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### Malaysian Society of Colorectal Surgeons
#### Office Bearers 2011 – 2013

- **President**: Dato’ Dr Wan Khamizar Wan Khazim
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- **Vice President**: Dr Lu Ping Yan
- **Hon Secretary**: Prof Azmi Md Nor
- **Hon Treasurer**: Assoc Prof Datuk Ismail Sagap
- **Council Members**: Dr Mohd Akhtar Qureshi, Assoc Prof April Roslani

### Organising Committee

- **Organising Chairperson**: Dato’ Dr Wan Khamizar Wan Khazim
- **Deputy Organising Chairperson**: Assoc Prof April Roslani
- **Hon Secretary**: Prof Azmi Md Nor
- **Scientific Programme**: Dr Lu Ping Yan
- **Allied Health Programme**: Dr Manohar Padmanathan, Puan Mariam Mohd Nasir
- **Social**: Dato’ Dr Meheshinder Singh
- **Pre-Congress Workshop**: Assoc Prof Datuk Ismail Sagap
- **Post-Congress Workshop**: Dr Samuel Tay
- **Committee Members**: Datuk Dr Yunus Gul, Dr M Sarkunna Thas, Dr Paul Selvindoss, Dr Mohd Akhtar Qureshi, Dr Ahmad Shanwani
Welcome Message

Welcome to the Coloproctology 2013. This time we are coming back to Kuala Lumpur. Even though this meeting can be held outside Kuala Lumpur, having it in the capital city is most convenient.

Once again, we have invited distinguished speakers from many parts of the world to come to our meeting. We are holding a post-congress workshop with the College of Radiology, focusing on Magnetic Resonance Imaging of Rectal Cancers. I am sure all of us would benefit from this update in the treatment of rectal cancer which is the most common malignancy in the large bowel.

The Scientific Committee has planned many interesting topics addressing common dilemmas in our practice. All the latest updates and recommendations will be put forward to help guide us in making crucial decisions when required.

We hope that you will enjoy this conference with a lot of take home messages.

Thank you,

Dato' Dr Wan Khamizar Wan Khazim
President MSCRS &
Organising Chairman, Coloproctology 2013
## Programme Summary

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<td>Symposium 8: Allied Health Professional Session (1)</td>
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<td>Symposium 2: Allied Health Professional Session (1)</td>
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<td>Tea</td>
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<td>1100 – 1130</td>
<td>Symposium 3: Difficult Anorectal Sepsis</td>
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<td>Symposium 4: Allied Health Professional Session (2)</td>
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<td>1700 – 1800</td>
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<td>Closing by MSCR\textsuperscript{S} President</td>
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<td>1800 – 1900</td>
<td>MSCR\textsuperscript{S} AGM / Official Poster Round</td>
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<td>1930 – 2200</td>
<td>GALA DINNER</td>
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### 14\textsuperscript{th} March 2013, Thursday

- **0800 – 1700**: Pre-Congress Workshop 1
  - Surgical Workshop
- **17\textsuperscript{th} March 2013, Sunday**

- **0900 – 1200**: Post-Graduate Round
- **1200 – 1300**: How to Interpret MR Imaging of Rectal Cancers
Pre-Congress Workshops
14th March 2013, Thursday

PRE-Congress Workshop 1
Surgical Workshop
Venue: Advanced Surgical Skills Centre
Universiti Kebangsaan Malaysia Medical Centre, Kuala Lumpur
Moderators: IAN FINLAY / FEZA REMZI
0800 – 0825
Registration
0830 – 0835
Welcoming speech by Chairman
ISMAIL SAGAP
0840 – 1030
OT4: Laparoscopic sigmoid colectomy
SHAILESH PUTAMBEKAR
OT5: SILS Laparoscopic sigmoid colectomy
JUN-GI KIM
1045 – 1100
Mid-morning tea break
1100 – 1300
OT4: Sphincter repair
KEMAL DEEN
OT5: EUA and LIFT
CHUCHEEP SAHAKITRUNGRUANG
1300 – 1400
Lunch
1400 – 1645
OT4: Stapled haemorrhoidopexy
ROY PATANKAR
OT5: Trans Anal Minimally Invasive Surgery (TAMIS)
ISMAIL SAGAP
1645 – 1700
Closing and afternoon tea break

PRE-congress Workshop 2
Allied Health Professional
Venue: Sports Medicine Room
University of Malaya Medical Centre
Kuala Lumpur
Moderators: MARIAM MOHD NASIR / ROZITA MOHAMAD / METNA COMMITTEE MEMBERS
1400 – 1430
Stoma sitting
PAAT SIU LIN
1430 – 1500
Assessment and classification of peristomal skin lesion: SAC instrument
MARIAM MOHD NASIR
1500 – 1530
Tea
1530 – 1600
Assessment and classification of peristomal skin lesion: DET score and AIM guidelines
MARIAM MOHD NASIR
1600 – 1630
Stoma sitting
METNA FACILITATORS
1630 – 1800
Hands-on application of pouching system in real stoma patients
Three Groups led by Enterostomal Therapists with participating companies:
CONVATEC, COLOPLAST, MAYCARE
### Daily Programme

**15th March 2013, Friday**

<table>
<thead>
<tr>
<th>Time</th>
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| 0830 – 1000| **SYMPHOSUIM 1** SABAH ROOM  
Appendicitis Revisited  
Chairpersons: MEHESHINDER SINGH / FOO CHANG LIM  
- Acute appendicities – Is clinical diagnosis alone sufficient? [page 15]  
  PAUL SELVINDOSS  
- Management of appendicular mass [page 15]  
  WAN KHAMIZAR WAN KHAZIM  
- Surgical techniques for handling complicated appendicitis  
  YUNUS GUL  
- Unexpected histological findings in acute appendicitis  
  KEMAL DEEN |
| 1000 – 1030| Tea                                                                |
| 1030 – 1115| **PLENARY 1** SABAH ROOM  
Surgical emergencies in inflammatory bowel disease  
FEZA REMZI |
| 1115 – 1245| **SYMPHOSUIM 3** SABAH ROOM  
Difficult Anorectal Sepsis  
Chairpersons: AKHTAR QURESHI / MOHAMAD ISMAIL ALI  
- Supralevator and post-anal abscesses  
  CHARLES TSANG  
- Management of recurrent fistulas-in-ano  
  KEMAL DEEN  
- Suppurative necrotising anorectal abscess  
  ROY PATANKAR  
- Perianal Crohn’s disease  
  FEZA REMZI |
| 1100 – 1300| **SYMPHOSUIM 2** SELANGOR/PERAK ROOM  
Allied Health Professional Session (1)  
Chairperson: TAI SEOW BENG  
0830 – 0900  
Introduction to Malaysian Enterostomal Therapy Nurses Association (METNA) & Enterostomal Therapy Nursing Education Program (ETNEP)  
[MARIAM MOHD NASIR  
0900 – 0930  
Overview of ostomy surgery: Gastro intestinal tract  
MANOHAR PADMANATHAN  
0930 – 1000  
 Malaysian enterostomal therapist (ET) nurses: What are their directions and career pathways? [page 16]  
TAN TANG PENG  
1000 – 1030  
Paediatric stoma  
MOHAN A NALLUSAMY |
| 1100 – 1300| **SYMPHOSUIM 4** SELANGOR/PERAK ROOM  
Allied Health Professional Session (2)  
Chairpersons: MARIAM MOHD NASIR / NG YENG LAI  
1100 – 1130  
Empowerment as an enterostomal therapist: Can an enterostomal therapist manage stomacare? [page 17]  
ROZITA MOHAMAD  
1130 – 1200  
Are we competent? Treating stoma complications [page 18]  
NG YENG LAI  
1200 – 1300  
Sharing practice and experiences among enterostomal therapist (ET) in Asia  
- Stomacare in Indonesia [page 19]  
  WIDASARI SRI GITARJA  
- Stomacare in Korea [page 20]  
  HEEJUNG KIM  
- Stomacare in Taiwan  
  LIN JUI-PING |
Daily Programme
15th March 2013, Friday (cont’d)

1245 – 1415  Lunch Satellite Symposium (Johnson & Johnson)
The Evolution of Laparoscopic Colorectal Surgery  
SHAILESH PUNTAMBEKAR
Friday Prayers

1415 – 1500  PLENARY 2  
Chairperson: SAMUEL TAY
How do we optimise national colorectal cancer outcomes?  
IAN FINLAY

1500 – 1630  SYMPOSIUM 6  
Management Of Complications In Colorectal Surgery  
Chairpersons: GERALD FITJERALD HENRY / M SARKUNNA THAS
• Acute management of anastomotic leak  
  FEZA REMZI
• Stenosis after colorectal surgery  
  KEMAL DEEN
• Stapler failures – What do you do?  
  CHARLES TSANG
• Incontinence after anorectal surgery  
  IAN FINLAY

1630 – 1800  HOW I DO IT (Incorporating Tea)  
Chairpersons: YUNUS GUL / JASIAH ZAKARIA
• Rectal reconstruction surgery:  
  1. Technical issues with reach in pouch surgery  
  2. Coloplasty  
  FEZA REMZI
• Artificial anal sphincter  
  IAN FINLAY
• Anorectal potpourri:  
  1. Over-the-scope clip (OTSC) in proctology  
  2. Laser ablation of haemorrhoids  
  3. Compression anastomosis  
  APRIL ROSLANI
• Colonic irrigation for ostomates  
  HARIKESH GULABRAI BUCH

1415 – 1545  SYMPOSIUM 5  
Allied Health Professional Session (3)  
Chairperson: MANOHAR PADMANATHAN
1415 – 1500  Overview of ostomy surgery: Genito urinary tract  
MUHILAN PARAMESWARAN
1500 – 1545  Psychosocial aspects in ostomates  
HARIKESH GULABRAI BUCH

1545 – 1700  WORKSHOP 1  
Allied Health Professional Session (4)  
COLOPLAST Presentations  
• Includes some oral presentations on stoma care management
• Product updates
• Practical session

1800 – 1900  MSCRS AGM / OFFICIAL POSTER ROUND
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<td>Arrival of Guests</td>
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<td>2000</td>
<td>Dinner is served / Entertainment</td>
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<td>2030</td>
<td>Welcome Speech by Dato’ Dr Wan Khamizar, President, MSCRS &amp; Organising Chairman, Coloproctology 2013</td>
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<td>2040</td>
<td>Speech by Datuk Dr Noor Hisham Abdullah, Director-General of Health Malaysia</td>
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<td>2050</td>
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<td>Induction of New Members of MSCRS</td>
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<td>Presentation of Best Poster Awards</td>
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<td>Lucky Draw</td>
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<td>2200</td>
<td>End of Event</td>
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Daily Programme
16th March 2013, Saturday

0830 – 1000
SYMPOSIUM 7
Rectal Cancer
Chairpersons: AZMI MD NOR / PRABHU RAMASAMY
- MRI staging of rectal cancers
  REGINA BEETS-TAN
- MRI restaging of rectal cancer and its impact on clinical decision-making
  REGINA BEETS-TAN
- Should radiological regression post-neoadjuvant treatment change surgical management?
  IAN FINLAY

1000 – 1045
PLENARY 3
Chairperson: APRIL ROSLANI
Can laparoscopic surgery improve long term oncologic outcome for right colon cancer? [page 21]
JUN-GI KIM

1045 – 1115
Tea

1115 – 1300
SYMPOSIUM 9
Laparoscopic Surgery
Chairpersons: PAUL SELVINDOSS / TEE SHIN SAN
- Single incision versus conventional laparoscopic anterior resection for sigmoid colon cancer [page 25]
  JUN-GI KIM
- Anticipating problems in laparoscopic surgery
  ROY PATANKAR
- Managing complications of laparoscopic surgery
  CHUCHEEP SAHAKITRUNGRUANG
- Selection criteria for laparoscopic sphincter-saving surgery
  SHAILESH PUNTAMBEKAR

0800 – 1030
SYMPOSIUM 8
Allied Health Professional Session (5)
Chairperson: PAAT SIU LIN

0800 – 0830
Guideline on stomacare [page 22]
TAI SEOW BENG

0830 – 1030
Stoma care in Malaysia: Enterostomal therapist clinic services
- UMMC
  NORSEHHA AHMAD
- HKL [page 23]
  ROSMAH ABD MAJID
- PPUKM
  KHADIJAH SULAIMAN
- Selayang
  NARIAH AWANG
- Melaka
  SARINA ABBAS
- Seremban [page 23]
  RASIDAH JAMALUDDIN
- Pahang [page 24]
  TAN GUAT EE
- Kedah
  WIDYASUHANA MOHD ZAIDA
- Johor
  NORAZLIN MD NOH
- Penang [page 24]
  VASSUGI SANDRASAGARAN
- Sarawak
  PAAT SIU LIN

1030 – 1100
Tea

1100 – 1300
SYMPOSIUM 10
Allied Health Professional Session (6)
Chairperson: ROZITA MOHAMAD

1100 – 1130
Nursing management of stoma : Peri-operative and after care [page 25]
NOR AZAH AZIZ
1300 – 1415

**Lunch Satellite Symposium (Merck Serono)**

Chairperson: MEHESHINDER SINGH

Oligometastatic Disease in Colorectal Cancer: Illusion or Reality?

MUHAMMAD AZRIF AHMAD ANNUAR

1415 – 1545

**SYMPOSIUM 11**

**Common Benign Colorectal Disease**

Chairpersons: MANOHAR PADMANATHAN / AHMAD SHANWANI

- Haemorrhoids – What now?
  
