

ANNUAL SCIENTIFIC MEETING



May 15-19, 2010

Hilton Minneapolis Hotel &
Minneapolis Convention Center



General Information

Overview and Objectives

This scientific program is designed to provide surgeons with in-depth and up-to-date knowledge relative to surgery for diseases of the colon, rectum and anus with emphasis on



Matthew Mutch, MD
Program Chair



Steven Hunt, MD
Program Vice-Chair

patient care, teaching and research. Presentation formats include podium presentations followed by audience questions and critiques, panel discussions, walk-around poster presentations and discussions, video presentations,

and symposia focusing on specific state-of-the-art diagnostic and treatment modalities. The purpose of all sessions is to improve the quality of care of patients with diseases of the colon and rectum. At the conclusion of this meeting, participants should be able to:

- ◆ Assess the equipment set up and technical steps of a transanal endoscopic microsurgical resection of benign and malignant rectal lesions.
- ◆ Identify the indications, utility, equipment set up and technical steps of the assistance of the robot for the laparoscopic treatment of rectal cancer.
- ◆ Explain the technical steps of laparoscopic colorectal resection, for both routine and complicated cases, as well as review of the current status of laparoscopic procedures for the diseases of the colon and rectum.
- ◆ Assess the techniques of endoanal and endorectal ultrasound and their potential applications in fecal incontinence, pelvic floor abnormalities, and rectal cancer.
- ◆ Recognize ways to improve physician-physician, physician-staff, and physician-patient communication and enhance standards of physician professionalism.
- ◆ Improve the ability to understand the literature and apply it the practice of colon and rectal surgery.
- ◆ Review the management strategies for complex abdominal wall and pelvic floor wounds.
- ◆ Explain the treatment options for fistula-in-ano along with their technical aspects and outcomes.
- ◆ Review and evaluate the advances in the medical and surgical treatment of diverticulitis.
- ◆ Address how changes in health care policy and assessment of surgeon performance is impacting physicians and their practices.
- ◆ Review the current management of colorectal cancer.

- ◆ Review and evaluate the advances in laparoscopic, endoscopic and robotic techniques in the management of diseases of the colon and rectum.
- ◆ Review the application and integration of genetic information in the treatment of colorectal cancer.
- ◆ Review and evaluate the preventative perioperative practices and their indications and recommendations.
- ◆ Review and evaluate the indications and outcomes for the local treatment of rectal cancer.
- ◆ Discuss the evaluation, interpretation of studies, treatment options, and outcomes for patients with pelvic floor abnormalities.
- ◆ Review and evaluate the advances in the treatment of hemorrhoidal disease.
- ◆ Describe the current treatment regimens for anal cancer and the impact of HIV on this disease.
- ◆ Review of the results of genetic testing and the surgical management of patients with inherited colorectal cancer syndromes.
- ◆ Identify the value of simulation, and understand how it is affecting education, training, and patient care.
- ◆ Demonstrate the advances in endoscopy and how to integrate these techniques into the practices of colon and rectal surgeons.
- ◆ Assess the current medical and surgical management of Crohn's disease and ulcerative colitis.

Goals

The goals of these programs are to improve the prevention, diagnosis and treatment of patients with diseases and disorders affecting the colon and rectum; and improve the quality of patient care by maintaining, developing and enhancing the knowledge, skills, professional performance and multidisciplinary relationships necessary to provide services for patients, the public and the profession.

Target Audience

The program is intended for the education of colon and rectal surgeons as well as general surgeons and others involved in the treatment of diseases affecting the colon, rectum and anus.

Speaker Disclosure

In compliance with the Standards of the Accreditation Council for Continuing Medical Education and the ASCRS, faculty have been requested to complete a *Disclosure of Significant Financial Relationships*. Disclosures will be made at the time of presentation and included in the Final Program. Disclosure forms for all speakers will be available at the convention registration desk.

General Information

Accreditation

The American Society of Colon and Rectal Surgeons (ASCRS) is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians. ASCRS takes responsibility for the content, quality and scientific integrity of this CME activity.

Continuing Medical Education Credit

The American Society of Colon and Rectal Surgeons designates this educational activity for a maximum of 47.75 *AMA PRA Category 1 Credit(s)*™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

Social Events

The **Welcome Reception** is scheduled Sunday, May 16, from 7:30 – 9:00 pm (complimentary) and will feature hors d'oeuvres, cocktails and entertainment. It will be held in Orchestra Hall (connected via Skywalk from the Hilton/Convention Center). The Research Foundation will join forces with ASCRS to welcome all at this reception.

The **Annual Dinner Dance** is scheduled Wednesday, May 19, with the reception beginning at 7:00 pm and dinner at 8:00 pm. Tickets are included in the registration fees for ASCRS members. Non-members may purchase tickets for \$75.

Accommodations

The meeting will be held at the Minneapolis Convention Center. The convention hotels include the Hilton Minneapolis and the Hyatt Minneapolis hotels.

Hotel reservations must be made via the internet www.fascrs.org or by phone.

Internet: For best availability, make your reservation via the internet at www.fascrs.org.

Hotel Information:

Hilton Minneapolis (Headquarters Hotel)
1001 Marquette Avenue
Minneapolis, MN 55403

Rates: \$181 Single
\$191 Double

Hilton Reservations Phone #: (800) Hiltons or
(800) 445-8667
Group Code is **CRL**

Hyatt Regency Minneapolis
1300 Nicollet Mall
Minneapolis, MN 55403

Rates: \$169 Single
\$189 Double

Hyatt Reservations Phone #: (888) 421-1442

The deadline for hotel reservations is Friday, April 16, 2010.

Hotel reservations / rate availability are not guaranteed after the room block is full or after April 16, 2010. Please register early – only a limited number of rooms are available.

ASCRS Official Travel Agency

ASCRS has arranged for special discounts on airfares with Delta / Northwest Airlines for travel to Minneapolis. Please mention the ASCRS file number (listed below) when making your airline reservations.

To book your reservation, call ASCRS's official travel agency, Uniglobe Preferred Travel, at 1-800-626-0359 and after the prompt dial "0" (M–F 8:30 am – 5:30 pm CST). Uniglobe Preferred Travel has ASCRS's file number and if applicable it will automatically be entered for every reservation called in or booked online. If you prefer you may:

- ◆ Book your travel online at www.uniglobepreferred.com. Scroll down and click on Rapid-Rez links. When the booking page comes up, click on "Create New User". Enter personal information, click "done"; the next page is for more detailed personal information – here you must enter a credit card number and billing address to make a reservation. Scroll down and click "Save". Click on the "Travel Planner" tab to make a reservation. Please record your User ID and your Password for future use. Discount fares are automatically displayed on this site and booking on this site will have a reduced agency service fee of \$15.
- ◆ Call Delta's toll-free number, 1-800-328-1111. Mention ASCRS' File number – NM49U, to qualify for discount fares.

Spouse/Guest Program

Please review the following and indicate your choices on the registration form.

- A. **Annual Reception**, 7:00 – 8:00 pm, Wednesday, May 19
 - B. **Annual Dinner Dance**, 8:00 – 10:30 pm, Wednesday, May 19
 - C. **Welcome Reception**, 7:30 – 9:00 pm, Sunday, May 16, Orchestra Hall, hors d'oeuvres, cocktails, reception
 - D. **Hospitality Suite**, 7:30 – 10:30 am, Sunday – Wednesday (Hilton Minneapolis)
 - E. **Admission** to scientific sessions and the exhibit area
- Package #1** (\$100) Includes items A thru E
Package #2 (\$55) Includes items C thru E only



General Information

Temperature

The average temperature in May ranges from a low of 48°F to a high of 72°F.

Dining in Minneapolis

Visit the ASCRS website at www.fascrs.org for a list of local restaurants and local events.

Child Care Services

Please contact the concierge at the hotel at which you are staying for a list of bonded independent babysitters and babysitting agencies.

Sunday – Get Your Rear In Gear: Join the 5k Run/Walk!



May 16, 2010 • Registration: 7:00 AM
5K Timed Run: 8:30 AM • 5K Walk: 8:35 AM
Location: Southdale Center, Edina
Bus transportation provided

Join thousands of runners, walkers and colon cancer survivors. Get Your Rear in Gear event will raise funds for screening and awareness of colon and rectal cancer.

Register: [HERE](#)

An Invitation to Tour Mayo Clinic

7:00 am – 3:00 pm
Thursday, May 20, 2010

Fee \$75 • *Registration Limited* • Minimum: 40 (*Tour will be cancelled if minimum not reached*)

You are cordially invited by Dr. Bruce Wolff and the Division of Colon and Rectal Surgery at Mayo Clinic to a social luncheon and tour of the Rochester campus following the ASCRS Meeting Thursday, May 20, 2010.

Mayo Clinic in Rochester is the largest integrated medical center in the world, providing diagnosis and treatment in virtually all medical and surgical specialties. More than 350,000 patients visit the Rochester campus each year. Mayo has a rich history in colon and rectal surgery, and Dr. Wolff and his colleagues would like to provide an opportunity for delegates to visit the institution. Following is the schedule:

- 7:00 am Bus leaves Minneapolis (Hilton Hotel) for Rochester
- 8:30 am Arrive at Mayo Clinic Gonda Building for tour of the Mayo Campus
- 10:00 am Tour of Mayo Clinic Surgical Simulation Center
- 11:00 am Tour of the Foundation House (Home of Dr. William Mayo)
- 12:00 pm Lunch at Foundation House with Division of Colon and Rectal Surgery
- 1:30 pm Bus leaves Rochester for Minneapolis



Laparoscopic Colectomy Workshop

7:30 am – 4:00 pm

Fee \$595 • *Registration Required* • Limit 34

Lunch included • *No refunds after April 26th*

Location: Excelen Center for Bone and Joint Research and Education
700 South Tenth Avenue
Minneapolis, MN 55415

Transportation provided

The didactic session will feature lectures with multiple videos demonstrating the anatomy of the colon, vasculature, and retroperitoneum associated with the various approaches to mobilization of the right colon, transverse colon, splenic flexure, left colon, and rectum. Pearls and tricks of the trade will be highlighted that will help to facilitate the learning curve and adoption of laparoscopic techniques. During the hands-on session, the attendees will perform either a straight laparoscopic or hand-assisted proctocolectomy under the close supervision of an expert faculty member.

This course is aimed at three populations of surgeons: 1) those that are currently not performing laparoscopic colectomy; 2) those that are doing it, but not routinely because of their current skill set; and 3) general surgery residents that are interested in colon and rectal surgery. General surgery residents will be placed at separate tables.

Existing Gaps:

What Is: Despite its widespread acceptance as a standard of care, many colon and rectal surgeons still have not adopted the laparoscopic approach to colon resections into their practices.

What Should Be: Several studies have demonstrated the effectiveness of the cadaver model for the teaching and facilitation of adoption of laparoscopic colectomy. We have progressed through the majority of the learning curve for most colon and rectal surgeons and attempt to close the gap with the population who remains reluctant to implement it on a routine basis.

Director: Peter W. Marcello, MD, Burlington, MA

Assistant Director: Genevieve Melton-Meaux, MD, Minneapolis, MN

The workshop will cover:

- ◆ Laparoscopic right colectomy
- ◆ Laparoscopic transverse colectomy
- ◆ Laparoscopic left colectomy
- ◆ Laparoscopic proctectomy
- ◆ Straight laparoscopic and hand-assisted techniques
- ◆ Single site laparoscopic right colectomy

Faculty:

Eugene Foley, MD, Madison, WI
Charles Friel, MD, Charlottesville, VA
Virgilio George, MD, Indianapolis, IN
Jason Hall, MD, Burlington, MA
David Maron, MD, Philadelphia, PA

Howard Ross, MD, Red Bank, NJ
Timothy Sadiq, MD, Chapel Hill, NC
Bashar Safar, MD, St. Louis, MO
Scott Steele, MD, Fort Lewis, WA
Sharon Stein, MD, Cleveland, OH

Objectives: At the conclusion of this session, participants should be able to understand: a) the basic techniques of laparoscopic intestinal surgery; b) the anatomy of the colon, its vasculature and retroperitoneum from a laparoscopic perspective; c) the sequence of steps necessary to perform these procedures safely; and d) the sequence of steps necessary to perform a single site laparoscopic right colectomy.



Saturday, May 15

An ASCRS/MIRA Workshop

Robotic Rectal Dissection Workshop

7:30 am – 4:30 pm

Didactic Session held at the convention center from 7:30 – 10:00 am

Didactic Session only complimentary to all registrants

Fee for Lab \$595 • **Registration Required** • Limit 24 • No refunds after April 26th

Location of Lab: University of Minnesota School of Medicine
425 E. River Parkway, Building Dwan
Minneapolis, MN

Transportation provided

The robotic rectal dissection workshop will include a didactic session and a cadaver model to perform a robotic-assisted proctectomy. The didactic session will address patient and robot set up, the basics of the robot equipment, and video demonstrations of a robotic rectal dissection. The anatomy of the pelvis will be covered including the parasympathetic and sympathetic nerves. The cadaver portion of the workshop will include total mesorectal excision, complete mobilization of the rectum down to the pelvic floor, and laparoscopic division of the rectum.

Existing Gaps

What Is: There is very little literature published regarding robotic colectomy and proctectomy at this time. As more surgeons begin to incorporate robotics into their practice we need to better understand the best ways to study this technique to ensure the best results for our patients.

What Should Be: The use of the robot to assist in the laparoscopic management of rectal cancer can help overcome many of the physical and ergonomic hurdles that hinder straight laparoscopic proctectomy.

Please Note: Interested participants who have not completed basic training will be contacted by the Course Directors to arrange basic training in advance of the hands-on course.

Director: Leela Prasad, MD, Park Ridge, IL

Assistant Director: Sonia Ramamoorthy, MD, San Diego, CA

7:30 am	Welcome/Objectives Leela Prasad, MD, Park Ridge, IL Sonia Ramamoorthy, MD, San Diego, CA	8:30 am	Troubleshooting: "Collisions/Retraction/Bleeding in the Pelvis – Tips to Avoid Frustration" George Chang, MD, Houston, TX
7:45 am	Learning Curve – "My Hospital Has a Robot, How Do I Get Started" (set-up, training, getting proctored, learning curve, the OR team) Eric Haas, MD, Houston, TX	8:45 am	Outcomes – Latest Update on Trials and Oncologic Outcomes Eduardo Parra-Davila, MD, Celebration, FL
8:00 am	Technique – Low Anterior Resection "The Hybrid Approach" Jonathon Efron, MD, Baltimore, MD	9:00 am	Outcomes – Cost Analysis Slawomir Marecik, MD, Chicago, IL
8:15 am	Technique – Low Anterior Resection – "Total Robotic Approach" Seon-Hahn Kim, MD, Seoul, South Korea	9:15 am	New Frontiers – Endoscopic and Mini Robots, SILS Sonia Ramamoorthy, MD, San Diego, CA
		9:30 am	Panel Discussion / Q&A
		10:00 am	Lab registrants and faculty will board buses to University of Minnesota

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Robotic Rectal Dissection Workshop *(Continued)*

Session #1

10:30 am **Wet Lab for Group 1:**

Faculty:

Garth Ballantyne, MD, Hackensack, NJ
George Chang, MD, Houston, TX
Jonathon Efron, MD, Baltimore, MD
Eric Haas, MD, Houston, TX
Seon-Hahn Kim, MD, Seoul, South Korea
Eduardo Parra-Davila, MD, Celebration, FL
Leela Prasad, MD, Park Ridge, IL
Sonia Ramamoorthy, MD, San Diego, CA

Dry Lab for Group 2:

(Includes basics on the robot, trainer and simulator)

Faculty:

Slawomir Marecik, MD, Chicago, IL
Ashwin De Souza, MD, Chicago, IL

Session #2

1:30 pm **Wet Lab for Group 2:**

Faculty:

Garth Ballantyne, MD, Hackensack, NJ
George Chang, MD, Houston, TX
Jonathon Efron, MD, Baltimore, MD
Eric Haas, MD, Houston, TX
Seon-Hahn Kim, MD, Seoul, South Korea
Eduardo Parra-Davila, MD, Celebration, FL
Leela Prasad, MD, Park Ridge, IL
Sonia Ramamoorthy, MD, San Diego, CA

Dry Lab for Group 1:

Faculty:

Slawomir Marecik, MD, Chicago, IL
Ashwin De Souza, MD, Chicago, IL

Objectives: Upon completion of this workshop, participants will be able to understand: a) the set up and operation of the robotic; and b) the necessary steps to perform a robotic rectal dissection including a total mesorectal excision.



Anorectal and Pelvic Floor Ultrasound Hands-on Lab

7:30 am – 5:00 pm

Fee \$295 • *Registration Required* • Limit 80

Lunch included • *No refunds after April 26th*

Endorectal ultrasound plays a central role in the clinical staging of rectal cancer and evaluation of anal sphincter for fecal incontinence. With technologic advances, the application of ultrasound is being expanded into the evaluation of pelvic floor abnormalities. The accuracy of the ultrasound examination depends upon the operator's ability to perform the exam and properly interpret the images that are obtained. Therefore, it is important that colorectal surgeons develop hands-on expertise in the use of this diagnostic modality by learning its applications and interpretation of the data that it provides.

The preoperative staging of rectal cancer is essential as it guides the need for neoadjuvant therapy. When compared to magnetic resonance imaging and computed tomography, transrectal ultrasonography provides better evaluation of tumor T stage, is more cost-effective, but is much more operator dependent. Regarding the management of fecal incontinence, most surgeons will not attempt a sphincter repair unless a defect can be demonstrated. Endoanal ultrasound is the best modality to document a sphincter defect. It is often used in conjunction with anal manometry to optimize outcomes. Finally, with the advances of high resolution 3-D ultrasonography, its use is being expanded to evaluate more dynamic disorders such as obstructed defecation. Although in its infancy, many feel that it may replace the need for other dynamic studies such as defecography and dynamic MRI. There clearly is a learning curve associated with the use of endorectal or endoluminal ultrasonography. Therefore, obtaining proper training regarding the machinery of the ultrasound machine, image acquisition, and interpretation is essential.

This course will provide the colorectal surgeon with training on the basic use of the ultrasound machine and probes, pertinent anatomy related to the specific examination, and interpretation of the images obtained.

Director: Anders Mellgren, MD, Minneapolis, MN

Co-directors: Giulio A. Santoro, MD, Treviso, Italy and Amy Thorsen, MD, Minneapolis, MN

7:30 am	Introduction Anders Mellgren, MD, Minneapolis, MN Giulio A. Santoro, MD, Treviso, Italy Amy Thorsen, MD, Minneapolis, MN	9:15 am	Break
		9:45 am	Ultrasound Staging of Benign Tumors Liliana Bordeianou, MD, Boston, MA
7:45 am	Ultrasound Technique and Image Interpretation Charles Tsang, MBBS, Singapore	10:00 am	Ultrasound Staging of Rectal Cancer Andreas Kaiser, MD, Los Angeles, CA
8:00 am	Normal Ultrasound Anatomy Charles Whitlow, MD, New Orleans, LA	10:15 am	Pitfalls in Ultrasound Cancer Staging Julio Garcia Aguilar, MD, Duarte, CA
8:15 am	Ultrasound Evaluation of Fistula and Abscess Juan Lucas Poggio, MD, West Palm Beach, FL	10:30 am	Postoperative Follow-up and Biopsy Technique Charles Finne, MD, Minneapolis, MN
8:30 am	Ultrasound Evaluation of Fecal Incontinence Sharon Gregorcyk, MD, Dallas, TX	10:45 am	How Can Ultrasound Change the Clinical Decision-making? Klaus Matzel, MD, Erlangen, Germany
8:45 am	Pelvic Floor Ultrasound: Technique, Normal Anatomy, Pelvic Floor Disorders Giulio A. Santoro, MD, Treviso, Italy	11:00 am	Patient Cases and Discussion Anders Mellgren, MD, Minneapolis, MN, Giulio A. Santoro, MD, Treviso, Italy Amy Thorsen, MD, Minneapolis, MN
		Noon	Lunch for program participants

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Anorectal and Pelvic Floor Ultrasound Hands-on Lab (*Continued*)

Hands-on Training

- 1:00 pm 1) ***Anal Ultrasound***
 Juan Lucas Poggio, MD, West Palm Beach, FL
- 2) ***Rectal Ultrasound***
 Julio Garcia Aguilar, MD, Duarte, CA
- 3) ***Pelvic Floor Ultrasound***
 Giulio A. Santoro, MD, Treviso, Italy
- 4) ***Biopsy Technique***
 Charles Finne, MD, Minneapolis, MN
- 5) ***3D Manipulation***
 Charles Tsang, MBBS, Singapore

Coordinator: Mary L. Roen, RN, Minneapolis, MN

Objectives: Upon completion of this lab, the participants should be able to: a) understand the set up and operation of the ultrasound machine and probes; b) understand the indications and limitations of the ultrasound for the evaluation of diseases of the colon, rectum and anus; c) understand the pertinent anatomy associated with each examination; d) interpret the images obtained for each examination.



Transanal Endoscopic Microsurgery

Didactic Session Only Fee: \$50 • 8:00 – 9:30 am • Open to all registrants

Didactic and Lab Fee: \$500 • *Registration Required*

Lab A: 9:30 am – Noon (Limit: 10)

Lab B: 1:00 – 3:30 pm (Limit: 10)

Lunch: Noon – 1:00 pm • *Included for Lab registrants only*

No refunds after April 26th

The Transanal Endoscopic Microsurgery course is a combination of didactic and practical lab sessions developed to instruct the participants in the indications, preoperative evaluation, patient selection, complications, and management of patients undergoing TEM for rectal masses, including benign and malignant disease. In addition, the technical aspects of the procedure, including equipment and set up, patient preparation and positioning, lesion excision, and wound closure will be taught in both didactic and laboratory sessions.

