Coloproctology 2011

3rd - 5th March 2011

Shangri-La Hotel
Kuala Lumpur, Malaysia

Souvenir Programme & Abstract Book
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ORGANISING COMMITTEE

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Wan Khamizar

Committee Members
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Mohd Akhtar Qureshi
Samuel Tay

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Ethicon
Endo-Surgery
WELCOME MESSAGE

I would like to take this opportunity to welcome all of you to this year’s meeting which is somewhat special in that we are collaborating with The Association of Colon & Rectal Surgeons of India in what will be our very first joint meeting. This will allow us to exchange ideas and hopefully lay the foundation for us to foster similar longstanding relationship with our other counterparts in Asia in an effort to develop colorectal surgery in this continent as a subspecialty to be reckoned with.

We are fortunate in that we have once again been able to call upon a highly distinguished faculty of speakers to provide us with an update in the field of colorectal surgery. The topics chosen reflect common diseases and challenges that we come across in our practice as well as emerging procedures and scientific discoveries that may change the future direction of our subspecialty. The programme for 2011 will benefit both the experienced surgeons and trainees alike and our traditional one-day pre-conference workshop will feature live demonstration on laparoscopic and complex ano-rectal pathology.

A lively social programme has been drawn up which I am certain will appease our delegates and family members. I would also like to express my gratitude to my fellow committee members for their efforts in helping organize this years meeting in what should culminate as a highlight for the MSCR list of activities for 2011.

I would like to take this opportunity to welcome our Indian counterparts and wish that everyone attending the meeting will enjoy a fruitful and enjoyable meeting.

YUNUS GUL
President, Malaysian Society of Colorectal Surgeons & Congress and Scientific Chairman, Coloproctology 2011
WELCOME MESSAGE

I take immense pleasure in inviting you all to this First Joint Conference of the Malaysian Society of Colorectal Surgeons, in association with The Association of Colon & Rectal Surgeons of India, being held at Kuala Lumpur from 3rd to 5th March 2011. It will be indeed my honour and privilege to welcome you all to this historic meeting. I am thankful to Dr Parvez Sheikh for co-ordinating this joint venture.

This conference gives an opportunity for all the colorectal surgeons and proctologists in this part of the world to get together and exchange knowledge and new ideas. Along with the Malaysian faculty, leading proctologists and colorectal surgeons from India will be speaking on topics of great importance.

I am sure this three day conference will give a lot of opportunities to our members to interact with the international faculty, exchange notes and update our knowledge. We have provided some attractive packages for you and hope you will take advantage of the same. You will certainly be benefited not only by the rich scientific content of the meeting, but you could also explore the culturally rich city of Kuala Lumpur. I look forward to meeting you in Kuala Lumpur.

MANU NARIANI
President
The Association of Colon & Rectal Surgeons of India
# Programme Summary

## 3rd March 2011 (Thursday)

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<th>5th March 2011 (Saturday)</th>
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<tbody>
<tr>
<td>0800 – 0900</td>
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<td>SYMPOSIUM 1 Basics</td>
<td>SYMPOSIUM 7 Colorectal Cancer</td>
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<td>0900 – 1000</td>
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<td>OPENING CEREMONY / Opening of the Trade Exhibition</td>
<td>COFFEE / TEA</td>
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<td>1000 – 1100</td>
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<td>PLENARY 1</td>
<td>PLENARY 2</td>
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<td>1100 – 1200</td>
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<td>SYMPOSIUM 3 Colorectal Potpourri I</td>
<td>SYMPOSIUM 8 Allied Health Professionals (4)</td>
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<td>1200 – 1300</td>
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<td>1300 – 1400</td>
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<td>LUNCH SATELLITE SYMPOSIUM 1 (FRESENIUS KABI)</td>
<td>LUNCH SATELLITE SYMPOSIUM 2 (JOHNSON &amp; JOHNSON MEDICAL MALAYSIA)</td>
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<td>1400 – 1500</td>
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<td>DEBATE LIFT For Fistula-In-Ano</td>
<td>SYMPOSIUM 10 Potpourri – Management Issues</td>
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<tr>
<td>1500 – 1600</td>
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<td>SYMPOSIUM 5 Colorectal Potpourri II – Pelvic Floor Disorders And Faecal Incontinence</td>
<td>COFFEE / TEA</td>
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<tr>
<td>1600 – 1700</td>
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<td>COFFEE / TEA</td>
<td>HOW I DO IT</td>
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<td>1700 – 1815</td>
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<td>PROFESSORS’ CORNER</td>
<td>MSCRS ANNUAL GENERAL MEETING</td>
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<tr>
<td>1930 – 2230</td>
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<td>ANNUAL DINNER</td>
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## 6th March 2011 (Sunday)

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<td>0900 – 1200</td>
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<td>POSTGRADUATE ROUND</td>
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Venue: Hospital Universiti Kebangsaan Malaysia, Kuala Lumpur, Malaysia
PRE-CONGRESS WORKSHOP

3TH MARCH 2011, THURSDAY

VENUE: Clinical Auditorium, University Malaya Medical Centre, Kuala Lumpur, Malaysia

Invited Faculty

Joel Jules Louis Leroy (Strasbourg, France)  Parvez Sheikh (Mumbai, India)
William Chen (Taiwan)  Charles Tsang (Singapore)
Robin Phillips (Oxford, UK)  Azmi Md Nor (Kuantan, Malaysia)
Arun Rojanasakul (Bangkok, Thailand)

0900 – 0905  OPENING ADDRESS

0905 – 0935  LECTURES

• SILS versus standard laparoscopic colectomy: How does it compare?
• Stapled haemorrhoidopexy vs DG-HAL/RAR
• ERUS vs MRI for rectal cancer staging

0935 – 0950  TEA

0950 – 1330  LIVE DEMONSTRATIONS

• SILS
• Laparoscopic anterior resection
• Starr procedure
• PPH / DG-HAL / Rectoanal repair
• Treatment of complex fistulas
• Endoanal/Endorectal ultrasound
• Anal manometry

1330 – 1430  LUNCH

1430 – 1730  LIVE DEMONSTRATIONS (Continued)

1730 – 1800  TEA and Closing

1930 – 2200  FACULTY DINNER (by invitation only)

Venue: Arthur’s Bar & Grill, 1st Floor, Shangri-La Hotel, Kuala Lumpur, Malaysia

DAILY PROGRAMME

4TH MARCH 2011, FRIDAY

0800 – 0930  SYMPOSIUM 1

Basics

CHAIRPERSONS : LING YAN / RETNA RASA

• Anal dilatation – does it still play a role in managing ano-rectal pathology?
  Manu G Narani (India)
• Ano-rectal assessment in the clinic  [PAGE 13]
  Akhtar Qureshi (Malaysia)
• Anastomosis – Stapled and sutured  [PAGE 13]
  April Roslani (Malaysia)
• How to make a good stoma
  Robin Phillips (UK)

0800 – 0930  SYMPOSIUM 2  ALLIED HEALTH PROFESSIONALS (1)

MODERATORS : ROZITA MOHAMAD / HALIMAHTON

• Maintaining a hospital-based ostomy support group  [PAGE 14]
  Mariam Mohd Nasir (Malaysia)
• Sexuality and body image in women with an ostomy  [PAGE 15]
  Ng Yeng Lai (Malaysia)
• Pain management : An enterostomal therapist’s perspective  [PAGE 15]
  Carmen Smith (Australia)
• Current challenges in the management of difficult stoma  [PAGE 16]
  Ang Swee Ling (Malaysia)
0930 – 1000  OPENING CEREMONY / OPENING OF THE TRADE EXHIBITION  
Coffee / Tea  
Sabah Room

1000 – 1045  PLENARY 1  
CHAIRPERSON: ISMAIL SAGAP  
Sabah Room

Update on minimal invasive surgery – Yesterday, today and tomorrow  
Joel Jules Louis Leroy (France)

1045 – 1230  SYMPOSIUM 3  
Colorectal potpourri I  
Sabah Room

CHAIRPERSONS: MEHESHINDER SINGH / MANOHAR PADMANATHAN

- The ethics of innovation in colorectal surgery [PAGE 17]  
  Francis Seow-Choen (Singapore)
- Management of FAP  
  Robin Phillips (UK)
- HNPCC – Current concepts [PAGE 17]  
  Wan Khamizar (Malaysia)
- Role of stem cells in colorectal cancer  
  Roberta Pang (Hong Kong)
- Current developments in colorectal cancer proteomics: From gels to cells [PAGE 18]  
  Saiful Anuar Karsani (Malaysia)

1045 – 1230  SYMPOSIUM 4  
ALLIED HEALTH PROFESSIONALS (2)  
Selangor/Perak Room

MODERATORS: MARIAM MOHD NASIR / NG YENG LAI

- Pressure ulcers in the elderly  
  Rozita Mohamad (Malaysia)
- Peristomal skin disorders: Impact on ostomy care  
  Ravathy Ramamurthy (Malaysia)
- Dual stoma: A nursing challenge [PAGE 18]  
  Tai Seow Beng (Malaysia)
- Diet and stoma management: Dispelling the myths [PAGE 18]  
  Carmen Smith (Australia)

1230 – 1415  LUNCH SATELLITE SYMPOSIUM 1 (FRESENIUS KABI)  
Sabah Room

CHAIRPERSON: YUNUS GUL

Improving patients outcome with balanced fish oil lipid emulsion  
Jesus Fernando B Inciong (Philippines)

1415 – 1500  DEBATE  
LIFT for fistula-in-ano  
Sabah Room

CHAIRPERSON: YUNUS GUL

Proponent Arun Rojanasakul (Thailand) [PAGE 19]  
Opponent Robin Phillips (UK)

1500 – 1615  SYMPOSIUM 5  
Colorectal potpourri II – Pelvic floor disorders and faecal incontinence  
Sabah Room

CHAIRPERSONS: JASIAH / FOO CHANG LIM

- Comprehensive evaluation of pelvic floor disorders [PAGE 19]  
  Azmi Md Nor (Malaysia)
- Management of obstructed defecation syndrome  
  Roy Patankar (India)
- Post-obstetrics faecal incontinence  
  Robin Phillips (UK)
- Faecal incontinence following fistula surgery [PAGE 20]  
  Parvez Sheikh
# Daily Programme

## March 2011, Friday

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| 1415 – 1715 | Symposium 6  
Stoma and wound care workshop  
Moderator: Ravathy Ramamurthy  
- Medico-legal concerns in enterostomal nursing practice (Page 20)  
  Carmen Smith (Australia)  
- Managing infected wounds  
  Pat Siu Lin (Malaysia)  
- Product updates  
  | Selangor/Perak Room |
| (1515 – 1715) | Practical and hands-on |
| 1615 – 1645 | Coffee / Tea |
| 1645 – 1815 | Professors’ Corner |
| 2000 – 2230 | Annual Dinner  
- Welcome Address by Emcee  
- Speech by Prof Yunus Gul  
  President, Malaysian Society of Colorectal Surgeons &  
  Organising Chairman, Coloproctology 2011  
- Dinner  
- Introduction of New Members  
- Entertainment  
- Lucky Draw  
- End of Function  
<p>| Sarawak Room |</p>
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<tr>
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<tr>
<td>0800 – 0930</td>
<td>SYMPOSIUM 7: Colorectal cancer</td>
<td>Sabah Room</td>
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<td>CHAIRPERSONS: GERALD FITZPATRICK / AZMI MD NOR</td>
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<tr>
<td></td>
<td>• Colorectal Screening [PAGE 21]</td>
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<td></td>
<td>Samuel Tay (Malaysia)</td>
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<td>• TEMS</td>
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<td>Joel Jules Louis Leroy (France)</td>
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<td>• Adjuvant therapy of colorectal cancer [PAGE 21]</td>
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<td>Daniel Wong (Malaysia)</td>
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<td>• Management of positive doughnut in rectal cancer surgery [PAGE 22]</td>
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<td>Varughese Mathai (India)</td>
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<td>0900 – 1200</td>
<td>SYMPOSIUM 8: ALLIED HEALTH PROFESSIONALS (4)</td>
<td>Selangor/Perak Room</td>
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<td>MODERATOR: MARIAM MOHD NASIR</td>
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<td>• Pre and post op ostomy care [PAGE 22]</td>
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<td>Rasidah Jamaluddin (Malaysia)</td>
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<td>• Stomacare: Clinical trial in the use of mouldable technology [PAGE 22]</td>
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<td>• Product updates: Low pressure adaptor and one piece system [PAGE 22]</td>
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<tr>
<td>(1000 – 1200)</td>
<td>• Practical and hands-on</td>
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<tr>
<td>0930 – 1015</td>
<td>PLENARY 2</td>
<td>Sabah Room</td>
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<td>CHAIRPERSON: APRIL ROSLANI</td>
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<td>Genetic testing in colorectal cancers: Relevance to colorectal surgeons in the genomic era [PAGE 23]</td>
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<td>Koh Poh Koon (Singapore)</td>
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<td>1015 – 1045</td>
<td>COFFEE / TEA</td>
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<td>1045 – 1215</td>
<td>SYMPOSIUM 9: Endo-laparoscopic colorectal surgery</td>
<td>Sabah Room</td>
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<td>CHAIRPERSONS: PAUL SELVINDOSS / ONG KEE THIAM</td>
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<tr>
<td></td>
<td>• Laparoscopic colorectal surgery – Patient selection [PAGE 23]</td>
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<td>Yunus Gul (Malaysia)</td>
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<td>• SILS [PAGE 24]</td>
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<td>Prashanth Rao (India)</td>
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<td>• NOTES</td>
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<td>G V Rao (India)</td>
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<td></td>
<td>• Endoscopic advances in colorectal disease [PAGE 24]</td>
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<td>Ryan Ponnudurai (Malaysia)</td>
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<tr>
<td>1215 – 1400</td>
<td>LUNCH SATELLITE SYMPOSIUM 2 (JOHNSON &amp; JOHNSON MEDICAL MALAYSIA)</td>
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<td>CHAIRPERSON: ISMAIL SAGAP</td>
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<td>Laparoscopic colorectal surgery: How I do it – The Taiwan experience</td>
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<td>William Chen (Taiwan)</td>
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DAILY PROGRAMME