  IAN FINLAY

- Chemical sphincterotomy for anal fissure
  
  CHARLES TSANG

- Management of pilonidal disease
  
  ROY PATANKAR

- Externally-stimulated graciloplasty for incontinence
  
  KEMAL DEEN

1545 – 1615

Tea

1615 – 1715

**PROFESSORS’ CORNER**

Chairpersons: LU PING YAN / RETNA RASA

IAN FINLAY / KEMAL DEEN / JUN-GI KIM / CHARLES TSANG

1715 – 1725

Closing by MSCRS President
Daily Programme
17th March 2013, Sunday

0900 – 1200
POST-GRADUATE ROUND
Venue:
Stargate, 8th Floor
Universiti Kebangsaan Malaysia
Kuala Lumpur, Malaysia
Faculty: KEMAL DEEN
Moderator: ISMAIL SAGAP

0900 – 1300
POST-Congress Workshop
How To Interpret MR Imaging Of Rectal Cancers
Venue:
Selangor/Perak Room, Shangri-La Hotel
Kuala Lumpur
Faculty: REGINA BEETS-TAN
Coordinator: SAMUEL TAY
Moderator: YAZMIN YAACOB

0800 – 0900
Registration

0900 – 1015
Workshop I

1015 – 1045
Break

1045 – 1200
Workshop II

1200 – 1230
Q & A

1230 – 1240
Closing Remarks

1240 – 1330
Lunch
Conference Information

Conference Venue
Shangri-La Hotel Kuala Lumpur
11 Jalan Sultan Ismail, 50250 Kuala Lumpur, Malaysia
Tel : (603) 2026 8488
Fax : (603) 2032 1245
Attention : Reservation Department
Email : reservations.slkl@shangri-la.com

Registration
The registration hours are:

- 14th March 2013 (Thursday) 1500 to 1900 hrs
- 15th March 2013 (Friday) 0730 to 1800 hrs
- 16th March 2013 (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
- Gala 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 Sabah Ante Room, Shangri-La Hotel, and the operating hours are:

- 14th March 2013 (Thursday) 1600 to 1900 hrs
- 15th March 2013 (Friday) 0730 to 1800 hrs
- 16th March 2013 (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

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Acknowledgements

The Organising Committee of the Coloproctology 2013 wishes to thank the following for their support and contribution:

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Acute appendicitis remains a clinical emergency and is one of the more common causes of acute abdominal pain. No single symptom or clinical findings, or diagnostic test accurately confirms the diagnosis of appendicitis.

The surgeon’s goals are to evaluate a relatively small population of patients referred for suspected appendicitis and to minimize the negative appendectomy rate without increasing the incidence of perforation.

While history and clinical examination are important, they are not sufficient to diagnose and treat acute appendicitis effectively.

As such blood investigation known as the triple screen which includes White count, Neutrophilia and CRP are been used as diagnostic tools. Imaging with ultrasound, Ct scan and MRI have become routine in confirming the diagnosis of acute appendicitis.

In conclusion clinical diagnosis alone is not sufficient to diagnose and treat acute appendicitis.

 Appendicular mass has been classically treated conservatively followed by interval appendicectomy. It is believed that an operation on an appendicular mass is more difficult with more bleeding on top of the unfriendly friable tissue. Hence surgical intervention later when there is no more inflammation is deemed to be a lot safer. However, more and more papers recently showed that this is not always true. More and more surgeons tend to operate early on an appendicular mass showing that it is quite safe. Another group of surgeons decided that interval appendicectomy is not really necessary after successful conservative management. Several papers have shown that this is also true. In fact, it is found that interval appendicectomy is more difficult due to dense adhesions. Perhaps, conservative treatment with interval appendicectomy will be something of the past.
Malaysian Enterostomal Therapy Nurses Association or formerly known as METNA is a professional association.

According to Wikipedia (2013), it is also called a professional body, professional organization, or professional society and is usually a nonprofit organization seeking to further a particular profession, the interests of individuals engaged in that profession, and the public interest.

The roles of professional associations have been variously defined: “A group of people in a learned occupation who are entrusted with maintaining control or oversight of the legitimate practice of the occupation also a body acting “to safeguard the public interest; organizations which “represent the interest of the professional practitioners,” and so “act to maintain their own privileged and powerful position as a controlling body.

The speaker will shared what are the objectives of METNA, what they have achieved and their future planning to strengthen the association including their future endeavor.

She also will be sharing the program organized by METNA, which is called Enterostomal Therapy Nursing Education Program (Malaysian ETNEP), an initiative to train more Nurses to be knowledgeable, competent and skillfully in providing stoma care, wound care and continence care as to ensure quality and safe care.

Malaysian enterostomal therapy nurses’ directions and career pathway evolve through the decades since our beginning in late 1980s, from ostomy rehabilitation, government services to the private sectors, self-practice entrepreneurship, education, as well as sales and marketing of products. Although some have also moved on from the core business of enterostomal therapy nursing practices as they get promoted into the diversified and leadership career pathway, many Malaysian ETs still lend support to the activities and growth of Malaysian Enterostomal Therapy Nurses Association and ostomy rehabilitation.
In Malaysia, Clinical Nurse Specialist is still at the infancy stage nevertheless many Nurses have carried out their roles and responsibilities as a Clinical Nurse Specialist regardless whatever discipline they are expert in.

The speaker will discuss and focuses about E.T. Nurses roles, whom are competent in stoma care only even Enterostomal Therapy Nursing also includes wound and continence care.

Clinical Nurse Specialist is defined as an advanced practice by registered nurse who has undergone a specialised training to become more knowledgeable, competence in their skill in carrying out the practice and also able to make certain decision, solve problems in managing the cases.

They are able to take steps to prevent complications and also manage them. Such as marking the stoma site pre operatively, treat skin excoriation in stoma cases, help patient managing retracted stoma and also take an active roles in making sure ostomate will go back to as normal life as possible.

According to Businessdictionary.com, Empowerment is a management practice of sharing information, rewards, and power with employees so that they can take initiative and make decisions to solve problems and improve service and performance. Empowerment is based on the idea that giving employees skills, resources, authority, opportunity, motivation, as well holding them responsible and accountable for outcomes of their actions, will contribute to their competence and satisfaction.

As an E.T., in order to be able to practice professionally and the need to practice independently, it is importance for them to be given empowerment.

In this discipline, they need to make decisions, solve problems and choose management options without empowerment this will hinder their practice and judgement. The speaker believes ET will be able to manage in carrying out their roles and responsibilities but empowerment is a must from the management, from the nursing and especially from the colorectal surgeons.

The speakers will discuss further on this interesting topic with all during the conference.
Patients undergoing ostomy surgery have potential risk in developing stoma complications. Post operative stoma complications such as stomal necrosis, mucocutaneous separation, prolapse, retracted, peristomal hernia and peristomal skin complication. These complications will influence postoperative care and have significant impact in quality of live for a person living with a stoma and rehabilitation.

The risk for stoma complications is affected by multiple preoperative, intraoperative, and postoperative factors. Pre operative stoma site marked by Enterostomal Therapy (ET) Nurse to find a suitable location for a stoma is crucial to ensure an optimal stoma site of obtaining a secure pouching seal to maintain intact peristomal skin. Post operatively frequent assessment with early recognition of sign & symptoms of a stoma complication and prompt interventions by the ward nurses, ostomies, Enterostomal Therapy (ET) Nurse and surgeons are essential in treating stoma complications and maintaining viable stoma. Nurses should carry out full assessment before treating stoma complication. Treating stoma complications can be re-educate patient on care of stoma, application / change of appliances, use of stoma accessories, in some cases may require surgical intervention.

In Malaysia we ET nurses, Colorectal surgeons / general surgeons, ward nurses and others health care provider work as a team to provide quality and excellent care to our patients/clients. We are competent in treating stoma complications. However prevention is better the cure ,risk of the stoma complications can be reduce with a pre-operative stoma sitting ,teaching counseling by ET nurses ,intra-op handle by a skillful and experienced surgeon and Post -operative ET nurses continue in emotional support, educate in stoma management and teach ostomy patients in recognize stoma complications and seek professional advice.
Introduction. Stoma nurse and ostomates gathered project to start a Stomanurse Ostomy Support -group, we called SOS-group. They offers counseling and role models to patient and their families, before and during their rehabilitation process after stoma surgery. They help them to understand what is happening, answering and dealing with the non medical problems, support them when they have the operation and follow up after.

2007, the first Stoma clinic leading by stoma nurse was build. The name of clinic is WOCARE. Their vision to provide a professional nurse leads service for people with stomas, wounds or incontinence. WOCARE works closely with professional nurse, stoma nurse, ETs and doctors to have a promote social project for people living with their “new life” such as ostomates.

Activities and Outcomes. SOS-group was a unique group of collaboration between stoma nurse and ostomates, with different academic levels, cultures, religions and social-economics status. We creating education and guideline for nurses and ostomate to be knowledgeable and skillful to look after stoma patients. Every month, there's many event in national or local scale of seminars and ostomate gathering for introducing ostomate to public. Our campaigns are “Friends of Ostomate”, “Moslem Fatwa”, “Certified Stomanurse Program” and “1000 bags for Ostomates”

Further details of aims that SOS-group try to reach are follows:

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

Conclusion

1. The SOS- group is very important and the best solution for working together between stoma nurses and ostomates to improve QOL of ostomates.
2. This group also important for any medical doctors, ETs, stoma nurses, nurses and others for creating and developing a operational standart procedure to help patients with stoma.
3. Stoma center will be the next issues in Indonesia for answering the QOL for Ostomate.

*SOS = Stomanurse Ostomy Support
The prevalence of colorectal cancer (CRC) has been increased in 2.5 times more during the past decade in Korea. Currently, approximately 68% of the CRC patients in Korea survive at least 5 years. In the light of the growing number of CRC patients and improvements in their survival rates, investigation of health-related quality of life (QoL) of CRC patients including patients with stoma becomes increasingly important.

The Enterostomal Therapist (ET) nurses work as a clinical specialist for patient with a stoma and the management of the stomas with the various problems is challenging for ET nurses. ET nurses have to take consideration into various aspects of care for stoma patients’ QoL including pain control, management of cancerous lesion around stoma, enterocutaneous fistula, peristomal skin dermatitis and stoma itself.

So, the largest clinical study in ostomy care (Dialogue study) was performed with more than 3,000 people with a stoma and 500 ET nurses in 18 countries including Korea. This study reported that disorders affecting the peristomal skin are common problem and have a negative impact in their QoL.

Knowledge with the quality should have dedicated and different point of view in stoma care. Besides evidence based practice is needed for a variety of health care professionals, especially for successful stoma care. With multidisciplinary team’s efforts in order to provide the better environment for the stoma rehabilitation, many things have been changed in Korea. The ET nurses obviously will play leading roles in stoma care, and our effort will be able to create cutting-edge stoma care. Targeted tailored stoma care are required to improve ostomates’ QoL.
CAN LAPAROSCOPIC SURGERY IMPROVE LONG TERM ONCOLOGIC OUTCOME FOR RIGHT COLON CANCER?


Division of Colororectal Surgery, Department of Surgery, The Catholic University of Korea, Korea

Background
There have been efforts to improve long-term oncologic outcome in colon cancer surgery for many years. Two distinct principles have been used thus far. The first, introduced by J Payton Barne and Rupert B. Turnbull in 1952 and 1967, is carried out with severing the major lymph vascular vessels without manipulating the diseased lesion to prevent cancer cells spreading into the systemic circulation. The second, reported by S. Toyota, is performed using high ligation (at the origin) of the main vessels with the widest possible resection of the mesentery whilst dissecting the regional lymph nodes along the main trunk artery up to the main nodes situated anterior to the superior mesenteric artery and vein. In our institute, we combined these two techniques to perform surgeries for right colon cancer since April 1986 and adopted the laparoscopic technique in April 1995 using the same principles as open surgery. In order to evaluate whether the laparoscopic surgery improved the long-term oncologic outcome, we analyzed the right colon cancer surgery data between 1986 and 2006.

Methods
The surgical principle is as follows: 1. Denude the front and right side of the superior mesenteric pedicle 2. Ligate the main trunk artery origin. 3. From such point, mesentery is divided up to the desired point of colon and is mobilized from the retroperitoneum laterally. 4. The specimen is then removed from the abdominal cavity. Groups were selected only from patients with stage II and III cancer (n=218). Subjects were divided into three groups by time sequence since the time needed to overcome the learning curve influences oncological outcome in laparoscopic surgery. Group 1: when only open surgery was performed. Group 2: when laparoscopic technique was introduced and the learning curve was being overcome. Group 3: when the surgery was performed once the learning curve was fully overcome. The local recurrence rate, DFS, and OS were analyzed to compare long term oncological outcome among three groups.

Results
Difference in overall survival rates (OS) between Group 1 and II was not statistically significant. However, disease-free survival rate (DFS) for Group I and III was higher than II. In group III, OS and DFS for laparoscopic surgery group were better than open surgery group, when compared. Local recurrence for group III (2.6%) was significantly lower than the group I (12.1%) and II (7.4%), with P value 0.013.

Conclusions
OS and DFS for right hemicolecotomy of right colon cancer showed similar outcome with open surgery when the learning curve was overcome. However, local recurrence rate was significantly decreased. To investigate further, it is necessary for studies to be conducted in a large number of institutions to find more concrete evidence for data analysis.
The main objectives are to provide a comprehensive care and support to ostomates and families in order for a smooth transition between hospital and home. Secondly the patient is able to achieve excellent rehabilitation whereby attainment of QOL.

The care is dividing into preoperative phase and post operative phase.

In the preoperative phase it covers physical and psychological. Under physical preparation, a routine investigation, skin preparation, bowel preparation is carry out. Psychological preparation will be counseling and health education. The topic discuss on how stoma is like, expectation after surgery, shown appliances, supply with reading materials, service and support that is available. The next preparation before surgery is stoma siting is crucial importance for the patient ability to lead a full active life by ET or Surgeon.

During postoperative phase nursing aims is to monitor the stoma base on anatomical location, type ,size of stoma .The stoma is closely monitored for 48 hours after surgery for the colour, shape. Immediately should also check that the appliance has been correctly fitted. The immediate appliance used must be transparent, filter free to facilitate easy observation. The nurse should monitor and record passage of flatus and volume and nature of effluent. The main wound is well protected. The patient needs encouragement and support to look at the stoma. Once patient is alert and family members, teaching the methods of draining, steps in changing the pouching system can begin slowly and a return demo by the patient.

