTS**
There were 21 patients (9 men and 12 ladies; mean age 62 years). The median hospital stay was 5 days. Blood loss was minimal during all surgeries and none of the patients required blood transfusion. Complications developed in 5 patients. 4 of them had high output ileostomy that resolved with conservative treatment and one had postoperative anastomotic leak that required a reoperation and Hartmann’s procedure.

**DISCUSSIONS**
Our series demonstrates that laparoscopic ultralow anterior resection is safe and yields better patient outcomes with earlier mobilization and better post-operative recovery. The outcomes are easily reproducible if meticulous attention to surgical technique and the steps are followed methodically. A larger series and longer follow up is required before survival benefit and tumour-free intervals can be compared objectively.
LAPAROSCOPIC MANAGEMENT OF ADULT INTUSSUSCESSION: EXPERIENCE OF FOUR CASES

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OBJECTIVES
Adult intussusception is rare and represents only 5% of all intussusceptions and 1% of bowel obstruction. Surgical intervention is the gold standard as up to 90% of adult intussusceptions have a pathological lead point, with the majority lesions being malignant neoplasms. This study reviewed our experience with laparoscopic management of adult intussusceptions to evaluate its safety, efficacy and outcomes.

METHODS
Between January 2010 and December 2010, 2 male and 2 female patients presented to us with adult intussusceptions. The mean age of patients was 49 years (range, 25-64 years). All patients presented in the emergency setting. Two patients presented with small bowel obstruction while one had chronic bouts of diarrhea and another had recurrent abdominal pain. Computed tomography scan diagnosis was accurate in all patients.

RESULTS
Laparoscopic resection of adult intussusceptions was completed successfully in all patients. There were no intra- and post-operative complications. The choice of surgery was tailored to the type of intussusceptions. One patient had laparoscopic-assisted small bowel resection; two had right hemicolecctomy and one had anterior resection. All patients recovered and were discharged well.

CONCLUSION
Laparoscopic management of adult intussusception is safe and feasible and confers all the advantages of minimally invasive surgery. Diagnostic laparoscopy allows real-time visualization of the bowels and assists surgeons’ decisions about the appropriate type of surgery and, where appropriate, reduction prior to en bloc resection.
AN AUBERGINE UP MY… CASE REPORT OF RECTAL FOREIGN BODY
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INTRODUCTION
Rectal foreign body is not an uncommon condition managed by the modern General Surgeon. It may well pose as a challenge to the unwary due to the variable presentation and management dilemma. The magnitude of variability in the associated injuries would also pose questions to the managing team. The presentation may be delayed, usually only after the patient is unable to remove the foreign body themselves.

PRESENTATION
We present a case of a young gentleman who presented with severe abdominal pain who just had an aubergine inserted per rectally for personal gratification. As we were unable to remove the object during per rectal examination, we proceed to Examination under anaesthesia in the operating theatre. Fortunately the object was able to be removed without reverting to major surgery.

DISCUSSION
We will illustrate the case in detail and also present a review of the literature with regards to the variable types of objects and management algorithm. Another important aspect to consider is the psychosocial aspect of the patient himself and whether it has anything to do leading to the patient inserting the foreign body.

CONCLUSION
Rectal foreign body is but one of the myriad conditions managed by any surgeon. A systematic approach should be employed in the majority of cases and most can be managed conservatively. Surgical intervention should be reserved only in cases involving large objects which may be wedged in the pelvis.
LOCAL EXPERIENCE WITH STAPLED TRANSANAL RECTAL RESECTION (STARR) FOR OBSTRUCTED DEFECATION SYNDROME (ODS) ASSOCIATED WITH RECTOCELE

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BACKGROUND
Obstructed Defecation Syndrome (ODS) is a common pathology among middle-aged female but often underdiagnosed due to its wide spectrum of clinical presentation. The pathogenesis of ODS is complex; secondary to either dysfunctional pelvic floor or anatomical rectal alteration as rectocele or rectal intussusception. Stapled transanal rectal resection (STARR) aims to restore normal rectal anatomy by strengthening rectovaginal septum and resecting redundant rectum, in treating rectocele causing ODS. This study describes a case-series of patients with ODS and rectoceles treated with STARR procedure in our centre.

AIM
This study aims to evaluate clinical outcomes and efficacy of stapled transanal rectal resection (STARR) in treating ODS patients.