5TH MARCH 2011, SATURDAY

1400 – 1530 SYMPOSIUM 10
Potpourri – Management issues
CHAIRPERSONS: SARKUNATHAS / MOHD ISMAIL ALI

- Irritable bowel syndrome – Medical management
  Ryan Ponnudurai
- Fibre in constipation – Good or bad
  Francis Seow-Choen (Singapore)
- Rectocoeles
  Robin Phillips (UK)
- Pilonidal sinus – Managing problematic wound healing
  Shekhar Suradkar (India)

1530 – 1600 COFFEE / TEA

1600 – 1730 HOW I DO IT
CHAIRPERSONS: SAMUEL TAY / MOHD AKHTAR QURESHI

- LIFT for fistula-in-ano
  Ahmad Shanwani (Malaysia)
- Laparoscopic management of complicated divertulitis
  Paul Selvindoss (Malaysia)
- Sacrectomy for advanced cancer
  Shailesh Shrikhande (India)
- Recto-vaginal fistula repair
  Robin Phillips (UK)
- Stapled anopexy
  Parvez Sheikh (India)
- Emergency hemorrhoidectomy for prolapsed thrombosed piles
  Arun Rojanasakul (Thailand)

1730 – 1900 MSCRS ANNUAL GENERAL MEETING

6TH MARCH 2011, SUNDAY

0900 – 1200 POSTGRADUATE ROUND
Venue: Hospital Universiti Kebangsaan Malaysia, Kuala Lumpur, Malaysia
Robin Phillips (UK)
CONFERENCE INFORMATION

CONFERENCE VENUE
Shangri-La Hotel
11 Jalan Sultan Ismail, 50250 Kuala Lumpur, Malaysia
Telephone : (603) 2026 8488     Facsimile : (603) 2032 1245
Email : reservations.slkl@shangri-la.com     Website : www.shangri-la.com

REGISTRATION
The registration hours are:

3rd March 2011, Thursday    1600 to 1800 hrs
4th March 2011, Friday       0730 to 1730 hrs
5th March 2011, Saturday     0730 to 1300 hrs

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

ENTITLEMENTS
Registered delegates will be entitled to the following:
• Admission to the scientific sessions, satellite symposia and trade exhibition
• Conference bag and materials
• Annual Dinner
• Lunches & Coffee/Tea

ANNUAL DINNER (4TH MARCH 2011)
The Annual Dinner will be held on 4th March 2011 at the Sarawak Room, Shangri-La Hotel, Kuala Lumpur.
This promises to be a night of great fun with good entertainment and plenty of lucky prizes.
Please confirm your attendance at the registration counter.
Delegates can bring their families and guests at RM 120 per person.
Dress : Smart Casual

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

3rd March 2011, Thursday    1600 to 1800 hrs
4th March 2011, Friday       0730 to 1700 hrs
5th March 2011, 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 Basement II. The Organizing Committee bears no responsibility for the safekeeping of posters. Any posters not collected by the close of the poster session will be discarded.

PHOTOGRAPHY & VIDEOTAPING POLICIES
No photography or videotaping of the presentations is permitted during the scientific sessions.

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

DISCLAIMER
Whilst every attempt would be made to ensure that all aspects of the Conference as mentioned in this publication will take place as scheduled, the Organising Committee reserves the right to make last minute changes should the need arises.
FUNCTION ROOMS & TRADE EXHIBITION
(Basement II, Shangri-La Hotel)

BOOTH STAND | COMPANY
--- | ---
1 | Lap Tech Medical Sdn Bhd
2 | MKS Medic Sdn Bhd
3 & 4 | Tyco Healthcare Medical Supplies Sdn Bhd (Covidien)
5 | Servier Malaysia Sdn Bhd
6 | Endodynamics (M) Sdn Bhd
7 | BH Enterprise Sdn Bhd
8 | GlaxoSmithKline Pharmaceutical Sdn Bhd
9 | United Italian Trading (M) Sdn Bhd
10 | WHPM Bioresearch & Technology Co Ltd
11 & 12 | Fujifilm (Malaysia) Sdn Bhd
13 | Malex Medical Asia (M) Sdn Bhd
14 | Vigilenz Medical Supplies Sdn Bhd
15 | KS Tekno-Med Sdn Bhd
16 | Yakult (Malaysia) Sdn Bhd
17 | AstraZeneca Sdn Bhd
18 | Sanofi-Aventis (Malaysia) Sdn Bhd
21 | Convatec Malaysia Sdn Bhd
22 & 23 | Johnson & Johnson Medical Malaysia
24 & 25 | Malaysian Healthcare Sdn Bhd
26 | QST Technologies Pte Ltd
27 | Stryker Corporation (M) Sdn Bhd
28 | B Braun Medical Supplies Sdn Bhd
29 | Avro Medical Sdn Bhd
30 | Fresenius Kabi Malaysia Sdn Bhd
ACKNOWLEDGEMENTS

The Organising Committee of the
Coloproctology 2011
wishes to thank the following for their support and contribution:

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Johnson & Johnson Medical Malaysia

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AstraZeneca Sdn Bhd
Avro Medical Sdn Bhd
B Braun Medical Supplies Sdn Bhd
BH Enterprise Sdn Bhd
Convatec Malaysia Sdn Bhd
Endodynamics (M) Sdn Bhd
GlaxoSmithKline Pharmaceutical Sdn Bhd
KS Tekno-Med Sdn Bhd
Lap Tech Medical Sdn Bhd
Malex Medical Asia (M) Sdn Bhd
MKS Medic Sdn Bhd
QST Technologies Pte Ltd
Sanofi-Aventis (Malaysia) Sdn Bhd
Servier Malaysia Sdn Bhd
Stryker Corporation (M) Sdn Bhd
United Italian Trading (M) Sdn Bhd
UMMI Surgical Sdn Bhd / Medi Life
Vigilenz Medical Supplies Sdn Bhd
WHPM Bioresearch & Technology Co Ltd
Yakult (Malaysia) Sdn Bhd
Ano-Rectal Assessment In The Clinic

AKHTAR QURESHI
Sunway Medical Centre, Petaling Jaya, Selangor, Malaysia

The rectum is the terminal portion of the digestive tract and is a continuation of the sigmoid colon and ends at the anus. It is a muscular tube lined by endothelium, with a complex sphincter that incorporates the circular sphincters, longitudinal muscle of the anus and the muscularis submucosae ani. The anal canal tends to slope obliquely backwards and inferiorly. There is a rich blood supply from the branches of the inferior mesenteric artery and contributions from the middle rectal artery and inferior rectal artery, being branches of the internal iliac artery and pudendal artery respectively. Innervation of the rectum and anal canal is derived from the sympathetic, parasympathetic and somatic nervous systems.

Due to the vast array of possibilities of differential diagnoses, a careful and systematic approach should be taken when enquiring about the patients’ symptoms. The primary symptoms relate to bleeding, mass, pain, pruritis, transit disorders and impaired continence. It is important to note that any diagnosis volunteered by the patient must not be accepted. The diagnosis must be established by the surgeon. The physical examination should help to confirm the provisional diagnosis established following the history.

Additional investigations that can be carried out in the clinic setting include proctoscopy, rigid sigmoidoscopy, endoanal ultrasound, endorectal ultrasound and anal manometry studies. Despite the growing list of tools to aid in the assessment of anorectal problems, the key to any assessment is a detailed history.

Anastomosis – Stapled And Sutured

A C ROSLANI
Department of Surgery, Faculty of Medicine, University of Malaya, Kuala Lumpur, Malaysia

The hallmark of a successful colorectal surgeon is the ability to restore bowel continuity safely following resection. A sound knowledge of anastomotic healing and principles of constructing an anastomosis is crucial if the incidence of complications, such as leak and bleeding, are to be minimized.

To this end, the construction of anastomoses has evolved over the years, both in techniques and materials. Sutures, staples and compression devices have all been used in a variety of reconstructions: end-to-end, functional end-to-end, end-to-side and side-to-side. These have been further adapted to accommodate the growth of minimally invasive surgery.

However, there are still some controversies with regard to the preferred technique, and surgeons are often influenced by traditional practices and cost implications. Unfortunately, interpretation of the scientific evidence is difficult, given the variability in definitions and surgical practice.

Early studies appeared to favour stapled over sutured anastomoses in regard to leak rates, but some more recent analyses show no difference. Low stapled anastomoses appear to be functionally superior, but there is a question mark over their oncologic safety. Compression devices and adjunctive measures such as buttressing need more rigorous study. Adding to the complexity are the differences in complication rates of different underlying pathologies, and at different anastomotic sites.

Decision-making should therefore be individualized, taking into account one’s experience, clinical factors and resources, and adapted accordingly based on rigorous audit of surgical outcomes.
Maintaining A Hospital-Based Ostomy Support Group

MARIAM MOHD NASIR
University Malaya Medical Centre, Kuala Lumpur, Malaysia

Ostomy surgery alters body image; this process can be distressing for patients, who must go through transition type of grieving process. Attending an ostomy support group provides an atmosphere of acceptance, a feeling of being able to cope, and mutual respect. The ET nurses together with the Stomacare Society is well positioned to facilitate such a group.

The physical alterations in the patient’s elimination pattern caused by the stoma not only demand immediate and long-term attention but also affect the patient’s psychological nature and social relationships for the duration of the stoma.

Our clinical experiences strongly suggest that patients move more rapidly through the stages of grief to acceptance of the ostomy when they interact with others who have shared similar experiences.

Ostomy support group is an often organized group of individuals who share a common experience – had an ostomy surgeries such as Colostomy, Ileotomy or Urostomy. It can also be a health care providers, Doctors/surgeons/Colorectal/Nurses/E.T. family members and friends, any interested parties.

Support must begins as soon as possible and start in the out-patient unit/clinic, at the time of diagnosis, pre operative counselling, preparation for surgery, post operative care and follow up.

Is a phase of life… The quicker one can adapt faster and gets ahead with life is BETTER. 1st few years – the toughest for most ostomates, Reason... ADAPTING PROCESS and COMFORT OF CARE WHILE IN HOSPITAL from Doctors, Nurses & Enterostomal Therapist (E.T.)

THE CHALLENGES BEGINS... when they are discharge. Are they equipped to face the challenges?? Are they given the knowledge on how and where to get their appliances??or even the worse... have they been introduced to the appliances. THIS LEAD TO FEARS, ANXIETIES, WORRIES.
Persons who undergone an ostomy surgery faces major surgery, experience loss of bodily function, a distortion of body image and changes in personal hygiene. All these changes profoundly influence sexuality and sexual function.

The most common female sexual problems are vaginal dryness and dyspareunia due to anatomical and physiological changes post surgical procedure. Studies reported that women with an ostomy feeling ashamed of their new body, fear of rejection of spouse, fear of odour and leakage of appliance during sexual relationship. Psychological distress like poor body image, low self-esteem, loss of physical attractiveness, anxiety and depression also contribute to Female sexual dysfunction. Female sexual dysfunction (FSD) with an ostomy is a multifactorial condition including anatomical, physiological, medical, psychological and social components. Thus, pre and post operative, the Surgeon and Enterostomal Therapist Nurse(ET) should provide adequate counseling and opportunities to discuss with ostomy patient and spouse about the changes of their sexuality or sexual function and potential sexual dysfunction and its treatment.