Prior discharge an individualized discharge teaching is essential to ensure practical and emotional needs are met as quoted by Curry 1991. Psychological support and education is continued. Patients need to aware of possible complications. The ET /nurse will ensure that patient leave the hospital know how to obtain future supply of appliance, storage and shown various appliance in the market. Prior to discharge patients have many concern about how stoma will affect their daily life and advice and information from the nurse will focus on diet, clothing, returning to work, bathing ,recreational activities, and religion. Ensuring that the patient is in possession of all Information on support that is available, association, contact numbers requires prior discharge.

Conclusion that nurse should be in the position to provide teaching, skilful care and support before and after surgery so that individual will be able to adapt a new way of life and return to lifestyle previously enjoyed prior creation of stoma (Salter 2002).
Colorectal Cancer is one of the commonest cancer in Malaysia.

Stoma clinic Hospital Kuala Lumpur is a place where ostomy patients who are planned for an ostomy surgery and for those who are already had their ostomy surgeries. Pre operation and post operation counselling are one of the main roles of our stoma clinic. Teaching patient and their carers are given privacy away from being heard by others.

Our stoma clinic is in the Surgical Out Patient Department of Hospital Kuala Lumpur. Not at all times, patients are able to seen in our clinic but patients can also be seen in the surgical wards. We ET nurses, are with the patients from the day they plan the surgery.

Rehabilitation process is the most vital part of an ostomy patients as it helps him/she had a quality life living with a stoma.

Services of stoma care in Hospital Tuanku Jaafar Seremban begins from Surgical Outpatient Department (SOPD). Once the date is confirmed, the surgeon plays an important role to explain the nature and the outcome of the operation to the patient and family members. Patient admitted one day before the operation and preop counseling begins.

E.T. Nurse will meet the patient and family members explained – why the siting done, show type of appliances, fliers, flip chart and introduce the patient to another ostomate.

Post op day – daily review, close observation, stoma appearance and type of discharge and whether able to ambulate.

With the support of surgeons, E.T. Nurse, ward staff and family members’ moral support, patient is able to manage the stoma and can be discharged.

Patient discharge with sufficient information, this can lead patient to good quality of life and shorten length of stay and avoid complications. Follow up will be given to patient.
The state of Pahang is located in the east of Peninsular Malaysia and bounded:

i. Kelantan in the north;
ii. Perak, Selangor and Negeri Sembilan in the west;
iii. Johor in the south and
iv. Terengganu and the South China Sea in the east

With an estimated population of 1.5 million, it occupies a central and eastern section on the map of Malaysia.

Three enterostomal therapists serve this region in Kuantan and Temerloh, referral centre in Hospital Tengku Ampuan Afzan, Kuantan and Hospital Sultan Haji Ahmad Shah in Temerloh.

Problems arise with patients seeking aid in stomal care are usually from outskirt areas with logistics, family and financial support.

If it is called as Enterostomal Therapy clinic or E.T Clinic in your hospitals but in Penang Hospital it is well known as Stoma Clinic. Even if establishment of our clinic is as young as 2 years old but services for stoma and wound care have been carried out way long ago by our pioneer ET nurses. At early years our ET nurses would go from ward to ward to render their care to patients. As we have more ET nurses in year 2010 which consist of 9 ET nurses in total, have served the purpose to improve the care of stoma and wound care of patients in Penang Hospital. The care of stoma patient have been more consistent and effective since the clinic has started up. Even though we does not have neither permanent Stoma Clinic nor a permanent ET nurse placed in the clinic, we are doing the duty calls by weekly rotation based on the time table done by our senior ET nurse. Our Stoma Clinic operates on every Thursdays 9am - 1pm for patients with appointment, but in case of emergencies the on-call ET nurse will see to the patient as needed. There are also patients that are refered to ET nurses from colorectal clinic on Tuesdays 10am – 1pm to give stoma care education or patients with any stoma or wound complications to be seen. We ET nurses also will review the patients in the wards for pre and post stoma care education, stoma siting, patients with stoma complications and also wound care as referred.

We ET nurses in Penang are also actively involved in Persatuan Ostomy Pulau Pinang to give care to more stoma patients out there. This is also a consideration of follow up care of patients that have been discharged from hospitals. This has been successfully helped stoma patients to adapt to their new life with stoma more confidently. So it is our responsibilities as ET nurses to give a continuous and endless care for our patients who needs our services. We would proudly say that we care to give the best to our patients and will always find ways to improve them.
Background
Recently, there have been some reports regarding safety and effects of single incision laparoscopic colectomy. The aim of this study was to compare the short-term outcomes of single incision laparoscopic anterior resection (SILAR) to conventional laparoscopic anterior resection (CLAR) for sigmoid colon cancer.

Methods
Between April 2010 and July 2011, 24 patients was performed SILAR. Case of obstruction or perforation and proven T4 lesion or metastasis in the pre-operative evaluation (CT scan) was excluded. Those that underwent SILAR were case matched for age, sex, body mass index, tumor location and history of abdominal surgery with patient undergoing CLAR. 24 patients were selected among 105 CLAR group from April 2009 to July 2011.

Results
There was no case of conversion to open surgery, and no conversion to conventional procedure. Both groups were similar in regard to age, body mass index and tumor location. Two patients in the SILAR group were complicated anastomotic leakage and one patient in the CLAR group, and they were received re-operation. There was no surgical mortality and re-admission within 30 days in either group. The operative time was longer in the SILAR group compared with the CLAR group (251±50 vs 234±58 min; P=0.268). With D3 dissection in all patients, specimen length, distal free margin and number of harvested lymph nodes (19.6 vs 22.3; P=0.338) were no different. There was no margin positive in all patients. The passage of flatus and oral diet was faster in the SILAR group (1.7 vs 2.4 days; P=0.018 and 2.8 vs 3.8 days; P=0.014).

Conclusion
Based on the early outcomes, we conclude that the SILAR is feasible and safe. There was no increase in morbidity. Moreover, adequate lymph node harvest and free margin was well supported. Further prospective trials may need to validate the benefits of early oral diet.

Stoma forming surgery is a life changing event that can be highly distressing physically and psychologically for some patient. Patient require information pre operatively to help them to prepare for the surgery. Enterostomal therapy nurse will provide as much information and guide them to adapt their new life. Post operatively will focus on learning practical stoma management skills and patients will continue to require information and support. This continuous support and encouragement will help them to live even with a stoma.
HELPING OSTOMATE IN THE SELECTION OF POUCHING SYSTEM
Paat Siu Lin
Burn Ward / Wound Care Team, Hospital Umum Sarawak, Kuching, Sarawak, Malaysia

Ostomates who had undergone ostomy surgery will experience some degree of depressive mood initially due to the uncertainties regarding their health condition (especially those who had been diagnosed as having cancer), alter body image, worries about leakage and odour of the stoma output and whether able to go back to their normal work and perform daily living activities. These uncertainties will lead to social isolation which will worsen their quality of life.

As an Enterostomal Therapy Nurse, helping them in the selection of an appropriate pouching system for their stomas and teaching them the proper technique of application of the pouching system will help them to manage the stomas confidently and thus able to return to their normal lifestyle. Ultimately they will experience their lives as being of good quality.

PALLIATIVE CARE FOR ADVANCED COLORECTAL CANCER
Lam Chee Loong
Palliative Medicine Division, University of Malaya, Kuala Lumpur, Malaysia

For patients with advanced colorectal cancer, a multitude of concerns may arise relating to their condition. Thoughts pertaining to treatments, be they surgical or oncological, side effects, and survival are no doubt concerns that modern medicine attempts to address. Palliative care is an approach that works alongside the multidisciplinary team that focusses on alleviating suffering and enabling people not just to live, but to live life to the full. When the goal of treatment is no longer curative, relief of distress and maintenance of comfort become imperative. Aside from physical symptoms that are common in advanced colorectal cancer, palliative care also attempts to provide a support structure that encompasses the other aspects that make a person - the psychological, social and spiritual domains. Cancer means different things to different people and care has to be individually tailored around the ideas, concerns and expectations of patients and their families. It is the role of all healthcare professionals to deliver this as a team, in order that the cancer journey may be made more manageable for the patient with advanced colorectal cancer.
**HOW EFFECTIVE IS MALAYSIAN OSTOMY ASSOCIATION (MOsA) IN SUPPORTING MALAYSIAN OSTOMATES?**

Mohd Rahime Ab Wahab
University Malaya Medical Centre, Kuala Lumpur, Malaysia

Malaysian Ostomy Association (MOsA) or formerly known as Stoma Care Society of 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 a stoma.

MOsA play an important role to make sure it can benefitted the Malaysian Ostomates through its program such as community outreach / screening collaboration with other NGO, Educational programs, recreational activities, rehabilitation, interview and social events.

By organizing this event, MOsA aims to increased number of membership in the association by reaching the ostomates by encouraging the healthcare providers and traders who have contact with ostomates to join MOsA. This will provide a platform for ostomate to exchange their knowledge, experiences and also to built up confident among them, so that they can be united and support each other.

The commitment, dedication and participation from Ostomates is the the most important thing to MOsA. MOsA continuously aims towards improving the Ostomates quality of life in Malaysia.
Poster Presentations

PO 1 Prevalence Of Pre-Operative Deep Venous Thrombosis In Malaysian Patients With Colorectal Cancer
E H B Ng1,2, Y T Cheong1, P W R Lee2, A H A Razack3
1Penang Hospital, Penang, Malaysia
2Penang Medical College, Penang, Malaysia
3University Malaya Medical Centre, Kuala Lumpur, Malaysia

PO 2 An Audit Of Initial Experience In Giving Colorectal Services In Hospital Melaka
S M Abd Jalil, M S Samsul Baharin, A Jalaludin, A H Y Amar
Surgical Department, Hospital Melaka, Melaka, Malaysia

PO 3 Survey Of Bowel Function After Colorectal Anastomosis In Hospital Selayang
Salahudin Baharom, Gerald Henry
Department of Surgery, Hospital Selayang, Selangor, Malaysia

PO 4 The Effect Of Preoperative Mechanical Bowel Preparation For Elective Colorectal Resection On Postoperative Realimentation And Hospital Stay
Fadli A R1, Zailani M H2, Andee D Z3, Zaidi Z3
1Department of Surgery, Hospital Tengku Ampuan Afzan, Kuantan, Pahang, Malaysia
2Department of Surgery, Hospital Pantai Ayer Keroh, Melaka, Malaysia
3Department of Surgery, Hospital Universiti Sains Malaysia, Kubang Kerian, Kota Bharu, Kelantan, Malaysia

PO 5 Single Incision Laparoscopic Colectomy Using a Glove And The Alexis Wound Protector As A Modified Port. A Feasible and Economical Method In Well Selected Cases
Pravin Lingam, Leong Quor Meng
Tan Tock Seng Hospital, Singapore

PO 6 Routine Culture Of Low Passage Colorectal Cancer Cells And Demonstration Of Variation In Selected Tumour Marker Expression
Melanie Arul1, Cheah Swee Hung1, April Camilla Roslani2
1Department of Physiology, Faculty of Medicine, University of Malaya, Kuala Lumpur, Malaysia
2Department of Surgery, Faculty of Medicine, University of Malaya, Kuala Lumpur, Malaysia

PO 7 Blood MicroRNAs That Potentially Regulate Deleted In Colon Cancer (DCC) Gene And Differentiation-Related Gene 1 (DRG1) In Metastatic Colorectal Cancer
Fung Lin Yong1, Chee Woon Wang2, Chee Wei Law1
1Department of Surgery, Faculty of Medicine, University of Malaya, Kuala Lumpur, Malaysia
2Department of Biochemistry, Faculty of Medicine, MAHSA University College, Kuala Lumpur, Malaysia
### Poster Presentations (cont’d)

**PO 8**  
*Blastocystis* sp. Infection In Colorectal Cancer Patients: Prevalence And Risk Factors  
Vinoth Kumarasamy¹, April Camilla Roslani², Umah Rani Kuppusamy³, Suresh Kumar Govind¹  
¹Department of Parasitology, Faculty of Medicine, University of Malaya, Kuala Lumpur, Malaysia  
²Department of Surgery, Faculty of Medicine, University of Malaya, Kuala Lumpur, Malaysia  
³Department of Biomedical Science, Faculty of Medicine, University of Malaya, Kuala Lumpur, Malaysia

**PO 9**  
Hyperbilirubinemia As A Diagnostic Marker Of Acute Appendicitis  
Sureiin K, Tikambari E, Tan K K, Abdel Aziz A A, Buvanesvaran T M  
Colorectal Unit, Department of Surgery, Hospital Kulim, Kedah, Malaysia

**PO 10**  
Does Stoma Affect Prayers? – Awareness Among Healthcare Personnel In Hospital Kulim  
Tan K K, Sureiin K, Tikambari E, Abdel Aziz A A, Buvanesvaran T M  
Colorectal Unit, Department of Surgery, Hospital Kulim, Kedah, Malaysia

**PO 11**  
Case Report Of Signet-Ring Cell Carcinoma Of The Colon In A 21 Year Old Man  
Ahmad Muhsin M N¹, Lee Y L¹, Nor Aishah M A¹, Huzlinda H²  
¹Hospital Ampang, Selangor, Malaysia  
²Hospital Serdang, Selangor, Malaysia

**PO 12**  
Natural Orifice Specimen Extraction (NOSE) In Concurrent Hysterectomy And Laparoscopic Anterior Resection  
Ausama A M¹, Law C W¹, Khong S Y², Kumar S¹, Roslani A C¹  
¹Department of Surgery, University of Malaya, Kuala Lumpur, Malaysia  
²Department of Obstetrics and Gynecology, University of Malaya, Kuala Lumpur, Malaysia

**PO 13**  
Laparoscopic Resection Of Adult Intussusceptions: Technique And Review Of The Laparoscopic Experiences With 8 Cases  
C H Chea, H A Mahendran, M Hardin, S L Siow  
Department of Surgery, Sarawak General Hospital, Kuching, Sarawak, Malaysia