Directors: Peter Cataldo, MD, Burlington, VT and Theodore Saclarides, MD, Chicago, IL

8:00 am	Introduction and History of TEM Theodore Saclarides, MD, Chicago, IL	8:55 am	TEM for Malignancy Emanuele Lezoche, MD, Rome, Italy
8:10 am	Indications, Equipment and Positioning Theodore Saclarides, MD, Chicago, IL	9:10 am	Video Review Panel
8:25 am	Technique Peter Cataldo, MD, Burlington, VT	9:30 am	Lab A
8:40 am	Complications Mark Whiteford, MD, Portland, OR	Noon	Lunch for all Lab participants
		1:00 pm	Lab B

Objectives: Upon completion of this workshop, participants will be able to: a) become familiar with the patient preparation, operative set up, and equipment used in Transanal Endoscopic Microsurgery; b) discuss the indications, preoperative evaluation, complications, and post operative follow up of patients undergoing TEM for benign and malignant diseases; and c) develop technical skills necessary to perform TEM.



Professionalism and Communication

11:00 am – Noon

The ability to be professional and to communicate information effectively with their residents, colleagues, and patients is essential to the success of a colon and rectal surgeon. As information and surgical technology continues to expand at a rapid rate, it is becoming more and more important for physicians to navigate through all of the various mediums of information. This has significant impact on how we educate, counsel, mentor medical staff, medical students, residents and patients. Surgeons, whether in private practice or academics, are exposed to innumerable members of the health care industry. Therefore, we voluntarily or involuntarily become mentors to many of these individuals so it is important to understand how to effectively relate to other health care professionals to foster and ensure their personal and professional success.

Through an integrated educational initiative you will learn: a) effective mentoring strategies; b) management of information technology; and c) determination of competency. You will learn effective communication strategies to use on our patients during difficult situations. This will be accomplished by in-depth discussions on mentoring, medical education, emotional intelligence, and the maintenance of professionalism while discussing end of life issues and medical mistakes with patients and their families.

Existing Gaps

What Is: Surgeons are faced with unprecedented issues in surgical education such as mentoring, processing continuous streams of information, assessing competency, and remaining professional through all of the stresses in our practices and lives.

What Should Be: Surgeons will be able to be effective mentors and educators to their staff, students, residents, and colleagues. They will understand their own strengths and weaknesses and incorporate all of the knowledge into effective and professional communication with patients, families and health care professionals.

Director: Richard Billingham, MD, Seattle, WA

Assistant Director: Kim Lu, MD, Portland, OR

11:00 am **Mentoring: Residents, Fellows, Partners, and Staff**

Yanek Chiu, MD, San Francisco, CA

11:36 am **Admitting Mistakes and Breaking Bad News**

Ira Kodner, MD, St. Louis, MO

11:12 am **Teaching Students, Residents, and Patients – Battling Technology**

Elizabeth Breen, MD, Boston, MA

11:48 am **Panel Discussion / Q&A**

11:24 am **Emotional Intelligence (ERI) – Building a Better Surgeon**

Kathryn Cramer, PhD, St. Louis, MO

Objectives: At the conclusion of this session, participants should be able to: a) provide mentoring and counseling to students, residents, colleagues, and staff; b) efficiently manage the wealth of information and technology that we are faced with in order to more effectively educate and communicate with our colleagues and patients; c) describe how our strengths and weaknesses impact our personal and professional lives; and d) discuss and counsel patients and families through difficult medical situations.



Saturday, May 15

Evidence Based Reviews

To Divert or Not, What is the Evidence? Let's Do EBRS Journal Club¹

1:00 – 2:30 pm

Evidence Based Reviews in Surgery is an internet-based journal club designed to teach critical appraisal skills to both residents and practicing surgeons. The aim of the program is for participants to evaluate the clinical article, further their knowledge about the topic and to learn critical appraisal skills that can be used to evaluate other articles in the future. A clinical and methodological review of the article is available at the end of each month and surgeons can participate in a listserv discussion and obtain CME credits. The internet program is free to all members of the American College of Surgeons and is endorsed by the American College of Surgeons, Canadian Association of General Surgeons, American Society of Colon and Rectal Surgeons and the Canadian Association of Colon and Rectal Surgeons.

In 2008, the colorectal module to Evidence Based Reviews in Surgery was introduced. There are 6 packages/year selected for the internet based journal club. The focused audience includes both colorectal fellows as well as practicing colorectal surgeons. There is an active listserv discussion that occurs with each article. In addition, Evidence Based Reviews in Colorectal Surgery is used for journal club by many fellowship programs. This 90 minute symposium will enhance the visibility of Evidence Based Reviews in Colorectal Surgery. There will be a demonstration of the web site followed by a "mock" journal club to demonstrate the nuts and bolts of the program.

Existing Gaps

What Is: Colorectal surgeons are faced with a large body of literature and in order to incorporate the data into clinical practice, critical appraisal skills are paramount.

What Should Be: EBRS is an effective method to review the current literature and give a better understanding to methodological issues to facilitate the decision to incorporate the literature into practice.

Director: Larissa Temple MD, New York, NY

Assistant Director: Robin McLeod MD, Toronto, ON, Canada

1:00 pm	Introduction and Objectives of the Session Larissa Temple, MD, New York, NY	1:40 pm	Expert Panel with Audience Discussion Zane Cohen, MD, Toronto, ON, Canada David Rothenberger, MD, Minneapolis, MN Steven Wexner, MD, Weston, FL
1:10 pm	Navigation of EBRS Website Marg McKenzie, RN, CCRP, Toronto, ON, Canada		
1:20 pm	Evidence from the Trial Nancy Baxter, MD, Toronto, ON, Canada	2:10 pm	What do the Experts Say? Carl Brown, MD, Vancouver, BC, Canada
1:30 pm	Poll the Audience on Their Practices Larissa Temple, MD, New York, NY	2:20 pm	Concluding Remarks Larissa Temple, MD, New York, NY

Objectives: At the end of this session, surgeons should be better able to understand: a) the current status of EBRS in colorectal surgery; b) the various methods of incorporating EBRS into training programs as well as clinical practice; and c) how to run a journal club.

¹To Divert or Not, what is the Evidence? Let's do EBRS Journal Club

Matthiessen P, Hallböök O, Rutegård J, Simert G, Sjö Dahl R. Defunctioning Stoma, Reduces Symptomatic Anastomotic Leakage after Low Anterior Resection of the Rectum for Cancer. *Ann Surg*. 2007. Aug; 246 (2): 207-214.



Symposium

Allied Health

Common Colon and Rectal Problems and Procedures for Allied Health Professionals

1:00 – 4:00 pm

This course is designed to provide an overview of important topics related to the field of colon and rectal surgery. There will be a focus on outpatient evaluation and treatment of common problems. Topics are designed to address a target audience of GI nurses, nurse practitioners, and physicians' assistants but may also be of interest to medical students and surgical residents.

Allied health professionals are encouraged to attend the Core Subject Update on Sunday

Director: Richard Karulf, MD, Minneapolis, MN

1:00 pm	Welcome and Introduction Richard Karulf, MD, Minneapolis, MN	2:25 pm	Break
1:05 pm	Office Ano-rectal Procedures Stanley M. Goldberg, MD, FACS, HonFRACS (Aust), HonFRCS (Eng), HonAFC (Fr), HonFRCPS (Glasg), HonFRSM (Eng), Hon FPCS (Phil), HonFRCS (Edin), Honoris Causa (Lleida), HonSAS (Spain), HonJSS (Japan), Minneapolis, MN	2:40 pm	Pelvic Floor Abnormalities Liliana Bordeianou, MD, Boston, MA
1:25 pm	Colon and Rectal Cancer Brett Gemlo, MD, Minneapolis, MN	3:00 pm	Colon Screening/Diagnostic Colonoscopy John Allen, MD, Minneapolis, MN
1:45 pm	Sexually Transmitted Diseases Mary Kwaan, MD, Minneapolis, MN	3:20 pm	Stoma Problems Vicki Haugen, RN, MPH, Edina, MN
2:05 pm	Documentation/Billing Sue Wilkus, St. Paul, MN	3:40 pm	Peri-anal Dermatology G. Eric Belzer, MD, Minneapolis, MN
		4:00 pm	Panel Discussion / Q&A Richard Karulf, MD, Minneapolis, MN

Objectives: At the conclusion of this session, participants should be able to: a) describe key steps in drainage of peri-rectal abscess, treatment of thrombosed external and prolapsing internal hemorrhoids; b) describe the TNM staging system for colon and rectal cancer and its implications for the adjuvant treatment; c) list the most common ano-rectal sexually transmitted diseases and the steps required to diagnose these conditions; d) list common documentation and billing errors for outpatient and inpatient consults; e) list the key diagnostic steps for evaluation of rectocele, fecal incontinence and rectal prolapse; f) list the indications for low risk and high risk screening colonoscopy; g) list treatment options for peri-stomal hernia, stoma stenosis or retraction and superficial bleeding from a stoma; and h) list a differential diagnosis for peri-anal rash.



Summarizing the Evidence: Systematic Review and Meta Analysis

2:30 – 4:00 pm

Review articles can be an efficient method to summarize and interpret evidence for the busy practicing surgeon. While traditional narrative reviews are valuable they are often subject to opinion, bias and random error. Systematic reviews are meant to conform to the rigors of evidence based medicine and are structured using a well defined systematic approach; formulation of a specific question, searching for and selection of evidence, assessment of the quality of the primary studies and a summary of the results of the primary studies. Many articles in the literature purport to be systematic reviews yet do not conform to the methodology set out by accepted guidelines. This symposium is designed to explore the methodology for conducting a quality systematic review.

The aim of this symposium is to provide a structure for the practicing surgeon to critically appraise systematic reviews and to provide a framework for surgeons interested in performing a systematic review on a surgical topic.

Director: W. Donald Buie, MD, Calgary, AB, Canada

Assistant Director: Susan Galandiuk, MD, Louisville, KY

2:30 pm	What is the Question; Is a Systematic Review Appropriate? Richard Nelson, MD, Sheffield, UK	3:30 pm	How to Analyze the Results Sue Duval, PhD, Minneapolis MN
2:50 pm	How to Obtain the Evidence Susan Galandiuk, MD, Louisville, KY	3:50 pm	Panel Discussion / Q&A
3:10 pm	What to Do With the Evidence? Andrew Renehan, PhD, Manchester, UK		

Objectives: At the conclusion of this session, participants should be able to: a) formulate a question that is suitable for systematic review; b) develop a search strategy for a specific question and conduct a complete and unbiased literature search; c) discuss and apply inclusion/exclusion criteria in article selection and understand how to assess the quality of the evidence; and d) describe how to analyze and generate pooled estimates and summarize the results.



Research Foundation Workshop

Clinical Trials: Basic Concepts on How to Get Started

4:00 – 6:00 pm

This session features three experienced clinical trial researchers and intends to provide a glimpse of what is required to design, develop, and conduct a clinical trial. Attendees will be exposed to some of the fundamental issues and challenges encountered in the development and conduct of a trial as well as learn of opportunities for participating in both NIH and industry-sponsored clinical trials.

Director: José Guillem, MD, New York, NY

4:00 pm	Introduction José Guillem, MD, New York, NY	5:05 pm	How to Get Involved with Industry-sponsored Clinical Trials Robin McLeod, MD, Toronto, ON, Canada
4:05 pm	How to Design and Conduct Your Own Clinical Trial: Things to Consider Before You Begin Mohit Bhandari, MD, Hamilton, ON, Canada	5:35 pm	Panel Discussion / Q&A
4:35 pm	How to Get Involved with NIH-sponsored Clinical Trials Heidi Nelson, MD, Rochester, MN		

Objectives: At the conclusion of this session, participants should be able to: a) understand the basic concepts of clinical trials and how to get started; and b) learn of opportunities within the NIH and industry, and encourage clinical trial research on diseases of the colon, rectum and anus.



Dinner Symposium

Managing Complex Abdominal Wall and Pelvic Reconstruction Problems

7:00 – 8:30 pm

Abdominal wall problems occur with a relatively high frequency after colorectal surgery. The impact of wound related problems such as incisional hernias, parastomal hernias, and chronically infected wounds such as enterocutaneous fistulas on patients and surgeons are tremendous. There are many options available to repair simple ventral hernias that provide good outcomes. However, there are significantly fewer options to deal with complex abdominal wounds or hernias and the results are not as durable. In order to minimize complications and maximize outcomes our membership must have comprehensive understanding of all options available to repair complex abdominal wall problems. This integrative symposium will inform you of options and outcomes for managing complex abdominal wall problems.

Existing Gaps

What Is: Repair of complex abdominal wall problems such as parastomal hernias and enterocutaneous fistulas are associated with significant morbidity and a high recurrence rate.

What Should Be: With the use of proper materials and technique, the morbidity associated with repairing complex abdominal wall problems can be reduced and good results may be achieved.

Director: Robin Boushey, MD, Ottawa, ON, Canada

Assistant Director: Bashar Safar, MD, St. Louis, MO

7:00 pm	Welcome Robin Boushey, MD, Ottawa, ON, Canada	7:38 pm	Pelvic Floor Reconstruction and Perineal Wounds – Help!! Patrick Lee, MD, Portland, OR
7:02 pm	Parastomal Hernia Repairs: Got Mesh? Eric Weiss, MD, Weston, FL	7:50 pm	Use of Mesh for Anorectal and Functional Diseases David Rivadeneira, MD, Smithtown, NY
7:14 pm	Ventral Hernia Repair After Colostomy or Enterocutaneous Fistula Takedown: Are You Kidding Me? Jorge Marcet, MD, Tampa, FL	8:02 pm	Panel Discussion / Q&A
7:26 pm	Abdominal Catastrophies: How Do You Close the Belly? Daniel Geisler, MD, Cleveland, OH		

Objectives: At the conclusion of this session, participants should be able to understand: a) the biology behind the various forms of biologic mesh; and b) the most effective techniques to repair parastomal hernias, complex abdominal defects and defects after contaminated cases as well as techniques to repair perineal wound defects.



Core Subject Update

8:00 – 10:30 am

The Core Subject Update is one of the highlights of the meeting, developed by ABCRS and ASCRS to assist in the education and recertification of colon and rectal surgeons. Core Subject Update has been restructured to include 24 topics rotating on a four-year cycle. Speakers give evidence-based reviews focused on current concepts and controversies. A written précis based on each talk will be available on the ASCRS website prior to the meeting. Questions developed from each presentation are included in the ABCRS recertification question bank.

Director: W. Donald Buie, MD, Calgary, AB, Canada

8:00 am	Ostomies and Stomal Therapy Sharon Dykes, MD, Minneapolis, MN	9:15 am	Medical Management of IBD Daniel Geisler, MD, Cleveland, OH
8:20 am	Discussion	9:35 am	Discussion
8:25 am	Benign Anorectal/Pruritis/Pilonidal/ Hydradenitis Bradley Davis, MD, Cincinnati, OH	9:40 am	GI Bleeding Anthony MacLean, MD, Calgary, AB, Canada
8:45 am	Discussion	10:00 am	Discussion
8:50 am	Rectovaginal Fistula/Rectourethral Fistula Andrew Shelton, MD, Stanford, CA	10:05 am	Rectal Cancer (Neoadjuvant Adjuvant) George Chang, MD, Houston, TX
9:10 am	Discussion	10:25 am	Discussion

Objectives: Upon completion of this session, participants should be able to: a) describe the different techniques for stoma formation; and understand the treatment options for managing enterostomal complications; b) summarize the anatomical derangements that make the anoperineal skin susceptible to disease; and outline the etiologies and associated treatments of the benign dermatologic conditions affecting the anoperineum; c) demonstrate an understanding of the current management of rectovaginal and rectourethral fistula; d) demonstrate an understanding of the current controversies and medical management of Crohn's disease in the era of biologics; e) discuss the options and principles in the investigation of lower GI bleeding; and understand the principles and outcomes of the surgical management of lower GI bleeding; and f) demonstrate an understanding of the current management of rectal cancer including the use of neoadjuvant and adjuvant therapy.



**For Primary Care Physicians,
NPs and PAs only**

Colon and Rectal Disease: An Update for the Primary Care Provider

9:30 am – 5:30 pm • Fee: \$150 • *Registration Required*

Lunch Included • No refunds after April 26th

This day-long program is designed to update primary care providers on recent advances in the diagnosis and treatment of diseases of the colon, rectum and anus that are commonly seen in a primary care practice. Special emphasis will be placed on patient care, including initial management and guidelines to aid in determining when referral to a colorectal surgeon is needed.

The goals of this program are to improve the prevention, diagnosis and treatment of patients with diseases and disorders affecting the colon and rectum; and improve the quality of patient care by maintaining, developing and enhancing the knowledge, skills, professional performance and multidisciplinary relationships necessary to provide services for patients, the public and the profession.

Director: Thomas E. Cataldo, MD, Providence, RI

9:30 am	Introduction: What is a Colon and Rectal Surgeon and Who is the ASCRS? Thomas E. Cataldo, MD, Providence, RI	1:30 pm	Update on HIV and Other Anorectal STDs, Anal Intraepithelial Neoplasia, and an Anal Squamous Cell Cancer Lester Gottesman, New York, NY
10:00 am	Impact of CR Disease, Medical Economics of CR Care Anthony J. Senagore, MD, Grand Rapids, MI	2:00 pm	Laparoscopic Approaches to Colon and Rectal Surgery; Benefits & Drawbacks, Unclouding the Mystery Amy J. Thorsen, MD, Minneapolis, MN
10:30 am	Update on Inflammatory Bowel Disease, Crohn's & UC – A Surgeon's Perspective Brian Kann, MD, Camden, NJ	2:30 pm	Colorectal Cancer Screening and Surveillance, Indications, Schedules and Implications in Primary Care Charles B. Whitlow, MD, New Orleans, LA
11:00 am	Common Benign Anorectal Conditions, Identifying Hemorrhoids, Fissures and the Like, Office Proctology and Procedures Michelle M. Olson, MD, Danville, PA	3:00 pm	Recognizing Hereditary Cancer Syndromes, Genetic Testing, Medicolegal Implications to Families James M. Church, MD, Cleveland, OH
11:30 am	Peri-anal Dermatology; Pruritus Ani, Condyloma etc. Charles O. Finne, MD, Minneapolis, MN	3:30 pm	Refreshment Break
12:00 pm	Functional Disorders of Defecation; Constipation, Diarrhea, Incontinence Anorectal Physiology Testing and Potential for Symptom Management and Lifestyle Improvement John H. Pemberton, MD, Rochester, MN		
12:30 pm	Lunch		

Continued next page



Colon and Rectal Disease: An Update for the Primary Care Provider *(Continued)*

4:00 pm **After Colon and Rectal Surgery: What Complications Should You Look Out For? What Do I Follow in My Cancer Patients?**
Timothy C. Counihan, MD, Pittsfield, MA

5:00 pm **Newest Advances in Colorectal Surgical Care, Robotics, TEM: What is Real and What is Hype**
Michael P. Spencer, MD, Minneapolis, MN

4:30 pm **Advanced and Metastatic Colorectal Cancer: What to Expect From Your Patient, Your Surgeon and Oncologist**
Richard E. Karulf, MD, Minneapolis, MN

Objectives: At the conclusion of this session, participants should be able to: a) identify and treat common anorectal and colorectal conditions; b) recognize rare colorectal/anal conditions with significant impact i.e. anal cancer, genetic syndromes; c) evaluate primary care presentations of complications of colorectal procedures; d) identify the appropriate conditions for referral to a surgical subspecialist; and e) evaluate changing and upcoming technologies for the treatment of conditions of the colon, rectum and anus.



Laparoscopic and Endoscopic Nuts and Bolts

10:30 am – Noon

Advances in technology and improvements in our understanding of many colorectal diseases have allowed for significant alterations in our management approaches to these diseases. As the drive for adoption of minimally invasive techniques moves forward, the continued expansion of laparoscopy, institution of single site procedures and utilization of advanced endoscopic techniques depend upon the acquisition of the appropriated technical skills sets. Therefore, obtaining knowledge and training of the technical aspects of advanced laparoscopic and endoscopic techniques will allow a surgeon to gain the appropriate skill sets and increase the likelihood of adopting them into their practices.

Through an integrated educational initiative we will provide you with video demonstrations of dissection approaches, operative strategies and operative pearls to advanced laparoscopic and endoscopic techniques. Each technique will be demonstrated from several different points of view in order to maximize your understanding of the specific procedure. At the conclusion, you should have a thorough understanding of how to implement these techniques into your practice.

Existing Gaps

What Is: Surgeons manage many diseases that may be approached laparoscopically or endoscopically. These approaches may provide a significant benefit to the patient. Many surgeons are reluctant to offer these techniques to their patients because of lack of familiarity with them.

What Should Be: Surgeons will have a complete armamentarium of treatment modalities from open, to laparoscopy, to endoscopy, to offer their patients. This will allow surgeons to optimize their patients' outcomes.