METHODS
A retrospective descriptive study of six patients diagnosed with rectocele and ODS from January 2009 to December 2011 in Hospital Sultanah Aminah Johor Bahru, all treated with STARR procedure. Data evaluated from patients’ files were baseline demographics, pre and post operative assessment of constipation (using standardized questionnaires and Longo's ODS score), early post operative complications (bleeding, incontinence, fissure, fistula, stenosis and suture line dehiscence) and patients overall satisfaction (graded as excellent, fair or poor) at 2 months post surgery.

RESULTS
All six patients were female, with median age of 49.5 (range 37-51 years old). The median score obstructive defecation score assessment was 22.2 over 40 (range, 12-32) before surgery and 4.4 over 40 (range, 8-12) post operatively. None of the patients develop any acute complications. Five patients graded overall satisfaction score as 'fair' and one patient graded 'poor' as she experience no change in symptoms score.

CONCLUSION
STARR procedure is a safe and effective surgical procedure to treat rectocele and provide significant symptoms improvement to patients with ODS in short term follow-up.

REFERENCE
EARLY EXPERIENCE OF SINGLE ACCESS LAPAROSCOPIC ANTERIOR RESECTION FOR RECTAL CARCINOMA

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OBJECTIVE
Single Access Laparoscopic Surgery (SALS) was initially performed in appendicectomies, cholecystectomies and has eventually progressed to be applied in colectomies as well as anterior resection (AR). The results of a prospective series of SALS Anterior Resection are presented.

METHODS
From September 2010 to August 2011, 6 patients with stage II and stage III rectal cancers were selected to undergo the procedure. A 4 cm “omega” incision is made over the umbilicus and 3 ports are then placed within this incision, using the direct trocar entry technique. The open technique of port placements is completely avoided to prevent air leaks during the surgical maneuvers. Henceforth, the techniques employed during this procedure mimics that of conventional laparoscopic anterior resection where the inferior mesenteric pedicles are clipped, followed by mobilization of the left colon, mesorectal excision and finally resection of the rectum. The resected colon and rectum is then exteriorized through the same “omega” incision over the umbilicus and the specimen removed. Colo-rectal anastomosis is achieved using the circular stapler. In 4 patients, a pelvic drain was placed through the right iliac fossa. None of the patients had a covering stoma.

RESULTS
Median total surgical time was 210 minutes. Intra-operative bleeding is minimal which did not require any blood transfusion. No conversion to conventional laparoscopic surgery or open anterior resection was performed. Post operatively period for all the patients were uneventful. There were no anastomotic leaks or any other surgical complications noted in any of the patients.

CONCLUSION
SALS Anterior Resection is a safe and feasible procedure with good outcomes, in terms of cosmetic, minimal tissue damage and pain as well as oncologic clearance.
78 years old Chinese gentleman presented with bleeding per rectum for 3 times over one year duration. He received blood transfusion in last two episodes. He was diagnosed as multiple colonic diverticulum after colonoscopy was done.

In June 2011, he underwent surgery which was Single Incision Laparoscopic Total Colectomy with “W” pouch and ileostomy. The surgery lasted for about 8 hours and postoperative period was unremarkable. He needed to stay in the ward for nearly one month because of high ileostomy output. The high ileostomy output was replaced accordingly and the patient also received parenteral nutrition during the hospital stay.

The ileostomy was closed back about one month after the first surgery and the patient was discharged well one week after second surgery. The patient now attends the surgical follow up clinic regularly and he is doing well.
BACKGROUND
A prospective case series of single access laparoscopic left hemicoelectomies using conventional laparoscopic trocars and instruments is described.

METHODS
There were three patients underwent single access laparoscopic left hemicoelectomies from January 2011 to December 2011 in our unit. Three trocars via a single omega-shape umbilical incision measuring 4cm were used. The bowel was mobilized and the vessels ligated intracorporeally with an extracorporeal anastomosis.

RESULTS
This case series of three patients had no conversion to conventional laparoscopic or open surgery. They were all female with mean age of 42 years (ranges from 29-59 years). Two of the patients had redundant transverse and sigmoid colon and another patient had descending colon cancer. The mean operating time was 233 minutes (ranges from 210-275 minutes). The mean hospital stay was 8 days with no documented post-operative complications. Histopathology of the patient with descending colon cancer showed adequate tumor excision margins and lymph node yield of 27 nodes.