The PLISST model intervention use in sexual counseling will guide the ET nurse in helping the ostomy patient to express their sexual problems and help in solving their sexual problems. ET nurses play important role in facilitate the ostomy patient in adaption to live with a stoma, management of stoma and rehabilitation.

As stomal therapy nurses we are uniquely positioned to assist our patients manage their pain. We are also able to predict when painful events will happen and advocate for our patients to have adequate pain control. As practitioners we need to be aware of our own attitude to pain and towards our patients experiencing the pain we also need to have an understanding of the effect the painful experience has on recovery and healing.
Many stoma patients and family members wrestle with the physical, psychological, and social demands of their illness and require support from our health-care system.

Stoma management in hospital and home care can together provide a more responsive approach. Education on stoma management:

- Is ongoing, requires pro-active, planned, integrated medical care.
- Requires patients and family members /care giver to be active partners in managing their condition.
- Requires both ET nurses and nurses in surgical ward to work together.

When dealing with difficult stoma, re-evaluating the pouching technique & pouching system is very important thus ET nurses and nurses in surgical wards need to:

- Have competent technical skill and knowledge of equipment alternative & preventive measure.
- Have Behaviour modification including emotional support.
- Assume the responsibility for stoma management and signs of complications.

Successful stoma management requires regular, ongoing contact with patients.

Interventions in the form of return visits, telephone calls and active participation in Stoma Care Society have been shown to be effective in maintaining sustainability of patient self management.
The Ethics Of Innovation In Colorectal Surgery

FRANCIS SEOW-CHOEN
Seow-Choen Colorectal Centre PLC, Singapore

Surgeons are innovation doctors. Each situation we meet on a daily basis requires on the stop innovation to overcome the difficulties and to secure healing for the patient. Such innovativeness must be based on a background of adequate scientific training in the medical sciences as well as on a desire to better the health of the patient in question.

First and foremost the surgeon's responsibility is to the patient under his charge and on the operating table right under his nose at the particular time. The safety and well being of that patient is the prime concern and focus of the surgeon. There is no excuse to compromise the safety of that particular patient so that mankind in general will benefit or so that the next patient will benefit or worse so that the surgeon or someone else will benefit.

A lot of harm had been done to people in the past and indeed continues in places in the name of medical progress. Witness the horrific medical experiments of the third reich and in more recent times in Africa and even in the US with experiments on unwilling and uninformed subjects with the ultimate results accepted and published by respectable medical journals. Advancing medical science is not an excuse for experimenting on people nor is it moral just because the next patient will benefit even if this one dies or suffers.

Surgeons have to recognise that innovation in surgery must take place otherwise there will not be advancements made in surgical sciences. However each modification large or small must be made with the utmost respect for that particular patient under his charge. Each step must be made with due consideration to the scientific and moral basis of that particular execution for the better health of the patient. This is the moral obligation of every surgeon.

HNPCC – Current Concept

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Colorectal cancers were thought to be familial for a very long time. It is estimated that familial risk of colorectal cancer is about 20% of all patients diagnosed to have such disease. About 5 to 10% of colorectal cancer patients have already been proven to be inherited in the United States. Familial colorectal cancer is divided into three main categories. The first two main groups are the Hereditary Non-Polyposis Colorectal Cancer (HNPCC) and the Familial Adenomatous Polyposis (FAP) and the rare third group is the Hamartomatous Polyposis Syndromes. In HNPCC, the first most important step leading to the diagnosis of this condition is the compilation of a thorough family history of cancer. The focus should be on identifying cancer of all types and sites in the family. This is because of frequent extracolonic manifestations of the disease. Once there is enough basis of suspicion based on the criteria available, the patient should be subjected to some molecular genetic testing or a specifically designed targeted surveillance. The latest criteria used for detecting HNPCC is the Bethesda guidelines (1996) taking over the Amsterdam criteria (1991). Once identified, the family should be counselled in depth and each member seen face to face. The need for regular surveillance and prophylactic surgery has got to be explained in detail. This is one of the biggest challenge faced on top of providing genetic testing and putting up a complete family tree on a registry.
Current Developments In Colorectal Cancer Proteomics:
From Gels To Cells

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Proteomics is the study of the protein complement of a given sample – cell, tissue, or an entire organism. This includes determination of the proteins’ identity, biochemical properties and functional roles and how their quantities, modifications and structures change in response to the needs of the cell/organism. The presence/absence of a protein and/or its isoforms may represent events occurring within a cell which in turn, correspond to cellular functions. Therefore, a proteomics study of cancer may potentially develop ways to diagnose cancer much earlier, identify new drug targets to be exploited for cancer treatment and in general understand the development and progression of the disease. Here we explore the challenges in conducting proteomics studies, focusing on technical developments that have catalyzed the evolution of proteomics to the state that it is in today. We also look at some discoveries made with the aid of proteomics in colorectal cancer and cancer in general.

Dual Stoma: A Nursing Challenge

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Having a dual stoma, client is confronted with physiological and psychological challenges of urinary and faecal or only faecal drainage. Ostomy literature reviews that ET nurse play a role in meeting challenges for a successful recovery after ostomy surgery (Turnbull 2002) Marking the site for two stomas demands a clinical skills on two different plane, consideration allowing adequate space for pouching system. Achieving and selecting appropriate appliances for a client with two stomas is crucial. Striving to improve rehabilitation requires a skillful ostomy care, supportive relationship; helping clients to cope with changes in body image can be a challenging experience for a nurse.

Diet And Stoma Management: Dispelling The Myths

CARMEN SMITH
Australia

What are the myths around diet and stomas? As stomal therapy nurses we need a comprehensive knowledge of both the anatomy of the gut and the physiology around digestion and nutrition. By basing the advice we give our patients on current evidence we avoid creating myths. By listening to our patients personal stories related to their eating habits we can assist them in understanding why certain events happen and can help dispel their personal myths.
LIFT Technique

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LIFT (Ligation of Intersphincteric Fistula Tract) is a total sphincter preserving procedure for fistula in ano. The technique was described by Rojanasakul et al. since 2007. Essential steps of the procedure include, incision at the intersphincteric groove, identification of the intersphinctic tract, ligation of intersphincteric tract close to the internal opening and removal of intersphincteric tract, scraping out all granulation tissue in the rest of the fistula tract and suturing of the defect at the external sphincter muscle. LIFT is a good option for transphincteric fistula since it is the most common type of fistula encountered in our practice. Thus, we estimate that LIFT is appropriate for more than 80% of fistula cases. Reports on healing after LIFT technique were 60-90% without disturbances in clinical anal continence.

Advantages of the LIFT technique are total anal sphincter saving, minimal tissue injury, shorter healing time, less pain, small scar, inexpensive, simple to learn and durable outcome.

At present, the LIFT procedure represents another effective tool that should be in the armamentarium of any surgeon who evaluates fistula-in-ano.

Comprehensive Evaluation Of Pelvic Floor Disorders

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Pelvic floor disorders are an underdiagnosed source of morbidity and decreased quality of life for women while it is a much less common disorder in men. Almost 24% of women in the United States report at least one pelvic floor disorder, which, unfortunately, increases with age, parity and obesity. The demand for pelvic floor services is expected to grow as the relative proportion of the elderly increases and physicians become more aware of these disorders.

Pelvic Floor Disorders incorporate a spectrum of symptoms which include constipation, fecal incontinence, pelvic organ prolapse and urinary incontinence which involve the central and posterior compartments of the pelvic floor. There are various etiologies involved varying from systemic illnesses to neuromuscular disturbances of the gastrointestinal tract.

A careful history and physical examination is key to establishing a provisional diagnosis and directing diagnostic testing. Often, patients present with vague complaints and it is vital that a careful description of the patient’s symptoms in their own words be obtained to better define the clinical scenario.

It is increasingly recognized that patients with pelvic floor complaints benefit from a multidisciplinary evaluation focusing on colorectal, gynaecological and urological surgical care. Each pelvic floor complaint has a high propensity to coexist with others, making multispecialty evaluation and care essential. Even for those patients without defined anatomical defects, functional disorders of the gastrointestinal tract or pelvic floor unrelated to prior obstetric experience are also common.

Numerous advances in radiological and physiological investigatory techniques have become available to clinicians. Comprehensive pelvic floor testing in a stand-alone laboratory facilitates this evaluation, and is very efficient and convenient process for patients. This can enable the underlying pathogenesis of the condition can be determined, which in turn aid diagnosis and guide medical, behavioral and surgical treatment. Tests germane to the posterior pelvis and frequently used by the colorectal surgeons will be the emphasis of this presentation.
Faecal Incontinence Following Fistula Surgery

PARVEZ SHEIKH
Charak Clinic Nursing Home, Mumbai, India

Fistula in ano is said to occur in one out of 10000 individuals. Treatment is surgical and is aimed at eradication of the fistulous tract without compromising continence and avoiding recurrence.

Any procedure that involves dividing the anal sphincter musculature, either surgically or by means of a seton will result in some degree of incontinence. The degree of incontinence will depend on the nature and aetiology of the fistula, the type of operation performed, and whether the setons were loose or cutting. Complex and high fistulae have higher incontinence rates.

Accurate estimation of incontinence rates following fistula surgery is difficult. There are no good quality randomised trials comparing different surgical interventions. Most studies have been retrospective series or non randomised comparisons.

Recurrence and incontinence are inversely related. In general, procedures with low incontinence rates have high recurrence rates and vice versa.

Incontinence rates are surprisingly high, even when cutting setons or flaps are used. The only procedures that do not result in incontinence are Fibrin Glue and the AFP plug.

The following incontinence rates have been reported after various procedures:

- Fistulotomy: 3%-7%
- Chemical Seton: 7%
- Setons: minor 34%-63%, major 2%-26%
- Endorectal flaps: minor 31%, major 12%

Incontinence rates are higher with cutting setons than with loose setons and staged fistulotomies. An overall rate of 18% has been reported for cryptoglandular fistule. Minor incontinence rates vary from 10-20% and major incontinence rates vary from 0-10%. Rates of 6% to 14% have been reported with loose setons.

Thus, incontinence continues to be a problem after fistula surgery. Newer techniques like the AFP Fistula plug and the LIFT procedure are efforts to develop methods to avoid or minimise incontinence.

Medico-Legal Concerns In Enterostomal Nursing Practice

CARMEN SMITH
Australia

Nurses in USA and increasingly in Australia face the prospect of being sued. An interesting concept is that one can do everything right but still end up in court over a medico legal issue. In the west employees such as nurses have protection against litigation through their employers professional indemnity insurance. Nurses are also protected by their practice, it is our responsibility as practicing stomal therapy nurses to have a recognised qualification in enterostomal therapy nursing, to maintain currency of practice, to keep up to date with research and evidence to support our practice, to contribute to the body of knowledge through our own research and to practice within our level of expertise and competence.
Colorectal Screening

SAMUEL TAY
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Colorectal cancer incidence is rising, especially in Asian countries. In several countries it has equalled that of the west, at 44.6 males per 100,000 and 33.1 females per 100,000. In Malaysia, Colorectal cancer is the commonest cancer in males and the 2nd commonest cancer in females. Treatment of colorectal cancer is only effective if performed early. In Malaysia, a large proportion of colorectal cancer is still detected relatively late. Proximal migration site of colorectal cancer has been observed in more developed countries. Colorectal screening has been shown to detect precancerous lesions and early colorectal cancer. If implemented, it can prevent cancer and also save lives affected by the cancer. Effective Screening methods include Fecal Occult Blood test, Colonoscopy and CT Colonography. Each method has its own drawbacks. All face the problem of poor compliance. Compliance can be improved if screening for colorectal cancer is combined with screening for other cancers. Public education and awareness is crucial to the success of population screening programmes.

Adjuvant Therapy Of Colorectal Cancer

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Adjuvant chemotherapy has been shown to improve survival in stage II and III colorectal cancer whilst neoadjuvant (chemo)radiotherapy improves local control of locally advanced rectal tumours. Neoadjuvant and adjuvant chemotherapy has been a controversial area in stage IV disease with few adequately powered randomised trials to guide management.