Director: Mark Whiteford, MD, Portland, OR
Assistant Director: Bradley Davis, MD, Cincinnati, OH

10:30 am	Introduction Mark Whiteford, MD, Portland, OR	10:49 am	Laparoscopic Parastomal Hernia Repair Bradley Davis, MD, Cincinnati, OH
10:32 am	Vascular Pedicle Identification and Control in the Obese Patient Paul Wise, MD, Nashville, TN	10:52 am	Panel Discussion / Q&A Mark Whiteford, MD, Portland, OR
10:35 am	Single Incision Laparoscopic Colectomy, Medial to Lateral Approach Daniel Geisler, MD, Cleveland, OH	11:03 am	Finding the Left Ureter in the Challenging Patient David Maron, MD, Philadelphia, PA
10:38 am	Safe Entry into the Reoperative Abdomen, Laparoscopic Management of SBO Sang Lee, MD, New York, NY	11:06 am	Laparoscopic TME: Establishing and Maintaining the Holy Planes Alan Herline, MD, Nashville, TN
10:41 am	Laparoscopic Sigmoid Colectomy for Complicated Diverticulitis Conor Delaney, MD, Cleveland, OH	11:09 am	Laparoscopic TME: The Ideal First Assistant for Mid and Distal Rectal Dissection Samuel Oommen, MD, Walnut Creek, CA
10:45 am	Reoperative Ileocolic Crohn's Disease Rocco Ricciardi, MD, Burlington, MA	11:12 am	Laparoscopic TME: The Robotic Experience George Chang, MD, Houston, MD

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Laparoscopic and Endoscopic Nuts and Bolts *(Continued)*

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|----------|--|----------|---|
| 11:15 am | Making the Pouch Reach: Laparoscopic Pouch Lengthening Maneuvers
David Larson, MD, Rochester, MN | 11:39 am | Endoscopic Stricture Management: Balloon Dilation, Stents
Charles Whitlow, MD, New Orleans, LA |
| 11:18 am | Laparoscopic Rectopexy for Prolapse
Madhulika Varma, MD, San Francisco, CA | 11:43 am | Laparoscopic Assisted Colonoscopic Polypectomy, Endoscopic Closure of Defects
John Park, MD, Park Ridge, IL |
| 11:21 am | Panel Discussion / Q&A
Bradley Davis, MD, Cincinnati, OH | 11:46 am | Colonoscopic Management of Lower GI Hemorrhage
David Margolin, MD, New Orleans, LA |
| 11:32 am | Improved Colonoscopic Diagnostics: NBI, Chromoendoscopy. How and When?
James Thiele, MD, Springfield, IL | 11:49 am | Panel Discussion / Q&A
Mark Whiteford, MD, Portland, OR |
| 11:35 am | Advanced Colonoscopic Polypectomy: Saline Lift, EMR, ESD
Tonia Young-Fadok, MD, MS, Phoenix, AZ | | |

Objectives: At the conclusion of this session, participants should be able to understand: a) different laparoscopic approaches to mobilize the colon; b) techniques to manage intra-operative complications laparoscopically; c) techniques available to endoscopically resect large colonic polyps; and d) techniques available to manage complications such as GI bleeding and post-polypectomy perforation endoscopically.



Lunch Symposium

Management of Fistula in Ano: Many Options But Which Ones Work?

Noon – 1:30 pm

The management of perirectal abscesses and fistula in ano encompass some of the most common and vexing problems that colorectal surgeons face. The principles of the definitive treatment of fistula in ano are destruction of the internal opening and preservation of the external sphincter. Primary fistulotomy is the most effective manner in which the internal opening is destroyed thus it has the lowest recurrence rate. This success comes at the expense of dividing the external sphincter. There are many patients and specific types of fistulas where division of the involved external sphincter will result in fecal incontinence. As a result, many alternative treatments such as endorectal advancement flap, fibrin glue, collagen plug, the Lateral Intersphincteric Fistula Transection (LIFT) procedure, and use of stem cells or fibroblasts, have been developed to destroy the internal opening and preserve sphincter muscle. The results of these procedures are variable depending upon the indication and the surgeon. Understanding the indications, limitations, and success rates of the various treatment modalities would allow for more effective and efficient treatment of fistula in ano.

This symposium will discuss the indications and reported success rates for these options to foster an improved understanding of the treatment modalities available.

Existing Gaps

What Is: There are many treatment modalities available to definitively treat fistula in ano. None of these modalities work 100% of the time so many surgeons are unsure how to incorporate these options into their practice.

What Should Be: Surgeons will understand the indications and success rates of the various modalities available for the definitive treatment of fistula in ano.

Director: José Cintron, MD, Chicago, IL

Assistant Director: David Etzioni, MD, Phoenix, AZ

Noon	Introduction José Cintron, MD, Chicago, IL	12:38 pm	Plugs: When to Use Them C. Neal Ellis, MD, Mobile, AL
12:02 pm	How Much Sphincter Can We Cut? Terry Hicks, MD, New Orleans, LA	12:50 pm	The Use of Autologous Fibroblasts and Collagen Paste – Check This Out! Robin Phillips, MD, Harrow, Middlesex, UK
12:14 pm	LIFT Stanley M. Goldberg, MD, FACS, HonFRACS (Aust), HonFRCS (Eng), HonAFC (Fr), HonFRCPS (Glasg), HonFRSM (Eng), Hon FPCS (Phil), HonFRCS (Edin), Honoris Causa (Lleida), HonSAS (Spain), HonJSS (Japan), Minneapolis, MN	1:02 pm	When to Say When: Seton for Life? Martin Luchtefeld, MD, Grand Rapids, MI
12:26 pm	Endorectal Advancement Flap Michael Shane McNevin, MD, Seattle, WA	1:14 pm	Panel Discussion / Q&A David Etzioni, MD, Phoenix, AZ

Objectives: At the end of this session, surgeons should be better able to understand: a) the role of imaging with ultrasound and MRI in the management of fistulas; b) the indications and limitations of surgical treatment options such as primary fistulotomy, endorectal advancement flaps, the LIFT procedure, and fistulectomy in the treatment of fistulas; and c) the indications and limitations of biologics such as fibrin glue, collagen plugs and stem cells in the treatment of fistulas.



Young Surgeons' Lunch Symposium

Starting a Clinical Practice

Noon – 1:30 pm

There are several critical components to building a successful career as a colorectal surgeon. As young colorectal surgeons after fellowship, we often assume that “the work is done.” After 4 years of medical school and 6–8 years of residency the preconceived myth of walking into a practice with an office full of patients, a research team with ideas and methods for funding, and a community that welcomes our arrival is just that, a myth.

There is a paucity of information provided to trainees that helps shape the beginning of their careers. Among all young surgeons, job turnover rate and attrition has been reported to be greater than 50% within five years of completing fellowship. There are several reasons for early job dissatisfaction and many of them are out of the control of the young surgeon. However, by focusing on defining a job that meets the needs of the trainee rather than the practice or institution, young surgeons may help ensure stability.

After finding the right match, identifying and assembling the critical parts of your team will help establish the ideal practice model. As your team develops, effectively networking in your community and establishing trust with your colleagues and referring physicians is vital.

Lastly, after several years of productivity and success you may feel saturated in your position. At this moment, opportunity will arise and the young surgeon must be certain that moving on is also moving up. This symposium strives to expand on career building concepts by providing pearls of wisdom from individuals that have achieved great initial and sustained success.

This program will present several strategies that will help you find the best position. You will be assisted in developing marketing plans to help build a viable practice, assembling a productive team, and understanding what you have in your current job and what to look for in a new job.

Existing Gaps

What Is: Residents finishing colorectal training have no formal or informal guidance and instruction in methods of obtaining a position in a practice or department that is consistent with their short and long term goals. Furthermore, there are no established systems that assist young colorectal surgeons in building their team, marketing and executing their plan of action, and ultimately deciding when it may be necessary to take a new position.

What Should Be: Young colorectal surgeons should be familiar with a myriad of opportunities that exist within an academic institution or practice. They should understand that asking for what they truly desire in a position is not only reasonable but obtainable. Young surgeons should also be familiar with the processes of marketing their abilities and the key components of creating a multidisciplinary team.

Director: Bradley Champagne, MD, Cleveland, OH
Assistant Director: Sharon Stein, MD, Cleveland, OH

Noon **Introduction**
Bradley Champagne, MD, Cleveland, OH

12:02 pm **How to Get What You Want in a Job After Fellowship**
Matthew Kalady, MD, Cleveland, OH

Continued next page



Starting a Clinical Practice *(Continued)*

12:14 pm	Winning Games: Marketing and Referrals David Rivadeneira, MD, Smithtown, NY	12:50 pm	Results of the Laparoscopic Colectomy Datashare Young Surgeons Committee
12:26 pm	Building the Team: Creating and Maintaining a Winning Team Neil Hyman, MD, Burlington, VT	1:02 pm	Panel Discussion / Q&A
12:38 pm	Trades: When Moving on is Necessary to Move Up Jonathan Efron, MD, Baltimore, MD		

Objectives: At the conclusion of this session, participants should be able to: a) understand how to apply for a job after fellowship and how to obtain a position with a group or within a department that is consistent with the surgeons' long term goals; b) understand the importance and best approaches of establishing a network within the community; c) recognize the critical steps required in building a team; d) learn how to decide when it may or may not be time to move to a new position; and e) recognize when one has reached maximum potential in the current position; learn when it is time to reevaluate ones long term goals or redefine ones career.



Sunday, May 16

Welcome and Opening Announcements

1:30 pm

James Fleshman, MD, St. Louis, MO
President, ASCRS

Matthew Mutch, MD, St. Louis, MO
Program Chair

Steven Hunt, MD, St. Louis, MO
Program Vice-chair

Robin Boushey, MD, Ottawa, ON, Canada
Awards Chair

Michael Spencer, MD, Minneapolis, MN
Local Arrangements Chair

José Guillem, MD, New York, NY
President, ASCRS Research Foundation

Masters in Colorectal Surgery Lectureship

2:15 – 2:45 pm

Honoring

Stanley M. Goldberg, MD,

FACS, HonFRACS (Aust), HonFRCS (Eng), HonAFC (Fr),
HonFRCPS (Glasg), HonFRSM (Eng), Hon FPCS (Phil),
HonFRCS (Edin), Honoris Causa (Lleida), HonSAS
(Spain), HonJSS (Japan)

Restless for Change: An Ode to Stanley Goldberg, MD



Richard K. Reznick, MD

MEd, FRCSC, FACS,
R.S. McLaughlin Professor and Chair,
Department of Surgery
University of Toronto
Vice-President of Education
University Health Network
Toronto, ON, Canada

Scientific Session

Neoplasia I

2:45 – 4:15 pm

2:45 pm	The Effect of Short-course Preoperative Irradiation on Local Recurrence Rate and 5-year Survival in Rectal Cancer. A Population-based National Study S1 M. Kressner, P. J. Nilsson, R. Johansson, B. Glimelius, L. Pahlman, Stockholm, Sweden; Umeå, Sweden; Uppsala, Sweden	3:33 pm	Panel Discussion
2:51 pm	Discussion	3:39 pm	Improving the Quality of Surgery in Colon Cancer Through Surgical Education S7 N. West, K. Sutton, P. Ingeholm, W. Hohenberger, P. Quirke, Leeds, West Yorkshire, United Kingdom; Copenhagen, Denmark; Erlangen, Germany
2:54 pm	Intraoperative Radiation Therapy for Advanced Colorectal Cancer Provides Effective Local Control with Acceptable Morbidity S2 J. C. Haney, B. Czito, D. Tyler, C. Mantyh, J. Migaly, Durham, NC	3:45 pm	Discussion
3:00 pm	Discussion	3:48 pm	What is the Risk of Permanent Stoma After Low Anterior Resection of the Rectum for Cancer? P. Matthiessen, R. Lindgren, O. Hallböök, J. Rutegård, R. Sjö Dahl, Örebro, Sweden, Linköping, Sweden; Umeå, Sweden S8
3:03 pm	Does Positron Emission Tomography CT Predict Patient Outcome Following Treatment for Rectal Cancer? S3 J. Yeung, V. Kalff, R. Hicks, M. Michael, S. Ngan, Y. Taouk, A. C. Lynch, A. G. Heriot, Melbourne, VIC, Australia	3:54 pm	Discussion
3:09 pm	The Predictive Role of Sequential FDG-PET/CT in Response of Locally Advanced Rectal Cancer to Neoadjuvant Chemoradiation S4 J. Huh, B. Oh, J. Joo, H. Kim, Y. Kim, Gwangju, South Korea	3:57 pm	Salvage Abdominoperineal Resection After Failed Chemoradiation for Squamous Cell Carcinoma of the Anus H. C. Burkholder, H. R. Bailey, M. Snyder, M. Pidala, Houston, TX S9
3:15 pm	Panel Discussion	4:03 pm	Discussion
3:21 pm	Transanal Endoscopic Microsurgery: A Single Institution's Experience with 75 pT1 Cancers S5 F. M. Abarca, T. J. Saclarides, Chicago, IL	4:06 pm	Complete Macroscopic Tumor Removal in 289 Patients with Peritoneal Dissemination from Perforated Appendiceal Tumors – Morbidity, Mortality and Long Term Outcome S10 H. Youssef, C. Newman, K. Chandrakumaran, F. Mohamed, T. Cecil, B. Moran, Basingstoke, United Kingdom
3:27 pm	Transanal Minimally Invasive Surgery S6 M. Albert, S. Larach, S. Atallah, S. Orlando, FL	4:12 pm	Discussion

Refreshment Break

4:15 – 4:30 pm

Sunday, May 16

Harry E. Bacon Lectureship



4:30 – 5:00 pm

**UK Perspective on
Healthcare Policy**

**Professor the Lord Darzi
of Denham, PC, KBE**
HonFREng, FMedSci
*Division of Surgery
St. Mary's Hospital Campus
Imperial College London
UK Global Health and
Life Sciences Ambassador
London, United Kingdom*

Norman Nigro Research Lectureship



5:00 – 5:30 pm

**The Surgeon – The Key to Major
Improvements in Colorectal
Cancer Outcomes**

Professor Philip Quirke, MD
*Yorkshire Cancer Research
Centenary Professor of Pathology
University of Leeds and Head Section
of Pathology and Tumour Biology
Leeds Institute of Molecular Medicine
Leeds, United Kingdom*



Advances in the Management of Diverticulitis

5:30 – 7:00 pm

The incidence of acute diverticulitis in the United States is rising, and our understanding of the natural history of diverticulitis continues to evolve, which has led to significant changes in our management of uncomplicated and complicated diverticulitis. The reported risk of recurrence of acute diverticulitis after hospitalization for a patient's first episode ranges from 9% to 30%. In early 2000, the recommendation for elective resection was after a 2nd attack, but now many are offering patients an elective resection after the 3rd or even 4th attack. The management of complicated diverticulitis, abscess or perforation, has undergone very dramatic changes. Percutaneous abscess drainage, non-operative management of perforations, and laparoscopic lavage and repair of perforation have significantly reduced the need for emergent colectomy and colostomy creation. For patients that do require emergent colectomy, several options to manage intestinal continuity are available such as colostomy creation, primary anastomosis with diversion, or on-table lavage and anastomosis.

This symposium will address the natural history of acute diverticulitis and current management strategies for uncomplicated and complicated diverticulitis. The focus will be on the indications for elective sigmoid resection, management of perforated diverticulitis, and the operative strategies for emergent colectomy in acute diverticulitis. After this symposium, surgeons should be able to improve the non-operative and operative care of patients with acute diverticulitis.

Existing Gaps

What Is: The understanding of the natural history of diverticulitis is unclear. As a result, there are a wide range of recommendations for the management of uncomplicated and complicated acute diverticulitis.

What Should Be: A comprehensive understanding of the natural history of acute diverticulitis will allow surgeons to improve their patient's outcomes.

Director: David Rivadeneira, MD, Smithtown, NY

Assistant Director: Jason Hall, MD, Burlington, MA

5:30 pm	Introduction David Rivadeneira, MD, Smithtown, NY	6:12 pm	Laparoscopic Lavage Daniel Feingold, MD, New York, NY
5:32 pm	When is Elective Resection Indicated? Charles Heise, MD, Madison, WI	6:27 pm	Resect Then What? Colostomy, Anastomosis, On-table Lavage Michael Stamos, MD, Orange, CA
5:47 pm	Non-operative Management of Perforated Diverticulitis Charles Friel, MD, Charlottesville, VA	6:42 pm	Panel Discussion / Q&A

Objectives: At the conclusion of this session, participants should be able to understand: a) the natural history of diverticulitis and indications for elective sigmoid resection; b) the indications and outcomes of non-operative management of perforated diverticulitis; c) the indications and outcomes for laparoscopic lavage and repair of perforated diverticulitis; and d) the indication for the operative management options in the surgical treatment of acute diverticulitis.



Video Session

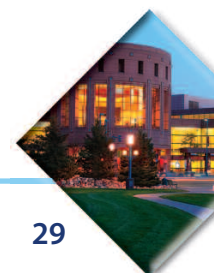
5:30 – 7:00 pm

5:30 pm	Laparoscopic Approaches for Rectal Prolapse: Anatomy and Technical Tips SV-1 B. Feng, M. Zheng, J. Yan, J. Kawamura, W. Lei, O. Olival, R. Pavoov, J. Milsom, Shanghai, China; New York, NY (V-8)	6:15 pm	Outcome of Karydakias Flap for the Treatment of Recurrent Pilonidal Disease SV-6 S. Suryadevara, M. Luchtefeld, D. Kim, Grand Rapids, MI (V-14)
5:36 pm	Stapler Resection of Full Thickness Prolapse SV-2 J. Orhalmi, Ostrava, Czech Republic (V-10)	6:21 pm	Discussion
5:42 pm	Panel Discussion	6:24 pm	Initial Experience with a New Synthetic Bio-absorbable Plug in the Treatment of Anal Fistula SV-7 C. Bouchard, N. Mantilla Farfan, H. Abcarian, M. Singer, Chicago, IL; Evanston, IL (V-17)
5:48 pm	Laparoscopy in the Management of Intestinal Endometriosis SV-3 L. Williams, D. Trottier, E. Davenport, R. Boushey, E. Poulin, J. Mamazza, Ottawa, ON, Canada (OV-15)	6:30 pm	Outcomes with the Use of Bioprosthetic Grafts to Reinforce the Ligation of the Intersphincteric Fistula Tract for the Management of Complex Anal Fistulas SV-8 N. Ellis, Mobile, AL (V-23)
5:54 pm	Discussion	6:36 pm	Transanal Endoscopic Microsurgery is a Viable and Effective Option to Repair Complex Anorectal Fistulas: A Case Series SV-9 R. Pigalarga, N. Maloney Patel, C. Rezac, New Brunswick, NJ (V-21)
5:57 pm	Anal Encirclement with Sphincter Repair using a Biologic Graft for Anal Sphincters Damaged in the Entire Circumference SV-4 M. Zutshi, B. Gurland, T. Hull, Cleveland, OH (V-11)	6:42 pm	Layered Closure of Primary Fistula Opening with Drainage in the Treatment of Fistula in Ano SV-10 S. Marecik, C. Bouchard, L. Prasad, V. Chaudhry, Park Ridge, IL and Chicago, IL (OV-21)
6:03 pm	Antegrade Colonic Enema SV-5 P. Ferreira, B. Gurland, M. Zutshi, R. Rackley, T. Hull, Cleveland, OH (V-12) <i>Presented by: B. Garland</i>	6:48 pm	Panel Discussion
6:09 pm	Panel Discussion		

Welcome Reception

7:30 – 9:00 pm

After a long day of scientific sessions, plan to unwind at the festive Welcome Reception. This fun-filled event will be held in Orchestra Hall (connected via Skywalk from the Hilton/Convention Center) and will feature entertainment, hors d'oeuvres and cocktails. It's the perfect place to catch up with old friends and make new acquaintances. You'll also have a final opportunity to "Meet the Challenge" and place your bids on terrific items at the Research Foundation's Silent Auction.



Breakfast Symposium

Health Care Policy in the 21st Century: Where in the World Are We Going?

6:15 – 7:45 am

The Congressional Budget Office has predicted that at the current rate of spending, Medicare will not be solvent beyond the middle of the next decade. In light of this, there is a sense of urgency on Capitol Hill to reform the system of reimbursement. While quality measures are sure to play some role in the adjustment of compensation, these changes alone are not likely to balance the budget of CMS or solve the crisis in health care. Already, many proposed changes in the reimbursement system have been offered, including the public option, medical homes, and the redirection of payment from specialist to the primary care providers. With or without the overarching reform legislation, the system is destined to change.

Surgeons often feel helpless. It is of the utmost importance that our membership is adequately educated about the major issues that are involved in our current health care system. We need a comprehensive understanding of the agenda that the private sector and CMS are developing in order to curb the crisis in health care. Finally, we need to become organized and involved on an individual basis. In order to do this, we need to understand the players involved and who is on our side looking out for our interests. This will allow surgeons to develop a collective and more influential voice in the matters that lie ahead.

This symposium will evaluate the crisis in health care reimbursement, assess the current financial state of CMS, the potential solutions currently being considered, and educate participants in their role as advocates.

Existing Gaps

What Is: The proposed compensation system for the colorectal surgeon is unclear at best, and there is a significant amount of anxiety among surgeons regarding their future.

What Should Be: The colorectal surgeon should understand the true nature of the current problem, the changes that have been proposed, and what is likely to happen to the compensation program.

Director: Anthony J. Senagore, MD, Grand Rapids, MI

Assistant Director: Larissa Temple, MD, New York, NY

6:15 am	Introduction Anthony J. Senagore, MD, Grand Rapids, MI	6:47 am	Solving it in the Private Sector – Quality and Reimbursement Donald M. Berwick, MD, Cambridge, MA
6:17 am	What are the Issues of our Current System? State of CMS and Private Insurance Arden Morris, MD, Ann Arbor, MI	7:02 am	Who is our Advocate? Guy Orangio, MD, Atlanta, GA
6:32 am	Bundled Payment Anthony J. Senagore, MD, Grand Rapids, MI	7:17 am	Panel Discussion / Q&A

Objectives: At the conclusion of this session, participants should be able to understand: a) who is acting as their advocate, both in the legislative process and in their interactions with CMS; b) the current financial problems at CMS; c) the proposed solutions for physician reimbursement; and d) how the national health care system works in other countries.