CONCLUSION
Single access laparoscopic left hemicoelectomy is feasible with standard laparoscopic instrumentation.
NON RANDOMISED COMPARATIVE STUDY COMPARING CONVENTIONAL VERSUS SINGLE INCISION LAPAROSCOPIC RIGHT HEMICOLECTOMY

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Conventional multi port Laparoscopic surgery for right hemicolecction has been shown to be as effective as open surgery with the advantage of smaller surgical wounds. Recent advances in the field of laparoscopic surgery has aimed for a lesser number of ports or single port/ single access. The objective of this study is to compare the various aspects of conventional against single incision laparoscopic right hemicolecction.

Patients undergoing laparoscopic right hemicolecction are subjected to conventional multi port or single incision method. After the initial placement of a umbilical port to view the operative field, the decision is made on whether the surgery proceeds with conventional of single incision method. The single incision method uses a 3 port, 4 cm long omega shaped skin insision. Resection and anastomosis is done extraperitoneally with staplers. The study compares operative time, length of hospital stay, pathological TNM staging, nodal involvement and complications.

The study comprises all right hemicolecction cases done in 2011 and 2012. The results show no significant difference in the various parameters studied.

In conclusion, single incision laparoscopic right hemicolecction is a feasible method of treating right colonic pathology with no significant difference in outcomes as compared to conventional laparoscopic method.
CASE REPORT: TRANSANAL ENDOSCOPIC OPERATION (TEO) FOR RECTAL CARCINOID

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INTRODUCTION
Transanal Endoscopic Operation (TEO) is a minimally invasive method used for removal of rectal polyps or early rectal tumour.

CASE PRESENTATION
We report a case of a 45 year old man who was referred from a private hospital for involved polypectomy margin following polypectomy for a rectal carcinoid. He first presented to the private hospital with fever and diarrhea. Colonoscopy done there showed pancolitis (Histology consistent with infective colitis) with an incidental rectal polyp. Polypectomy was performed for the rectal polyp. Histopathological examination of the polyp showed a polyp measuring 12x8x5mm consistent with a well differentiated neuroendocrine tumour (carcinoid), the tumour extends to the submucosal excision margin of the polyp. Computed tomography showed no local nodes or metastatic lesions. We proceed with a Transanal Endoscopic Resection of the polypectomy scar which was located 5cm from the anal verge at 9 o’clock position. The scar tissue measuring 1.5x1cm was excised full thickness with a 1cm margin. The defect was closed with a continous non-absorbable suture. The histopathological examination showed chronic inflammation with no evidence of tumour. He was discharged well on post-operative day two without any complications. He did not have any incontinent or complaints during follow-up after a week and at three months.

CONCLUSION
Transanal endoscopic operation allows for local resection of rectal lesions up to the rectosigmoid region. Small carcinoid tumours limited to the mucosa can be removed endoscopically. Transanal endoscopic operation can be used for primary resection or following incomplete resection following endoscopic treatment for carcinoids when the tumour is <2cm without high risk features. Rectal carcinoids larger than 2cm or with high risk features should undergo anterior resection or abdomino-perineal resection.
LAPAROSCOPIC REPAIR OF COLONOSCOPIC PERFORATION
– A REPORT OF 2 CASES

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Incidence of colonic perforation following a colonoscopy examination has been reported around 0.2 to 0.6 percent. Incidences increase if concurrent therapeutic procedure is performed. Perforation following colonoscopy may occur for many reasons. In general it can be either due to pneumatic forces, when attempting to visualise more or during mechanical trauma of biopsy. Due to its rarity a spectrum of management ranging from conservative to operative methods have been reported. We present two cases of post colonoscopy perforation due to two different scenarios. In both cases the colonic perforation were repaired laparoscopically under emergency setting with no immediate complications.
ACUTE AORTIC THROMBOSIS POST ANTERIOR RESECTION: A RARE CASE REPORT

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Acute aortic thrombosis following an anterior resection for rectal cancer is an extremely rare complication. Abnormal blood coagulation in cancer patient, the presence of peripheral vascular disease, deep abdominal retractors and prolonged lithotomy position are predisposing factors that contribute to this rare complication. A routine and frequent neurovascular examination of the extremities should be done during the immediate postoperative period to help detect early any neurovascular complication for rapid intervention. The use of graduated compression stockings and prophylactic anticoagulant are strongly recommended in high risk surgery patients undergoing a major procedure which helps prevent thromboembolic episode following surgery. We report a rare case of acute aortic thrombosis following an anterior resection for rectal cancer and discuss some factors that may contribute to this devastating complication.

KEY WORDS
Colorectal cancer – Pelvic surgery – Aortic thrombosis – Lithotomy position – Compartment syndrome – Abdominal retractors