Targeted agents such as bevacizumab and cetuximab, in addition to standard chemotherapy have improved outcome in the metastatic setting. With the increasing interest in the resection of liver metastases, there have been trials investigating the role of these agents in peri-perioperative systemic therapy. Whilst there has been a benefit in terms of downsizing liver lesions for potentially curative surgery, there has been no significant benefit for targeted agents in “true adjuvant” treatment for stage II and III disease.

Conventional chemotherapy in the form of fluoropyrimidines with or without oxaliplatin remains the standard of care for stage II and III colorectal cancers. Chemotherapy and targeted agents may be used to downsize liver metastases in selected cases. Pre-operative (chemo)radiotherapy is indicated in bulky, resectable rectal cancer.
Management Of Positive Doughnut In Rectal Cancer Surgery

VARUGHES MATHAI
Global Hospitals, Hyderabad, India

A positive rectal doughnut after rectal resection is an uncommon finding. Routine evaluation of the doughnut histology is recommended only when the margins are close. No large series exist to give a clear cut answer as to what the best method of tackling this problem is. The management of the positive doughnut cannot be taken in isolation. Other patient factors and histology of the main resected specimen have to be taken into account. The most important of these factors are:

1. If the patient has received neoadjuvant therapy
2. The circumferential margin on histology
3. The overall stage of the disease.
4. Poor prognosis indicators of overall survival

Reresection, adjuvant therapy and a wait and watch policy with salvage surgery are the options left in one’s armamentarium. However, which of the options to choose still remains a dilemma.

Pre And Post Op Ostomy Care

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Preoperative assessment is required once patient had decided and agreed for surgery. Assessment in pre operative phase are the basis for planning and implementary care effectively during the post operative phase. General physical-selection and marking of stoma site. Mobility and activities-previous illness may obstruct self management of stoma.

Sense of hearing and vision-can cause-difficulty in understanding advise given. Changes in body image-psychological support required.Sexuality counseling required to established patients relationships with their partners.

Post operative phase – close observation of physical assessment-stoma appearance. Education and teaching once patients discharge. Patients with stoma can resume social relationships and anticipate active and develop good quality of life.
Genetic Testing In Colorectal Cancers: Relevance To Colorectal Surgeons In The Genomic Era

KOH POH KOON
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Approximately 20-30% of all colorectal cancers (CRCs) exhibit a familial clustering. Of these, Lynch syndrome (HNPCC) accounts for 5%-10% and is inherited in an autosomal dominant fashion. With the rising incidence of CRC worldwide, identifying potential HNPCC patients and their families will become an increasingly important aspect of preventive cancer care, as predictive gene testing is available for presymptomatic diagnosis of Lynch syndrome and clinical surveillance guidelines have been established to target the population at risk. Prophylactic colectomies and hysterectomies have been advocated for obligate gene carriers in high-risk families as a cancer-risk reduction strategy. Genetic testing in other hereditary polyposis syndromes such as FAP (Familial Adenomatous Polyposis) can streamline the clinical management of these families and allow for more optimal use of limited clinical resources targeted at those at risk.

In sporadic colorectal cancers, KRAS testing has been shown to be a useful predictor of response to Cetuximab therapy. BRAF and MSI testing are also showing promise in aiding clinical decision making for adjuvant treatment of colorectal cancers.

Key principles and applications of genetic testing of relevance to the Colorectal Surgeon will be discussed.

Laparoscopic Colorectal Surgery – Patient Selection

YUNUS GUL
Prince Court Medical Centre, Kuala Lumpur, Malaysia

Laparoscopic colorectal resections are being performed with increasing frequency even though a great deal of controversy initially surrounded its utilization since the first laparoscopic colectomy was described in 1991. This is especially in relation to the management of colorectal cancer and issues related to port site metastasis. Several important studies have since demonstrated the benefits and safety of laparoscopic colorectal surgery, making it now the preferred approach in the surgical management of many colorectal diseases. Recent multicentre randomized trials such as the COST (Clinical Outcomes of Surgical Therapy), COLOR (Colon Cancer Laparoscopic or Open Resection) and CLASICC (Conventional versus Laparoscopic-Assisted Surgery in Colorectal Cancer) trials have shown no difference in the rates of postoperative morbidities. Patient selection plays an integral role in laparoscopic colorectal surgery even though the majority of patients can be considered as suitable candidates with few relative and absolute contraindications for minimally invasive surgical intervention. Nevertheless, complications are still reported in the literature varying from minor to major, in particular during the so called ‘learning curve’ period. The practicing laparoscopic surgeon has to be aware of potential complications and avoid these mishaps, most of which are related to inexperience and lack of awareness. The use of minimally invasive approaches in the surgical management of colorectal diseases will only be considered as the acceptable norm if complications are kept to a minimum in comparison to open surgery with improved overall outcome.
SILS

PRASHANTH RAO
Department of MAS, Mamata Hospital, Mumbai, India

Scarless surgery is the Holy Grail of surgery and the very raison d’etre of Minimal Access Surgery. Laparoscopic procedures, which were started in the latter decades of the last century, have rapidly become the gold standard for many intra abdominal procedures. Natural Orifice Surgery (NOTES) was developed for scarless surgery, but did not gain popularity due to a variety of reasons. Single incision laparoscopic surgery is a very exciting new modality in the field of Minimal Access Surgery. LESS is Laparo-Endoscopic Single-site Surgery, a term coined by a multidisciplinary consortium in 2008 for single incision laparoscopic surgery or SILS. In spite of the difficulties of access, lack of triangulation and inadequate instrumentation as of date, LESS or SILS seems to offer an advantage to surgeons with its familiar field of view and instruments similar to those used in conventional laparoscopy, as opposed to NOTES. LESS remains an evolving special technique used successfully in many a centre for a variety of procedures. Starting with the cholecystectomy, it has now been used for even colorectal and other advanced procedures. It currently stands between standard laparoscopy and NOTES in the armamentarium of Minimal Access Surgery. This talk centers onto our pioneering work in LESS using the access device, the evolution of the technique of LESS, and its adaptation to colorectal surgery. It also talks of the various devices, tips and tricks to make the surgery easier.

Endoscopic Advances In Colorectal Disease

RYAN PONNUDURAI
Gleneagles Intan Medical Centre, Kuala Lumpur, Malaysia

Endoscopic therapy in colorectal pathology continues to evolve with newer equipment allowing the endoscopist to perform successful endoscopic therapy negating surgery.

The presentation will focus on 1) the latest colonoscopes which allow virtual chromoendoscopy to viewing lesions at a microscopic level. 2) Endoscopic mucosal and submucosal resection. 3) colonic stenting for malignancy and 4) EUS in staging and therapy.
Irritable Bowel Syndrome

RYAN PONNUDURAI
Gleneagles Intan Medical Centre, Kuala Lumpur, Malaysia

Irritable Bowel Syndrome (IBS) is a functional bowel disorder. It is characterised by episodes of abdominal pain associated with altered bowel habits, in the absence of any structural abnormality or organic lesion. This disorder affects approximately 10% of the world’s population. In the developed world, IBS is the most commonly diagnosed gastrointestinal disorder and is found predominantly in women.

There are three recognised variants of IBS: diarrhoea-predominant (Type D), constipation-predominant (Type C), and an alternating pattern (Type A). The Rome Criteria define a frequency of symptoms including abdominal pain and change in stool frequency, stool consistency or relief of pain upon defecation, bloating, flatulence, passage of mucus, straining, urgency or incomplete evacuation, which allow diagnosis.

The presentation will concentrate on the pathophysiology, management and a clinical update on the latest therapies in Irritable bowel syndrome.

Fibre In Constipation – Good Or Bad

FRANCIS SEOW-CHOEN
Seow-Choen Colorectal Centre PLC, Singapore

Fibre is often touted as a healthy and nutritious food by both the popular media and indeed by doctors and nutritionists alike.

Nonetheless we have to be aware that not all is truth about this statement.

Firstly we have to examine why we eat in the first place. There are three good reasons for eating. First we eat to get nutrition stay alive, second we eat to get energy for work, place and procreation. Lastly we eat for enjoyment and socialization. Therefore except for the third reason, food that is nutritious must be digested or broken down and absorbed, to be useful to the body. Food that cannot be absorbed must be junk food; that is; whatever is eaten is not used at all but changed immediately into faeces. The truth of the matter is that Fibre is indigestable by the human body; there is some fermentation by gut bacteria but that is another story and contributes greatly to the gas and bloatedness seen after fibre ingestion. Protein, carbohydrates and fat on the other hand are totally or almost totally digestible. The modern world with its warped thinking now considers food which makes people fat to be junk and food which is undigestable to be healthy. When we talk of nutrition, we speak of making a person who is still growing taller and bigger and stronger. When we talk of adult nutrition we talk of making the person fatter and stronger as well. People must not equate thin with health and fat with disease. Of course many fat people have diabetes and high cholesterol and heart diseases and so on. But on the other hand so do many thin people. Fat but not overly obese people are generally more able to withstand a sudden severe sickness than some too thin and within bodily reserves. Of course, if one wants to be loose weight, or cut cholesterol or sugar content in the blood, the best way is just to eat less fatty or sugary foods. Eating more fibre is a waste of resource and pollutes the planet. Furthermore it does not improve one’s health.

Some people claim that eating fibre prevents cancers especially cancer of the colon and rectum. This had never been proven and is in fact a myth. The real evidence is that proteins are needed for the body’s...
immunity and defense against both infection and cancer. Eating only fibre following a diagnosis of cancer is one sure way of leading one’s body to weakness, pessimism and ultimately death by starvation. Fibre is furthermore the main cause of constipation, irritable bowel syndrome and not the cure for these problems. Our forebears who seemed smarter than our present generation called fibre other names like bulking agents and roughage for good reasons. They made faeces bigger and bulkier. Eating protein and fat or carbohydrate made very little residue but eating fibre makes for a high leftover rate that needs to be passed out. How it is possible that more faeces is easier to pass than less faeces is impossible to comprehend. Furthermore fibre results in gaseous production and this leads to abdominal bloatedness, cramps and pain which is one of the main gastrointestinal problem of the modern world.

HOW I DO IT

LIFT For Fistula-In-Ano

AHMAD SHANWANI
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Initial reports from Chulalongkorn University, Bangkok by Professor Arun Rojanasakul (J Med Assoc Thai. 2007;90:581–5) have described a novel technique of ligating the intersphincteric fistula tract (LIFT) for the treatment of fistula-in-ano. A success rate of 94.4% was reported in the treatment of 18 patients.

Operative Technique

No mechanical bowel preparation was attempted before the procedure. After regional anaesthesia, the patient was placed in a prone position with the buttocks taped widely apart.

An Eisenhammer anal retractor was then gently inserted. The location of the internal opening was identified by injection of hydrogen peroxide (H2O2) through the external opening or by gently probing the fistula tract. Once both openings were delineated, the complexity of the fistula was then assessed.

The intersphincteric groove or plane at the site of fistulous tract was then entered via curvilinear skin incision using a scalpel. Care was taken not to injure the sphincter. A Lone Star or Langenbeck retractor was used to deepen and expose the intersphincteric plane.

The intersphincteric tract was identified and isolated by meticulous dissection using electrical cautery and scissors.

Once isolated, the intersphincteric tract was hooked using a small, right-angled clamp. The tract was then ligated close to the internal sphincter with polyglactin no. 3/0. Following that, the tract was divided distal to the point of ligation. Hydrogen peroxide was then injected through the external opening to confirm the division of the correct tract.

Subsequently, the external opening and the remnant fistulous tract were cored out up to the proximity of the external sphincter complex. Finally, the intersphincteric incision was loosely reapproximated with interrupted polyglactin 3/0. A cored-out wound was left opened for dressing.

Intraoperatively, the following data were documented: the number and location of the external opening, the location of the internal opening in relation to the dentate line, the course of the primary tract in relation to the sphincters, the presence of a secondary extension, and the identification of any procedure-related complications.
Conclusion
This new technique for fistula-in-ano surgery aimed at total anal sphincter preservation has shown encouraging early results comparable to those found with other sphincter-saving techniques. This procedure is relatively easy to perform and appears to be safe.