Meet the Professor Breakfasts

6:45 – 7:45 am

Limit: 30 per breakfast • Fee \$35 • *Registration Required* • Continental Breakfast

Registrants are encouraged to bring problems and questions to this informal discussion.

Please register early and indicate your 1st and 2nd choice on the Physicians' Registration Form.

M-1 **Familial Cancer Syndromes, Genetic Testing and Surgical Management**

David Larson, MD, Rochester, MN
Paul Wise, MD, Nashville, TN

M-2 **Bowel Preps – Yes or No?**

Lisa Poritz, MD, Hershey, PA
Mark Welton, MD, Stanford, CA

M-3 **Medical Legal Issues – What the Expert Witness is Looking For**

H. Randolph Bailey, MD, Houston, TX
Terry Hicks, MD, New Orleans, LA

M-4 **Pathology and Colorectal Cancer**

Werner Hohenberger, MD, Erlangen, Germany
Philip Quirke, MD, Leeds, York, United Kingdom
Thomas Read, MD, Burlington, MA

M-5 **Anorectal Potpourri: The Cases We Love to Hate**

Herand Abcarian, MD, Chicago, IL
Martin Luchtefeld, MD, Grand Rapids, MI
Giovanni Romano, MD, Avellino, Italy

M-6 **CRC Screening and Surveillance, Guidelines and Reimbursement**

Nancy Baxter, MD, Toronto, ON, Canada
Eugene Foley, MD, Madison, WI

M-7 **The Oral Boards: A Survival Guide**

(Invitation Only)

Residents' Breakfast



6:45 – 7:45 am

**Colorectal Surgery:
What's it all About?**

**Philip H. Gordon, MD, FRCS(C), FACS,
FASCRS, Hon FRSM, Hon FACBGI**
*Professor, Surgery and Oncology
McGill University
Director of Colon and Rectal Surgery
Sir Mortimer B. Davis Jewish General
Hospital and McGill University
Montreal, QC, Canada*

Residents Only • Registration Required



Laparoscopic Proctosigmoidectomy: Simulation Workshop

This course will be given four times, as follows:

Monday, May 17 – 7:30 – 11:30 am
12:30 – 4:30 pm

Tuesday, May 18 – 7:30 – 11:30 am
12:30 – 4:30 pm

Fee \$50 each session • *Registration Required*

Limit 6 physicians for each of the four sessions

Registrants are encouraged to attend the Laparoscopic Colectomy didactic session on Saturday

This Simulation Laboratory will involve hands-on training in the steps necessary for laparoscopic colorectal surgery. Anatomy and videos of each simulated procedure will be reviewed. The steps of each procedure will be performed by participants using hybrid virtual reality (VR) and full VR systems with the close supervision of expert faculty. Each participant will perform a complete VR colectomy, perform a complete hybrid VR colectomy, and assist on a further hybrid VR colectomy.

Director: Conor P. Delaney, MD, Cleveland, OH

Co-director: Joseph Gallagher, MD, Orlando, FL

Faculty:

Drs. Brad Champagne, Neal Ellis, Morris Franklin, Charles Heise, Rebecca Hoedema, Fabien Leblanc, Floriano Marchetti, David Maron, Deborah Nagle, Vincent Obias, and Harry Reynolds

Objectives: At the conclusion of this session, participants should be able to: a) demonstrate the basic techniques of laparoscopic intestinal surgery; b) discuss the anatomical approaches as they relate to laparoscopy; c) apply laparoscopic techniques for dissection in correct anatomical planes to intestinal surgery; and d) describe the sequence of steps necessary to perform the procedure safely and efficiently.

Simulator Education Center

Open Monday and Tuesday
7:30 – 11:30 am and 12:30 – 4:30 pm

Master SLS and experience Top Gun using validated video games, desk top, hybrid, computer and endoscopic simulators. Win prizes so you can brag to your friends. Low end to high end simulation with the goal of easing the training burden within the confines of the 80 hour work week. Additional goals include maintaining surgical skills for likely recertification requirements of the future.

Night of the Simulator

7:00 – 8:30 pm, Tuesday

Enjoy friendly competition of men vs women with Dr. "Butch" Rosser as the referee to decide who is the "Master of Simulation".



Symposium

Pay for Performance

8:00 – 9:30 am

In 1999, the Institute of Medicine published “To Err is Human: Building a Safer Health System.” This landmark report documented a staggering number of preventable medical errors in the health care system. This report was followed in 2001 by “Crossing the Quality Chasm: A New Health System for the 21st Century.” In this report, the Institute elaborated on reform measures that would address quality delivery of health care in the United States. At the same time, many of the largest employers in the country formed the Leapfrog Group, whose stated goal is to use their purchasing power to ensure and reward safety, quality, and value in the health care system.

Some of the initiatives suggested by the Institute of Medicine, the Leapfrog Group, and other coalitions of health care purchasers have been adopted by the Center for Medicare/Medicaid Services (CMS) and have already become part of the CMS reimbursement schedule for physicians. Most of these current initiatives are actually “pay for reporting” systems and provide financial incentives to physicians merely for documenting that certain quality initiatives have been completed.

CMS and many of the larger insurers are currently in the process of developing true quality initiatives for specific diseases, specialties, and procedures. These initiatives will likely be rolled out slowly over the next several years. These initiatives will not only reward practitioners for meeting certain quality measures, but they will also begin to phase in punitive measures in cases where the designated quality measures are not met. This is a massive undertaking and is sure to have an enormous impact on the practice of colorectal surgery.

This symposium will address the current and future initiatives regarding pay for performance.

Existing Gaps

What Is: Very few surgeons understand the impact that these quality measures will have on their practice and the way in which they are developed, creating fear and uncertainty.

What Should Be: Surgeons should understand the consequences of these initiatives on their practice and reimbursement. They should understand the system by which these initiatives are developed and introduced into the reimbursement schedule.

Director: Patricia Roberts, MD, Burlington, MA
Assistant Director: James Merlino, MD, Cleveland, OH

8:00 am	Introduction Patricia Roberts, MD, Burlington, MA	8:29 am	NSQIP: Fact or Fiction? Clifford Ko, MD, Los Angeles, CA
8:02 am	What is It? Who's Pushing It? What Does It Mean? Nancy Baxter, MD, Toronto, ON, Canada	8:41 am	The Use of a National Data Base to Track Performance: The UK National Audit Paul Finan, MD, Leeds, West Yorkshire, United Kingdom
8:14 am	Core Measures and HSCAPS: Who's Watching and What Does it Mean? James Merlino, MD, Cleveland, OH	8:53 am	Where is this Going? Frank Opelka, MD, New Orleans, LA
		9:05 am	Panel Discussion / Q&A

Objectives: At the conclusion of this session, participants will be able to: a) identify the driving force behind the quality measures; b) discuss the coming measures and how they will affect their practice; and c) describe the current quality measures and systems that are already in place.



Scientific Session

Minimally Invasive and Endoscopy

10:00 – 11:30 am

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| <p>10:00 am Single Port Laparoscopic Right Hemicolectomy: A Safe Alternative to Conventional Laparoscopy S11
J. A. Waters, M. J. Guzman, D. J. Selzer, E. A. Wiebke, B. W. Robb, V. George, Indianapolis, IN</p> <p>10:06 am Discussion</p> <p>10:09 am Clinical Outcome of Laparoscopic Right Hemicolectomy with Transvaginal Anastomosis and Retrieval of Resected Specimen S12
G. Choi, J. Park, K. Lim, Y. Jang, S. H. Jun, Daegu, South Korea</p> <p>10:15 am Total Intracorporeal Colon Surgery Using the Transvaginal Extraction Technique S13
K. C. Russek, M. E. Franklin, A. Alvarez, San Antonio, TX</p> <p>10:21 am Panel Discussion</p> <p>10:27 am Utilization of Laparoscopic Colectomy in the United States Before and After the Clinical Outcomes of Surgical Therapy (COST) Study Group Trial S14
J. D. Rea, M. M. Cone, B. S. Diggs, K. E. Deveney, K. C. Lu, D. O. Herzig, Portland, OR</p> <p>10:33 am Discussion</p> <p>10:36 am Robotic vs. Laparoscopic Resection of Rectal Cancer: Short-term Outcomes of a Case Control Study S15
J. Kwak, S. Kim, D. Son, J. Kim, S. Baek, J. Cho, Seoul, South Korea</p> | <p>10:42 am A Matched-case Analysis of Intraoperative and Postoperative Outcomes Following Conventional vs. Hand-assisted vs. Robotic-assisted Laparoscopic Colorectal Surgery S16
C. B. Patel, M. Ragupathi, D. I. Ramos-Valadez, E. M. Haas, Houston, TX</p> <p>10:48 am A Comparison of Laparoscopically-assisted and Robotic TME for Rectal Cancer S17
J. P. Ricci, H. Abcarian, L. M. Prasad, A. L. deSouza, A. Zimmern, S. Marecik, J. Park, Chicago, IL; Park Ridge, IL</p> <p>10:54 am Laparoscopic vs. Open Resection for Rectal Cancer Patients: Comparison of Perioperative Outcomes and Long Term Survival S18
S. Baik, M. Mutch, E. H. Birnbaum, J. W. Fleshman, St. Louis, MO</p> <p>11:00 am Panel Discussion</p> <p>11:12 am Detection of Intestinal Dysplasia Using Angle-resolved Low Coherence Interferometry S19
C. Mantyh, N. Terry, Y. Zhu, A. Wax, C. Guy, J. Migaly, J. Thacker, Durham, NC</p> <p>11:18 am Discussion</p> <p>11:21 am Optimal Timing of Anticoagulation Pre- and Post-colonoscopy with Polypectomy S20
M. Heyrosa, S. Thekkeurumbil, S. Eid, I. Khubchandani, Allentown, PA</p> <p>11:27 am Discussion</p> |
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Presidential Address



11:30 am

The Impact of Professionalism

James Fleshman, MD
*Professor of Surgery
Chief of Colon and Rectal Surgery
Washington University
St. Louis, MO*

Lunch and Poster Walk-Arounds

Noon – 1:30 pm
Authors are requested to be at their poster

Symposium

Colorectal Cancer – Optimizing Therapy

1:30 – 3:30 pm

Unlike colon cancer, the treatment algorithm for rectal cancer has several points of diversion before and after surgery. Treatment of this disease requires the coordination of many different specialties and diagnostic tests. A subset of patients with more advanced disease clearly benefit from the addition of neoadjuvant radiation or chemoradiation. Operating in the pelvis can prove to be challenging, and the technique of surgery in rectal cancer has a significant effect on oncologic results. Pathologists also play an integral role in the care of these patients. The quality of the mesorectal excision is a direct measure of the quality of the surgery.

Additionally, the nodal harvest and radial margins have a direct bearing on outcomes and the need for additional adjuvant therapy. Sentinel lymph nodes, which have a proven role in the treatment of breast cancer, have a less defined role in the treatment of rectal cancer. Based on the pre-operative and pathologic staging, many patients can benefit from adjuvant chemotherapy. While a plethora of literature exists on these issues, the approach to rectal cancer treatment remains highly variable between surgeons and medical centers.

This symposium will examine the evidence relating to each of these issues and define a clear, consistent algorithm for the approach to the treatment of patients with rectal cancer.

Existing Gaps

What Is: Treatment of rectal cancer is extremely variable in regards to the use of neoadjuvant therapy, quality of surgery, pathologic evaluation, and post-operative treatment. Very few centers have quality assessment measures in place to evaluate their rectal cancer results.

What Should Be: Patients with rectal cancer should be approached in a systematic fashion, and should be treated with appropriate adjuvant and surgical therapies based on the best available evidence. Surgeons should have quality assessment measures as a routine part of their rectal cancer programs.

Director: Thomas Read, MD, Burlington, MA • **Assistant Director:** Marc Brozovich, MD, Pittsburgh, PA

1:30 pm	Introduction Thomas Read, MD, Burlington, MA	2:05 pm	Assessing the Quality of Resection for Rectal Cancer Neil Hyman, MD, Burlington, VT
1:35 pm	Neoadjuvant Therapy for Rectal Cancer: Who Should Get It? How Much? Robert Beart, Jr., MD, Los Angeles, CA	2:20 pm	Downstaging After Neoadjuvant Therapy: What to do with “Complete” Responders? Robert Fry, MD, Philadelphia, PA
1:50 pm	Proctectomy for Rectal Cancer: What’s Important and What’s Not? Optimal Surgical Technique Bruce Wolff, MD, Rochester, MN	2:35 pm	Impact of Surgical Technique in Colon Cancer Outcomes – Colonic Mesenteric Excision Werner Hohenberger, MD, Erlangen, Germany
		2:50 pm	Case Presentation and Discussion

Objectives: At the end of this session, surgeons should be able to: a) institute a quality assessment program as part of their rectal cancer treatment program; b) appropriately select patients who require neoadjuvant therapy and understand the appropriate selection of the neoadjuvant regimen; c) understand and practice appropriate surgical techniques in the operative treatment of the disease; d) understand the important role the pathologist plays in the therapy and quality assessment of rectal cancer treatment; e) discuss the role of sentinel nodes in the treatment of rectal cancer; and f) appropriately refer patients for adjuvant chemotherapy.

Refreshment Break

3:30 – 4:00 pm



Pelvic Floor

4:00 – 5:30 pm

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| <p>4:00 pm Measurements of Paradoxical Contractions of Puborectalis: Which Test Result Matters? S21
L. Bordeianou, L. Savitt, A. Dursun, Boston, MA</p> <p>4:06 pm Prospective Multicenter Trial Comparing Echodefecography with Defecography in the Assessment of Anorectal Dysfunctions in Patients with Obstructed Defecation S22
F. S. Regadas, E. M. Haas, M. A. Abbas, J. M. Jorge, A. P. Habr-Gama, D. Sands, S. D. Wexner, I. M. Amaral, C. Sardinhas, D. M. Lima, U. E. Sagae, S. M. Murad-Regadas, Ceara, Brazil; Houston, TX; Los Angeles, CA; Sao Paulo, Brazil; Weston, FL; Caracas, Venezuela; Parana, Brazil</p> <p>4:12 pm Panel Discussion</p> <p>4:18 pm No Rectopexy Versus Rectopexy for Full-thickness Rectal Prolapse: A Randomized Multicenter Trial S23
J. Karas, S. Uranues, D. F. Altomare, S. Sokmen, Z. Krivokapic, J. Hoch, R. Bergamaschi, Stony Brook, NY; Graz, Austria; Bari, Italy; Inciralti, Turkey; Belgrade, Serbia; Prague, Czech Republic</p> <p>4:24 pm Discussion</p> <p>4:27 pm Stapled Transanal Rectal Resection Successfully Treats Obstructed Defecation Syndrome: A Single Institution Experience S24
H. Bahna, L. K. Burns, P. Williamson, S. DeJesus, J. Gallagher, A. Ferrara, R. Mueller, Orlando, FL</p> <p>4:33 pm Stapled Transanal Rectal Resection for Obstructed Defecation: Disappointing Long-term Outcomes Despite Promising Short-term Results S25
K. Madbouly, K. Abbas, A. Hussein, Alexandria, Egypt</p> <p>4:39 pm Panel Discussion</p> | <p>4:45 pm Efficacy of Sacral Nerve Stimulation for the Treatment of Fecal Incontinence S26
J. Murphy, D. J. Boyle, K. Prosser, M. L. Gooneratne, N. S. Williams, C. L. Chan, London, United Kingdom</p> <p>4:51 pm Long-term Efficacy and Safety of Sacral Nerve Stimulation for Fecal Incontinence S27
A. Mellgren, S. D. Wexner, J. A. Coller, G. Devroede, T. Hull, R. McCallum, M. Chan, J. Ayscue, A. S. Shobeiri, D. Margolin, M. England, H. Kaufman, W. J. Snape, E. Mutlu, H. K. Chua, P. Pettit, D. Nagle, R. Madoff, D. R. Lerew, Minneapolis, MN; Weston, FL; Burlington, MA; Fleurimont, QC, Canada; Cleveland, OH; Kansas City, KS; Hong Kong, China; Washington, DC; Oklahoma City, OK; New Orleans, LA; Ft. Worth, TX; Los Angeles, CA; San Francisco, CA; Chicago, IL; Jacksonville, FL; Boston, MA</p> <p>4:57 pm Sacral Nerve Stimulation for Fecal Incontinence: Causes of Surgical Revision, From a Series of 123 Patients Operated on in a Single Institution S28
J. Faucheron, D. Voirin, B. Badic, Grenoble, France</p> <p>5:03 pm Panel Discussion</p> <p>5:12 pm Magnetic Anal Sphincter for the Treatment of Fecal Incontinence. A Preliminary Report S29
S. Buntzen, P. A. Lehur, S. McNevin, A. Mellgren, S. Laurberg, R. Madoff, Aarhus, Denmark; Nantes, France; Spokane, WA; Minneapolis, MN</p> <p>5:18 pm Long Term Results of Biofeedback Therapy for Anal Incontinence: Optimal Outcomes is Related to Improvement in Quality of Life S30
L. C. Oliveira, Rio de Janeiro, Brazil</p> <p>5:24 pm Panel Discussion</p> |
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Current State of Minimally Invasive Surgery *Laparoscopy, Single Site Laparoscopy, NOTES and Endoluminal Therapy*

4:00 – 5:30 pm

Advances in surgical technology are impacting the manner in which colorectal surgeons manage many diseases. As laparoscopy has finally reached the mainstream, many short-term benefits have been identified such as faster return of bowel function, less narcotic use, shorter length of stay, and better cosmesis. There also appears to be long-term benefits such as lower incidence of incisional hernias and small bowel obstructions. Technology continues to push the barriers of accessing the colon and peritoneal cavity with smaller, fewer or no incisions and with endoluminal techniques. Laparoscopy appears to be a stepping stone to advanced techniques for managing colorectal diseases. Newer techniques such as single site laparoscopic surgery and natural orifice transluminal endoscopic surgery (NOTES) remain investigational and are being applied to gallbladder surgery and appendectomies. Because of the modest improvements in short-term outcomes with laparoscopy, many remain leery of the advances of single site laparoscopy and NOTES. These techniques are being embraced by many surgeons both general and colon and rectal, so it is clear that they will continue to evolve and eventually become part of our practices. Therefore, it is important to fully understand the current role of laparoscopy in colon and rectal surgery, and to understand the development, benefits and hurdles associated with the newer techniques of single site laparoscopy, NOTES, robotics, and endoluminal therapies.

This symposium will address the current state and role of laparoscopy in the management of colon and rectal diseases. This initiative will focus on the advances of robotics, single site laparoscopy, NOTES, and endoluminal techniques and examine how best to investigate and adopt these approaches into our clinical practices in order to provide the patient with the safest and most beneficial techniques.

Existing Gaps

What Is: A significant number of surgeons are not performing laparoscopic colectomy because of the belief that benefits are not clinically significant enough to routinely adopt it. With the continued advances of technology into the realm of robotics, single site laparoscopy, NOTES, and advanced endoluminal techniques, the clinically significant advantages are harder to measure and realize.

What Should Be: Surgeons need to have a comprehensive understanding of the advantages to laparoscopic colectomy. This will allow for the meaningful implementation of these newer laparoscopic and endoluminal techniques into their armamentarium of skills to treatment of disease of the colon and rectum.

Director: Peter W. Marcello, MD, Burlington, MA
Assistant Director: Virgilio George, MD, Indianapolis, IN

4:00 pm	Introduction Peter W. Marcello, MD, Burlington, MA	4:26 pm	SILS Colectomy – Moving Forward or Backward? Feza Remzi, MD, Cleveland, OH
4:02 pm	NOTES and Alternative Access Sites – Is it Practical? Mark Whiteford, MD, Portland, OR	4:38 pm	Robotics – Colon, Rectum, or the Corner? Sonia Ramamoorthy, MD, San Diego, CA
4:14 pm	Endoscopic Submucosal Resections – Beyond Snare Polypectomy David Margolin, MD, New Orleans, LA	4:50 am	Why Do It? If You Don't, We Will! Santiago Horgan, MD, San Diego, CA
		5:02 pm	Panel Discussion / Q&A

Objectives: At the conclusion of this session, participants should be able to understand: a) the indications and uses for submucosal resection of colonic polyps; b) the indications, technical aspects and benefits of single incision laparoscopy; c) the indications, benefits, and barriers for the use of robotics in colon and rectal surgery; and d) the technology associated with and the potential uses and pitfalls of NOTES.



Breakfast Symposium

Tailored Therapy for Colorectal Cancer

6:15 – 7:45 am

Advances in chemotherapy and our understanding of the genetics in colorectal cancer are greatly impacting the fashion in which patients with adenocarcinoma of the colon and rectum are being treated. The introduction of newer chemotherapeutic regimens is leading to improved outcomes compared to the traditional regimen of 5-FU/leucovorin. The impact is seen in patients with distant metastatic disease, Stages II and III colon cancer, and rectal cancer in the neoadjuvant setting. Despite all of these improvements in response and survival, there still remains a large percentage of patients who receive these drugs but do not derive any benefit. Also, there are large groups of patients who do not receive chemotherapy and may benefit from it. The genetic make up of individual tumors is allowing for identification of patients who have the greatest need for adjuvant therapy and who will respond best to specific therapies. Therefore, patients are currently being treated with multimodality therapy in a tailored fashion for their individual tumor.