**PO 14**  
Neuroendocrine Tumour – A Rare Cause Of Adult Intussusception  
C H Chea, M Hardin, S L Siow  
Department of Surgery, Sarawak General Hospital, Kuching, Sarawak, Malaysia

**PO 15**  
Emergency Correction Of Stoma Prolapse Using A Linear Stapling Device  
Clement Chia, Kwang Yeong How, Richard Sim  
Department of General Surgery, Tan Tock Seng Hospital, Singapore
PO 16  Perforated Caecal Diverticulitis: I Thought It's Appendicitis, What Should I Do?  
A J Hadi, K N Tan, N J Louis  
Hospital Enche’ Besar Hajjah Khalsom, Kluang, Johor, Malaysia

PO 17  Endoscopic Management Of Radiation Proctitis  
H A Mahendran, C J Seo, M Hardin, S L Siow  
Department of Surgery, Sarawak General Hospital, Kuching, Sarawak, Malaysia

PO 18  Short-Term Outcomes Following Laparoscopic Surgery For Rectal And Rectosigmoid Cancers  
Kharlina K, Mahendran H A, Shehab Phung C W, Siow S L  
Department of Surgery, Sarawak General Hospital, Kuching, Malaysia

PO 19  An Extremely Rare Case Of A Primary Colonic Lymphoma Of The Descending Colon Presenting With Obstruction  
Hari V S, Lee C H, Davaraj B  
Department of Surgery, Hospital Tuanku Ampuan Najihah, Kuala Pilah, Negeri Sembilan, Malaysia

PO 20  Retrorectal Cyst In HRPZ II: A Case Report  
Husna Syakirah A B, Ahmad Shanwani, Zaidi Z, Ainilhayat A B, Muhammad Ezzra  
Surgical Department, Hospital Raja Perempuan Zainab II, Kota Bharu, Kelantan, Malaysia

PO 21  Gastrointestinal Involvement Of Polyarteritis Nodosa: A Case Report  
Husna Syakirah A B, Ahmad Shanwani, Zaidi Z, Ainilhayat A B, Muhammad Ezzra S, Noor Hidayah A B  
Hospital Raja Perempuan Zainab II, Kota Bharu, Kelantan, Malaysia

PO 22  Intussusception Secondary To Mucinous Cystadenoma Of Appendix: Rare In Elderly  
Husna Syakirah A B, Ahmad Zuraimi Z, Cheah S D  
Hospital Raja Perempuan Zainab II, Kota Bharu, Kelantan, Malaysia

PO 23  Dual Pathology, Double Trouble…  
Y Huzairi, M Ikhwan Sani, Z Zaidi, S A Syed Hassan  
Department of Surgery, School of Medical Sciences, Universiti Sains Malaysia, Kota Bharu, Kelantan, Malaysia

PO 24  A Case Report Of Worm Bolus Causing Small Bowel Gangrene  
Y Huzairi1, A S Ridzuan1, R N Venkatesh2, A Seoparjo2  
1Department of Surgery, School of Medical Sciences, Universiti Sains Malaysia, Kota Bharu, Kelantan, Malaysia  
2Department of Pathology, School of Medical Sciences, Universiti Sains Malaysia, Kota Bharu, Kelantan, Malaysia
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PO 25  **Surgical Intervention In Rectal Cancers**  
Illyasha M I, Chan K K  
Department of General Surgery (Colorectal Unit), Hospital Sultanah Aminah Johor Bahru, Johor, Malaysia

PO 26  **The Chronic Anal Fissure: Is It Becoming A Medical Disorder?**  
K J Obaid¹, A Alshaham², S Sood¹, M A Yahya¹  
¹Discipline of General Surgery, Faculty of Medicine, Universiti Teknologi MARA, Malaysia  
²Department of Surgery, International Medical School, Management and Science University, Malaysia

PO 27  **Oh My Doughnut! A Forbidden Carcinoids In A Stapled Hemorrhoidopexy Specimen**  
K Kharlina, Shehab C W Phung, I Sagap  
Department of Surgery, Sarawak General Hospital, Kuching Sarawak, Malaysia  
Department of Surgery, University Kebangsaan Malaysia Medical Centre, Kuala Lumpur, Malaysia

PO 28  **Robotic-Assisted Abdominoperineal Resection: A Report Of A First Robotic Colorectal Surgery Experience In Malaysia**  
Shehab C W Phung, K Kharlina, Susan W M, Hun Meng A Quah, N A Nik Azim  
Department of Surgery, Sarawak General Hospital, Kuching, Sarawak, Malaysia

PO 29  **Single Incision Laparoscopic Surgery For Revision Of Defunctioning Ileostomy Following Early Post Operative Stoma Dehiscence And Retraction**  
K Y How, Q M Leong  
General Surgery Department, Tan Tock Seng Hospital, Singapore

PO 30  **A 5-Year Review Of Liver Resection For Colorectal Cancer Liver Metastases In UMMC**  
Sivaneswaran L, Koh P S, Ausama A M, Kumar S, Roslani A C, Yoong B K  
Department of General Surgery, University of Malaya Medical Centre (UMMC), Kuala Lumpur, Malaysia

PO 31  **Stage IV Rectal Cancer With Unresectable Metastases – A Role For Radical Surgery?**  
Siti Nur Masyithah M, C W Law, T A Ong, Alizan Khalil  
Department of Surgery, University of Malaya Medical Centre, Kuala Lumpur, Malaysia

PO 32  **Prostate Carcinoma As The Cause For Colorectal Symptoms – A Clinical Entity Not To Be Overlooked**  
Z B Liu¹, Q M Leong², R Sim²  
¹General Surgery Department, Tan Tock Seng Hospital, Singapore  
²Colorectal Department, Tan Tock Seng Hospital, Singapore
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Wong Shiak Sun  
Universiti Kebangsaan Malaysia, Kuala Lumpur, Malaysia
PREVALENCE OF PRE-OPERATIVE DEEP VENOUS THROMBOSIS IN MALAYSIAN PATIENTS WITH COLORECTAL CANCER

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¹Penang Hospital, Penang, Malaysia
²Penang Medical College, Penang, Malaysia
³University Malaya Medical Centre, Kuala Lumpur, Malaysia

Background
Venous thromboembolism (VTE) contributes major and potentially fatal complications to oncological surgery. The significant incidences of VTE and its associated complications among colorectal cancer patients have led to the advocacy of thromboprophylaxis in the perioperative period. A recent study among Caucasian colorectal cancer patients in Denmark reported a high pre-operative prevalence of deep vein thrombosis (DVT) especially among women with ASA group III and IV. There has been conflicting studies on the prevalence of perioperative DVT among Asian patients and no studies on pre-operative prevalence of DVT among Asian colorectal cancer patients. This questions the possibility of a similar finding with the Denmark study in our patient population and challenges our current national thromboprophylaxis guideline if so.

Methodology
A 14-month prospective observational trial to screen all patients diagnosed with colorectal cancer in Penang Hospital, Penang, Malaysia, for evidence of pre-operative DVT and to assess its associated risk factors. An additional post-operative screening for DVT was also performed to assess the efficacy of our current thromboprophylaxis guideline.

Results
A total of 79 patients were recruited. Mean age of presentation was 64 years with male-to-female ratio of 1.1:1. Chinese was the predominant race. 66% were ASA 2 with 90% of the patients being fully independent and mobile on presentation. 33% had a smoking history. 51% were in Stages III and IV. Pre-operative deep venous thrombosis was not detected in this study. However, there was one reported post-operative deep venous thrombosis after discharge from hospital.

Conclusion
VTE may not be as common among Asians even in the context of malignancy. The current perioperative VTE prophylaxis guideline is still appropriate in our practice.
AN AUDIT OF INITIAL EXPERIENCE IN GIVING COLORECTAL SERVICES IN HOSPITAL MELAKA
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Surgical Department, Hospital Melaka, Melaka, Malaysia

Abstract
It is a great challenge to start the subspeciality services in hospital where for decade under general surgical umbrella. It is in deed a privilege commencing colorectal services as a surgical subspeciality in Hospital Melaka started in October 2012.

Objective
To determine the workload of colorectal cases operated in Hospital Melaka since availability of colorectal services and to serve as an audit to determine areas for improvement in the future. Method: Prospective data collection with retrospectively analyzed.

Result
In 15 months period, started from 1st October 2012 until 31st December 2013, we have operated 243 colorectal cases. Nearly equal operation performed for cancer and benign diseases [125 cases (50.4%) vs 118 cases (48.6%)]. In cancer cases, majority operation were performed for colon as compared to rectal cancer [75 cases (60%) vs 50 cases (40%)]. Most of the cases were operated electively compared to emergency [49.6% (62 cases) vs 29.6% (37 cases)]. 29.3% (22 cases) cancer cases were operated laparoscopically for colon and 14.7% (11 cases) for the rectum. All of laparoscopic cases were operated electively. In benign diseases, by large we operated on haemorrhoidal disease such 3/4th degree and thrombosed haemorrhoid, [34 cases (28.8%), only eight cases (23.5%) opted for stapler]. Secondly, fistula in ano, [27 cases (27.9%) and eight cases (29.6%) were selected for ligation of intersphincteric fistula tract]. Others such colorectal polyps, ten cases (8.5%); perianal and colorectal trauma, seven cases (5.9%); complicated diverticular disease, six cases (5.1%); pilonidal sinus, five cases (4.2%); anal fissure, eight cases (6.8%) and others 27 cases (27.9%).

Conclusion
Colorectal cases in Hospital Melaka are and will increasing in time. There are a lot of work need to be done, to make the colorectal services in Hospital Melaka sustainable, relevant, dynamic and progressive in years to come.
SURVEY OF BOWEL FUNCTION AFTER COLORECTAL ANASTOMOSIS IN HOSPITAL SELAYANG

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Objective
To study long term bowel function following a colorectal anastomosis after resection of sigmoid or rectal tumours.

Method
A group of patients with sigmoid and rectal tumours were extracted from the hospital database. These patients had been operated for more than 1 year, and in patients with defunctioning stomas, a period of 1 year had lapsed since closure of the stoma. Patients who were complicated with anastomotic leaks and patients with tumour recurrences after surgery were excluded. A questionnaire is distributed which covers question on stool frequency, continence problems, and defecation problems.

Results
A total of 25 patients that qualify the criterias completed the questionnaire. Five patients had distal sigmoid tumours, while 8 had upper rectal, 7 had mid rectal, and 5 had low rectal tumours. Stool frequency was one to two bowel movements per day in 13 (51%) patients. Six (25%) patients reported three or more bowel movements per day. Continence affected lifestyle in 5 (20%) patients. Defecation problem occur in 4 (18%) patients.

Conclusion
Stool frequency generally increase compared to before surgery, as expected due to decrease volume of faecal reservoir. It affect more of the patient with rectal tumour as compared to sigmoid tumours. The trend in our patient is the lower tumour cause more increment in stool frequency. Radiotherapy is not shown to directly influence stool frequency. Of five patients with continence problem, 3 were patients with low rectal tumours where 2 are elderly female. This may to some extend be attributed to generalised pelvic floor weakness. Defecation problem also affected more of our female patients, however it involved a younger age group with low rectal tumour, though we do not have any data to support if they have pre existing pelvic floor disorders.
THE EFFECT OF PREOPERATIVE MECHANICAL BOWEL PREPARATION FOR ELECTIVE COLORECTAL RESECTION ON POSTOPERATIVE REALIMENTATION AND HOSPITAL STAY

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The role of preoperative mechanical bowel preparation (MBP) prior to colorectal resection has always been a controversial issue. The aim of the practice is to reduce the risk of postoperative complications by rendering the bowel clean before patient is brought into the theatre. Most of the literatures reviews have been looking mainly into the association of preoperative MBP and postoperative infectious as well as anastomosis complications. The other outcomes such as nosocomial infection, post operative day for realimentation and duration of hospital stays had also been studied.

We reviewed a total of 82 cases of patients who underwent elective colorectal resection in Hospital Tengku Ampuan Afzan Kuantan from 2009 until 2011. 27 patients were subjected to MBP while the rest of 55 patients weren’t. The decision whether to subject the patients for preoperative MBP was solely based on the operating surgeon’s preference. The result showed that the mean of post operative day for patient to resume normal diet was 3.7 days for patient with MBP and 3.9 for those without MBP. The mean for post operative hospital stay was 6.2 days for patients with MBP and 6.6 days for those without MBP.

Our retrospective study showed that the practice or abandonment of preoperative MBP does not affects the post operative day for patient’s realimentation and duration of post operative hospital stay.
Introduction
Single incision laparoscopic surgery (SILS) is gaining acceptance as an alternative to conventional laparoscopic surgery. SILS is technically more challenging because of the lack of triangulation, clashing of equipment and need for articulating instruments. We present our results of our initial experience using a modified SILS port (Glove and Alexis Wound Protector) and conventional laparoscopic equipment for colorectal resections in 20 selected patients.

Method
Data from 20 patients with colorectal pathology who underwent modified SILS colorectal resection was prospectively collected between April 2011 to December 2012 from a single institution.

Results
There were 12 males and 8 females with a median age of 65 years. The median operative time was 110 minutes, with one conversion to open surgery. All incisions were transumbilical, 4cm in length. Ten right hemicolecotomies, 9 anterior resections and 1 left hemicolecotomy were performed. Histologically, there were 12 adenocarcinomas, 4 diverticular disease, 3 polyps and 1 terminal ileum ulcer. The median number of lymph nodes harvested for malignancy was 23. All margins were negative in malignant cases. The median blood loss was less than 100mls. The median length of stay was 3 days. The median time to resuming oral intake is less than 24 hours. One patient developed anastomotic bleed requiring endoscopic clip application and transfusion. There were no leaks. The only conversion to open surgery was due to the intra-operative discovery of a sealed tumour perforation with dense interloop adhesions. There were no surgical mortalities.