Reference

HOW I DO IT

Emergency Hemorrhoidectomy For Prolapsed Thrombosed Piles

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Technique of urgent closed hemorrhoidectomy is not different from elective surgery. Retrospective study of urgent closed hemorrhoidectomy in KCMH during 2000-2005 showed comparable outcome to elective surgery. Complications included 7.5% urinary retention, 1.2% post operative bleeding and 2.2% wound dehiscence. We conclude that urgent hemorrhoidectomy is an effective and safe procedure for prolapsed thrombosed haemorrhoid.
PO 1 A Lady With Large Intra Abdominal Mass. A Diagnostic Dilemma  
A Salleh, A Hassan, A H Daud
1Department of Surgery, Universiti Kebangsaan Malaysia Medical Centre, Kuala Lumpur, Malaysia  
2Department Surgery, Hospital Sultan Haji Ahmad Shah, Temerloh, Pahang, Malaysia

PO 2 Predictors Of ClinicoPathological Response In Rectal Cancer After Neoadjuvant Chemotherapy  
A Hilan Raj, Mahadevan D, Loo G L, Jasiah Z
Department of Surgery, Tuanku Ja’afar Hospital Seremban, Negeri Sembilan, Malaysia

PO 3 Colon Cancer Recurrence Mimicking Renal Cell Carcinoma : A Case Report  
A R Yusoff, M S Jahit
1Faculty of Medicine, University Teknologi MARA, Hospital Sungai Buloh, Selangor, Malaysia  
2Hospital Sungai Buloh, Selangor, Malaysia

PO 4 LIFT Procedure For Fistula-In-Ano : Our Experience  
Asma’ Razak, Chan Koon Khee
Department of General Surgery (Colorectal Division), Hospital Sultanah Aminah, Johor Bahru, Johor, Malaysia

PO 5 Retrospective Study Of Hartmann’s Procedure In Tuanku Ja’afar Hospital Seremban  
N Balasekaran A Hilan Raj, Mahadevan D, Jasiah Z, Loo G L
Hospital Tuanku Ja’afar Seremban, Negeri Sembilan, Malaysia

PO 6 Faecal Incontinence After Fistula-In-Ano Surgery – Under Diagnosed Problem  
Hoong-Yin Chong, H C Lim, C W Law, A C Rosli
Colorectal Surgery Unit, General Surgery Division, Department of Surgery, University Malaya Medical Centre, Kuala Lumpur, Malaysia

PO 7 Quantitative Immunochemical Faecal Occult Blood Test : An Effective Tool For Colonoscopic Prioritization In Colorectal Carcinoma Screening  
Hoong-Yin Chong, A C Rosli, C W Law
Colorectal Surgery Unit, General Surgery Division, Department of Surgery, University Malaya Medical Centre, Kuala Lumpur, Malaysia

PO 8 Sacrococcygeal Teratoma With Malignant Transformation In An Adult – A Case Report  
Hoong-Yin Chong, G H Tan, C W Law, A C Rosli
Colorectal Surgery Unit, General Surgery Division, Department of Surgery, University Malaya Medical Centre, Kuala Lumpur, Malaysia
POSTER PRESENTATIONS

PO 9
Chemometrics Of Differentially Expressed Proteins In Colorectal Cancer – Application In The Future Design Of A Diagnostic Kit

EH B Ng1, L C Yeoh2, S Dharmaraj3, L H Gam2, S Manjit1, B H Gooi1

1Department of General Surgery, Penang Hospital, Penang, Malaysia
2School of Pharmaceutical Sciences, Universiti Sains Malaysia, Penang, Malaysia
3Centre for Drug Research, Universiti Sains Malaysia, Penang, Malaysia

PO 10
Perianal Abscess And Fistula : Predisposing Factor For Fistula In Patients With Perianal Abscess

H Suthan, M Deva Tata, J Zakaria, G L Loo
Department of Surgery, Hospital Tuanku Ja’afar Seremban, Negeri Sembilan, Malaysia

PO 11
Progression Of Perianal Abscess Into Fistula In Ano : A Case Series

H Suthan, Mahadevan D Tata, G L Loo, J Zakaria
Department of Surgery, Hospital Tuanku Ja’afar Seremban, Negeri Sembilan, Malaysia

PO 12
Preoperative Carcinoembryonic Antigen (CEA) As Prognostic Factor Of Recurrence In Stage II Colorectal Cancer

J R Sathiyananthan, Law Chee Wei, April Roslani
Colorectal Surgery Unit, University Malaya Medical Centre, Kuala Lumpur, Malaysia

PO 13
Massive Lymph Node Metastasis As A Rare Manifestation Of Colon Cancer

C K Lai1, D Z Ande2, A H Azahar1, M Maya1, S Hassan1, S Ikhwan1, Z Ismazizi1, A Zuhdi1, Z Zaide1, M Zainal1, M N Gohar1, M Pasha1, A O bhayo1, S Emil1a2, R Muhammad3

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PO 14
Critical Analysis Of Malignant Polyps In Tuanku Ja’afar Hospital Seremban

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PO 15
Haemorrhoidectomy For Haemorrhoidal Crisis : Profiling Of Patient Characteristics

Narentharen S, Mahadevan D, Jasiah Z, Loo G L
Department of Surgery, Hospital Tuanku Ja’afar Seremban, Negeri Sembilan, Malaysia
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<td><strong>S F Anuar, K K Chan, Haironi</strong>&lt;br&gt;Hospital Sultanah Aminah, Johor Bahru, Johor, Malaysia</td>
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<td><strong>S M Wong, G C Gan, M K Wan, F Henry</strong>&lt;br&gt;1Department of General Surgery, Selayang Hospital, Selangor, Malaysia&lt;br&gt;2Department of Biomedical Imaging, University Malaya Medical Centre, Kuala Lumpur, Malaysia</td>
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S M Wong1, G C Gan2, F Henry1  
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2Department of Biomedical Imaging, University Malaya Medical Centre, Kuala Lumpur, Malaysia

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Iyad A J1, Zaidi Z2, I Azim2, H Harunarashid1, I Sagap1  
1Colorectal Unit, Universiti Kebangsaan Malaysia Medical Centre, Kuala Lumpur, Malaysia  
2Department of Surgery, Universiti Sains Malaysia, Penang, Malaysia

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Zaidi Z2, I Sagap1  
1Colorectal Unit, Universiti Kebangsaan Malaysia Medical Centre, Kuala Lumpur, Malaysia  
2Department of Surgery, Universiti Sains Malaysia, Penang, Malaysia

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Rosliza G1, Zaidi Z2, I Sagap1  
1Colorectal Unit, Universiti Kebangsaan Malaysia Medical Centre, Kuala Lumpur, Malaysia  
2Department of Surgery, Universiti Sains Malaysia, Penang, Malaysia

PO 28  Intraoperative Injection Of Diluted Methylene Blue As A Pain Control Following Operation In The Perianal Region  
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2Department of Surgery, Universiti Sains Malaysia, Penang, Malaysia
A Lady With Large Intra abdominal Mass. A Diagnostic Dilemma

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This is a case report of a lady with large intra-abdominal mass and massive bilateral pleural effusion. Diagnosis of GIST made due to clinical presentation and supported by biopsy with presence of skeletal muscle fibres and positivity to CD 117. Dilemma in treatment also encountered either for neoadjuvant Gleevec due to large tumor but explorative laparotomy performed as CT Scan showed well capsulated tumor without involvement of any surrounding structure or major vessels. However histology report after resection confirmed this tumor as dysgerminoma that have totally different treatment. It have very good response to chemoradiation compared to GIST which need targeted therapy.

CONCLUSION
Positive CD117 is not only indicative GIST but other soft tissue sarcoma need to be ruled out.

Predictors Of ClinicoPathological Response In Rectal Cancer After Neoadjuvant Chemotherapy

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OBJECTIVES
To identify pre-treatment factors that predicts tumour progression of rectal cancer after neoadjuvant chemo radiotherapy.

METHOD
Total 46 patients with rectal carcinoma patients’ records from June 2009-Dec 2010 were reviewed. 36 completed records were analysed. 16 patients who had neoadjuvant chemo radiotherapy were included into this study. Univarient analysis was done to determine odds ratio for each prognostic factors on probability of progression.

RESULTS
50% were Malay, 31.3% Indians and 18.8% Chinese. Mean age of these patients were 58.8 (SD 8.836). Male to Female ratio was 1.3:1. Overall pathological response was seen in 56.3%, complete pathological response seen in 18.8%. Factors with strong association for positive tumour response to neoadjuvant chemo radiotherapy include Indian race, tumour distance from anal verge more than 5cm, early tumour stage, PR bleeding as presenting symptoms and non diabetes patients.

CONCLUSION
Pre-treatment factors that predict tumour response in rectal cancer after neoadjuvant chemotherapy can be helpful especially when these factors can outline the course of the disease and prognosis of the patients. However, larger sample size needed to consolidate the findings.
Colon Cancer Recurrence Mimicking Renal Cell Carcinoma: A Case Report

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INTRODUCTION
Colorectal cancer (CRC) is one of the most common gastrointestinal cancers in the world. In the UK and US, it is the second most common cause of cancer death after lung cancer. Surgical resection with en bloc removal of the regional lymph nodes remains the mainstay of its treatment. Nonetheless, about 1 in 3 CRC patient treated with curative intent will suffer from local recurrence or metastasis. Among the usual sites of recurrence are liver, lungs, local and/or regional intraabdominal, retroperitoneal and peripheral lymph nodes. We report a case of a patient with colon cancer that metastasized to the left kidney after curative surgery and adjuvant therapy which mimicked left renal cell carcinoma.

CASE PRESENTATION
A 21-year-old male presented in January 2007 with worsening lower abdominal pain, abdominal distension and vomiting. An exploratory laparotomy was performed due to worsening of symptoms which found a splenic flexure tumour that needed left hemicolectomy. Histologically, a poorly differentiated adenocarcinoma of the colon was confirmed and he received standard adjuvant chemotherapy. No recurrence was detected on follow up a year later until August 2010 when he presented again with left upper abdominal pain, constipation and raised CEA. Colonoscopy did not show any colonic recurrence. A restaging CT scan revealed a huge left renal mass which featured as locally advanced left renal cell carcinoma. However the biopsy of the mass with immunohistochemistry staining favoured metastatic carcinoma over a primary renal tumour. He currently underwent palliative chemotherapy with further intent for palliative nephrectomy.

CONCLUSIONS
Although implantation of colon cancer cells onto the renal pelvis as well as intraluminal renal metastasis of rectal cancer has been described, metastases of colorectal cancer in the kidney are considered to be exceptionally rare. Thus renal metastasis from primary colon cancer despite its rarity is hereby reported.
OBJECTIVES
This study is designed to look into the overall outcome of ligation of intersphincteric tract (LIFT) procedure for fistula-in-ano, including complete healing and recurrence rate, healing time and the benefit of pre-operative endo-anal ultrasound (EAUS).

METHODS
We performed a prospective observational study for patients with transphincteric fistula-in-ano treated with LIFT procedure from March 2009 until December 2010. The surgery was performed only by the colorectal surgeon following standard operating technique for LIFT procedure. We looked into clinical presentations, anatomy of fistula, definitive role of pre-operative EAUS, complete healing rate, healing time, recurrence rate, and post-op incontinence during standard follow-up protocol.

RESULTS
Thirty one patients were included in this prospective study. Fistula-in-ano is commonly seen in male (80.6%). Mean age of the patient is 39.3 years. Twenty eight (58.1%) of them have had previous perianal surgery with twelve (38.7%) had an incision and drainage of perianal abscess and the remaining six (19.4%) had previous fistula surgery. Majority of the patients presented with perianal discharge (93.5%) and perianal pain (42%). Sixteen (51.6%) of them presented with anterior fistula. Pre-operative EAUS was performed in twenty four (77.4%) patients. Majority of the patients had good outcome from the surgery with twenty six (83.9%) had complete healing of the fistula, and the median time taken to heal ranges from 6 to 8 weeks. Only seven patients (22.6%) had recurrent fistula and required subsequent surgery; two patients with completely healed fistula whilst the remaining five with partially healed wound. None of the patients had post-operative incontinence during routine follow-up visit. There was no significant correlation between anatomy of fistula and the outcome of surgery (p=0.122). We also found that the pre-operative EAUS does not significantly determine the outcome of surgery (p=0.187). Nonetheless, it is important that the type of fistula is properly identified prior to the surgery, as this procedure is only reserved for patients with transphincteric fistula-in-ano.

CONCLUSION
The ligation of intersphincteric fistula (LIFT) procedure, a sphincter-preserving procedure, is proven to be safe, relatively easy to perform & provides good outcome for patients with transphincteric fistula-in-ano in terms of complete healing as well as early recovery compared to other procedures.
OBJECTIVE
To study the indications and outcome of Hartmann’s procedure.

METHOD
Retrospective data review of all Hartmann’s procedure done in HTJS from Jan 2010-Dec 2010.