This symposium will update surgeons about this implementation of genetic and pathologic data into the development of tailored treatment regimens for patients with adenocarcinoma of the colon and rectum. This will allow surgeons to improve the care of patients with metastatic colorectal cancer, Stage II and III colon and rectal cancer.

Existing Gaps

What Is: Chemotherapeutic regimens are rapidly changing and tumor specific genetic information is being used to employ these regimens. As a result, some patients are being under or over treated for their individual tumor.

What Should Be: More efficient integration of pathologic and genetic staging will allow for more efficient use of multimodality treatment regimens, thus continuing to improve patients' outcomes with colorectal cancer.

Director: Martin Weiser, MD, New York, NY

Assistant Director: Najjia Mahmoud, MD, Philadelphia, PA

6:15 am	Introduction Martin Weiser, MD, New York, NY	6:53 am	Predictive and Prognostic Molecular Markers in Metastatic Colorectal Cancer Neil Segal, MD, New York, NY
6:17 am	Risk Stratifying Stage II Colon Cancer Patients for Adjuvant Chemotherapy Martin Weiser, MD, New York, NY	7:05 am	Identifying Patients for Sphincter Preserving Surgery Larissa Temple, MD, New York, NY
6:29 am	Predictive Molecular Biomarkers in Colorectal Cancer Adjuvant Chemotherapy Robert Gryfe, MD, Toronto, ON, Canada	7:17 am	Panel Discussion / Q&A
6:41 am	Molecular Determinates of Response to Neoadjuvant Chemoradiation in Rectal Cancer Parag Parikh, MD, St. Louis, MO		

Objectives: At the conclusion of this session, participants will be able to understand: a) how to treat patients with metastatic colorectal cancer; b) which patients with Stage II colon cancer are at highest risk for recurrence and will benefit the most from adjuvant chemotherapy; c) how to integrate a patient predicted metabolism of 5-FU into the neoadjuvant treatment protocol for local advanced rectal cancer; d) how to integrate the genomic data of an individual rectal cancer into the treatment protocol for neoadjuvant, surgical, and adjuvant therapies; and e) the use of testing an individual tumor's response to various chemotherapy agents prior to the implementation in the patient.



Meet the Professor Breakfasts

6:45 – 7:45 am

Limit: 30 per breakfast • Fee \$35 • *Registration Required* • Continental Breakfast

Residents are encouraged to bring problems and questions to this informal discussion.

Please register early and indicate your 1st and 2nd choice on the Physicians' Registration Form.

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| <p>T-1 Coding and Reimbursement – Help!
David Margolin, MD, New Orleans, LA
Guy Orangio, MD, Atlanta, GA</p> <p>T-2 C. Diff Colitis – Taming the Beast
Philip Cole, MD, Shreveport, LA
Walter Longo, MD, New Haven, CT</p> <p>T-3 Fecal Incontinence – The Latest and Greatest
Tracy Hull, MD, Cleveland, OH
M. Shane McNevin, MD, Spokane, WA</p> <p>T-4 Health Care Policy – Measures of Excellence
Paul Finan, MD, Leeds, Yorkshire, United Kingdom
P. Ronan O'Connell, MD, Dublin, Ireland
Frank Opelka, MD, New Orleans, LA</p> | <p>T-5 Training, Credentialing, and Resident Evaluations
Gerald Isenberg, MD, Philadelphia, PA
Graham Newstead, MB, BS, Sydney, Australia
Patricia Roberts, MD, Burlington, MA</p> <p>T-6 Clinical Trials: The Do's and Don'ts when Starting Out
Alessandro Fichera, MD, Chicago, IL
Heidi Nelson, MD, Rochester, MN</p> <p>T-7 The ABCRS – The Inner Workings of Certification and MOC (Invitation Only)</p> |
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Best Practice Parameters Based on Level 1 Data and JACHO Recommendations

8:00 – 9:30 am

While dogma, convenience, and common sense govern many of the practice habits of colorectal surgeons, many of our routines have no basis in the literature or have been disproven. As quality measures and pay for performance loom on the horizon, it is important that the colorectal surgeon understand and follow the evidence supporting perioperative practices.

Complications contribute to increased morbidity and health care related costs. The complication rate for elective colorectal resections ranges from 10–20%. Reducing these complications through standard, evidence based treatment, and application of new emerging technology will improve safety, reduce morbidity and costs.

This symposium focuses on the evidence based practice of colorectal surgery. Several topics covering the perioperative management of the surgical patient will be examined and the evidence supporting these practices will be reviewed.

Existing Gaps

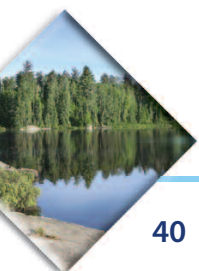
What Is: Surgical practices in the perioperative period are highly variable and differ dramatically between institutions.

What Should Be: The colorectal surgeon should use evidence based routines in their management of patients in the perioperative period.

Director: Alan Herline, MD, Nashville, TN
Assistant Director: Anne Lin, MD, St. Louis, MO

8:00 am	Introduction Alan Herline, MD, Nashville, TN	8:34 am	Smoking Cessation Daniel Herzig, MD, Portland, OR
8:02 am	Bowel Preps Mark Welton, MD, Stanford, CA	8:42 am	Diabetic Control Maher Abbas, MD, Los Angeles, CA
8:10 am	DVT Prophylaxis Laurence Yee, MD, San Francisco, CA	8:50 am	Fluid Management – Liberal vs Goal Directed Luca Stocchi, MD, Cleveland, OH
8:18 am	Surgical Site Infections Prevention and Improvement Harry Papaconstantinou, MD, Temple, TX	8:58 am	Enhanced Bowel Recovery Conor Delaney, MD, Cleveland, OH
8:26 am	Pain Control Douglas Brewer, MD, Macon, GA	9:06 am	Panel Discussion / Q&A

Objectives: At the conclusion of this session, participants will be able to: a) describe the evidence for routine bowel preparation in colorectal resections; b) identify the evidence for reducing surgical site infections including prophylactic antibiotics and patient warming; c) provide their patients with optimal prophylaxis against venous thromboembolism; d) provide their patients with optimal pain control; e) counsel their patients on the importance of smoking cessation; f) practice optimal glucose control; g) identify the importance of fluid restriction; h) discuss the evidence regarding post-operative ileus; and i) organize and educate their nursing staff in the best care of the post-operative patient.



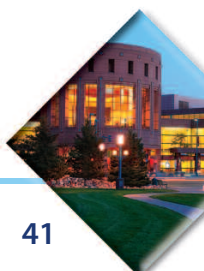
Inflammatory Bowel Disease

8:00 – 9:30 am

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| 8:00 am | A Simple to Use Risk Score for Predicting Surgical Site Infections in Inflammatory Bowel Disease S31
K. Alavi, P. Sturrock, W. B. Sweeney, J. A. Maykel, J. A. Cervera-Servin, E. F. Cook, Worcester, MA; Boston, MA | 8:45 am | Desulfovibrio Species are Increased Ulcerative Colitis S36
J. C. Coffey, F. Rowan, N. Docherty, B. Murphy, P. R. O'Connell, Cleveland, OH; Dublin, Ireland |
| | | 8:51 am | Discussion |
| 8:06 am | Surgical Resection in Crohn's Disease: Are Immunosuppressor Medications Associated with Higher Postoperative Infection Complication? S32
J. Canedo, R. Pinto, S. M. Murad-Regadas, S. Lee, L. Rosen, S. D. Wexner, Weston, FL | 8:54 am | The Use of Genotype to Predict Phenotype in Patients with Perianal Crohn's Disease S37
S. Dharmarajan, G. Nandakumar, R. A. Busch, C. Hamm, E. Li, S. Hunt, St. Louis, MO |
| | | 9:00 am | Discussion |
| 8:12 am | Panel Discussion | 9:03 am | NOD2 Mutations Correlate with Severe Pouchitis After Ileal Pouch Anal Anastomosis S38
R. Sehgal, A. Berg, J. Hegarty, A. Kelly, Z. Lin, L. Poritz, W. Koltun, Hershey, PA |
| 8:18 am | Efficacy of Infliximab and/or Azathioprine in Patients Developing Crohn's Disease Like Complications After Ileal Pouch Anal Anastomosis S33
L. Haveran, R. Sehgal, D. B. Stewart, K. McKenna, L. S. Poritz, W. Koltun, Hershey, PA | 9:09 am | Discussion |
| | | 9:12 am | Correlation Between MR Enterography and Histopathology in Patients with Resected Small Bowel Strictures from Crohn's Disease S39
E. Messaris, D. Grand, B. Winn, M. Resnick, V. Pricolo, Providence, RI |
| 8:24 am | Biologic Immunomodulators Increased the Healing Rate of Surgically Treated Perianal Crohn's Fistulas S34
G. El-Gazzaz, T. Hull, J. M. Church, Cleveland, OH | 9:18 am | Discussion |
| 8:30 am | Panel Discussion | 9:21 am | Oncologic Outcome in Ulcerative Colitis Patients with Dysplasia or Cancer who Underwent Stapled or Hand-sewn Ileal Pouch Anal Anastomosis S40
W. Al-Sukhni, R. McLeod, H. MacRae, B. O'Connor, H. Huang, Z. Cohen, Toronto, ON, Canada |
| 8:36 am | Using Raman Spectroscopy to Discriminate Inflammatory Bowel Diseases S35
X. Bi, A. Walsh, A. Mahadevan-Jansen, A. Herline, Nashville, TN | | |
| 8:42 am | Discussion | 9:27 am | Discussion |

Refreshment Break

9:30 – 10:00 am



Tuesday, May 18

Ernestine Hambrick Lectureship



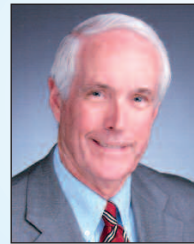
10:00 – 10:30 am

The Evolving Role of Minimally Invasive Surgery in Rectal Cancer

Heidi Nelson, MD

*Fred C. Andersen Professor of Surgery
Mayo Clinic College of Medicine
Rochester, MN*

Parviz Kamangar Humanities in Surgery Lectureship



10:30 – 11:00 am

Striving for Competency, Compassion and Communication

Thomas R. Russell, MD, FACS

*Adjunct Professor, Feinberg School of Medicine, Northwestern University
Chair, American College of Surgeons Foundation Board
San Francisco, CA*

Joseph Mathews Oration



11:00 – 11:30 am

**Healthcare Reform:
The Perspective of the American College of Surgeons**

H. Randolph Bailey, MD

*Clinical Professor, Dept. of Surgery
Chief, Div. of Colon and Rectal Surgery
University of Texas Health Science Center Houston
Chief, Div. of Colon & Rectal Surgery
The Methodist Hospital
Houston, TX*

Lunch and Poster Walk-arounds

11:30 am – 12:30 pm

Authors are requested to be at their poster

Women in Colorectal Surgery Luncheon

11:30 am – 1:30 pm • Fee \$28 • Registration Required

The Women's Luncheon offers an opportunity for women to renew friendships and make new contacts. Female surgeons, residents and medical students attending the Annual Meeting are welcome. Trainees are particularly encouraged to attend as the Women's Luncheon provides an opportunity to meet experienced colon and rectal surgeons from a variety of settings.



Local Treatment of Rectal Cancer

12:30 – 2:00 pm

Local therapy for early stage rectal cancer has been used for decades with variable results reported in the literature. No standard of care for these early lesions exists, with wide variation in approaches between institutions and surgeons. Historically, radical resection has had superior oncologic results compared to local treatment, but improved results come at a price. Compared to local treatment, radical resection of the rectum is costly, morbid, and can lead to functionally inferior results.

With increased colorectal cancer screening, more early stage rectal cancers are being detected. The population is aging and patients are frequently presenting with more significant co-morbid disease, making them poor candidates for radical surgery. In the case of rectal cancer, local therapy clearly offers a viable alternative for high risk patients. Additionally, local treatment may prove to be a rational choice for selected patients with early stage rectal cancers who are not at prohibitive risk for abdominal surgery. The key lies in the proper selection of patients and treatment.

In recent years, several large series of outcomes for local excision of rectal cancer have been published, with relatively dismal results. The addition of adjuvant radiation can improve the outcome for these patients. Endocavitary radiation alone or in combination with local excision, offers another viable alternative to radical surgery. A relatively recent innovation in the local treatment of rectal cancer is the introduction of transanal endoscopic microsurgery (TEM). TEM allows tumors in the mid and upper rectum to be excised, and has increased the number of tumors which can theoretically be excised locally. Small, non-randomized series using TEM for early stage rectal cancers have shown improved results compared to historical controls for local excision. A single prospective randomized trial comparing TEM to radical resection for T2 cancers treated with neoadjuvant chemoradiation showed equivocal oncologic results for both groups, with dramatically decreased morbidity in the TEM group. The advances in surgical technique with TEM and with the delivery of adjuvant chemo- or radiation therapy have allowed surgeons to expand their use of local therapy for selected early stage tumors. Therefore, it is imperative that a surgeon understands the issues and indication for TEM resection of rectal cancer and the implementation of neoadjuvant or adjuvant therapy.

This symposium will update the surgeon on the use of local therapy in the treatment of early stage rectal cancer. The primary purpose of the symposium is to systematically evaluate the evidence related to the suitability of the technique, selection of tumors, the benefit of adjuvant therapy, and the appropriate follow-up of patients treated with local therapy.

Existing Gaps

What Is: There is no consensus on the use of local therapy or the selection of the proper treatment modalities.

What Should Be: Surgeons should understand the criteria for selection of patients for local treatment, and should understand when to use alternative or adjuvant treatments once the decision to avoid radical surgery is made.

Director: David Rothenberger, MD, Minneapolis, MN
Assistant Director: David Maron, MD, Philadelphia, PA

12:30 pm **Introduction**
David Rothenberger, MD, Minneapolis, MN

12:44 pm **Locally Advanced Lesions**
Emanuele Lezoche, MD, Rome, Italy

12:32 pm **Favorable Lesions**
Philip Paty, MD, New York, NY

12:56 pm **Radiation as Definitive Therapy**
Parag Parikh, MD, St. Louis, MO

Continued next page



Symposium

Local Treatment of Rectal Cancer *(Continued)*

1:08 pm **Surveillance – If so, Why and How?**
Anders Mellgren, MD, Minneapolis, MN

1:32 pm **Case Discussion**

1:20 pm **Less is not Better**
Herand Abcarian, MD, Chicago, IL

Objectives: At the conclusion of this session, participants will be able to: a) identify patients eligible for local therapy; b) demonstrate how to treat higher stage tumors in patients who are at prohibitive risk for radical surgery; c) explain the benefit of using radiation as definitive therapy; d) discuss how to follow patients who have been treated with local therapy; and e) understand the arguments against local therapy.



Research Forum

12:30 – 2:00 pm

This Forum will highlight the works of young researchers, including residents in surgery and colon and rectal surgery. It is a forum for new ideas, works in progress and completed projects. Seven papers will be presented with a three minute discussion by an invited discussant immediately followed by three minutes of questions from the floor.

12:30 pm	Promoter Methylation of Specific Genes is Associated With the Tumorigenesis and Progression of Colorectal Adenocarcinomas RF-1 J. C. Kim, S. Roh, D. H. Cho, J. S. Choi, T. W. Kim, Y. Kim, Seoul, South Korea; Daejeon, South Korea	1:16 pm	Invited Discussant
12:37 pm	Invited Discussant	1:19 pm	Discussion
12:40 pm	Discussion	1:22 pm	The Dietary Phytochemical Piperine Inhibits HT-29 Human Colon Cancer Cell Growth RF-5 P. B. Yaffe, M. J. Walsh, D. W. Hoskin, Halifax, NS, Canada
12:43 pm	The Regulatory Role of Micro-RNA Let-7a During Colorectal Cancer Metastasis RF-2 C. A. Messick, K. L. DeJulius, X. Liu, M. F. Kalady, Cleveland, OH	1:29 pm	Invited Discussant
12:50 pm	Invited Discussant	1:32 pm	Discussion
12:53 pm	Discussion	1:35 pm	Gene Expression of Colonic Submucosa Differs Between the Inflammatory Colitides RF-6 A. E. M'Koma, P. E. Wise, D. A. Schwartz, M. K. Washington, R. L. Muldoon, W. M. El-Rifai, A. J. Herline, Nashville, TN
12:56 pm	A Novel 6-gene Signature Predicts Rectal Cancer Response to Preoperative Chemoradiation Therapy RF-3 A. Zuckerman, S. Dharmarajan, C. Hamm, E. Li, M. Mutch, St. Louis, MO	1:42 pm	Invited Discussant
1:03 pm	Invited Discussant	1:45 pm	Discussion
1:06 pm	Discussion	1:48 pm	Is the Expression of HLA Genes Affected by Microsatellite Instability in Colorectal Cancer? RF-7 A. M. Jarrar, K. L. DeJulius, J. C. Coffey, J. M. Church, M. F. Kalady, Cleveland, OH
1:09 pm	Increase in Tight Junction Transmembrane Proteins in the Ileal Pouch in a Rat Model of Ileal Pouch Anal Anastomosis RF-4 N. J. Hansen, L. R. Harris, III, L. S. Poritz, Hershey, PA	1:55 pm	Invited Discussant
		1:58 pm	Discussion

Refreshment Break

2:00 – 2:30 pm



Neoplasia II

2:30 – 4:00 pm

- | | | | |
|---------|--|---------|--|
| 2:30 pm | Safe Length of Distal Bowel Margin in Lower Rectum Cancer Surgery S41
A. Rutkowski, M. Chwalinski, J. Oledzki, K. Bujko, M. Bednarczyk, P. Liszka Dalecki, A. Gornicki, Warsaw, Poland | 3:21 pm | Impact of Tailored-chemotherapy Based on Adenosine Triphosphate-chemotherapy Response Assay on Increasing Resectability in Patients with Liver Metastasis from Colorectal Cancer S47
T. Kim, H. Hur, B. Min, K. Lee, N. Kim, Seoul, South Korea |
| 2:36 pm | Influence of a Subcentimeter Distal Clearance Margin During Restorative Resection for Rectal Cancer on Long-term Oncologic Outcomes S42
L. Lian, P. R. Kiran, I. C. Lavery, Cleveland, OH | 3:27 pm | Prognostic Significance of Mismatch Repair Status in Terms of MLH1/MSH2 Immunohistochemistry and Microsatellite Instability S48
Y. S. Yoon, C. S. Yu, J. C. Kim, Seoul, South Korea |
| 2:42 pm | Panel Discussion | 3:33 pm | Panel Discussion |
| 2:48 pm | The Diagnostic Value of Lymph Node Ratio after Neo-adjuvant Chemoradiation and Rectal Cancer Surgery S43
C. L. Klos, L. Bordeianou, P. Sylla, Y. Chang, D. L. Berger, Amsterdam, Netherlands; Boston, MA | 3:42 pm | Clinical Implications of Acellular Mucin in Resected Rectal Cancers with Pathologic Complete Response to Neoadjuvant Chemoradiation S49
L. de Campos-Lobato, M. F. Kalady, D. Dietz, L. Stocchi, J. D. Vogel, I. C. Lavery, Cleveland, OH |
| 2:54 pm | Predictive Factors Affecting Survival In Stage II Colorectal Cancer: Is Lymph Node Harvesting Relevant? S44
C. E. Peeples, J. Shellnut, H. Wasvary, J. Sacksner, Royal Oak, MI | 3:48 pm | Discussion |
| 3:00 pm | Lymphatic Vessel Distribution in the Colorectal Wall and Potential Implications for T1 Colorectal Tumors S45
K. J. Smith, D. A. Burke, P. Finan, P. Jones, P. Quirke, Leeds, West Yorkshire, United Kingdom | 3:51 pm | Defining Phenotypes and Cancer Risk in Hyperplastic Polyposis Syndrome S50
M. F. Kalady, A. M. Jarrar, L. LaGuardia, M. O'Malley, B. Leach, C. Eng, J. M. Church, Cleveland, OH |
| 3:06 pm | Panel Discussion | 3:57 pm | Discussion |
| 3:15 pm | Molecular Markers as a Method of Predicting Response to Combined Modality Therapy for Advanced Stage Rectal Cancers S46
M. Berho, S. D. Wexner, Weston, FL | | |



A Comprehensive Evaluation of Pelvic Floor Disorders

2:30 – 4:00 pm

Functional disorders of the colon, rectum and anus present significant physical, psychological and burdens on the affected patients, their families and the treating physicians. These problems range from chronic constipation to obstructed defecation to pelvic organ prolapse to fecal incontinence. To further complicate the care of these patients, these processes often occur together with multifactorial etiologies. Therefore, the evaluation of these patients is of the utmost importance to best understand the pathophysiology of each individual patient. There are many modes of evaluating these patients including a thorough history and physical, plain films and cross-sectional imaging as well as functional or dynamic studies such as colon transit studies, defecography, anal manometry, EMG, and ultrasound. The surgeon must be able to interpret these studies in the context of the patient's constellation of symptoms to identify the optimal treatment plan. Finally, there are many potential medical and surgical options available to treat these patients. When the right treatment is prescribed for the right patient, the patients can experience significant improvement in their bowel function.

This comprehensive symposium addresses the evaluation, diagnosis, interpretation, and management of patients with functional GI disorders. A panel of experts will discuss several case presentations designed to work through issues such as colonic inertia, obstructed defecation, pelvic organ prolapse, and fecal incontinence in real-time scenarios. The discussion will focus on topics such as the advances of dynamic ultrasonography and the indications and outcomes for sacral nerve stimulation, the SECCA procedure, the STARR procedure and the use of biologics.