Conclusion
The modified single port method is safe and feasible for colorectal resections. The flexibility of the glove enables conventional laparoscopic equipment to be used. This translates to financial savings whilst achieving excellent cosmesis and clinical outcome in well selected patients.
ROUTINE CULTURE OF LOW PASSAGE COLORECTAL CANCER CELLS AND DEMONSTRATION OF VARIATION IN SELECTED TUMOUR MARKER EXPRESSION

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Background
Tumours are heterogeneous in nature, containing a multiplicity of cells. The development and progression of cancers involve complex interactions among cells of the tumor and response to chemotherapeutic drugs may depend on the biological and genetic properties of these cells. Thus, studying low passage heterogeneous cell-lines obtained from patients with known progression and disease would give more relevant information than using immortal homogeneous cell lines.

Methods
A novel method was developed to routinely culture cells from individual patients' colorectal cancer specimens, using cell culture conditions which successfully eliminate the microbial contamination frequently present in samples obtained from the gastrointestinal tract. These cultures were then studied for variations in tumour marker expressions.

Results
A variety of growth forms representing numerous cells typically found in primary tumors were retained in the initial cultures. Immunocytochemistry showed that they are cancerous as they express tumour markers CEA and C2 antigen. Interestingly not all cells secrete the two markers to the same extent, with some expressing both, and others only one of either and some neither; again demonstrating the heterogeneity of the cells from each tumour.

Conclusion
The high heterogeneity in the cellular morphology of the cell lines makes the tumor cell bank a valuable resource for future studies of the growth characteristics of colonic carcinoma. Therefore, an understanding of the basic biological properties of colorectal cancer cells will potentially lead to better rational strategies and discovery of new drugs for the treatment of the disease.
BLOOD MicroRNAs THAT POTENTIALLY REGULATE DELETED IN COLON CANCER (DCC) GENE AND DIFFERENTIATION-RELATED GENE 1 (DRG1) IN METASTATIC COLORECTAL CANCER

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Background
Colorectal cancer (CRC) metastasis occurs in diverse organs, most commonly in liver. Deleted in colon cancer (DCC) gene and Differentiation-related gene 1 (DRG1) are metastasis suppressor genes that play important roles in cancer metastasis. In recent years, microRNAs (miRNAs) have been shown to hold much potential as novel non-invasive biomarkers for cancer diagnosis, prognosis and therapeutic approaches. The objective of this study was to investigate the blood microRNA profile in metastatic CRC patients.

Methods
Blood samples were collected from primary CRC patients from University Malaya Medical Centre (UMMC). MiRNA microarray was performed using samples from healthy controls (n = 18) and CRC patients at stage II (n = 12), stage III (n = 12) and metastatic stage IV (n = 12). In silico miRNA target prediction was conducted using Targetscan software.

Results and Discussion
DCC and DRG1 expressions have been shown to be down-regulated in metastatic CRC. Based on our in silico analysis, we have identified three miRNAs (miR-4267, miR-616* and miR-96) that could target DCC and one miRNA (miR-624) that could target DRG1 from the blood miRNA profile. These four miRNAs were found to be highly up-regulated in metastatic stage IV cases and could be used as targets for miRNA inhibition.

Conclusion
These findings suggest the potentiality of blood miR-4267, miR-616*, miR-624 and miR-96 as prospective physiological regulators of cell invasion and metastasis. Further investigation via miRNA modulation would enhance our understanding of CRC metastasis and provide patient-specific insights to clinical prognostication and therapeutic strategies.
Blastocystis SP. INFECTION IN COLORECTAL CANCER PATIENTS: PREVALENCE AND RISK FACTORS

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Studies have reported that the presence of solubilized antigen of Blastocystis sp. can stimulate colon cancer cells proliferation in vitro. Colorectal cancer (CRC) patients in Malaysia are usually not screened for Blastocystis sp., and therefore its prevalence in this population is not known. The objective of the current study is to determine the prevalence and risk factors of Blastocystis sp. infection in CRC patients compared with a cohort of normal individuals. Colonic washout samples were collected from patients undergoing colonoscopy. A questionnaire was used to evaluate the lifestyle and severity of symptoms. Polymerase chain reaction (PCR) was conducted for genotyping purposes. The student’s t-test was used to analyze the association of symptoms and presence of Blastocystis sp. Multivariate logistic regression modeling was used to analyze risk factors and infection. Colonic washout was collected from a total of 204 CRC patients and 221 normal individuals. The overall prevalence of Blastocystis sp. infection among CRC patients was 20.1% (41/204) and 9.5% (21/221) in normal individuals. These results suggest that PCR is a powerful tool to screen Blastocystis sp. from clinical samples. The subtype-specific prevalence of Blastocystis sp. among cancer patients was as follows: Subtype 1 (3.92%), Subtype 2 (0.49%), Subtype 3 (7.35%), Subtype 1 and Subtype 2 (0.98%), Subtype 2 and Subtype 3 (1.96%), and Subtype 5 (0.49%). Blastocystis sp. Subtype 3 infection is significantly more prevalent compared to other subtypes (P<0.05). The infection of Blastocystis sp. was significantly higher in female (25.64%) compared to male (12.64%; P < 0.05) CRC patients. The risk factors which were significantly associated with Blastocystis sp. infection in CRC patients were gender (female: OR = 0.404, 95% CI: 0.195, 0.949), age (less than or equal to 51: OR = 2.465, 95% CI: 1.186, 5.123) and low fibre diet (OR = 0.415, 95% CI: 0.173, 0.995). Furthermore, symptoms such as chronic diarrhea (24.39%), abdominal pain (73.17%) and stomach bloating (19.51%) were reported to be significantly higher (P<0.05) in Blastocystis sp. harbouring CRC patients compared to non-infected CRC patients. Blastocystis sp. is more likely to be present in CRC patients than normal individuals. Therefore there is a need to screen asymptomatic patients below 51 especially if they are females with low fibre diets. These patients might benefit from earlier screening through colonoscopy.
Background
Acute appendicitis (AA) is the most common abdominal surgical emergency. History and physical examination aided by basic investigation is the mainstay of diagnosis. Although computed tomography is highly sensitive but its use is limited due to its radiation hazard. Hyperbilirubinemia has been suggested as a highly sensitive diagnostic marker in AA (sensitivity: 80%)

Objective
To evaluate significance of hyperbilirubinemia in diagnosing acute appendicitis and its comparison with White blood cell and Alvarado score.

Methods
This is a retrospective study of all patients clinically diagnosed as acute appendicitis and underwent appendicectomy from January 2012 to October 2012 in Hospital Kulim, Kedah. Clinico-demographic Data, Alvarado Score (AS), Serum Bilirubin (SB), White Blood cell (WBC) and Histopathological examination (HPE) of all the cases were analysed.

Result
117 patients were included in the study. Histopathology revealed that 77 were acute appendicitis (AA), 28 were perforated appendicitis (PA) and 12 were white appendix (WA). WBC was elevated in 63 cases of AA (81.8%), 25 cases in PA (89.2%), 7 in WA (58%). 88% of patient with AA had Alvarado score >4, suggestive of AA. Serum bilirubin was raised in only 9 cases of AA (11.68%), 15 of PA (60%) and 3 of WA (25%).

Conclusion
Hyperbilirubinemia is an unreliable diagnostic marker of acute appendicitis.
Introduction

Lack of awareness among patients and healthcare workers increases reluctance to surgery when counseled on stoma. Apart from common stoma complications, Muslims are concerned that its presence will affect their ‘wudhu’ before performing prayers. The Malaysian Islamic Council has decreed (Fatwa) that muslim stomates can perform prayers normally, however they need to repeat ‘wudhu’ before each prayer.

Objective

The aim of this study is to assess awareness of stoma complications and its effect on muslim prayers among healthcare personnel in Hospital Kulim.

Materials and Methods

100 healthcare workers in Hospital Kulim were recruited and responded to a ‘quality of life of stoma patient’ questionnaire.

Results

62% of respondents were Malays, 17% were Chinese, 14% were Indians and 7% others. 41 respondents were doctors, 47 nurses and 12 medical students. Their awareness of stomal complications included stomal necrosis(93%), stenosis(94%), prolapse (93%), retraction(99%), skin excoriation(98%), parastomal hernia(90%), stomal diarrhea(85%) and bleeding(97%). Healthcare workers perceived that patients with stoma can work normally(97%), exercise(97%), have sexual intercourse (97%) or take a flight (95%). Although 97% of the respondents thought that muslim stomates can pray normally, only 83% of the respondents were aware that ‘wudhu’ needs to be performed before each prayer. In addition, 13% of the Malay respondents were unaware of the requirements.

Conclusion

Lack of awareness among healthcare personnel may negatively impact a patient in need of stoma. Educating healthcare personnel may improve stoma awareness and increase acceptance among patients and the general public.

CASE REPORT OF SIGNET-RING CELL CARCINOMA OF THE COLON IN A 21 YEAR OLD MAN

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Signet-ring cell carcinoma of the colon is a rare and aggressive form of colonic cancer which is associated with a very poor prognosis. We report a case of a 21-year old man who presented with abdominal pain and altered bowel habit. Colonoscopy examination showed a circumferential growth causing a narrowed bowel lumen at the descending colon. Both barium enema and computed tomography findings showed a long segment malignant stricture at the descending colon. Tissue biopsy indicated features of signet-ring cell carcinoma. He underwent segmental resection of the cancerous lesion with colostomy when he presented to us with an obstructed and advanced malignant stricture of the descending colon.
NATURAL ORIFICE SPECIMEN EXTRACTION (NOSE) IN CONCURRENT Hysterectomy AND LAPAROSCOPIC ANTERIOR RESECTION
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Introduction
Many Patients present with Pelvic conditions involving both the colorectum and gynaecological organs simultaneously. However, Laparoscopic colectomy and laparoscopic hysterectomy are rarely performed in a combined single setting surgery. The new era of Natural Orifice Specimen Extraction Surgery (NOSE) procedures has the potential for a paradigm shift in surgery for these kinds of cases. There has been an evolution of abdominal surgery from open surgery to minimally invasive surgery for better post-operative pain control and for better cosmetics. From this the idea of NOSE surgery arose. However, complications of trans-vaginal extraction such as dyspareunia make this approach not as widely accepted by both surgeons and patients.

We report a patient for colectomy who also needed concurrent vaginal hysterectomy for a gynecological pathology. In this case, extraction the colectomy specimen trans-vaginally is less controversial.

Objective
The aim of this case report is to highlight the feasibility of retrieval of colorectal specimen trans-vaginally in a combined laparoscopic anterior resection and laparoscopic hysterectomy.

Case Report
74 year old lady diagnosed with recto-sigmoid colon cancer with pre-existing utero-vaginal prolapse (POPQ Stage 4). She underwent laparoscopic anterior resection combined with laparoscopic assisted vaginal hysterectomy and bilateral salpingo-oopherectomy and anterior fascial vaginal repair. The colonic specimen was extracted transvaginally with the use an ALEXIS wound protector to reduce the risk of wound infection and tumor seeding. The vaginal vault was then closed with single layer of sutures.

Postoperative, the patient recovered without any complications and was discharged on the 3rd post-operative day. During her follow up, all the laparoscopic wounds and the vaginal vault wound had healed.

Discussion
Laparoscopic colorectal surgery shares many of the minimally invasive benefits of other laparoscopic procedures such as cholecystectomy and fundoplication; however the need for a specimen extraction incision remains a drawback. There are many reports in the literature describing the use of laparoscopic surgery for both benign and malignant colorectal conditions; however none of them give any importance to specimen retrieval.

The common incisions for trans-abdominal specimen retrieval after laparoscopic colorectal surgery are lower quadrant, midline, or transverse supra-pubic incision. The mini-laparotomy might compromise the very benefits of minimally access surgery, which is set out to accomplish in the first place.

By completely avoiding mini-laparotomy for specimen extraction, these wound-related complications can be prevented. The vagina as a colon specimen retrieval site has significant implications for the future of natural orifice colorectal surgery. The only disadvantages of the trans-vaginal route are obvious: only married women patients can enjoy the benefits and risk of tumour seeding along the colpotomy route. However, they are rarely performed as a simultaneous procedure. Furthermore, removal of the colon specimen through the vaginal cuff has been described fewer than 6 times in the surgical literature. Moreover, other surgeries, such as laparoscopic hysterectomy, could be combined with certain colorectal resections and the specimens could all be removed together. There have been no previously reported cases of laparoscopic rectal anterior resection and total hysterectomy with bilateral salpingo-oopherectomy (LapAR & THBSO) performed at the same session.

In our case, we performed both laparoscopic anterior resection and THBSO in the same session. We used the vaginal vault as the point of extraction of the colonic specimen hence avoiding a mini-laparotomy incision. To reduce the incidence of wound infection and the possibility of tumor seeding we used an ALEXIS protector during the process and hence taking full advantage of the combined minimally invasive procedure.
Conclusion
Our results confirm that LapAR & THBSO is feasible and offers the advantages of a laparoscopic procedure in the hands of a well-trained laparoscopic colorectal surgeon and gynaecologist working together

Due to technical advances and improved experience in laparoscopic colorectal and gynaecological surgery, more complex and difficult challenges have become feasible and safe in recent years

This case report demonstrates the feasibility of combined anterior resection and hysterectomy via the laparoscopic approach. Furthermore, this report demonstrates that colon specimen retrieval via the vagina is an acceptable alternative to a cutaneous extraction incision. As the technology for NOTES continues to develop, hybrid techniques such as this may bridge the learning curve from pure laparoscopy to NOSE.

In our opinion, in this era during which a mini-laparotomy is the preferred method for specimen retrieval in laparoscopic colorectal surgery, trans-vaginal retrieval of specimen seems ideal because it avoids the potential damage of the anal sphincter and the potential risk of port-site metastasis.

POSTER 13

LAPAROSCOPIC RESECTION OF ADULT INTUSSUSCEPTIONS: TECHNIQUE AND REVIEW OF THE LAPAROSCOPIC EXPERIENCES WITH 8 CASES
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Objective
This paper describes our tailored approach and specific operative techniques in the laparoscopic resection of both adult enteric and colonic intussusceptions.