RESULTS
A total of 20 patients were analyzed. Male patients were 15 (75%) and females were 5 (25%). The Malay were most in number followed by Chinese and Indian race, 11 (55%), 7 (35%) and 2 (10%) respectively. The majority of the patients who had undergone Hartman’s operation were between the 50-59 age group (30%), followed by the 60-69 age group (25%), 70-79 age group (15%) and 80-89 age group contributed to 10% of the patients. There were no patients under the age of 40 years. The indications for Hartmann’s procedure were palliation (65%) and obstruction (35%) either alone or with perforation. The mode of the Hartmann’s procedure for elective case and emergency case was 12 (60%) and 8 (40%) respectively. There were no peri-operative mortalities seen in our series. The average surgery duration was 275.2 minutes.

CONCLUSION
Hartmann’s procedure, irrespective of emergency indication, is safe and can be associated with long-term survival.
Faecal Incontinence After Fistula-In-Ano Surgery – Under Diagnosed Problem

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BACKGROUND
Faecal incontinence is defined as the involuntary loss of rectal contents (faeces, gas) through the anal canal and the inability to postpone an evacuation until socially convenient. Minor degree of incontinence after fistula-in-ano (FIA) surgery had been reported especially with fistulotomy or cutting seton. It had been quoted ranging from as low as 0% up to 45%. Excellent result of surgery was reported with the latest techniques of sphincter saving procedure like LIFT, ERAF and fibrin glue. Various tools had been designed to assess incontinence of patient, namely Wexner’s score, Faecal incontinence severity index (FISI), faecal incontinence quality of life scale (FIQLS), etc. It is a subjective tool and it is describe by patient and might not reflect what the finding on examination was. In our previous audit on FIA surgery in UMMC, there are only 2 documented cases of incontinence out of 110 patients. The aim of our studies is to find out the actual incontinence rate after FIA surgery and factors contributed to it.

METHODOLOGY
All patients who underwent various types of surgery for FIA from 2005 to 2009 were audited retrospectively. The type of surgery performed for each patient was recorded. All patients were contacted through phone interview and specific questions regarding incontinence were asked according to Wexner’s score scale.

RESULTS
Out of 110 patients underwent surgery for FIA in UMMC, 70 patients were contacted and responded to the interview. 13 patients found to have various degree of incontinence with score ranging from 1-20. 3 patients had incontinence to feces, 8 to fluid and 2 to gas. One patient underwent fistulotomy had score of 20. No statistical significant factor was identified in the analysis.

CONCLUSIONS
Our incontinence rate after FIA surgery is comparable with other published series. Incontinence is under diagnosed, as most patients not volunteer the information unless specifically questioned.
Quantitative Immunochemical Faecal Occult Blood Test: An Effective Tool For Colonoscopic Prioritization In Colorectal Carcinoma Screening

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BACKGROUND
Screening for colorectal cancer has been shown to improve outcomes and reduce incidence. However, population-based screening in Malaysia continues to be a challenge, in view of cost and limited availability of colonoscopic skills and facilities. For example, the colonoscopy waiting list for symptomatic patients in University of Malaya Medical Centre is 6 months to a year. Patients who are asymptomatic will wait even longer, causing a delay in diagnosis and management of those in the asymptomatic stages of colorectal carcinoma.

Conventional qualitative faecal occult blood tests help to prioritize those who require earlier colonoscopies, but cannot distinguish between benign and malignant causes. More recently, quantitative immunochemical faecal occult blood tests (qFOBT) have demonstrated some discriminatory ability in distinguishing benign and malignant causes. We aim to assess if qFOBT is useful in further stratifying colonoscopic priority in these asymptomatic patients.

METHODS
A health awareness exhibition was held in a major shopping complex in Kuala Lumpur on the 6th and 7th of February 2010. All asymptomatic individuals above the age of 40 years, and those below 40 with a family history of colorectal cancer, were invited to participate. Eligible participants were given a questionnaire and screened using a qFOBT. A faecal haemoglobin level of 100 - 199 ng/mL was considered moderately positive, while a level of 200 ng/mL or more was strongly positive. Participants with a strongly positive qFOBT result were scheduled for a colonoscopy within the month, while those who were moderately positive were scheduled within 3 months.

RESULTS
A total of 152 (54% male, 46% female) participants with a median age of 54 years (range, 21 to 80 years) took part in the screening event. One hundred and twenty five (82%) participants returned the qFOBT samples of which twelve (8%) participants were tested positive. Eleven patients were in the high risk group whereas one patient was in the moderate-risk group. As a colonoscopy list is available three times per week, the addition of one qFOBT positive patient per list would be sufficient to meet the targeted screening time based on risk stratification.

CONCLUSION
The qFOBT is an effective tool to screen and prioritize asymptomatic patients in need of an early colonoscopy for colorectal carcinoma screening.
Sacrococcygeal Teratoma With Malignant Transformation In An Adult – A Case Report

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Sacrococcygeal teratoma is the most common solid neoplasm in neonates, with an incidence of 1 in 35,000 - 40,000 live births. Reported cases of sacrococcygeal teratomas in adults are rare. Reviews of the literature found less than 120 reported cases, with only 16 described as malignant or with malignant transformation.

A 25 year-old Chinese lady was initially presented to a private hospital back in 2007 with a presacral mass. Laparotomy and debulking surgery was done. Histopathology reported as malignant teratoma with infiltrating adenocarcinoma. Post-operatively, she was given adjuvant chemotherapy. However, during follow-up, it was noted her CEA level was raised. MRI showed residual disease in sacrum and PET scan reported focal FDG uptake in right hemipelvis. Wide excision of the S4-S and coccyx were performed and patient recovered uneventfully.

Treatment for presacral teratomas ideally includes complete surgical resection of the tumor. For malignant disease, aggressive, multimodal approach with possible combination of chemotherapy, radiation therapy and surgery may be indicated. No concrete standards for therapy exist and multiple protocols have been used in the past. There are no clinical trials to date to test the most optimal treatments.

Chemometrics Of Differentially Expressed Proteins In Colorectal Cancer – Application In The Future Design Of A Diagnostic Kit

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3Centre for Drug Research, Universiti Sains Malaysia, Penang, Malaysia

When patients present with metastatic disease from an unknown primary despite exhausting available investigative means, a design of a diagnostic kit to identify the primary tumour from sampled metastatic tissues would help in directing the therapeutic approach for these patients. Unfortunately, the current use of histochemical stains on these samples does not specifically identify the primary tumour. This study aims to assess the capacity of identified expressed proteins of colorectal cancer (CRC) in diagnosing colorectal cancer.

METHODOLOGY
26 matched-pairs of colorectal cancer tissue and normal colonic mucosa 10cm from tumour margin were sampled from resected specimens during surgery. Aqueous-soluble and membrane-associated proteins were extracted using Tris and Thiourea (TLB) buffers respectively. Protein mixtures were separated using 2D-gel electrophoresis and further analyzed using mass spectrometry followed by Principal Component Analysis (PCA) and Linear Discriminant Analysis (LDA) for statistical assessment.

RESULTS
37 aqueous-soluble proteins and 24 membrane-associated proteins were identified. PCA-LDA model from Tris extract identified 6 aqueous-soluble proteins (DJ-1, GST, SBP-1, TA-3CP, CAPZB, and PSMB6) to jointly discriminate true CRC from normal tissues in 82.7% of both original and cross-validated samples. Analysis on the Thiourea extract identified 6 membrane-associated proteins (PDI, GC1q-R, annexin A5, actin cytoplasmic 2, TPI, CLIC1) to correctly classify true CRC and normal tissues in 78.8% of original samples and 71.2% in cross-validated samples. This analysis shows statistical reliability of these 2 groups of identified proteins in the prediction of true CRC specimens.
CONCLUSION
This study suggests that these 2 groups of aqueous-soluble and membrane-associated proteins can reliably identify true colorectal cancer in tissue specimens. This has the potential to be clinically applied in the design of a kit to identify primary colorectal cancer from tissue samples in cases where the primary tumour cannot be grossly identified.

POSTER 10

Perianal Abscess And Fistula: Predisposing Factor For Fistula In Patients With Perianal Abscess

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OBJECTIVES
To determine patients with perianal abscess and fistula that required intervention; to identify the number of patients with perianal abscess whom presented again with fistula-in-ano that required intervention.

METHODS
All patients who underwent any surgical procedure for perianal abscess or fistula in ano from January 2005 until January 2011 were included in the study. Patients were subcategorised to perianal abscess, ischiorectal abscess, pilonidal abscess, intersphincteric abscess and also patients who had recurrent perianal abscess. Patients who underwent surgical treatment for fistula were identified;

RESULTS
151 patients had perianal abscess. 122 of them were males and 29 of them females. Division by ethnicity is 71 malays, 11 chinese and 7 indians. 26 patients presented with ischiorectal abscess. 7 patients with pilonidal abscess. 8 patients with intersphinteric abscess. Of the 151 patients with perianal abscess, 7 patients had history of recurrent perianal abscess. Mean age of patients with abscess is 40.5.

181 patients with fistula in ano had undergone either fistulectomy, fistulotomy, ligation of internal fistula tract. Gender breakdown is 143 males and 38 females. Ethnicity Malays 86, Chinese 35 and 57 indians. Patients were further subcategorised to high rectal fistula, 8 patients; low rectal fistula, 17 patients and complex fistula in ano, 15 patients. Mean age of patients with fistula is 41.4.

15 patients with perianal abscess whom underwent incision and drainage presented again with fistula-in-ano. All these patients were male. 47% of patients had recurrent episodes of perianal abscess. 13% of patients presented with first episode of perianal abscess. 87% of patients were under the age of 45.

CONCLUSION
Higher percentage of males affected with perianal abscess proceed to have fistula. Age lesser than 45 is also a predisposing factor. Recurrence of perianal abscess predisposes to fistula-in-ano, necessitates proper, advice and surveillance in patient with recurrent perianal abscess.
OBJECTIVES
To study natural progression of perianal abscess to fistula.

METHODS
All patients who underwent any surgical procedure for perianal abscess or fistula in ano from Jan 2005 – Jan 2011 were included in the study. Patients who underwent surgical treatment for fistula were identified and included into this study.

RESULTS
Total of 151 patients had perianal abscess in our series. 122 males and 29 females. There were 71 Malays (41%), 11 Chinese (15%) and 7 Indians (4.6%). Mean age of patients with abscess is 40.5. 26 patients (11%) presented with ischiorectal abscess. 7 patients (2.9%) with pilonidal abscess. 8 patients (3.5%) with intersphincteric abscess. 7 patients (2.9%) had history of recurrent perianal abscess. In fistula in ano group; 181 patients had undergone either fistulectomy, fistulotomy, ligation of internal fistula tract. In this group there were 143 males and 38 females; with Malays 86 (48%), Chinese 35 (19.3%) and 57 (31.5%) Indians. Subcategory of fistula were divided into to high rectal fistula, 8 patients (6.1%); low rectal fistula, 17 patients (9.4%) and complex fistula in ano, 15 patients (8.3%). Mean age of patients with fistula is 41.4yrs. 15 patients with perianal abscess whom underwent incision and drainage presented again with fistula-in-ano. All these patients were male. 47% of patients had recurrent episodes of perianal abscess. 13% of patients presented with first episode of perianal abscess. 87% of patients were under the age of 45.

CONCLUSION
Higher percentage of males affected with perianal abscess subsequently developed fistula in ano. Recurrence of perianal abscess predisposes to fistula-in-ano, necessitates proper advice and surveillance in patient with recurrent perianal abscess.
Preoperative Carcinoembryonic Antigen (CEA) As Prognostic Factor Of Recurrence In Stage II Colorectal Cancer

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BACKGROUND
Various studies have shown raised preoperative CEA as an adverse prognostic factor of survival in colorectal cancer (CRC). Currently evidence is inconclusive to recommend preoperative CEA level as a prognostic factor of recurrence in CRC.

OBJECTIVE
The objective of this research is to evaluate the use of preoperative CEA in the Malaysian population, as a prognostic factor of recurrence in stage II CRC, and target patients who may benefit from adjuvant therapy.

METHODOLOGY
Retrospective analysis of stage II CRC patients who underwent curative surgery between year 2000 and 2008 was done. Preoperative CEA level, follow up duration, and outcome were recorded. Preoperative CEA was tested as prognostic factor of recurrence by parametric and nonparametric test for statistical significance.

RESULTS
Data was obtained from 84 patients with stage II CRC. Mean follow up was 31.77 months. Preoperative CEA ranged from 0.5 – 85.3 ng/ml.

19 patients (22.6%) developed recurrence, with mean preoperative CEA of 14.15 ng/ml, compared with 65 who remained recurrence free with mean CEA of 8.74 ng/ml (P=0.214).