The moderators will present the panel of experts with a series of case presentations to address several pelvic floor abnormalities. The presentations will contain histories and physicals and appropriate investigative studies. These investigative studies will be shown and interpreted. Audience interaction will be encouraged. The symposium will cover these conditions: a) obstructive defecation; b) incontinence; c) colonic inertia; and d) pelvic floor fallout. This will be followed by a 20-minute discussion and question period.

Existing Gaps

What Is: These patients often present with complex symptoms. There are many modes of evaluation and treatment; as a result, many patients are not properly evaluated and treated.

What Should Be: With appropriate understanding of the patient's symptoms and test results, surgeons can provide the most appropriate medical or surgical treatment.

Director: Ira Kodner, MD, St. Louis, MO

Assistant Director: Sharon Gregorcyk, MD, Dallas, TX

Panelists:

C. Neal Ellis, MD, Mobile, AL
Tracy Hull, MD, Cleveland, OH

Ann Lowry, MD, Minneapolis, MN
Madhulika Varma, MD, San Francisco, CA

Objectives: At the conclusion of this session, participants should be able to: a) evaluate, interpret the studies, and prescribe treatment for patients with obstructed defecation; b) evaluate, interpret the studies, and prescribe treatment for patients with fecal incontinence; c) evaluate, interpret the studies, and prescribe treatment for patients with colonic inertia; and d) evaluate, interpret the studies, and prescribe treatment for patients with pelvic organ prolapse.



General Surgery Forum

2:30 – 4:00 pm

General Surgery residents will present work they have researched and written in a podium format. General Surgery resident colleagues will critique the presentations and start the discussions.

2:30 pm	Complications and Outcomes in Obese Patients Undergoing Laparoscopic Colectomy F. Quinteros, A. L. deSouza, A. Zimmern, J. Park, S. Maricek, L. M. Prasad, Chicago, IL; Park Ridge, IL	GSF-1	3:10 pm	Discussion	
2:37 pm	Invited Discussant		3:15 pm	Single Port Access Surgery – Comparison of a 30 Month Experience with 30 Lower Gastrointestinal Procedures to Multiport Laparoscopy E. R. Podolsky, P. G. Curcillo, Philadelphia, PA	GSF-4
2:40 pm	Discussion		3:22 pm	Invited Discussant	
2:45 pm	Colorectal Subspecialty Training: Impact on Likelihood of Colostomy During Operation for Acute Diverticulitis R. R. Cannom, G. T. Ault, R. Madoff, R. W. Beart, Jr., P. Vukasin, D. A. Etzioni, Los Angeles, CA; Minneapolis, MN	GSF-2	3:25 pm	Discussion	
2:52 pm	Invited Discussant		3:30 pm	Variability in Guideline-recommended Follow-up in Colorectal Cancer Patients in the Veterans Affairs Healthcare System E. Messaris, Z. Gregg, K. Hunt, M. Vezeridis, T. Cataldo, Providence, RI	GSF-5
2:55 pm	Discussion		3:37 pm	Invited Discussant	
3:00 pm	Mismatch Repair Protein Expression is Associated with Mesenteric Lymph Node Yield in Colon Cancer Resection Specimens T. Fancher, J. Shia, P. Paty, L. Temple, M. Weiser, D. Wong, J. Guillem, G. Nash, Waterbury, CT; New York, NY	GSF-3	3:40 pm	Discussion	
3:07 pm	Invited Discussant		3:45 pm	Current Morbidity and Rate of Colostomy Closure Following Hartmann’s Procedure J. S. Pressett, M. Joyce, W. B. Sweeney, K. Alavi, P. R. Sturrock, J. A. Maykel, Worcester, MA	GSF-6
			3:52 pm	Invited Discussant	
			3:55 pm	Discussion	



Symposium

Hemorrhoids – Yesterday, Today, and Tomorrow

4:15 – 5:15 pm

Symptomatic hemorrhoids are the most common condition seen by a colon and rectal surgeon. The degree of a patient's symptoms determines the aggressiveness with which the hemorrhoids are treated. The vast majority of patients respond well to a high fiber diet, but for those whose symptoms do not improve, surgical therapy is often warranted. The major drawbacks to surgical intervention are the associated post-operative pain and disability. As a result, many different options for the treatment of symptomatic hemorrhoids have been developed in attempts to effectively treat the hemorrhoids and minimize post-operative pain with minimal complications. Whether it is office based treatments such as rubber band ligation or infrared coagulation or operative procedures such as excision, PPH or hemorrhoid artery ligation, the specific treatment modality and expected outcomes depends upon the specific patient. The surgeon must be able to discuss the risks, benefits and outcomes for each treatment option in order to manage their patient effectively.

This session will discuss the treatment options of yesterday, today, and the future for symptomatic hemorrhoid disease. You will learn the indications, technical components, and expected outcomes for the various treatment options for hemorrhoids. This will allow you to provide the most effective care for your patients.

Existing Gaps

What Is: There are many options available for the surgical treatment of hemorrhoids. Each of the available options has its optimal time and place; thus, surgeons are often unclear when to utilize the various treatment options.

What Should Be: Surgeons are able to discuss all treatment options and identify the most effective management plan for each individual patient.

Director: Robert Madoff, MD, Minneapolis, MN
Assistant Director: Marc Singer, MD, Evanston, IL

4:15 pm	Introduction Robert Madoff, MD, Minneapolis, MN	4:53 pm	Excisional Hemorrhoidectomy with Ligature or Harmonic Scalpel Guy Orangio, MD, Atlanta, GA
4:17 pm	Office Based Treatment Rebecca Hoedema, MD, Grand Rapids, MI	5:05 pm	Panel Discussion / Q&A
4:29 pm	PPH – Has It Passed the Test of Time? David O'Brien, MD, Portland, OR		
4:41 pm	Ultrasound Guided HAL – The New Kid on the Block Lawrence Rusin, MD, Burlington, MA		

Objectives: At the conclusion of this session, participants will be able to: a) discuss the treatment options and outcomes for office based therapies for hemorrhoidal disease; b) identify the indications and outcomes for stapled hemorrhoidectomy; c) discuss the indications, limitations and outcomes for ultrasound guided hemorrhoid artery ligation; and d) identify the indications and outcomes for standard excisional hemorrhoidectomy and use of energy sources with this procedure.



Video Session

5:15 – 6:45 pm

- | | |
|---|--|
| <p>5:15 pm Perineal and Pelvic Anatomy of Extralevator Abdominoperineal Resection for Rectal Cancer: Cadaveric Dissection TV-1
H. Acar, A. Aslar, M. Kuzu, Ankara, Turkey (V-3)
<i>Presented by: M. Kuzu</i></p> | <p>6:06 pm Robotic Total Mesorectal Excision in Female Patient with Low Rectal Cancer TV-7
S. Marecik, A. deSouza, J. Ricci, J. Park, L. Prasad, Park Ridge, IL and Chicago, IL (OV-25)</p> |
| <p>5:21 pm Feasibility of Cylindrical versus Standard Abdomino-perineal Resection TV-2
N. Brindzei, A. Demercurio, E. Breen, J. Goldberg, R. Bleday, Boston, MA (V-25)</p> | <p>6:12 pm Laparoscopic Total Mesorectal Excision for Rectal Cancer: a Surgical Technique Utilizing Bipolar Energy Device TV-8
K. Umanskiy, J. Holder-Murray, M. Katdare, R. Hurst, A. Fichera, Chicago, IL (OV-27)</p> |
| <p>5:27 pm Panel Discussion</p> | <p>6:18 pm Panel Discussion</p> |
| <p>5:33 pm Laparoscopic Ultralow Anterior Resection with Intersphincteric Dissection for Low Rectal Cancer TV-3
M. Bun, A. Canelas, B. Helman, M. Laporte, C. Peczan, N. Rotholtz, Buenos Aires, Argentina (OV-5)</p> | <p>6:27 pm Posterior Pelvectomy with Pelvic Floor Reconstruction for Recurrent Rectal Cancer TV-9
P. Delrio, U. Pace, D. Scala, F. Ruffolo, C. Sassaroli, F. Cremona, G. Nasti, G. Romano, Naples, Italy (V-28)</p> |
| <p>5:39 pm Single Abdominal Incision Laparoscopic APR TV-4
L. Yee, T. Chung, San Francisco, CA (OV-10)</p> | <p>6:33 pm Rectosigmoid Flap for Perineal and Neovaginal Reconstruction after En bloc Abdominoperineal Resection with Vaginectomy for Rectovaginal Gastrointestinal Tumor TV-10
P. Atittharnsakul, C. Sahakitrungruang, Bangkok, Thailand (V-24)</p> |
| <p>5:45 pm Laparoscopic Transanal Abdominal Transanal Proctosigmoidectomy with Descending Coloanal Anastomosis TV-5
J. Marks, R. Essani, E. Larkin, Wynnewood, PA (OV-20)</p> | <p>6:39 pm Panel Discussion</p> |
| <p>5:51 pm Panel Discussion</p> | |
| <p>6:00 pm Robotic Total Mesorectal Excision in Obese Male TV-6
L. Prasad, S. Marecik, A. deSouza, J. Ricci, J. Park, Park Ridge, IL; Chicago, IL (OV-24)</p> | |



Anal Cancer and the New Millennium

5:15 – 6:45 pm

The incidence, presentation, and treatment of anal cancer have dramatically changed in the last decade. The HIV infection has had the greatest impact on the disease particularly in the areas of anal intraepithelial neoplasia (AIN) and the definitive treatment for invasive squamous cell neoplasia in these immunocompromised patients. As a result, many controversies regarding the optimal management of AIN have arisen and our understanding of the impact of HIV on AIN and invasive cancer is continually evolving. In all patient populations, advances in chemotherapeutic agents have led to significant changes from the chemoradiation regimen originally described by Norman Nigro. Having a thorough understanding of the natural history, impact of HIV, and treatment of AIN and anal cancer will allow surgeons to provide the best care for their patients.

Through a multidisciplinary educational initiative, participants will be updated about the current understanding, staging, and treatment of AIN, invasive squamous cell carcinoma, and recurrent and metastatic disease.

Existing Gaps

What Is: There is uncertainty regarding the natural history of AIN and the impact of HIV on AIN, anal cancer and their treatments. There have been significant changes in the chemoradiation regimens for anal cancer.

What Should Be: Appropriate evaluation and staging will allow patients with AIN, anal cancer, and metastatic anal cancer, both HIV+ and HIV–, to receive the most optimal therapy.

Director: Janice Rafferty, MD, Cincinnati, OH
Assistant Director: Bard Cosman, MD, San Diego, CA

5:15 pm	Introduction Janice Rafferty, MD, Cincinnati, OH	5:47 pm	The HIV+ Patient Lester Gottesman, MD, New York, NY
5:17 pm	Anal Cancer Basics: Anatomy, Definitions, and Screening Bruce Robb, MD, Indianapolis, IN	6:02 pm	Management of Recurrence and Inguinal Adenopathy George Chang, MD, Houston, TX
5:32 pm	What's the Best Chemoradiation Regimen? Larissa Temple, MD, New York, NY	6:17 pm	Discussion and Case Presentation

Objectives: At the conclusion of this session, participants should be able to: a) discuss the natural history and treatment of AIN; b) describe how best to stage anal cancer; c) discuss the best chemoradiation regimen for the treatment of anal cancer; and d) identify the best methods for surveillance and the optimal management of recurrent disease and inguinal metastasis.

Residents' Reception

5:15 – 6:45 pm

Open to General Surgery residents and colorectal program directors.

General Surgery residents will have an opportunity to meet colorectal program directors.



Dinner Symposium

Surgical Management of Familial Cancer Syndromes

7:00 – 8:30 pm

Hereditary colorectal cancers account for as many as 10% of all cases of colorectal cancer in the United States. Patients and families affected by familial cancer syndromes require special attention for the diagnosis, surveillance and treatment of their particular syndrome. A recent survey revealed that an average colorectal surgeon will evaluate two patients with Familial Adenomatous Polyposis and 4 patients with Hereditary Nonpolyposis Colorectal Cancer Syndrome. The colorectal physician is faced with the responsibility of counseling the patients and their families. As our understanding of these syndromes has increased and as new syndromes have been identified there have been significant changes in our management strategies. For all these reasons it is important that the membership of the ASCRS have the opportunity to be updated regarding the genetics of hereditary colorectal cancer and the application of genetic knowledge to patient care.

Existing Gaps

What Is: Patients with inherited cancer syndromes often go unrecognized and are under-diagnosed. As a result, they do not receive appropriate genetic counseling, surveillance or treatment.

What Should Be: Patients with inherited cancer syndromes are readily identified and offered appropriate genetic counseling, surveillance strategies, medical therapy, and surgical therapy.

Director: James Church, MD, Cleveland, OH
Assistant Director: Paul Wise, MD, Nashville, TN

7:00 pm	Introduction James Church, MD, Cleveland, OH	7:25 pm	Lynch Syndrome: Surgery or Surveillance Matthew Kalady, MD, Cleveland, OH
7:05 pm	Genes and Genetic Testing: A Guide for the Colorectal Surgeon Kate Lynch, MS, CGC, Cleveland, Ohio	7:35 pm	What to Do about Those that Don't Quite Make It as a Syndrome, but Make Us Nervous as Surgeons: The Young, The Family Cluster Anne Lin, MD, St. Louis, MO
7:15 pm	Polyposis Syndromes: Who Needs Colectomy, When and Which Option? Paul Wise, MD, Nashville, TN	7:45 pm	Panel Discussion / Q&A

Objectives: At the conclusion of this session, participants will be able to: a) describe ways to diagnose patients with hereditary colorectal cancer; b) discuss the optimal work-up of affected patients and their relatives; c) describe techniques to prevent colorectal cancer and cancer in other organs; and d) discuss the genetic basis of the syndromes of hereditary colorectal cancer.



Breakfast Symposium

Endoscopy: Taking it to the Next Level

6:15 – 7:45 am

Colonoscopy is an extremely important adjunct for colorectal surgeons. While the surgeon is safe and effective in performing colonoscopy, advanced techniques receive very little attention. The miss rates for large adenoma (>1cm) can be as high as 12% when compared to virtual colonoscopy. The consequences of a missed adenoma or cancer can be devastating for both the patient and the endoscopist. There are several tools and techniques meant to enhance polyp detection, including chromoendoscopy, narrow band imaging, third-eye retrosopes, and cap-fitted endoscopes. The improvement in polyp detection with the use of the techniques depends upon the endoscopists understanding and utilization of them.

The literature supports the practice of performing repeat colonoscopy for patients referred for surgery with endoscopically unresectable polyps, as surgery can be avoided in many of these patients. The surgeon can be highly motivated to attempt endoscopic removal of difficult lesions, especially in medically frail patients who would not tolerate an abdominal procedure. New technology such as submucosal resection and endoscopic clipping of defects are allowing for an increase in the endoscopic resection rate of large polyps. Understanding the indications and shortcomings of these advanced techniques are necessary to maximize their utility.

Massive lower gastrointestinal bleeding is another situation where the colorectal surgeon may be called upon to intervene. Endoscopic management of active GI bleeding can be very technically demanding, but if successful, is of great benefit to the patient. There are several techniques that can be employed to help with the success of identifying the sources of bleeding. Once identified, the endoscopist has several tools available to treat the bleeding depending upon its cause.

Existing Gaps

What Is: Colorectal surgeons possess excellent flexible endoscopic skills, but lack the exposure to new techniques and technology.

What Should Be: The colorectal surgeon should have the knowledge and exposure to advanced techniques and technology to perform all of the necessary colonoscopic interventions encountered in their practice.

Director: David Beck, MD, New Orleans, LA
Assistant Director: Barry Jenkins, MD, Augusta, GA

6:15 am	Introduction David Beck, MD, New Orleans, LA	6:47 am	What's Next in Endoluminal Therapy Sang Lee, MD, New York, NY
6:17 am	Polyps – When to Attempt Aggressive Polypectomy Mark Pidala, MD, Houston, TX	6:57 am	Chromoendoscopy – Narrow Band Imaging, Aberrant Crypt Foci Douglas Rex, MD, Indianapolis, IN
6:27 am	GI Bleeding – Wading Through the Blood Anthony Vernava, III, MD, Naples, FL	7:07 am	Reimbursement for Procedures and Follow-up Jeffrey Cohen, MD, Hartford, CT
6:37 am	Stenting – When, Why, and How Charles Whitlow, MD, New Orleans, LA	7:17 am	Panel Discussion / Q&A

Objectives: At the conclusion of this session, participants will be able to: a) understand the techniques needed to perform a difficult polypectomy; b) use all available means to colonoscopically treat lower gastrointestinal bleeding; c) understand the indications and available tools for endoscopic stenting; and d) understand and use new technologies available for treatment and identification of colonic lesions.



Meet the Professor Breakfasts

6:45 – 7:45 am

Limit: 30 per breakfast • Fee \$35 • *Tickets Required* • Continental Breakfast

Residents are encouraged to bring problems and questions to this informal discussion.

Please register early and indicate your 1st and 2nd choice on the Physicians' Registration Form.

W-1 Healthcare Policy – Who's Taking Your Money Now?
Frank Opelka, MD, New Orleans, LA
Anthony Senagore, MD, Grand Rapids, MI

W-2 Adjuvant Therapy for Colorectal Cancer – Stage II, III, and IV
Garrett Nash, MD, New York, NY
John Pemberton, MD, Rochester, MN

W-3 Accelerated Pathways – What Are They and How Do We Do It?
Conor Delaney, MD, Cleveland, OH
Kirk Ludwig, MD, Milwaukee, WI

W-4 Pouchitis and Other Pouch Problems
David Dietz, MD, Cleveland, OH
Randolph Steinhagen, MD, New York, NY

W-5 TEM – When, Where and How?
Charles Finne, III, MD, Minneapolis, MN
John Marks, MD, Wynnewood, PA

W-6 Reconstruction after Proctectomy
Daniel Geisler, MD, Cleveland, OH
Bruce Orkin, MD, Boston, MA



Video Session

8:00 – 9:30 am

8:00 am	Single Incision Laparoscopic Right Hemicolectomy: Technique WV-1 D. Gandhi, C. Patel, D. Ramos-Valadez, M. Ragupathi, E. Haas, Houston, TX (V-9)	8:50 am	Transperineal Proctocolectomy with End Ileostomy WV-8 A. Fajardo, S. Hunt, M. Frisella, J. Fleshman, M. Mutch, St. Louis, MO (OV-9)
8:06 am	Sigmoidectomy Using Single Incision Laparoscopic Surgery WV-2 V. Ho, J. DiRocco, J. Milsom, T. Sonoda, S. Lee, New York, NY (V-18)	8:56 am	Panel Discussion
8:12 am	Single-access Laparoscopic Colectomy with Magnetic Force WV-3 D. Uematsu, G. Akiyama, Saku City, Nagano, Japan (V-19)	9:01 am	Endoscopic Restoration of a Completely Obstructed Ileorectal Anastomosis WV-9 D. O'Brien, M. Whiteford, Portland, OR (V-6)
8:18 am	Single Incision Laparoscopic Colectomy: Lessons Learned WV-4 M. Katdare, P. Marcello, Burlington, MA (V-27)	9:07 am	Transanal Endoscopic Microsurgery: An Alternative Method WV-10 H. Kim, B. Christensen, Salt Lake City, UT (V-20)
8:24 am	Single Port Right Hemicolectomy and Sigmoid Colectomy for Crohn's Ileosigmoid Fistula WV-5 R. Makhija, B. Champagne, C. Delaney, Cleveland, OH (OV-6)	9:13 am	The Use of Carbon Dioxide Colonoscopy to Guide Laparoscopic Resection of a Cecal Pole Lesion WV-11 E. Davenport, S. Zolfigari, L. Williams, R. Boushey, Ottawa, ON, Canada (OV-28)
8:30 am	Panel Discussion	9:19 am	Laterally Spreading Granular Type Adenoma into a Large Ascending Colon Diverticulum: Endoscopic Assisted Laparoscopic Wedge Resection WV-12 C. Coco, A. Verbo, G. Rizzo, A. Manno, C. Mat-tana, M. Mastromarino, Rome, Italy (OV-1)
8:38 am	Single Incision Laparoscopic Total Proctocolectomy with Ileo-anal J-pouch WV-6 K. Garrett, D. Geisler, F. Remzi, Cleveland, OH (OV-12)	9:25 am	Panel Discussion
8:44 am	Transvaginal Extraction of the Specimen after Laparoscopic Total Colectomy WV-7 A. Canelas, M. Bun, B. Helman, M. Laporte, C. Peczan, N. Rotholtz, Buenos Aires, Argentina (OV-3)		

Refreshment Break

9:30 – 10:00 am



Inflammatory Bowel Disease: Drugs vs Surgery

8:00 – 9:30 am

The relatively recent introduction of biologics in the treatment of inflammatory bowel disease (IBD) has provided an alternative to long term steroid therapy. The efficacy of these agents in the long term maintenance of Crohn's disease is well established in the literature, as is their effectiveness in the treatment of anorectal disease. Many clinicians have begun using anti-TNF therapy in the setting of acute flares of ulcerative colitis and Crohn's disease. While biologics have a clear role for some patients in the maintenance therapy of inflammatory bowel disease, their use in the acute setting is controversial. These agents are effective in a subset of patients with acute colitis who have failed steroid therapy, but defining the population that will respond to these agents has proven elusive. Additionally, these agents take time to work in the acute setting. For patients who do not respond to treatment, surgery is delayed and patients are often more ill at the time of surgery. Reports of infectious complications in surgical patients under therapy with these agents has led many to question their safety in the acute setting. Nonetheless, their place in the medical armamentarium against IBD is established.