Method
This is a prospective review of 8 adults who were diagnosed with intussusceptions and treated with laparoscopic approaches in our hospital between Jan 2010 and November 2012. Demographic data, the clinical presentation, operative procedure, perioperative outcomes and pathological results were reviewed.

Result
Between January 2010 and December 2012, 5 male and 3 female patients presented with adult intussusception. The mean age was 50 years (range, 25-78 years) and all our patients presented as emergencies. Three patients presented with small bowel obstruction while four had recurrent bouts of abdominal pain and one had persisting diarrhoea. Computed tomography (CT) scan was performed in all but one of our patients and was accurate in diagnosing in all instances. Laparoscopy and resection of the 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. Four patients had laparoscopic-assisted small bowel resection; three had right hemicolectomy and one had low anterior resection. All patients recovered and were discharged well.

Conclusion
Adult intussusception is rare and often difficult to diagnose preoperatively without CT scan. CT scan is diagnostic and enables the safe undertaking of laparoscopic management.
**POSTER 14**

NEUROENDOCRINE TUMOUR – A RARE CAUSE OF ADULT INTUSSUSCEPTION

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**Background**

Gastro-entero-pancreatic neuroendocrine tumours (GEP-NET) are a compendium of complex tumours originating from neuroendocrine cells of the embryological gut. The incidence of GEP-NETs is on the rise, from 3.0 cases per 100 000 in 1990 to 5.2 per 100 000 in 2010 in the United States. Symptoms are notoriously diverse leading to its usually late presentation.

**Method**

We report a 78 year-old man who presented with acute small bowel obstruction. Examination was unremarkable except for a soft, distended abdomen. Computed tomography scan revealed ileo-ileal intussusception with no discernible lead point. He underwent laparoscopic-assisted small bowel reduction and resection with extracorporeal end-to-end re-anastomosis. Two ileal polyps were identified as the lead points intra-operatively.

**Result**

Post-operative recovery was uncomplicated; patient was allowed home on post-op day 5. Upon follow-up, specimen HPE was reported as neuroendocrine tumour with positive immunohistochemistry stains for both chromogranin and synaptophysin. Directed questioning did not reveal any suspicion of carcinoid syndrome. Serum chromogranin A and 5-HIAA levels were found to be raised. The patient is currently under oncological unit care for treatment with octreotide.

**Conclusion**

GEP-NETs typically present with carcinoid symptoms; rarely do they present with mass effect and even more so as an intussusception.

**POSTER 15**

EMERGENCY CORRECTION OF STOMA PROLAPSE USING A LINEAR STAPLING DEVICE

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**Background and aims**

Stoma prolapse is a common complication in loop stomas with an incidence of 2-22%. Various corrective methods have been described which include manual reduction, osmotic therapy, surgical resection of a redundant stoma and button-pexy fixation. Correction of a stoma prolapse using a stapling device has been described in case reports as an easy and safe technique. We aim to demonstrate the reduction and resection of an acute-on-chronic stoma prolapse using a stapling device.

**Methods**

Our patient is a 51 years old HIV positive gentleman with anal canal squamous cell carcinoma and had a trephine diverting loop colostomy prior to chemoradiotherapy. He presented to the emergency department 1.5 years after the diverting loop colostomy with severe abdominal pain. Physical examination revealed an oedematous stoma prolapse/intussusception involving both proximal and distal limbs. He subsequently underwent reduction and resection of the stoma prolapse/ intussusception using a stapling device.

**Results**

Under general anaesthesia, the prolapsed stoma was first reduced. GIA 100 stapler was then used to staple off excess prolapsed sigmoid colon for both the proximal and distal limbs, first longitudinally then transversely. Mucocutaneous union was re-established with interrupted 3/0 vicryl sutures. Our patient had an uneventful post operative recovery and his stoma was functioning on discharge on post operative day 5.

**Conclusion**

Usage of a stapling device to correct stoma prolapse is an easy and safe technique. Long-term follow-up for recurrence is required.
PERFORATED CAECAL DIVERTICULITIS: I THOUGHT IT’S APPENDICITIS, WHAT SHOULD I DO?

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Perforated solitary caecal diverticulitis is a rare diagnosis, which is likely to be diagnosed intra-operatively for presumed appendicitis. We describe a rare case of right iliac fossa (RIF) pain which mimicked an acute appendicitis in a 31-year-old female, who presented to a district hospital to highlight this diagnosis and its surgical management so that trainees can make informed decisions if this is first encountered in the operating theatre. The Para2 lady presented with a 2-day history of RIF associated with nausea, vomiting and low-grade fever. There was no genitourinary symptoms and past surgical or gynaecological history. Clinically, her RIF was tender and guarded with leucocytosis but, no mass palpable. We proceeded to appendicectomy through a Lanz incision. The appendix was only mildly inflamed resembling periappendicitis. There was a marked anterior caecal thickening resembling a mass. As malignancy could not be excluded, right hemicolectomy was performed. Post-operative specimen showed a solitary ulcerated ostium next to appendix lumen connecting to the caecal mass, differentiating a perforated diverticulitis with an inflammatory mass from a carcinoma. She was subsequently discharged well following an uncomplicated recovery. Histology confirmed a perforated caecal diverticulitis. There was no malignancy. Colonoscopy 6 weeks later showed no evidence of diverticular disease. Perforated caecal diverticulitis is a rare condition and often misdiagnosed due to lack of characteristic features. Few treatment options have been discussed including conservative management with postoperative antibiotics alone, inversion of the diverticulum, diverticulectomy, limited ileocaecal resection, and right hemicolectomy. Right hemicolectomy, though not the treatment of choice, may be performed in selected cases, particularly if malignancy cannot be completely excluded.

ENDOSCOPIC MANAGEMENT OF RADIATION PROCTITIS

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Introduction
Radiation proctitis is a debilitating complication which significantly affects quality of life. There remains no consensus on its management.

Methods
This is a retrospective review of 193 patients who presented with per rectal bleeding and had endoscopic features of radiation proctitis between January 2002 and December 2013. The endoscopic intervention, severity of bleeding, duration of therapy required and outcomes were reviewed.

Results
Majority of patients [144 patients] received radiotherapy for gynaecological malignancies followed by colorectal [39 patients] and urological [10 patients] malignancies. The mean interval between the last dose of radiation administered and the onset of symptoms was 21 months [range 2-96 months]. The mean duration of follow up was 20 months [range 6-120 months]. 171 patients were treated with argon plasma coagulation [APC], 13 patients were treated with topical formalin application while 9 patients did not warrant any intervention. There was no significant correlation between length of involved bowel with the severity of bleeding [Pearson correlation coefficient r=0.303]. However, the number of therapeutic interventions required significantly increased proportionate to the length of involved bowel [r=0.179, p=0.013] and severity of bleeding [r=0.248, p=0.001]. There was also a positive correlation between the endoscopic severity of proctitis with severity of bleeding [r=0.169, p=0.019] and number of interventions required [r=0.230, p=0.001]. APC was superior to topical formalin application in treating radiation proctitis with significantly less number of interventions required [Pearson chi square p=0.001].

Conclusion
The endoscopic grading of severity correlates with severity of bleeding and number of endoscopic interventions required. In our experience, argon plasma coagulation is better than topical formalin applications in the treatment of radiation proctitis.
Objective
The aim of this study was to evaluate the short-term outcomes of laparoscopic surgery for rectosigmoid cancer and rectal cancer.

Methods
This is a retrospective review of 128 patients with cancer of rectosigmoid (n=53) and rectum (n=75) who underwent laparoscopic surgery between January 2008 and December 2012. Patient demographics, location of cancers and postoperative outcomes were reviewed.

Results
A total of 128 patients with a mean age 60.7 (18-83) years underwent surgery. There were 53 anterior resection for rectosigmoid junction tumour (41.4%), 19 low anterior resection with total mesorectal excision (14.8%), 24 ultralow anterior resection (18.8%), 25 abdominoperineal resection (19.5%) and 7 robotic assisted resections (5.5%). Eleven (8.5%) patients were converted to open surgery. The major causes for conversion were locally advanced cancer and technical difficulties in dissection. Three (2.3%) patients had combined procedures: liver wedge resection, en-bloc resection of dome of bladder and adrenalectomy. Major complications occurred in 8 (6.2%) patients requiring reoperation. Three had anastomotic dehiscence. One had inadvertent small bowel injury, two had intestinal obstruction due to adhesions and two had stoma-related complications. There was one mortality (0.7%) due to anastomotic dehiscence related sepsis.

Conclusions
Laparoscopic surgery for rectosigmoid and rectal cancers is safe with comparatively low morbidity and mortality rates. Furthermore, laparoscopy is also versatile and facilitates combined resection of other organs with the benefit of faster return to normal activity and shorter hospital stay.
AN EXTREMELY RARE CASE OF A PRIMARY COLONIC LYMPHOMA OF THE DESCENDING COLON PRESENTING WITH OBSTRUCTION

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Introduction
Primary colonic lymphomas are rare tumors of the gastrointestinal tract and account for only 0.2-1.2% of all colorectal malignancies. The absence of desmoplastic reaction is a unique pathological feature of colonic lymphomas which makes it pliable and hence they rarely present with bowel obstruction despite their large size.

Case
We report a case of a 50 year old Indian gentleman who presented with symptoms of large bowel obstruction associated with a painful left lumbar mass, altered bowel habits and significant weight loss. Investigations revealed a descending colon tumor measuring 15.6 cm in length and 5.8 cm in diameter. Emergency laparotomy with left hemi-colectomy was performed and a histopathological diagnosis of Non-Hodgkin’s Diffuse Large B-Cell Lymphoma (DLBCL) NOS Stage IIE of the descending colon was made. Our patient successfully completed 6 cycles of adjuvant R-CHOP chemotherapy with no evidence of recurrence.

Discussion
Most evidence are based upon case reports, case series, and a handful of retrospective studies with limited sample size. To date, only one case of an obstructed descending colon lymphoma has been reported, even then in a paediatric age group.

In the management of primary colonic lymphoma, with the exception of MALT lymphomas, surgical resection followed by adjuvant chemotherapy with R-CHOP has showed statistically significant overall survival and disease-free survival.

Conclusion
Primary colonic lymphoma are rare tumors of the gastro-intestinal tract but should be kept in mind as a possible differential diagnosis when patients present with large palpable mass per abdomen.

RETRORECTAL CYST IN HRPZ II: A CASE REPORT

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Retrorectal cyst is a rare disease which usually occurred in middle-age women. It usually occurred among middle-age that usually affected woman, about 3:1 female: male ratio. Most of the cases are congenital. Patient usually presented with vague symptoms, especially lower abdominal pain, sometime with constipation. In view of these nonspecific symptoms, retrorectal cyst usually misdiagnosed and inappropriate operation. Diagnosis can be made by doing digital rectal examination. Retrorectal cyst sometime found incidentally via imaging such as CT scan and endoanal ultrasound. Once diagnosis has been made, excision of the retrorectal cyst must be carried out.

We report a case of a young lady, presented with chronic lower abdominal pain, was misdiagnosed as dysmenorrhea until CT abdomen/pelvis done where it was revealed as retrorectal cyst. Here, we discuss about the rarity of disease and its management.
GASTROINTESTINAL INVOLVEMENT OF POLYARTERITIS NODOSA: A CASE REPORT
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Polyarteritis nodosa (PAN) is a disease of blood vessel called vasculitis. PAN is a systemic disease that characterized by necrotizing inflammation lesions that affect medium and small size muscular arteries, preferentially at vessel bifurcations, resulting in microaneurysm formation, aneurismal rupture with hemorrhage, thrombosis and consequently causes organ ischeamia or infarction. It can occur in many different organ systems such as in kidney, liver and GIT. It is associated with hepatitis B virus in about 7% of cases. PAN is a rare disease, with an incidence of about 3-4.5 cases per 100000 population annually. Because of it rarity, it is usually misdiagnosed with colorectal cancer and inflammatory bowel disease, where the presentation usually about the same.

We reported a case in HRPZ II, a patient who was difficult to be diagnosed initially, until patient was subjected for operation and histopathologically showed polyarteritis nodosa. Here, we discuss about the rarity of the disease, its management and complications of PAN with GIT involvement.

INTUSSUSCEPTION SECONDARY TO MUCINOUS CYSTOADENOMA OF APPENDIX: RARE IN ELDERLY
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Mucinous cystadenoma of appendix is rare disease1,2,3. It is characterized by cystic dilatation of the lumen with retention of mucus inside it2,3. It also called as mucocoele of appendix. It is also associated with other neoplasia, especially adenocarcinoma of colon and ovary2. Mucinous cystadenoma is a benign neoplasm that may become malignant. Intussusceptions is also rare in adult and if occur, usually due to pathological cause. Mucinous cystadenoma is one of the rare causes of intussusceptions in adult. It is only account 0.25% of patient undergoing appendicectomy4.

We report a case of a 61year-old lady presenting with chronic right iliac fossa pain, diarrhea and PR bleeding. CT abdomen showed features of ileocolic intussusceptions. She was subjected for laparotomy and well post operatively. This poster will discuss the case further.
DUAL PATHOLOGY, DOUBLE TROUBLE...
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Introduction
The incidence of multiple primary cancers is uncommon. There is an increased risk of developing cancer at other sites in patients with colorectal cancer and vice versa. We highlight a case of two primary cancers which was initially colon cancer then followed by breast cancer.

Case Report
A 32 years old Malay nulliparous lady had undergone anterior resection for sigmoid cancer (Duke's B) in April 2010. She had completed adjuvant chemotherapy and surveillance follow-up showed no evidence of local recurrence or distant metastasis.

She presented to SOPD clinic in April 2012 with complaint of painless left breast lump for 1 month duration which was small and gradually increasing in size. No nipple discharge and no family history of breast cancer. Triple assessment done, core biopsy showed infiltrating ductal carcinoma and staging was T2N1M0. She underwent left wide local excision with level II axillary dissection. Recovery was uneventful.