At preoperative CEA cut-off value of 5 ng/ml, 40% with raised preoperative CEA developed recurrence compared with 12.96% with normal CEA (P=0.005). Significance was observed with CEA cut-off values of 5-7 ng/ml (P=0.005 – 0.008).

Kaplan-Meier survival plot showed patients with preoperative CEA > 5ng/ml recurred by 14.58 months compared with 27.27 months with CEA < 5ng/ml (P=0.023).

CONCLUSION
Raised preoperative CEA predicts higher probability and earlier time to recurrence in stage II colorectal cancer. Patients who are at higher risk of recurrence may benefit from adjuvant therapy.
Massive Lymph Node Metastasis As A Rare Manifestation Of Colon Cancer

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Colon cancer with massive lymph node metastasis to the para-aortic region, mediastinal region and Virchow's lymph node without liver and lung involvement is extremely rare. We are reporting a case of such systemic lymph node metastasis as a sole manifestation of colonic cancer. The patient is a 37 years old female without known medical illness presented with multiple left supraclavicular lymph node. There were no symptoms of chronic cough, chronic fever, loss of weight or appetite, epigastric pain, vomiting, regurgitation, nasopharyngeal bleeding, altered bowel habit, per rectal bleeding or per vaginal bleeding. Clinically, there was no positive physical finding apart from palpable left supraclavicular lymph node. She was investigated for pulmonary tuberculosis with negative result. Indirect laryngeal scope examination failed to detect any sign of para-nasal pharyngeal malignancy. An upper gastroduodenal scope and Ultrasonography of pelvic organ assessment were normal. Lymph node excision biopsy revealed a metastatic adenocarcinoma from gastrointestinal tract supported by a colonoscopic finding of rectosigmoid malignancy. Computed tomography staging found patient had massive whole body lymph node enlargement without liver and lung metastasis. Within a short period, she developed palpable abdominal lymph node and her left supraclavicular lymph node increased in number and size. She had no sign and symptom of intestinal obstruction. Oncology team decided to give her neoadjuvant chemotherapy FOLFOX IV regime for six cycles before surgery. Neoadjuvant chemotherapy in colon cancer is not commonly practised. Most of the literature gave this therapy in advanced colon cancer with liver metastasis with subsequent aim of curative surgery. There was a case reported neoadjuvant chemotherapy in colon cancer is not commonly practised. Most of the literature gave this therapy in advanced colon cancer with liver metastasis with subsequent aim of curative surgery. There was a case reported neoadjuvant chemotherapy achieves complete pathology response in this rare presentation. Currently, patient was under the chemotherapy described and seems to be improving.
Critical Analysis Of Malignant Polyps
In Tuanku Ja’afar Hospital Seremban

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OBJECTIVE
To study the incidence and distribution of malignant polyp in Hospital Tuanku Ja’afar Seremban.

METHOD
Retrospective data review of all colonic polyps in HTJS from 2005-2010. To study the incidence of malignant polyps in HTJS.

RESULTS
A total of 280 patients with colonic polyps were analyzed. 210 patients (75%) were male and 70 patients (25%) were female. 123 patients (43.9%) patients who had colonic polyp were in 60-69 yrs age group, 98 patients (35%) were in 70-79 age group followed by were 59 patients (21.1%) in 50-59 yrs age group. The mean age was 63.1yrs. Colonic polyps were predominant in Chinese 196(70%) followed by Malays 53(18.9%) and Indians 31(11.1%). 263 (93.9%) were benign polyps, 17(6.1%) were malignant polyps. All patients who had malignant polyp were males. Malignant polyps were predominant among Chinese 15(88.2%) followed by Malays 2 (11.8%). There were no Indians with malignant polyp in our series. The majority of the patients who had malignant polyp were between the 50-59 age group were 7 patients(41.2%), and the 50-59 age group were 7 patients (41.2%) and followed by 70-79 age group were 3 patients (17.6%). There were no patients below the age of 50 years who had malignant polyps. Indications for colonoscopy for the patients with malignant polyp were due to lower gastrointestinal bleed 16(88.9%) and altered bowel habits 2 (11.1%).

CONCLUSION
In this study, we found that malignant polyps were predominant among Chinese and elderly male. However, Indians and female gender have low risk of developing malignant polyps. These findings necessitate further molecular studies.

Haemorrhoidectomy For Haemorrhoidal Crisis:
Profiling Of Patient Characteristics

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OBJECTIVES
To analyse patients characteristics who present with haemorrhoidal crisis.

METHODS
All patients who underwent haemorrhoidectomy for haemorrhoidal crisis between Jan-2008 and Dec-2010 were included in this study. Acute haemorrhoidal crisis was defined as painful fixed prolapsed or strangulated prolapse leading to thrombosis, ulceration or gangrene. Demographics, clinical symptoms, operative data, and operative diagnosis, type of procedure and surgery time were analysed.

RESULTS
Total of 64 patients (24 females and 40 males) were included in this study. Majority of patients (70.3%) were from ASA (American Society of Anaesthesiology) Class 1 and mean age on admission was 42 years. Among the 64 patients, 50 had prolapsed thrombosed haemorrhoids while 14 had prolapsed haemorrhoids alone. 54 patients had emergency haemorrhoidectomy while the remaining had it done electively. 53 patients had the Milligan Morgan procedure done while 10 had the Ferguson procedure done. 1 patient had staple haemorrhoidectomy. Mean surgery time was 47.22 minutes.

CONCLUSION
From our study hemorrhoidal crisis tends to occur in patients who are males in their early forties. Most patients are fit individuals with no other comorbidities.
The Significance Of Peritoneal Swab Cultures In Patients Undergoing Appendectomy In Hospital Seberang Jaya

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Appendicitis is one of the commonest causes of abdominal pain requiring emergency surgery. However, there is still no consensus regarding the optimal antimicrobial therapy in cases of complicated or uncomplicated appendicitis.

OBJECTIVE
To ascertain the significance of positive peritoneal swab cultures in appendicitis and the subsequent need of post op antibiotics.

METHODOLOGY
A prospective study starting from April 2010 till December 2010 involving all patients undergoing emergency appendectomy in Hospital Seberang Jaya. IV antibiotics (IV Cefoperazon 1g bd, IV Metronidazole 500mg tds) were prescribed upon diagnosis till the patient goes for surgery.

RESULTS
A total of 327 patients were diagnosed clinically with appendicitis and underwent appendectomy. Out of this number, 117 cases were complicated appendicitis. Majority of culture positive cases were found in the complicated appendicitis group & there is a significant statistical relationship between positive peritoneal swab cultures in cases of complicated appendicitis.

CONCLUSION
It is recommended that post operative antibiotics should only be prescribed in cases complicated of appendicitis.

Pelvic Embryonal Rhabdomyosarcoma With Gluteal Infiltration Mimicking An Abscess : A Case Report

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Rhabdomyosarcomas are malignant myogenous tumors that can occur in any part of the body, including both skeletal muscle tissue and sites that are devoid of muscle1. The histological classification divides them into embryonal, botryoid, alveolar, and pleomorphic subtypes2. These tumours commonly involve the extremities, genitourinary tract and the head & neck region. However, such tumours arising arising from the pelvis are rare with a reported incidence of less than 2% of all rhabdomyosarcomas. We present a case of embryonal rhabdomyosarcoma of the pelvic floor muscles infiltrating into the gluteal muscles and the labia, mimicking an abscess.
Appendectomy is the most frequently performed emergency surgery in practice. The increase in antimicrobial resistances, has affected the efficacy of antimicrobial therapy.

OBJECTIVE
To determine the common organism spectrum in cases of acute appendicitis in Hospital Seberang Jaya.

METHODOLOGY
A prospective study was performed starting from April 2010 till December 2010 involving all patients undergoing emergency appendectomy in Hospital Seberang Jaya.

RESULTS
There were 337 patients who were diagnosed with appendicitis and underwent appendectomy. Out of this number, 50 (14.8%) cases were culture positive while 4 (1.2%) cases had mixed growth. E. coli was the commonest organism. 92% of the organisms were sensitive to the antibiotics used.

CONCLUSION
Prudent and appropriate use of antibiotics is necessary in order to prevent antibiotic resistance. Thus, it is important know the bacterial spectrum in the respective population in order to identify the suitable antibiotic therapy.
Use Of Self Expandable Metal Stents (SEMS) In Colorectal Cancer Patients Who Present With Obstruction

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BACKGROUND
Colonic cancers frequently cause obstruction. This causes problems of two types. First, patients require urgent intervention, with all the risks associated with emergency surgery. Second, even inoperable cases require surgery such as diverting colostomy. Patient have to deal with stoma for the rest of his/her remaining life. Self expandable metal stents (SEMS) have been used for the last ten years. Some series have been reported, but these are small and therefore the role of SEMS role in colon cancer is still being evaluated. We report our experience with four cases.

CASES

Table 1: Details of colonic cancer with total/near total obstruction

<table>
<thead>
<tr>
<th>CASE #</th>
<th>AGE/SEX</th>
<th>DIAGNOSIS</th>
<th>TOTAL/NEAR TOTAL OBSTRUCTION</th>
<th>DEFINITIVE TREATMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>75 M</td>
<td>Rectosigmoid carcinoma</td>
<td>Total</td>
<td>Colonic stenting followed by neoadjuvant radiochemotherapy and surgical resection</td>
</tr>
<tr>
<td>2</td>
<td>78 M</td>
<td>Advanced sigmoid ca with IHD</td>
<td>Total</td>
<td>Palliative colonic stenting</td>
</tr>
<tr>
<td>3</td>
<td>76 F</td>
<td>Advanced sigmoid ca</td>
<td>Total</td>
<td>Palliative colonic stenting</td>
</tr>
<tr>
<td>4</td>
<td>80 M</td>
<td>Advanced ascending colon ca with IHD, COAD and Recent MI</td>
<td>Near Total</td>
<td>Palliative colonic stenting</td>
</tr>
</tbody>
</table>

RESULTS
All four cases presented with intestinal obstruction secondary to colon cancer. Colonic stenting was successful in relieving the obstruction. All the patients was discharged the next day without any morbidity. All the four cases survived minimum of 6 months and did not present again with obstruction.

COMMENT
Approximately a fifth of patients with colorectal cancer present with total or near total intestinal obstruction. They require emergency surgery, which is associated with increase in both morbidity and mortality. SEMS have been evaluated in the literature. They may become obstructed, or may migrate. Despite these drawbacks, stents SEMS have showed promise both as a temporary palliation prior to surgery (“bridge to surgery”) as well as a definitive treatment for inoperable cases. Our early experience with stents shows that stenting for malignant colorectal obstruction is feasible. When used as bridge to surgery this procedure avoids a stoma. Palliation in advanced cancer avoids the dangers of surgery in these very sick patients. The morbidity associated with SEMS insertion is low, and even if the procedure fails, surgery can be carried out. We recommend a SEMS as definitive therapy in patients with obstructing advanced colorectal cancer, and as a bridge to surgery in patients who have obstruction due to potentially curable colorectal cancer.
Irreducible Rectal Prolapse: Emergency Surgical Management
Of Eight Cases And Review Of The Literature

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BACKGROUND
The management of irreducible rectal prolapse is controversial. Surgeons may attempt conservative
management by application of sugar. When surgery becomes inevitable the choice of procedure varies.

PATIENTS
We reviewed case records of patients seen by us in the last five years. The details of the cases are listed
in Table 1. All patients were had a good postoperative outcome on follow up.