This symposium will examine the role of biologic therapy in the treatment of inflammatory bowel disease and systematically focus on the safety and integration of these agents into the surgical algorithm of patients with acute colitis, ileocolic Crohn's disease, and anorectal Crohn's disease.

Existing Gaps

What Is: Many surgeons and gastroenterologists have contradictory views on the use of biologic therapy in the maintenance and acute treatment of IBD.

What Should Be: Both surgeons and gastroenterologists should understand the role of surgical and medical therapy in the treatment of IBD patients. They should understand the benefits and risks of both forms of treatment and should use a collaborative approach to treating these patients.

Director: David Dietz, MD, Cleveland, OH

Assistant Director: David Stewart, MD, Hershey, PA

8:00 am	Introduction David Dietz, MD, Cleveland, OH	8:26 am	Acute Colitis – Biologics, Methotrexate or Surgery? Philip Fleshner, MD, Los Angeles, CA
8:02 am	Initial Presentation with Severe Terminal Ileal Crohn's Disease – Top Down or Bottom Up? Paul Wise, MD, Nashville, TN	8:38 am	Tailored Post-operative Maintenance Therapy Jean-Paul Achkar, MD, Cleveland, OH
8:14 am	Anal Fistulas – Drugs, Definitive Surgery or Prolonged Drainage? Marc Singer, MD, Evanston, IL	8:50 am	Case Presentations and Discussion

Objectives: At the conclusion of this session, participants will be able to: a) understand the rationale and benefits of medical therapy in the treatment of Ileocolic Crohn's disease; b) discuss the role of biologics in the treatment of anorectal Crohn's disease; c) understand the risks, benefits, and selection of patients for the medical therapy of acute colitis; and d) select patients that might benefit from the use of aggressive medical maintenance therapy in the post-operative setting.

Refreshment Break

9:30 – 10:00 am



Scientific Session

Benign Disease

10:00 – 11:30 am

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| <p>10:00 am HeLP vs. Rubber Band Ligation: Prospective Randomized Trial Comparing Two Mini-invasive Treatments for 2nd–3rd Degree Hemorrhoids S51
P. Giamundo, R. Salfi, Bra, Italy; Cagliari, Italy</p> <p>10:06 am ALTA: A Novel Sclerosing Agent for Noninvasive Treatments of Internal Hemorrhoids and Prolapse (V-2) S52
M. Takano, J. Iwadare, H. Takamura, Y. Matsuda, S. Tsuchiya, Kumamoto, Japan; Tokyo, Japan; Amagasaki, Japan; Hamamatsu, Japan; Yokohama, Japan</p> <p>10:12 am Minimally Invasive Hemorrhoidectomy: Results of Doppler Guided Hemorrhoidal Arterial Ligation with RectoAnal Repair in 175 patients S53
M. R. Albert, S. Atallah, S. Larach, Orlando, FL</p> <p>10:18 am Conservative Management for Hemorrhoidal Disease S54
C. Helmes, F. Pakravan, B. Meshkat, H. Abcarian, Duesseldorf, Germany; Dublin, Ireland; Chicago, IL</p> <p>10:24 am Panel Discussion</p> <p>10:36 am Early Results of Ligation of Intersphincteric Fistula Tract for Fistula-in-Ano (V-15) S55
A. Aboularian, A. Kaji, R. Kumar, Torrance, CA</p> <p>10:42 am Topical Treatment of Anal Fistulotomy Wounds with Sucralfate: A Placebo Controlled Randomized Study S56
P. J. Gupta, P. S. Heda, S. Kalaskar, Nagpur, Maharashtra, India</p> | <p>10:48 am Surgeons Should Not Hesitate to Perform Episiotomy for Rectovaginal Fistula Secondary to Cryptoglandular or Obstetrical Origin S57
G. El-Gazzaz, T. Hull, M. Zutshi, J. M. Church, B. Gurland, Cleveland, OH</p> <p>10:54 am Panel Discussion</p> <p>11:03 am Long-term Follow-up After an Initial Episode of Diverticulitis: What are the Predictors of Recurrence? S58
J. F. Hall, P. L. Roberts, R. Ricciardi, T. Read, P. W. Marcello, C. Wald, D. J. Schoetz, Burlington, MA</p> <p>11:09 am The Efficacy of Nonoperative Management of Acute Perforated Diverticulitis S59
S. Dharmarajan, S. Hunt, E. H. Birnbaum, J. W. Fleshman, M. Mutch, St. Louis, MO</p> <p>11:15 am Panel Discussion</p> <p>11:21 am Radiologic and Clinical Predictors of Outcome in Patients with Clostridium Difficile Colitis S60
G. Nandakumar, S. Dharmarajan, C. Coughlin, C. Menias, M. Ray, S. Hunt, St. Louis, MO; Davis, CA</p> <p>11:27 am Discussion</p> |
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Traveling Fellows and Impact Paper

11:30 am – 12:10 pm

11:30 am **The Robert W. Beart, MD, 2009 Impact Paper of the Year Award**

Resident / Fellow Presentations

Moderator: Graham Newstead, MBBS, Sydney, NSW, Australia

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| <p>11:40 am ASCRS International Scholarship Winner
The Surgeons' Impact on Surgical Site Infections in Colorectal Surgery
Martin Hübner, MD
Lausanne University Hospital
Lausanne, Switzerland</p> <p>11:45 am ASCRS International Scholarship Winner
Identifying Lynch Syndrome in Jamaica
Joseph Plummer, MBBS, DM
University of the West Indies
Kingston, Jamaica</p> <p>11:50 am ASCRS International Scholarship Winner
New Frontiers in Colorectal Surgery
James O'Riordan, MD
Tallaght Hospital
Dublin, Ireland</p> | <p>11:55 am ASCRS International Scholarship Winner
Transforming Training in Laparoscopic Colorectal Surgery
John (Ian) Jenkins, MD
St. Mark's Hospital
London, England</p> <p>12:00 pm British Traveling Fellow
To Be Announced</p> <p>12:05 pm Mark Killingback Prize Winner
Double Blind Randomized Controlled Trial of the Influence of Glucocorticoids on Post-operative Recovery Following Colectomy
Tarik Sammour, MD
Department of Surgery
South Auckland Clinical School
University of Auckland
Auckland, New Zealand</p> |
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ASCRS Annual Business Meeting and State of the Society Address

12:15 – 1:30 pm



Scientific Session

Outcomes

1:30 – 3:00 pm

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| <p>1:30 pm A Prospective Randomized Controlled Trial of Enhanced Recovery Program in Patients Undergoing Laparoscopic Resection for Colon Cancer S61
T. Lee, S. Kang, S. Hong, D. Kim, Seongnam-si, Gyeonggi-do, South Korea</p> | <p>2:15 pm Surgical Complications are Associated with Omission of Chemotherapy for Stage III Colorectal Cancer S66
S. K. Hendren, J. Birkmeyer, C. Sonnenday, H. Yin, M. Banerjee, A. M. Morris, Ann Arbor, MI</p> |
| <p>1:36 pm Prolonged Length of Stay after Colorectal Surgery: What Does NSQIP Data Tell Us? S62
L. de Campos-Lobato, E. Wick, P. R. Kiran, F. Remzi, J. D. Vogel, Cleveland, OH; Baltimore, MD</p> | <p>2:21 pm How Much do we Need to Worry About Venous Thromboembolism After Hospital Discharge? A Study of Colorectal Surgery Patients Using the NSQIP Database S67
F. Fleming, M. J. Kim, R. Salloum, J. R. Monson, Rochester, NY</p> |
| <p>1:42 pm Panel Discussion</p> | <p>2:27 pm Panel Discussion</p> |
| <p>1:48 pm Health Care Disparities in Postoperative Care: Do We Treat All Patients the Same? S63
S. L. Stein, J. Rose, B. J. Champagne, P. Knoll, H. Reynolds, B. J. Ermlich, J. Stulberg, C. P. Delaney, Cleveland, OH</p> | <p>2:33 pm Mechanical Bowel Preparation with Oral Antibiotics: Is it Superior? S68
K. I. El-Badawi, T. Asgeirsson, C. Mascarenhas, S. Suryadevara, R. Hoedema, D. G. Kim, M. Luchtefeld, A. Senagore, Grand Rapids, MI</p> |
| <p>1:54 pm Discussion</p> | <p>2:39 pm Comparative Study of One Stage Left Colectomy in Emergency and Elective Surgery without Mechanical Preparation S69
M. Ciga, F. Oteiza, L. Fernández-Rico, J. Marzo, P. Armendáriz, M. De Miguel, H. Ortiz, Pamplona, Spain</p> |
| <p>1:57 pm Is it Time to Lower the Recommended Screening Age for Colorectal Cancer (CRC)? S64
D. M. Davis, J. Mateka, J. Marcet, V. Nfonso, J. Frattini, Tampa, FL</p> | <p>2:45 pm Panel Discussion</p> |
| <p>2:03 pm Discussion</p> | <p>2:51 pm Should Postoperative Surveillance for Patients with PT1 Colorectal Cancer Be Carried Out? The Analysis of Risk Factors Affecting Postoperative Recurrence and Cost-effectiveness on Screening S70
S. Iida, H. Hasegawa, Y. Ishii, T. Endo, K. Okabayashi, Y. Kitagawa, Tokyo, Japan</p> |
| <p>2:06 pm Morbidity and Mortality Following Colorectal Surgery in Patients with Dialysis Dependent Renal Failure: A Population-based Study S65
S. Drolet, A. M. Shaheen, R. P. Myers, E. Dixon, A. R. MacLean, W. D. Buie, Calgary, AB, Canada</p> | <p>2:57 pm Discussion</p> |
| <p>2:12 pm Discussion</p> | |

Refreshment Break

3:00 – 3:15 pm



Consultants' Corner *Stump the Past Presidents – Difficult Cases*

3:15 – 3:45 pm

Steven Hunt, MD

Colorectal Jeopardy

3:45 – 4:45 pm

Moderator: Terry Hicks, MD

Colorectal Jeopardy is a good-natured, informal competition in which contestants match wits about colorectal disease and related topics. We encourage all attendees to watch the game and cheer the participants on to victory! Beer, wine and pretzels will be served free of charge to get you in the Jeopardy mode.

Annual Reception and Dinner Dance

Reception

7:00 – 8:00 pm

Dinner Dance

8:00 – 10:30 pm

Tickets Required



Poster Presentations

Poster Display Hours: Monday and Tuesday: 9:00 am – 4:00 pm
Poster walk around will be during lunch time Monday and Tuesday

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Prognostic Factors and Follow-up in Cancer	P182 – P202
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Benign

Benign Diverticulitis

- P1** Race and Insurance are Associated with Presentation, Treatment and Mortality in Diverticulitis in a Statewide Database
V. P. Ho, G. Nash, M. Neidell, E. Feldman, K. Trencheva, J. Milsom, S. Lee, New York, NY
- P2** Natural History of Diverticulitis does not Support an Aggressive Surgical Treatment
G. Binda, A. Arezzo, A. Serventi, L. Bonelli, Genova, Italy; Torino, Italy; Novi Ligure, Italy
- P3** Acute Diverticulitis of the Young – Can Clinical Presentation Help Stratify Risk?
A. Shah, A. Malhotra, W. Baddoura, Paterson, NJ
- P4** Does Preservation of the Inferior Mesenteric Artery or Superior Rectal Artery Affect Anastomotic Leak Following Sigmoidectomy for Diverticulitis? A Retrospective Review
R. Lehmann, L. Brounts, E. Johnson, J. Rizzo, S. Steele, Tacoma, WA; Fort Gordon, GA
- P5** Acute Diverticulitis in the Under 40 Age Group: A Different Disease Process or a Disease Process Managed Differently?
F. Fleming, R. Johnson, J. Miller, S. Schwartz, J.R. Monson, R. Salloum, Rochester, NY

Benign Fecal Incontinence

- P6** Three-dimensional Endoanal Ultrasonography Improves Evaluation of Fecal Incontinence
L. A. Julien, C. A. Ternent, R. S. Nelson, G. J. Blatchford, J. S. Beaty, M. S. Shashidharan, E. Boland, J. S. Reyes, A. G. Thorson, Omaha, NE
- P7** Does Fecal Incontinence Cause Non-relaxing Puborectalis?
N. Mantilla Farfan, A.S. Gallo, J.R. Cintron, H. Abcarian, M. Singer, Chicago, IL; Evanston, IL
- P8** Modification of Cleveland Clinic Score is a Predictor of Success when Sacral Nerve Stimulation is used to Treat Fecal Incontinence
C. Ratto, E. Gaudio, M. Indinnimeo, D. F. Altomare, E. Falletto, A. Masin, Rome, Italy; Vercelli, Italy; Bari, Italy; Turin, Italy; Padua, Italy
- P9** There is no Causal Relation Between the Risk of Delayed Fecal Incontinence and Childbirth
J. B. Adams, C. B. Whitlow, D. E. Beck, A. Timmcke, T. C. Hicks, D. Margolin, New Orleans, LA
- P10** Long-term Improvement in Quality of Life after Submucous Injection of NASHA/Dx for Anal Incontinence
J. Danielson, U. Karlbom, A. Sonnesson, W. Graf, Uppsala, Sweden
- P11** Intra-anal Permacol for the Treatment of Passive Fecal Incontinence
K. J. Smith, S. Gonsalves, S. Qureshi, P. Finan, D. A. Burke, P. Sagar, Leeds, West Yorkshire, United Kingdom



Poster Presentations

- P12** **Biologics in Anal Sphincter Repair: To Use or Not to Use**
P. Ferreira, B. Gurland, T. Hull, M. Zutshi, Cleveland, OH
- P13** **Percutaneous Tibial Nerve Stimulation and Effect on Fecal Incontinence: Results from Two Recent Overactive Bladder Trials**
S. Siegel, K. M. Peters, D. J. Carrico, S. A. MacDiarmid, L. S. Wooldridge, Woodbury, MN; Royal Oak, MI; Greensboro, NC; Muskegon, MI
- P14** **Outcome and Management of Patients who Failed Sacral Nerve Stimulation for Fecal Incontinence**
G. Meurette, F. Rodat, V. Wyart, P. A. Lehur, Nantes, France
- P15** **Temporary Sacral Nerve Stimulation is a Successful Treatment for Fecal Incontinence Caused by Pelvic Radiotherapy**
Y. Maeda, M. Høyer, L. Lundby, S. Buntzen, S. Laurberg, Aarhus, Denmark
- P16** **Sacral Nerve Stimulation can be Successful in Patients with Ultrasound Evidence of External Anal Sphincter Disruption**
B. Lieske, P. Conaghan, R. Farouk, Reading, United Kingdom
- P17** **Sacral Neuromodulation for Management of Intractable Constipation**
A. Sharma, B. Liu, P. Waudby, G. S. Duthie, Hull, United Kingdom
- P18** **Sacral Nerve Stimulation for Treatment of Irritable Bowel Syndrome. Results after One Year**
L. Lundby, J. Fassov, K. Krogh, S. Buntzen, S. Laurberg, Aarhus, Denmark
- P19** **Is the Early and Frequent Changing of Parameter Settings a Predictor of Negative Outcome in Sacral Nerve Stimulation for Constipation?**
J. Martellucci, G. Naldini, Siena, Italy; Pisa, Italy
- P25** **Advancement Flap Repair: A Good Option for Complex Fistulas**
A. M. Jarrar, X. Khaja, J. M. Church, Cleveland, OH
- P26** **Long-term Outcome Following Advancement Flaps for High Anal Fistulas in an Asian Population: A Single Institution's Experience of 50 Patients.**
K. Tan, C. Tsang, W. Cheong, D. C. Koh, Singapore
- P27** **Results of Rectal Advancement Flap for High Anal Fistula**
J. H. Jongen, A. Koepcke, H. Peleikis, J. Bock, V. Kahlke, Kiel, Germany; St. Gallen, Switzerland
- P28** **Park's Fistulectomy: Long-term Healing Rate and Functional Outcome**
D. Shibru, E. Raskin, R. Madoff, F. D. Nemer, S. M. Goldberg, A. Mellgren, Minneapolis, MN
- P29** **Cutting Seton: Outcomes, Safety, and Efficacy for the Treatment of Anorectal Fistulas**
F. M. Abarca, M. I. Brand, T. J. Saclarides, Chicago, IL
- P30** **Cutting Seton Usage in Transsphincteric Fistula: Is Fecal Incontinence an Issue?**
P. R. Sturrock, A. Abodeely, J. A. Lagares-Garcia, A. A. Klipfel, M. Vrees, S. Schechter, Pawtucket, RI; Worcester, MA
- P31** **Prospective Randomized Comparison of Cutting Seton vs Surgisis Collagen Plug for Transsphincteric Fistula-in-Ano**
B. Sung, D. Klaristenfeld, H. Dudukgian, R. R. Cannom, A. M. Kaiser, Los Angeles, CA
- P32** **The Anal Fistula Plug in Simple and Complex Fistula-in-Ano: A Western New York Experience**
C. P. Anyadike, B. O. Attuwaybi, J. Visco, B. Butler, G. Barrios, Buffalo, NY
- P33** **Long-term Success of Fibrin Glue in the Treatment of Perianal Fistulas – A Multicenter Study**
N. Haim, D. Neufeld, Y. Ziv, H. Tulchinsky, M. Koller, M. Khaikin, O. Zmora, Tel Hashomer, Israel; Zerifin, Israel; Tel Aviv, Israel
- P34** **Long-term Results of Ligation of Intersphincteric Fistula Tract Technique in the Management of Anal Fistula**
K. Tan, I. Tan, D. C. Koh, C. Tsang, Singapore
- P35** **Usefulness of Interferon-gamma Release Assay for Diagnosis of Tuberculosis Fistula-in-Ano**
S. Kim, D. Hwang, S. Song, S. Cho, J. Lee, H. Kwon, Seoul, South Korea

Benign Fistula

- P20** **Does Catheter Drainage Time Affect Outcome of Perianal Abscesses?**
J. B. Adams, C. B. Whitlow, D. E. Beck, T. C. Hicks, A. Timmcke, D. Margolin, New Orleans, LA
- P21** **The Evolution of Treatment of Fistula-in-Ano**
J. Blumetti, F. Quinteros, A. Abcarian, J. Harrison, V. Chaudhry, J. Cintron, L. M. Prasad, H. Abcarian, Chicago, IL
- P22** **Management of Anal Fistulas: What Patients Want**
N. Ellis, Mobile, AL
- P23** **Visualization of Gender-specific Anatomical Features of Anal Fistula with 3-D Anorectal Ultrasonography**
S. M. Murad-Regadas, F. S. Regadas, L. V. Rodrigues, G. O. Fernandes, G. Buchen, E. C. Holanda, Fortaleza, Ceara, Brazil
- P24** **Three-dimensional Endoanal Endosonography in the Evaluation of Perianal Fistulas. Correlation of Ultrasonographic with Intraoperative Findings**
S. A. Garcia Botello, M. Garces-Albir, P. Esclapez-Valero, A. Sanahuja-Santafe, A. Espi-Macias, B. Flor-Lorente, E. Garcia-Granero, Valencia, Spain

Benign Hem

- P36** **Hemorrhoids and Blood per Rectum: How Innocuous a Presentation is This?**
V. J. Obias, G. Montenegro, B. A. Orkin, Washington, DC; Boston, MA
- P37** **Assessment of Hemorrhoidal Arteries Location within the Rectum using Endorectal Ultrasound and Echo-color Doppler**
C. Ratto, A. Parello, G. Zacccone, L. Donisi, F. Litta, G. B. Doglietto, Rome, Italy
- P38** **Transanal Hemorrhoidal Dearterialization for IV-degree Hemorrhoids**
C. Ratto, P. Giordano, L. Donisi, A. Parello, F. Litta, G.B. Doglietto, Rome, Italy; London, United Kingdom



Poster Presentations

P39 Pain Scores After Stapled Hemorrhoidopexy vs Transanal Hemorrhoidal Dearterialization: A Prospective Study of 70 Consecutive Patients
K. P. Ong, M. H. Kam, K. W. Eu, Singapore

P40 Hemorrhoidal Arterial Ligation: The Experience of a Single Institution
U. Szmulowicz, B. Gurland, T. Garofalo, M. Zutshi, Cleveland, OH

P41 Prospective Randomized Multicenter Study Comparing Stapler Hemorrhoidopexy with Doppler-guided Transanal Hemorrhoid Dearterialization for III-Degree Hemorrhoids
D. F. Altomare, A. Infantino, C. Bottini, M. Gentile, M. Buonanno, J. Hoch, P. Giamundo, T. Yalti, A. El Gaddal, S. Mancini, C. Pagano, Avellino, Italy; Bari, Italy; Naples, Italy; Tagliamento, Italy; Gallarate, Italy; Istanbul, Turkey; Bra (CN), Italy; Civitanova Marche, Italy; London, United Kingdom; Prague, Czech Republic; Milan, Italy

P42 Doppler-guided Hemorrhoid Artery Ligation and Rectoanal Repair for Grade 2 and 3 Hemorrhoids: Outcomes after Surgery
R. Farouk, B. Lieske, P. Conaghan, Reading, United Kingdom

P43 Transanal Hemorrhoidal Dearterialization – A Short-term Prospective Case Series in a Single Institution
O. S. Lo, K. P. Ong, M. H. Kam, K. W. Eu, Singapore