She presented again in September 2012 with right pleural effusion. No local recurrence of breast cancer and re-staging showed disseminated disease and currently on palliative chemotherapy.

Discussion
Multiple primary malignancies in different organ and tissue are rare. It is neither an extension, recurrence nor metastasis. It generally falls into two categories either synchronous or metachronous cancers. An individual may develop second primary cancer because of a genetic predisposition, environmental exposure, cancer therapy or combinations of these three mechanisms.

Conclusion
Management of multiple primary cancers poses a significant challenge to surgeons and require high index of suspicion. Increased incidence of multiple primary cancers should initiate further studies and approaches to evaluate genes, environment and effect of treatment.
A CASE REPORT OF WORM BOLUS CAUSING SMALL BOWEL GANGRENE

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Introduction
Ascaris Lumbricoides is among the three major soil-transmitted intestinal nematodes in human. It frequently affecting children where their personal hygiene is at the lowest and people living in poor hygienic condition. We herein report a case of acute abdomen secondary to worm bolus.

Case Report
Six year old Malay girl presented with generalized abdominal pain and distension for four days. Pain was colicky in nature associated with non-bilious vomiting. She had low grade fever and obstipation for last two days prior to admission.

Child was septic looking and tachycardic. Abdominal grossly distended with signs of peritonitis. X-ray showed dilated small bowel and no distal gas seen.

At laparotomy noted long segment gangrenous small bowel with heavy worm bolus but no perforation. We performed segmental resection and total one hundred nine (109) of ascaris worms were found in the resected segment. Recovery was slow but uneventful.

Discussion
Diagnosis of worm infestation is challenging to clinician since the clinical symptoms varies from asymptomatic to fatal complications like bowel gangrene and perforation. Child with ascariasis is more vulnerable to intestinal obstruction. Partial or sub-acute intestinal obstruction can be managed conservatively. Surgical exploration is crucial when signs of toxicity are imminent and failed conservative management. Pneumonitis, biliary and pancreatic ascariasis are potential major clinical sequelae.

Conclusion
Ascariasis should be a differential diagnosis when child come with acute abdomen especially in developing country. Management should be individualized depend on the clinical presentation. Aim of treatment to prevent complication which associated with high morbidity and mortality.
POSTER 25

SURGICAL INTERVENTION IN RECTAL CANCERS
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Objective
To audit the outcome of rectal cancer patients who underwent surgery in the Colorectal Unit, Hospital Sultanah Aminah Johor Bahru.

Methods
All cases of rectal cancer who underwent surgery from March 2009 to December 2012. Cases were evaluated against: (a) mortality rate; (b) complications; (c) anastomotic leak mortality rate. The audit is carried out by going through the patient’s case notes as well as clinic follow up.

Results
115 cases were audited. Male to female ratio is 72 : 43 with a racial distribution of Chinese : Malay : Indian of 57 : 55 : 3. Mean age of the cases is 61.31 years. The youngest case reported is 22 and oldest was 84 years old. Overall mortality rate for the cases is 6.09%. 15.65% developed complications which includes anastomotic leak, recurrence, metastases and wound infection. 12 cases had anastomotic leak (10.43%) with a mortality rate of 33.33%.

Conclusion
The overall survival rate in patients diagnosed with rectal cancers who undergoes surgery in Hospital Sultanah Aminah Johor Bahru is fairly good at 93.91%. However, if it is complicated with an anastomosis leak, then the mortality rate is higher. Therefore, good technique in anastomosing the bowels, which is good blood supply and tension free anastomosis should be practiced in order to reduce the risk of anastomosis leak.

POSTER 26

THE CHRONIC ANAL FISSURE: IS IT BECOMING A MEDICAL DISORDER?
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Physiologically, it is the resting tone of the internal anal sphincter that chiefly interferes with the healing of the fissure. Although surgical therapy in the form of sphincterotomy or anal dilatation reduces anal tone and sphincter spasm and promotes fissure healing, it is associated with cases of faecal incontinence and soiling.

We conducted a literature review on nonsurgical therapy for fissure in ano. There are exciting new advances in the form of chemical sphincterotomy, by the application of drugs that relax the sphincter. Glyceryl trinitrate and isosorbide dinitrate promote healing in about half of patients, but often cause headaches. Consequently compliance is a problem. The calcium antagonists nifedipine and diltiazem also reduce anal pressure by 28%, but healing rates are low. Botulinum toxin is the most promising of the agents used for chemical sphincterotomy. It decreases resting anal pressure by 18–30%, and relieves pain almost immediately. Cure rates are over 60%, and the procedure can be repeated. It is less expensive and easier to perform as an outpatient procedure. No adverse effects or permanent sphincter damage resulted from the injections of the toxin.
OH MY DOUGHNUT! A FORBIDDEN CARCINOIDS IN A STAPLED HEMORRHOIDOPEXY SPECIMEN

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Rectal carcinoids comprises of about 1-2% of all rectal tumors. It is often found incidentally following colonoscopy for non specific symptoms of bleeding or constipation. These tumors are hormonally inactive and almost never produces carcinoid syndrome even when spread to liver. We report a case of incidental finding of rectal carcinoids in a doughnut specimen following stapled hemorrhoidopexy in a 40 years old female who presented with a symptomatic hemorrhoids

Keywords
Carcinoid tumors, rectal carcinoids, neuroendocrine tumors, carcinoids syndrome

ROBOTIC-ASSISTED ABDOMINOPERINEAL RESECTION: A REPORT OF A FIRST ROBOTIC COLORECTAL SURGERY EXPERIENCE IN MALAYSIA

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Robotic surgery is the one of the latest development in the field of minimally invasive surgery. With its magnified 3D visualization, motion scaling, tremor reduction, and wristed movements, it is an emerging technology that may prove advantageous for complex surgical procedures. Malaysia embarked on its first robotic-assisted surgery in April 2004 when robotic-assisted radical prostatectomy was performed in Hospital Kuala Lumpur. Subsequently, the Gynaecology fraternity adopted the usage of robotic technologies for its surgical procedures. As to our knowledge, no other disciplines had ventured into robotic surgery in Malaysia except for the two mentioned above. We herein present our first experience in robotic-assisted abdominoperineal resection using a three arm da Vinci robotic system, dual docking technique, which was performed in March 2012. The patient was an 55 year old lady with a low rectal tumor, 2.5cm from anal verge. She had two previous abdominal surgeries and received neoadjuvant chemoradiotherapy. The total console time was 285 minutes with no complications and she was discharged on postoperative day three.
SINGLE INCISION LAPAROSCOPIC SURGERY FOR REVISION OF DEFUNCTIONING ILEOSTOMY FOLLOWING EARLY POST OPERATIVE STOMA DEHISCENCE AND RETRACTION

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Introduction
Complications after creation of an ileostomy are common. They range from benign to potentially life-threatening conditions. Common early complications include metabolic derangements, skin irritation, ischemia, mucocutaneous separation and stoma retraction. Most early complications can be treated conservatively, although serious complications may require surgical revision and re-siting.

This report describes a technique of managing an early mucocutaneous separation and retraction of ileostomy, utilizing the original ileostomy site as a single incision laparoscopic surgery (SILS) port for revising and re-siting the stoma.

Case Report
A 65 year old man with known generalized exfoliative dermatitis on long term steroids underwent laparoscopic low anterior resection with defunctioning ileostomy. His recovery was complicated by mucocutaneous separation and retraction of the ileostomy, resulting in severe sepsis from extensive subcutaneous emphysema and abdominal wall abscess. A single incision laparoscopic surgery technique was used for revision and re-siting of the ileostomy at the previous anterior resection extraction site. The original ileostomy incision was closed at the fascial level but the subcutaneous tissue and skin were left to drain and heal by secondary intention. The revised ileostomy functioned well and the infected wound resolved with antibiotics. 3 months after the initial surgery, the patient had his ileostomy reversed.

Discussion and Conclusion
Early recognition of complications of ileostomy and prompt appropriate management, including possible revision and re-siting of stoma, is vital in ensuring good outcome. This case illustrates the use of a novel technique for ileostomy revision and re-siting, thus avoiding a laparotomy and retaining the benefits of the index laparoscopic surgery.
A 5-YEAR REVIEW OF LIVER RESECTION FOR COLORECTAL CANCER LIVER METASTASES IN UMMC
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Introduction
Treatment of colorectal cancer liver metastases (CRLM) has advanced over the years, with improved survival seen among those amenable to surgical resection. There is limited data on long-term outcomes with this approach in Malaysia. We reviewed the outcomes of patients with CRLM diagnosed in UMMC over a 5-year period who underwent liver resection.

Objective
To determine the long-term outcomes of our patients who underwent surgical resection for CRLM.

Methods
Patients with CRLM who underwent liver resection during a 5-year period from January 2008 to December 2012 were identified. Data on their demographics, tumour status, staging and treatment plan were obtained. Phone interviews were conducted to determine patient's current status. Analysis of patient's demographics, treatment modalities, operative findings, imaging results, Survival Rates (SR), Progression Free Survival (PFS) and Overall Survival (OS) were made. Statistical analyses were performed using the Kaplan-Meier survival analyses.

Results
A total of 12 patients underwent resection of CRLM during the 5 year period, all of whom had no extra-hepatic metastasis prior to surgery. There were five males and seven females with a mean age of 52.5 years.

Half of our patients had synchronous liver lesions at presentation. Three had solitary lesions and nine had multiple lesions at presentation.

Mean SR, PFS and OS were 40.5, 40.5 and 68.0 months respectively. Where there was liver recurrence following resection (n = 4), OS was not affected (p > 0.05).

Conclusion
CRLM in our patients have acceptable long-term outcomes. Awareness and early referral guided by a multidisciplinary approach in treating CRLM is vital in ensuring that all patients who would benefit are accorded this treatment.
Stage IV rectal cancer with unresectable metastases is usually managed conservatively. Surgery does not confer a survival benefit. However in certain circumstances, radical surgery may improve quality of life.

Case Report
A 68 year old man had an anterior resection for rectal tumour. However he presented 2 years later with recurrence involving the bladder dome, manifesting as persistent haematuria. MRI further delineated the recurrence as a fungating bladder mass with involvement of the anterior abdominal wall. In addition restaging CT and bone scans showed metastases to the lungs, 8th rib, T2 vertebral body and rectus sheath. In view of extensive metastatic disease, he was managed conservatively with antifibrinolytics and continuous bladder irrigation. After one month his haematuria was still persistent and he had required multiple blood transfusions. A decision was made for radical surgery consisting of en-bloc resection of the anterior abdominal wall tumour, partial cystectomy and reconstruction of the anterior abdominal wall with a right tensor fascia lata fasciocutaneous pedicled flap. He recovered uneventfully and was discharged home 8 days later.

Discussion
Stage IV rectal cancer with unresectable metastases is managed conservatively as surgery confers no benefit in terms of survival. However this case illustrates that radical surgery may have a role when conservative measures fail. Consideration should be given to radical surgery to improve quality of life and reduce disabling symptoms even though survival remains unchanged.

Conclusion
Stage IV rectal cancer with unresectable metastases is not an absolute contraindication for radical surgery when conservative management fails to improve quality of life of the patient.
PROSTATE CARCINOMA AS THE CAUSE FOR COLORECTAL SYMPTOMS – A CLINICAL ENTITY NOT TO BE OVERLOOKED

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Objectives
To review the cases in our colorectal department where prostate carcinoma is the cause for colorectal symptoms for 2009-2012 and to review the literature. This aims to update colorectal surgeons on this clinical entity and not to overlook it.

Methods
Four patients were identified through our prospectively maintained colorectal database where prostate carcinoma was the cause for colorectal symptoms from 2009-2012. A retrospective review of the clinical records of these patients was done. The literature was searched from Pubmed using the keywords: adenocarcinoma, colon, rectum, prostate, invasion and metastasis.

Results
Advanced prostate carcinoma may present to the colorectal department with colorectal symptoms without any prior diagnosis of prostate carcinoma. Due to similarities in presenting complaints, physical examination, endoscopic findings and even biopsies, it is difficult to differentiate it from primary colorectal malignancies. The use of prostate-specific immunohistochemical stains in biopsies, serum PSA (although it can also be low) and MRI rectum can be very useful in differentiating between the two. Prostate carcinoma in these cases will often be locally advanced or even metastatic and the prognosis is guarded. Palliative colorectal operations to relieve symptoms may be needed and diverting colostomies is the most common procedure.

Conclusions
Prostate carcinoma may be the cause for colorectal symptoms. It is a diagnostic dilemma especially in patients without any prior diagnosis of prostate carcinoma. A high index of suspicion is needed and the colorectal surgeon should be aware of this clinical entity. The use of prostate-specific immunohistochemical stains in biopsies, serum PSA and MRI rectum can be useful in making the diagnosis.

THE ANALPULATOR, A CASE OF AN INGENIOUS CARPENTER WITH SOLUTIONS FOR CONSTIPATION

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Insertion of foreign bodies in rectum for anal eroticism is not uncommon. It is rare to see foreign bodies being inserted for constipation. In this report, we describe a case of a 42 year-old gentleman who inserted a huge water pipe into his anus for his chronic constipation which ultimately went wrong. The patient attempted self-removal with a 20cm modified metal hook, which also became lodged, resulting in two rectal foreign bodies. Patient was subjected for extraction of rectal foreign bodies under general anaesthesia due to presence of sharp object. The sharp metal hook was successfully retrieved under direct visualization with colonoscope. The 18cm x 5cm PVC pipe was then retrieved with sponge forceps following digital anal dilatation with lubricant and muscle relaxant. Adequate analgesia and direct visualization are critical to successful extraction. Because of the potential complications, rectal foreign bodies should be regarded seriously and treated expeditiously. Respect for their privacy is also a key factor in the patient’s care.
SMOKING + FAT = COLORECTAL POLYPS. OR IS IT?
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Introduction
Adenomatous polyps are known precursor for colorectal carcinoma based on adenoma-carcinoma sequence. Smoking and obesity are also known risk factors for colorectal carcinoma.