Table 1: Details of cases of irreducible rectal prolapse

<table>
<thead>
<tr>
<th>CASE #</th>
<th>AGE/SEX</th>
<th>FINDINGS</th>
<th>SUGAR APPLICATION</th>
<th>DEFINITIVE TREATMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>18 M</td>
<td>Edema. No ulceration or gangrene</td>
<td>Failed</td>
<td>Anal dilatation, reduction, Wells’ repair</td>
</tr>
<tr>
<td>2</td>
<td>40 M</td>
<td>Edema. No ulceration or gangrene</td>
<td>Failed</td>
<td>Anal dilatation, reduction, Wells’repair</td>
</tr>
<tr>
<td>3</td>
<td>40 F</td>
<td>Edema. No ulceration or gangrene</td>
<td>Not attempted</td>
<td>Laparotomy, sigmoid colectomy</td>
</tr>
<tr>
<td>4</td>
<td>58 M</td>
<td>Edema. No ulceration or gangrene</td>
<td>Not attempted</td>
<td>Perineal resection with ileostomy</td>
</tr>
<tr>
<td>5</td>
<td>37 M</td>
<td>Edema, ulceration. No gangrene (Fig 1)</td>
<td>Failed</td>
<td>Reduction only, under anesthesia</td>
</tr>
<tr>
<td>6</td>
<td>60 F</td>
<td>Edema, ulceration. No gangrene</td>
<td>Failed</td>
<td>Delorme’s operation</td>
</tr>
<tr>
<td>7</td>
<td>83 M</td>
<td>Edema, ulceration, gangrene</td>
<td>Not attempted</td>
<td>Perineal resection with colostomy</td>
</tr>
<tr>
<td>8</td>
<td>50 M</td>
<td>Edema, ulceration, gangrene</td>
<td>Failed</td>
<td>Laparotomy, sigmoid colectomy, colostomy</td>
</tr>
</tbody>
</table>

COMMENT
Rectal prolapse is usually treated electively by resection or a rectopexy. Irreducibility is a complication,
and requires emergent management. Since irreducible prolapse is rare, surgeons have little experience,
and management is controversial. Our experience and a review of the literature indicate that surgery
should be performed early in irreducible prolapse. Sugar application often does not reduce the prolapse,
and may contribute to delay. Several types of surgical procedures have been described in the literature,
but perineal resection may be the most suitable emergency procedure.
Unusual Foreign Body In The Rectum : Case Report And Review Of Literature

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INTRODUCTION
Surgeons may encounter patients who have a rectal foreign body that does not pass out spontaneously. We describe an unusual case and briefly mention points of interest for foreign bodies of the rectum.

CASE
A 53 year old man presented to the emergency department with symptoms of bowel obstruction, having inserted a wine glass into his rectum two days earlier. A plain X-ray demonstrated this wineglass lodged above the symphysis pubis. Endoscopic removal and examination under anesthesia were unsuccessful. The patient required laparotomy and colostomy. He had an uneventful recovery with reversal of the colostomy 2 months later.

COMMENT
A literature review shows that the commonest types of foreign body are glass objects like bottles, sexual devices such as vibrators and artificial phalluses, and food items like bananas. Some very unusual objects have been reported, and include cattle horns, carborundum sharpening stone, frozen pig tail, light bulb, and spectacles. The wine glass inserted by the patient in the present case must rank among the more unusual of objects. The causes of insertion of foreign body into the rectum vary with age. In children the chief cause is a broken medical device such as a thermometer, while in adults the main cause is attempted sexual gratification. About 90% of objects can be removed transanally; the remainder need laparotomy. Transanal techniques typically include a hand or an endoscope, but some ingenious techniques have been described. One author inserted liquid plaster of paris and a stick into a jar lodged in the rectum. When the plaster hardened the jar was removed by simply pulling on the stick. Another reported extraction of a light bulb by attaching a bulb holder on to a stick, screwing it over the bulb in the rectum, and carefully pulling it out!

CONCLUSION
Most rectal foreign bodies are inserted by patients in an attempt for sexual gratification. About 90% can be removed via the anus; the remainder need laparotomy.
INTRODUCTION
Studies have shown that laparoscopic colorectal surgery is equal in terms of safety to open surgery. Benefits looking at length of stay, blood loss, immune suppression and analgesia requirements showed reasonable results. The aim of this study was to audit the safety and feasibility of introducing laparoscopic colorectal surgery to our hospital.

METHODS
A prospective collective study of twenty nine patients with colorectal pathology, who underwent laparoscopic colorectal surgery from March 2009 till November 2010 at Hospital Sultanah Aminah, Johor Bahru. The primary endpoint was to look at 30-day postoperative morbidity in elective laparoscopic colorectal surgery. Secondary endpoints cover on the late complication.

RESULTS
A total of 29 patients (21 males and 8 females) with a mean age of 60.5 years (median range of 61 years) underwent laparoscopic surgery. A total of 26 patients (89.7%) underwent laparoscopic resection for colorectal malignancy. Most tumors are located in the mid-rectum. The conversion rate for all cases was 4%. Mean operative time was 204 min (median range of 196 min). The mean postoperative stay was 8.5 days. The early post operative anastomotic leak in need of surgical intervention was 2 cases. The overall 30-day morbidity rate was 13.8%. There were no early postoperative deaths. The service is performed by one colorectal consultant.

CONCLUSION
Colorectal resections are common surgical procedures all over the world. Laparoscopic colorectal surgery is technically feasible in a considerable amount of patients under elective conditions. The results from this series will help in continuing development of this service to our hospital.
P O S T E R  2 3

Right Sided Diverticular Disease

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AIM
To determine the clinical presentation of right sided diverticular disease

METHODS
A retrospective review was done of all the case notes of patients who presented to our centre with diverticular disease from 1st January till 31st December 2010. Of these patients, a total of eleven patients with right sided diverticular disease were included in this short series.

RESULTS
The mean age of the patients was 49.4 years. Nine of the patients were diagnosed with right sided diverticulitis and two patients presented with bleeding diverticulum. All the nine patients with diverticulitis had right iliac fossa pain. Two of the nine patients had a right iliac fossa mass on examination. Six (66.7%) of the patients underwent surgery for suspected acute appendicitis. Three had right hemicolecctomy. Two had laparoscopic examination and one open appendicectomy. Six (66.7%) were successfully managed conservatively with antibiotics. Two other patients presented with haematochezia. One of the patients had the bleeding diverticulum confirmed by computed tomography (CT) angiogram and was embolized. The other patient was managed conservatively as the bleeding had stopped spontaneously.

CONCLUSION
Right sided diverticulitis is commonly mistaken for acute appendicitis as both entities can present with right iliac fossa pain. Patients with right sided diverticulitis are commonly operated on for acute appendicitis. If clinically suspected, CT scan may help in the diagnosis and surgery can be avoided. Other presentations include lower gastrointestinal bleeding and right sided abdominal mass.

P O S T E R  2 4

Case Report : Ruptured Aneurysm Of The Right Colic Artery

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Aneurysms of the branches of super mesenteric artery are very rare. Most present with spontaneous rupture. Rarely are they diagnosed on imaging studies. We report a case of a 41 year old man who presented to our hospital with generalized peritonitis. He sought treatment at the emergency department a day earlier with right sided abdominal pain and he was discharged home with analgesics. He again presented with generalized abdominal pain the next day and a diagnosis of perforated appendicitis was made. Intraoperatively, there was blood noted in the peritoneal cavity and a laparotomy was performed. There was a large retroperitoneal haematoma involving the right side and extending to the center of the abdomen. Exploration of the haematoma revealed a defect in a dilated segment of the right colic artery which bled actively after removal of the clots. The aneurysm was ligated and a diagnosis of a ruptured right colic artery aneurysm was made. The colon was still viable after ligation of the aneurysm. Post-operatively, he made a good uneventful recovery and was discharged on post-operative day ten. He had an echocardiogram to look for vegetations as a cause of a mycotic aneurysm but this was normal. His connective tissue screen was negative. Gram stain of the blood clots revealed gram positive cocci but failed to culture the organism.

Ruptured aneurysm of the branches of the superior mesenteric artery is a rare cause of acute abdomen and early diagnosis is life saving. A computed tomography angiogram (CTA) may help in the diagnosis if there is a high index of suspicion.
A Prospective, Observational Study Of The Efficacy Of Doppler Ultrasound – Guided Ligation Of Hemorrhoidal Artery For The Treatment Of Hemorrhoid

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BACKGROUND
Postoperative pain is the main adverse effect of formal hemorrhoidectomy. A new technique based on Doppler-guided ligation of the terminal branches of the superior hemorrhoidal artery was introduced in 1995 as an alternative to hemorrhoidectomy.

OBJECTIVE
The object of this article was to evaluate the efficacy of procedure for Doppler-guided hemorrhoid artery ligation (DG – HAL) in treatment of hemorrhoids.

METHODS & MATERIALS
29 patients with symptomatic hemmorhoids of grade II( 13 patients ) and grade III underwent haemorrhoidal artery ligation between February 2010 and August 2010; 13 males and 16 females, patient’s age ranged between 20 and 67 years ( median 42.55), followed up for 3 months

RESULTS
There were no intra- and immediate postoperative complications. The post operative pain was minimal , with mean post operative pain was highest at 12 hours 3.034 on VAS, 1.862 at 24 hours on VAS. the mean postoperative hospital stay was 1.12 days; the time of returning to work was 2.52 days and 25(86.2%) of patients were satisfied with the results. There were recurrence in 3 patients (10.3%), and one patient presented with ischeamic anal fissure one month post op. There were no faecal incontinence after short term follow-up (3months).

CONCLUSION
Results show that DG – HAL safe, painless, effective method for symptomatic hemorrhoids with, low complications ,shorter hospital stay and earlier recovery.
Colonoscopy Experience Of LGI Bleeding In UKMMC

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INTRODUCTION
The annual incidence of LGI bleeding is estimated to be 20 to 27 cases per 100,000 adult population at risk.

METHOD
Total number patients who undergone colonoscopy for LGIH between January 2007 and May 2010 was 801 patients retrospectively reviewed from our database. From the 801 patient, 540 plan as elective and 261 as emergency colonoscopy.

RESULT
Normal findings in 23% (122) patients for elective and 11% (28) for emergency. Common causes for lower gastrointestinal bleeding in both elective and emergency colonoscopy haemorrhoids 19% (150), polyp 12% (94), sigmoid/rectal/anal Ca 11% (85), diverticulosis 11% (81), ? bleeding site 1% (48), solitary rectal ulcer (SRU) 1% (51), colitis/proctitis 1% (66) and others 0.5% (37). For emergency lower gastrointestinal bleeding the most common cause of bleeding were diverticulosis 18% (47), ? bleeding site 15% (39), SRU 13% (35), hemorrhoids 13% (32), sigmoid/rectal/anal Ca 10% (25), proctitis/colitis 8% (22) and others 8% (22).

CONCLUSION
Major causes of LGI bleeding were haemorrhoids, polyp, sigmoid/rectal/anal Ca but for acute lower gastrointestinal bleeding we found that diverticulosis, ? bleeding site, SRU, hemorrhoids.
Effectiveness Rectal Stump Washout With Povidone Iodide In Anterior Resection In Preventing Possible Local Recurrence – A Prospective Control

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BACKGROUND
The aim of our study was to determine the effectiveness of rectal stump washout using 5% povidone iodine vs normal saline in elimination of exfoliated malignant cells in the rectal stump and prevent possible local recurrence.

METHOD
Between December 2008 and April 2010, 53 patients with carcinoma of the rectum and distal sigmoid colon undergoing anterior resection under the care of two surgeons were randomized prospectively into two groups. 29 patients received 5% povidone iodine and 24 patients received normal saline as an agent for rectal stump washout. The fluid was sent for cytological analysis then classified as “acellular”, “malignant cells identified” and “benign cells identified”.

RESULT
Cytological examination of rectal stump fluid (Cytology A) demonstrated acellular in 12 (41.4%) patients from povidone group and 8 (33.3%) patients in saline group. Benign cells were identified in 17 (58.6%) patients and 16 (66.7%) patients from povidone group and saline group respectively. Cytological examination of circular stapler fluid (cytology B) revealed acellular in 7 (24.1%) patients from povidone group and 5 (20.8%) in saline group. Benign cells were collected in 22 (75.9%) patients and 19 (79.2%) patients in povidone group and saline group respectively. However, there was no significant difference statistically and no malignant cells identified from fluid collection of rectal stump and circular stapler in both groups. There was no association between the demographic factors of the patients and tumour characteristics with the outcomes of the cytological result.

CONCLUSION
As a result, the value of performing rectal stump washout during anterior resection is doubtful significant as the good technique of surgery is adequate in avoiding exfoliation of malignant cells and causing recurrence.
Intraoperative Injection Of Diluted Methylene Blue As A Pain Control Following Operation In The Perianal Region

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INTRODUCTION
We conduct a study to inject diluted methylene blue as a pain control following surgery in the perianal region.

METHODS
Patient was devided randomly into two groups. Group A (treatment group) receiving four ml 1% methylene blue and 16 ml 1% lignocaine was injected into the periwound and to the wound bed. Group B (control group) only receiving same volume of 1% of lignocaine without methylene blue. Primary outcome was pain score. Patients were asked to fill in a pain chart with a visual analog scale of 0 to 10 at day 1 to day 7 post operation. Secondary outcome was the used of analgesia.

RESULTS
There were 30 patients studied during this period, consist of fistula 18 patients, hemorrhoid 8 patients, and anal fissure 4 patients which were equally distributed in between the two groups. Analgesic requirement in the treatment group were lower compared to the control group from day 1 till day 7. Statistic calculation was not significant due to probably small sample size.

CONCLUSION
Injection of methylene blue together with local anesthetic in the perianal region gives better post-operative pain control with no complications.