Objective
To determine the association between smoking and obesity in the development of colorectal polyps, we retrospectively reviewed 200 case notes of patients who underwent colonoscopy between 2000 and 2011 in Hospital Seberang Jaya.

Methods
200 colonoscopy findings were reviewed with 100 assigned in the polyp arm and another 100 in the non-polyp arm as control. The number of patients in the polyp arm who were both obese and smokers were compared to the control arm. Exclusion criteria include patients with familial colorectal cancer, inflammatory bowel disease, or history of colorectal carcinoma.

Results
Cross tabulation between both the study group and control were done and it revealed a significant association (p value <0.05) between presence of polyps and smokers as well as obese subjects. However, other variables such as gender, age, and ethnicity were noted insignificant.

Conclusion
This study has demonstrated that smokers and obese patients are more prone to develop colorectal polyps and its complications.

POSTER 35

COLONIC STENTING: PALLIATION OF COLONIC OBSTRUCTION
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Introduction
Estimated about 8-25% of colorectal cancer presented with colonic obstruction. Surgical decompression is a standard procedure, however is associated with high morbidity and mortality. Colonic stent placement is another option for rapid decompression with high success rate and acceptable patency rate.

Objective
To study the effectiveness and efficacy of palliative colonic stent in resolving malignant colonic obstruction.

Method
Patient with evidence of colonic obstruction who underwent palliative stenting was evaluated under average period of 3 months.

Results
From 2011, out of 12 patients underwent colonic stenting, 92% were for palliative purpose. Out of that, 91% had clinical successs for the obstructive symptoms. 3 months post-procedure evaluation showed patency in all stented patients.

Conclusion
Colonic stenting as an alternative option to surgical intervention is an effective method in decompressing acute colonic obstruction with good clinical outcome and better quality of life.
**OBSTACLES TO LAPAROSCOPIC COLORECTAL SURGERY IN A MALAYSIAN TERTIARY CENTRE**

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**Introduction**
Colorectal cancer surgery has evolved over the years with a shift from that of an open approach to minimally invasive surgery. The clear benefits of earlier return of bowel function, earlier recovery and shorter hospitalization, while still maintaining the basic principle of oncological resection, is the reason behind the shift. However, in UMMC, a tertiary referral centre, the proportion of patients undergoing laparoscopic resection for colorectal cancer remains low.

**Objective**
The aim of this study was to assess the reasons limiting the delivery of laparoscopic colorectal surgery in UMMC.

**Methods**
All patients who underwent elective laparoscopic colorectal surgery for colorectal cancer between January 2008 and December 2012 were identified. Data on their demographics, stage at presentation, co-morbidities, adjuvant therapies, indications for type of surgery (laparoscopic or open) and surgical outcomes was collected and compared to those of the general colorectal cancer patients’ database to determine appropriateness of the operative approach, and identify the main reasons contraindicating a laparoscopic approach.

**Results**
The records of 80 patients who underwent laparoscopic colorectal surgery during the five-year period were successfully traced (retrieval rate > 80%). This number did not include patients who were privately managed. The annual proportion of laparoscopic in relation to all patients undergoing colorectal cancer resection ranged from less than 20% to over 30%. Nonetheless, the incidence of serious morbidity was low (6.25%) and there were no mortalities, nor local recurrences. Reasons identified for the open approach in the other cases were patient factors (multiple co-morbidities with cardiac or respiratory contraindications to pneumoperitoneum, multiple surgeries with excessive adhesions, recurrent disease, locally advanced disease requiring extended resections, emergent presentations) and institutional factors (insufficient OT time, insufficient equipment, availability of expertise).

**Conclusion**
Expanding laparoscopic services for colorectal cancer resections remains a challenge in UMMC. Efforts to address the contributing factors identified must be made in order for all eligible patients to benefit from its application.

**STAPLER HAEMORRHOIDOPEXY – ALOR SETAR EXPERIENCE**

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Haemorrhoid is a common condition in Malaysia. Chief complaints from patient are bleeding and prolapse. Stapler haemorrhoidopexy is a feasible procedure which can give good result and fast recovery. This audit is to look at the experience of stapler haemorrhoidopexy in Sultanah Bahiyah hospital, Alor Star. We are assessing the complication rates in our center and how to overcome it, in order to improve the outcome of this procedure.

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POSTER 38

EXTRAMAMMARY MAMMARY TYPE MYOFIBROBLASTOMA IN ANAL CANAL:
CASE REPORT OF A RARE TUMOUR
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Extra mammary tumour of mammary type myofibroblastoma (EMM) is a rare benign tumour: only 11 cases of EMM has been reported in the literature and none in the anorectal region. We report a case of anal canal EMM with a literature review.

Myofibroblastoma of the breast is a benign, well circumscribed tumor, composing of cells with the immunophenotype and ultrastructural features of myofibroblasts. The EMM cases reported in the literature commonly affect older men and postmenopausal women. It has been hypothesized that the mammary type of myofibroblastoma in extramammary tissues arises along the embryonic mammary line from the fibroblastic or myofibroblastic cells. No EMM ano-rectal tumour has been reported.

The classical presentation is solitary slow growing painless mass between 1 and 4 cm size; though masses up to 10 cm, and synchronous masses, have been reported. The differential diagnoses include malignant tumours or tumours of uncertain behaviour (such as atypical lipoma, gastro-intestinal stromal tumour). Accurate pre-operative radiological and histological diagnosis is difficult. No tumour recurrence has been reported for previously resected cases of EMM but the natural history of unresected EMM is unclear as the number of reported cases is very limited.

Due to difficulty in excluding a malignant lesion pre-operatively, surgical resection is the management of choice.

POSTER 39

DEFINITIVE CHEMORADIATION FOR SQUAMOUS CELL CARCINOMA OF THE RECTUM
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Squamous cell carcinoma of the rectum is a rare malignancy. We illustrate a case of squamous cell carcinoma of the rectum in a 57 years old male who was treated with chemoradiation. Complete clinical response was proven through surveillance sigmoidoscopy and computed tomography, thus avoiding surgery. Compared to adenocarcinoma of the rectum and squamous cell carcinoma of the anal canal, squamous cell carcinoma of the rectum, has different epidemiology, etiology, pathogenesis and prognosis, but most importantly, requires different therapeutic approach. Radical surgery has been advocated as the primary treatment modality with or without adjunctive therapies despite the proven benefits of primary chemoradiotherapy for squamous cell carcinoma (SCC) of the rectum. Complete clinical response was achieved in this patient, thus definitive chemoradiation should be considered as a treatment for this rare malignancy.
ADOLESCENT SIGMOID VOLVULUS MASQUERADING AS PERFORATED APPENDICITIS
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Sigmoid volvulus is a rare and potentially life-threatening condition with few cases reported in the adolescent group. Prompt diagnosis requires high index of suspicion. The diagnosis should be considered in children presenting with abdominal pain and distension. We report a case of sigmoid volvulus in a 14 year-old boy who presented with features of perforated appendicitis to highlight the issue. Emergency colonoscopy successfully decompressed the volvulus and patient recovered without any further sequelae. Later, he had rectal biopsy done that excluded Hirschsprung’s disease. At 12-month follow up, he was well with no recurrence.

POORLY-DIFFERENTIATED NEUROENDOCRINE TUMOUR OF SMALL BOWEL
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Introduction
Poorly-differentiated neuroendocrine tumour (NET) of small bowel is a rare malignancy with the incidence of 2.5–5 per 100,000 per year. The clinical presentation of NET varies depending on the tumour functional status which frequently leads to misdiagnosis at early stage.

Case Report
A 15 years old girl was referred for symptomatic anaemia for 5 months which required multiple blood transfusions. There were no symptoms of intestinal obstruction, altered bowel habit, loss of appetite or loss of weight. On examination of her abdomen, there was a mass at left lower quadrant measuring about 8cm X 8cm. Tumour markers which are Ca 19.9, CEA and Ca125 were within normal range. CT scan was done and it showed small bowel mass with multiple paraaortic lymph nodes enlargement suggestive of neoplasm. Diagnostic laparotomy was done. Intraoperatively there was multicystic and solid lesion at the mesentery of small bowel at 80 cm from ligament of Treitz with multiple lymph nodes enlargement. Complete resection of the tumour and regional lymph nodes was done. The tumor was immunohistochemically positive for chromogranin A (CGA) and synaptophysin. The Ki67 index more than 20%. The tumour was diagnosed as poorly-differentiated neuroendocrine tumour of small bowel with lymph nodes metastasis.

Discussion
Due to the low incidence and non specific symptom, the possibility of NET often overlooked and diagnosis is delayed. Functioning tumours are detected earlier because of recognizable symptoms. In this case, it was a non-functioning tumour which was picked up intraoperatively and diagnosed by pathological study. Biomarker such as CGA is useful to aid the diagnosis, to predict the prognosis and aid to proper management. The prognosis for poorly-differentiated NET is poor with overall median survival rate of 5 months. This rate improves when it is diagnosed and treated at early stage with complete resection.
LOWER GASTROINTESTINAL BLEED... REVISITED
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Introduction
Lower gastrointestinal (GIT) bleeding accounts for about 1% of hospital admissions per year. Though the vast majority of lower GIT bleeds will stop without therapeutic intervention, it is the cases with clinically significant persistent bleeding which may pose a challenge to the managing surgeon. Prompt resuscitation, localization and intervention is vital to ensure the optimum outcomes for these patients. We present a case of lower GIT bleeding secondary to a Meckel's diverticulum.

Case Presentation
A 14 years old boy presented to our centre with haematochezia. It was of sudden onset with no previous episodes or preceeding bleeds. He had no previous history of haemorrhoids or peptic ulcer disease.

Interesting to note, he had two episodes of non-specific right sided lower abdominal pain which resolved spontaneously.

Despite being haemodynamically stable initially, he continued to have persistent bleeding and his haemoglobin began to drop. OGDS was unremarkable whereas colonoscopy revealed fresh blood mixed with clots in the rectosigmoid region.

Mesenteric angiography revealed an arterial blush from the small bowel but as no interventionalist was available, we proceeded with exploratory laparotomy and resected and actively bleeding Meckel’s diverticulum. Histopathology confirmed ulcerated gastric mucosa.

He made an uneventful recovery and was discharged well.

Discussion
Meckel’s diverticulum is a fairly common cause of lower GIT bleeding in young patients. However, as the cause for lower GIT bleeding may initially be obscure, we must always follow a methodological approach in its assessment and management. A review of the literature in the management of lower GIT bleeding will also be presented.

MUCINOUS CYSTADENOMA OF THE APPENDIX
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Introduction
Mucinous cystadenoma is a rare neoplasm of the vermiform appendix, uncommonly presenting as acute appendicitis. We present a case report of Mucinous Cystadenoma of the appendix with metaplasia of the resected margins and discuss the clinical entity, management and literature review.
POSTER 44

DIAGNOSTIC LAPAROSCOPY IN ACUTE INTESTINAL OBSTRUCTION... BEYOND DIAGNOSIS

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Introduction
Management of acute intestinal obstruction involves adequate resuscitation and prompt diagnosis based on clinical and radiological assessment, followed by either operative or non-operative intervention. Diagnostic laparoscopy is being utilized increasingly by general surgeons in the management of intestinal obstruction. We present a case of large bowel obstruction with inconclusive radiological findings which subsequently required diagnostic laparoscopy for both diagnostic and therapeutic purposes.

Case Report
A 52 year old male presented with one week history of abdominal distention, no bowel opening and absent bowel sounds on auscultation. Plain radiograph showed significant large bowel dilatation proximal to the splenic flexure with absence of air in the upper rectum. CT abdomen showed left pelviureteric junction stone with mild hydronephrosis and perirenal fat streakiness. A homogenous intraperitoneal mass in proximity to the left kidney was noted to cause external compression at the splenic flexure. Following failed conservative management, he underwent diagnostic laparoscopy which revealed clumps of omentum around the splenic flexure causing luminal compression. The omentum was released laparoscopically with almost immediate return of peristalsis distal to the point of obstruction. Colonoscopy at follow-up was non-contributory.

In retrospect the patient provided further history of intermittent renal colic in the preceding two months prior to presentation. We therefore postulate that the PUJ stone had triggered subclinical pyelonephritis which resulted in the omental clumping as described.

Conclusion
Diagnostic laparoscopy provides a useful adjunct to the general surgeon in the management of intestinal obstruction. It potentially offers a therapeutic modality in addition to the diagnostic purpose. The risk of negative laparotomy and its associated morbidity are also prevented.

POSTER 45

PANCREATIC DUCTAL ADENOCARCINOMA WITH INVASIVE GROWTH INTO THE COLON AND SPLEEN

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Ductal adenocarcinoma is the most common form of pancreatic cancer and accounts for 85%–90% of all pancreatic neoplasms. Genetic predisposition has also been implicated in higher rate of ductal adenocarcinoma of the pancreas, including, the BRCA2 gene mutation, which may account for 10% to 20% of familial pancreatic cancers. Other inherited cancer syndromes such as inherited colorectal cancer and inherited tendency for melanoma may also be associated with pancreatic cancer. Metastases are common at diagnosis and local extension of the tumor are most often found in the head of the pancreas. We report a ductal adenocarcinoma of the pancreas that was initially considered to be colon cancer. Post-operatively, the tumor was confirmed to be a ductal adenocarcinoma of the pancreas.

POSTER 46

A CASE OF RECTAL NEUROFIBROMATOSIS TYPE 1

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A Rectal Neurofibromatosis was found in a 44-year-old man with a history of neurofibromatosis type 1. Diagnosis was made with the help of CT scan and Histopathological examination. Patient was followed up for 8 years since diagnosis with occasional episodes of per rectal bleeding noted. He was advised for Anterior Resection for which he has so far persistently declined. No major complications have arisen from the conservative approach till date.