P44 One-year Outcome of Hemorrhoidectomy: A Prospective, Multicenter French Study
D. Soudan, A. Castinel, J. M. Suduca, G. Staumont, D. Bouchard, F. Devulder, R. Ganansia, F. Pigot, P. Guyot, L. Abramowitz, Paris, France; Bordeaux, France; Toulouse, France; Talence, France; Reims, France; Lyon, France

Benign Miscellaneous

P45 Sigmoid Dyskinesia as an Indication for Sigmoid Colectomy
A. M. Jarrar, R. Gao, T. Jessie, J. M. Church, Cleveland, OH

P46 Total Abdominal Colectomy with Ileorectal Anastomosis for Benign Disease: Data from the National Surgical Quality Improvement Program
P. Ferreira, L. de Campos-Lobato, M. Zutshi, J. D. Vogel, J. M. Church, B. Gurland, Cleveland, OH

P47 A Novel Treatment for Hemorrhagic Radiation Proctitis Using Colonic Irrigation and Oral Antibiotic Administration
C. Sahakitrungruang, S. Thum-umnaysuk, A. Pati Wongpaisarn, P. Atittharnsakul, Bangkok, Thailand

P48 Are Echoendoscopic Findings Predictors of Surgical Treatment in Patients with Bowel Endometriosis?
P. De Nardi, G. Stratta, S. Ferrari, P. Persico, F. Di Puppo, V. Di Carlo, C. Staudacher, Milano, Italy

P49 Computed Tomography Features Associated with Operative Management for Nonstrangulating Small Bowel Obstruction
R. R. Suri, P. Vora, J. Kirby, K. Chan, S. Smith, L. Ruo, Hamilton, ON, Canada

P50 Sigmoid Volvulus: Our 10-year Experience
C.Y. Ngu, L.S. Lee, C.M. Chen, Singapore

P51 Stoma Closure is Associated with a High Rate of Complications in Patients Treated for Ischemic Colitis
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P54 Healing by Primary vs Secondary Intention after Surgery for Pilonidal Sinus: A Cochrane Systematic Review and Meta-analysis
A. AL-Khamis, I. McCallum, P. King, J. Bruce, Aberdeen, Aberdeenshire, United Kingdom; Gateshead, Tyne And Wear, United Kingdom

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P59 A Novel Dynamic 3-D Anorectal Ultrasound Technique to Assess Perineal Descent Compared with Conventional Defecography
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P60 Posterior Pelvic Floor Dysfunction: A Comparison of Defecography, MRI, and Anorectal Physiology
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P61 The Impact of Dynamic MRI on Diagnosis and Management of Patients with Difficulty in Evacuation of Stool
K. C. Ratnatunga, R. Nardiyasamy, R. Siriwardena, R. Prasad, K. I. Deen, Ragama, Sri Lanka; Colombo, Sri Lanka



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- P63 Prospective Validation Study Demonstrating Improved Outcomes of Synchronous STARR with Urogynecological Repairs for Pelvic Floor Dysfunction**
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A. Carriero, J. Martellucci, P. Talento, Montecchio, Emilia, Italy

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H. Dudukgian, C. Gonzales-Ruiz, R. R. Cannom, A. M. Kaiser, Los Angeles, CA

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- P81 The Burden of Perineal Crohn's Disease on the Patient and on the Medical System. Do we Know what we are Doing?**
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- P83 The Efficacy and Outcomes of Noncutting Seton and Immunosuppressive Therapy for Complex Anorectal Fistula in Inflammatory Bowel Disease**
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W. Gaertner, C. O. Finne, A. Mellgren, R. Madoff, Minneapolis, MN

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- P85 Does Unsuspected Crohn's Disease in Ulcerative Colitis Patients Influence Postoperative Surgical Morbidity after Ileal Pouch-anal Anastomosis**
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- P86 Bacterial Dysbiosis in Ileoanal Pouches – An Assessment of Luminal Fecal Flora in Patients with an Ileoanal Pouch Anastomosis Using Best Culture Techniques**
S. Gonsalves, M. K. Lim, M. Wilcox, P. Sagar, P. Finan, D. Burke, Leeds, United Kingdom



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- P87** **Perioperative Factors During Ileal Pouch-anal Anastomosis Predict Pouchitis**
J. M. Lipman, P. R. Kiran, B. Shen, F. Remzi, V. Fazio, Cleveland, OH

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- P88** **Laparoscopic Surgery for Recurrent Crohn's Disease**
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- P89** **Diakenchuto Improves Bowel Microvascular Dysfunction and Inflammation in Animal and Clinical Studies of Crohn's Disease**
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- P90** **Inflammatory Bowel Disease Complicated by Primary Sclerosing Cholangitis and Cirrhosis – Is Colectomy Safe?**
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- P92** **Immunosuppressive Therapy does not Increase Postoperative Morbidity in Patients with Crohn's Disease**
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- P94** **Variant Two-stage Ileal Pouch-anal Anastomosis is a Safe Alternative to a Three Stage Approach in Severe Ulcerative Colitis**
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- P95** **Optimal Interval Time for Ileal Pouch-anal Anastomosis after Subtotal Colectomy in Ulcerative Colitis Patients**
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- P96** **Does Early Pouch Evaluation Lead to Increased Pouch Complications?**
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- P97** **Minimally Invasive Pouch Surgery for Ulcerative Colitis. Is There a Benefit in Staging?**
S. Pandey, K. Umanskiy, G. Luther, G. Malhotra, M. Rubin, R. Hurst, A. Fichera, Chicago, IL
- P98** **Does Referral Bias Influence Reported Outcomes after Ileal Pouch-anal Anastomosis For Chronic Ulcerative Colitis? A Population-based Study in Olmsted County, Minnesota**
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- P99** **Anti-adhesion Effect of Daikenchuto in an Animal Model of Postoperative Adhesion Formation**
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- P100** **Is Laparoscopic Ileal Pouch-anal Anastomosis Associated with Fewer Adhesions when Compared with Open Pouch Surgery?**
M. R. Joyce, T. Hull, D. Geisler, F. Remzi, M. F. Kalady, J. D. Vogel, J. C. Coffey, L. Stocchi, V. Fazio, Cleveland, OH

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- P103** **Surgical Outcome of Mid and Distal T4 Rectal Cancer in the Neoadjuvant Era**
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- P104** **Improved 3-year Disease-free Survival Following Short-course Preoperative Radiotherapy for Node-positive Rectal Cancer**
Y. F. Yao, L. Wang, C. Du, J. Gu, Beijing, China
- P105** **Effect of the Addition of Bevacizumab to Oxaliplatin-based Preoperative Chemotherapy on Liver Injury and Complications after Resection of Colorectal Liver Metastases**
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Y. C. Chang, H. C. Kim, Seoul, South Korea
- P107** **The Impact of the Serum CEA Changes on Pathological Tumor Response after Preoperative Chemoradiotherapy with Mesorectal Excision for Rectal Cancer**
Y. Kim, H. Lee, N. Kim, H. Hur, B. Min, K. Lee, S. Sohn, Seoul, South Korea
- P108** **Mismatch Repair Proteins (MLH1, MSH2, MSH6) as a Predictive Marker for Radiosensitivity in Rectal Cancer**
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- P109** Can UGT1A1 Gene Polymorphism Predict Tumor Responsiveness after Irinotecan-based Neoadjuvant Chemoradiotherapy for Locally Advanced Rectal Cancer?
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- P110** Bevacizumab Associated Fistula Formation in Postoperative Patients with Advanced Colorectal Cancer
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- P111** Capecitabine vs 5-FU as Neoadjuvant Therapy for Advanced Rectal Adenocarcinoma. Is There a Difference in Tumor Regression Grade and Downstaging of the Surgical Specimen?
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R. Ricciardi, N. Baxter, T. Read, P.L. Roberts, P. W. Marcello, D. J. Schoetz, Burlington, MA; Toronto, ON, Canada
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K. Boyle, M. Thomas, Leicester, Leicestershire, United Kingdom
- P117** Prone or Lithotomy Positioning During Abdominoperineal Resection for Rectal Cancer Results in Comparable Oncologic Outcomes
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- P118** Preoperative Weight Loss Reduces the Risk of Abdominoperineal Resection in Obese Patients
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B. A. Orkin, Boston, MA

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- P130** Long-term Results of Infrared Coagulator Ablation of High-grade Anal Dysplasia
A. B. Goldstone, J. Russ, S. E. Goldstone, New York, NY
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- P132** Follow-up of Treated HPV-induced Lesions with High Resolution Anuscopy and Oncologic Cytology of the Anal Canal
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- P133** Value of Cytological Smears and PCR Screening for Human Papilloma Virus DNA in Detecting Anal Intraepithelial Neoplasia
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- P134** Is Smoking a Predictor of Local Failure in the Treatment of Squamous-cell Carcinoma of the Anus?
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P. De Nardi, F. Merlini, C. Staudacher, Milano, Italy

P136 Anal Carcinoma: Diagnosis and Therapy in the Anorectal Office

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S. Jung, J. Kim, M. Shim, M. Park, Daegu, South Korea

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E. Aitken, A. MacDonald, E. Yu, M. McCabe, A. McGhee, Airdrie, United Kingdom

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F. Taylor, U. Patel, B. Moran, P. Quirke, R. Swift, R. Heald, L. Blomqvist, P. P. Tekkis, D. Sebag-Montefiore, G. Brown, London, United Kingdom; Sutton, United Kingdom; Leeds, United Kingdom; Basingstoke, United Kingdom; Stockholm, Sweden

P144 Use of Magnetic Resonance Imaging Increases use of Preoperative Neoadjuvant Therapy and Reduces Recurrence Rates for Rectal Cancer

B. Lieske, J. Q. Gildersleve, R. Robertson, P. Conaghan, R. Farouk, Reading, United Kingdom

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Lymph Nodes in Cancer

P146 The Impact of the Number of Retrieved Lymph Nodes on Survival in Nodes-negative Patients Undergoing Laparoscopic Colorectal Surgery for Cancer

S. Avital, S. Nir, R. Greenberg, E. Sacham-Shmueli, S. Schneebaum, I. White, Y. Scornick, Tel-Aviv, Israel

P147 Clinical Impact of Lymph Node Ratio as Prognostic Factor in Node-positive Rectal Cancer Treated with Preoperative Chemoradiation Followed by Curative Resection

J. Kang, B. Min, K. Lee, N. Kim, Seoul, South Korea

P148 Prognostic Value of Lymph Node Ratio in Stage III Colorectal Carcinoma

K. P. Wong, W. Law, J. T. Poon, J. K. Fan, O. S. Lo, H. K. Choi, Hong Kong, China

P149 Lymph Node Ratio is a Powerful Prognostic Factor of Node-positive Colon Cancer Patients Undergoing Laparoscopic Colorectal Surgery with Curative Intent

S. Avital, R. Itah, E. Sacham-Shmueli, S. Nir, R. Greenberg, Y. Scornick, Tel-Aviv, Israel

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J. Huh, B. Oh, H. Kim, Y. Kim, Gwangju, South Korea

P152 Lymph Node Ratio in Patients with Stage III Distal Rectal Cancer Treated with Total Mesorectal Excision with and without Pelvic Sidewall Dissection

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P153 Routine Use of an Enhancing Solution Improves Lymph Node Harvest in Colectomy for Cancer

M. S. Hashmi, D. Levien, K. Shekitka, J. Hickey, G. Franco, J. Khan, Baltimore, MD

P154 The Influence of Lymph Node Size and Number on ypN Staging for Rectal Cancer Following Preoperative Radiotherapy: A Study with Fat Clearance

L. Wang, J. Gu, Beijing, China

P155 Predictors of Lymph Node Retrieval in Patients Undergoing Surgical Resection as Initial Therapy for Rectal Cancer

T. K. Pandian, H. Nathan, E. Wick, T. Pawlik, Q. Yu, A. Shore, S. L. Gearhart, Baltimore, MD

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Z. Bamboat, D. DePeralta, A. Dursun, D. L. Berger, L. Bordeianou, Boston, MA

P157 Prognostic Significance of Apical Lymph Nodes Detection for Node Positive Rectal Cancer

J. Peng, S. Cai, Y. Xu, Z. Guan, M. Wang, Shanghai, China

P158 Node Metastasis Around Inferior Mesenteric Artery in the Stage III Rectal or Sigmoid Colon Cancer is a Poor Prognostic Factor

T. Lee, S. Kang, D. Kim, Seongnam-si, Gyeonggi-do, South Korea



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- P159** Discordance in Histological Signs of Tumor Regression Between Primary Rectal Adenocarcinoma and the Mesorectal Lymph Nodes Following Neoadjuvant Chemoradiation
Y. Edden, S. D. Wexner, S. Shawki, J. Canedo, J. Nogueras, M. Berho, Weston, FL

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- P160** Outcome of T1N0 Rectal Cancer Undergoing Standard Resection and Local Excision
J. Peng, Y. Xu, S. Cai, W. Chen, Z. Guan, Shanghai, China; Ann Arbor, MI
- P161** Local Excision of Rectal Lesions: Does Size Matter?
B. A. Orkin, K. Fischkoff, S. Choxi, V. J. Obias, Boston, MA; Washington, DC
- P162** Dose Endoscopic Mucosal Resection for T1 Cancer has Influence on Long-term Outcome?
H. Hoshino, H. Hasegawa, Y. Ishii, T. Endo, K. Okabayashi, Y. Hoshino, A. Matsunaga, Tokyo, Japan
- P163** Rectal Carcinoid Tumors Resected by Transanal Endoscopic Microsurgery: First Reported U.S. Series
A. S. Kumar, T. J. Stahl, J. F. Fitzgerald, J. Ayscue, L. E. Smith, Washington, DC
- P164** Rectosigmoid Resection Using Transanal Endoscopic Microsurgery: Experience in Human Cadavers
P. Sylla, M. C. Kim, A. Dursun, D. K. Sohn, B. G. Turner, I. Ajari, Y. Konuk, D. W. Gee, W. R. Brugge, D. Rattner, Boston, MA; Goyang, South Korea

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- P165** Complete Macroscopic Tumour Removal Significantly Improves Long-term Survival in Patients with Perforated Appendiceal Tumours – A 15-year Experience with 441 Patients
H. Youssef, K. Bevan, K. Chandrakumaran, F. Mohamed, T. Cecil, B. Moran, Basingstoke, United Kingdom
- P166** Colorectal Lymphoma: Do Outcomes Differ Based on Anatomic Location and Treatment Modality?
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- P167** Factors Influencing Choice of IRA vs IPAA in FAP
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- P168** Does Desmoid Disease Affect Patients with a Pouch Worse than Those with an IRA?
A. N. Burgess, J. M. Church, Cleveland, OH

Neoplasia Surgical Outcomes

- P169** Surgical Morbidity and Long-term Oncological Outcomes after Short Course Radiotherapy and Total Mesorectal Excision for Rectal Cancer
B. Lieske, R. Robertson, R. Barnes, J. Q. Gildersleve, P. Conaghan, R. Farouk, Reading, United Kingdom

- P170** Effect of Neoadjuvant Radiation on Perioperative Morbidity in Low Anterior Resection for Rectal Cancer
V. R. Kakarla, S. J. Nurkin, D. E. Ruiz, H. Tiszenkel, Flushing, NY

- P171** Reoperation for Complications after Resection of Colon Cancer Adversely Affects Long-term Oncologic Outcomes
W. Khoury, P. R. Kiran, I. C. Lavery, Cleveland, OH

- P172** Colon J-pouches Have a Higher Anastomotic Complication Rate than Straight Colorectal Anastomoses in Restorative Resection for Rectal Cancer
A. L. Grucela, E. Steinhagen, A. M. Lipskar, D. B. Chessin, R. Steinhagen, New York, NY

- P173** Impact of Anastomotic Leakage on Long-term Disease Recurrence and Survival Following Curative Surgery for Colorectal Cancer
A. Mirnezami, R. Mirnezami, K. Sasapu, K. Chandrakumaran, P. Sagar, P. Finan, Southampton, United Kingdom; Croydon, United Kingdom; Basingstoke, United Kingdom; Leeds, United Kingdom

- P174** Management Strategy to Anastomotic Sinus Developed from Leakage Following Rectal Cancer Resection
J. Kwak, S. Kim, D. Son, J. Kim, S. Baek, J. Cho, Seoul, South Korea

- P175** Obesity Significantly Worsens Perioperative Outcomes in Rectal Cancer Surgery
T. L. Hedrick, C. Wirtalla, R. Kelz, N. Mahmoud, Philadelphia, PA

- P176** Complete Mesocolic Excision with Central Vascular Ligation as Standardized Surgical Technique for Colonic Cancer: A Japanese Multicenter Study
T. Higuchi, K. Sugihara, Tokyo, Japan

- P177** Outcomes of Surgery for Middle and Low Rectal Cancer in Patients who had a Pelvic Radiation in their Medical Past History
C. Sabbagh, O. Brehant, D. Fuks, F. Browet, F. Mauvais, F. Brazier, T. Yzet, J. Regimbeau, Amiens, France; Beauvais, France

Obstructing Cancer

- P178** Trends of Surgery and Results in Left Colon Cancer Obstruction
H. P. Kessler, W. Hohenberger, Erlangen, Germany

- P179** Colonoscopic Obstruction as a Preoperative Predictable Prognostic Factor
S. Lee, K. Hong, H. Moon, Seoul, South Korea

- P180** Stenting vs Colostomy for Malignant Colonic Obstruction: Comparison of Clinical Outcomes and Hospital Costs
S. Varadarajulu, A. Roy, T. Lopes, M. Kim, E. R. Drelichman, Birmingham, AL; Natick, MA

- P181** Oncologic Outcomes of Curative Resection for Left-sides Colon Cancer Obstruction Followed by Stent Insertion: Interim Result in a Single Center
S. Kim, H. J. Kim, J. Lee, B. H. Kye, I. K. Lee, H. M. Cho, W. K. Kang, J. G. Kim, S. T. Oh, Seoul, South Korea; Suwon, South Korea



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- P182** Neutrophil-to-Lymphocyte Ratio is an Independent Predictor of Outcome Following Colectomy for Cancer
T. Fancher, M. Hsu, A. Weiss, J. Shia, M. Gonen, G. Nash, L. Temple, P. Paty, J. Guilem, D. Wong, M. Weiser, New York, NY
- P183** An Elevated Neutrophil/Lymphocyte Ratio Predicts Worse Outcome in Resected Stage II Colon Cancer
G. I. Urrejola, C. Bambs, M. Espinoza, A. Zuñiga, J. Campbell, S. Niklitschek, D. Pulgar, G. Pinedo, Santiago, Chile
- P184** The Predictive Value of Preoperative CEA Level in the Prognosis of Colon Cancer
H. T. Kirat, P. R. Kiran, E. Ozturk, F. Remzi, I. C. Lavery, Cleveland, OH
- P185** Influence of Obesity on the Serum Carcinoembryonic Antigen Value in Patients with Colorectal Cancer
G. Choi, J. Park, K. Lim, Y. Jang, S. H. Jun, Daegu, South Korea
- P186** Impact of Preoperative CEA Level on Recurrence Free Interval after Curative Resection of Colorectal Cancer
S. Oh, O. Paek, J. Park, H. Song, D. Oh, K. Suh, Suwon, South Korea
- P187** Increasing Incidence of Rectal Cancer in the Young
V. Reddy, H. M. Einarsdottir, S. Alva, K. Wilkins, B. T. Chinn, New Haven, CT; New Brunswick, NJ
- P188** A Population-based Study of Long-term Illness and Childbirth in Young Adult Survivors of Colorectal Cancer
S. S. Forbes, R. Sutradhar, L. Paszat, L. Rabeneck, D. R. Urbach, N. Baxter, Toronto, ON, Canada
- P189** Increasing Incidence of Colorectal Cancer in Patients Less than 50 Years Presents at Advanced Stage
J. F. Lessmann, M. E. Murday, C. Koehler, J. A. Griffin, P. W. Bossart, J. E. Waldron, Murray, UT; Salt Lake City, UT
- P190** Carcinoma Rectum: A Disease of Aggression in Young Patients
A. Kumar, R. Daga, A. Prakash, R. K. Singh, A. Behari, V. K. Kapoor, R. Saxena, Lucknow, UP, India
- P191** Tumor-infiltrating Lymphocytes Predicts Survival Undergoing Curative Resection for Colorectal Cancer
J. Huh, B. Oh, H. Kim, Y. Kim, Gwangju, South Korea
- P192** Tumor Budding in Submucosa: An Optimal Predictive Factor for Clinical Outcome in Colorectal Cancer
H. Uchida, H. Hasegawa, Y. Ishii, T. Endo, K. Okabayashi, Y. Masugi, Y. Kitagawa, Tokyo, Japan
- P193** Lymphovascular or Perineural Invasion May Predict Lymph Node Metastasis in Patients with T1 and T2 Colorectal Cancer
J. Huh, B. Oh, H. Kim, Y. Kim, Gwangju, South Korea
- P194** Distribution of Lymphatics within Stage II Colorectal Adenocarcinomas using D240 Immunostain
K. J. Smith, D. A. Burke, P. Finan, P. Jones, P. Quirke, Leeds, West Yorkshire, United Kingdom
- P195** Outcomes Predictor for the Patients with Stage II and III Rectal Cancer
A. Hiranyakas, H. Yik-Hong, J. Kirsch, B. Bashankaev, L. Rosen, S. D. Wexner, Weston, FL
- P196** pT4N0 Colon Cancer has Oncologic Outcomes Comparable to Stage III Even in a Specialized Center
M. Rottoli, L. Stocchi, D. W. Dietz, Cleveland, OH
- P197** Survival and Metastatic Patterns of Signet Cell and Mucinous Carcinoma vs Adenocarcinoma of the Colon and Rectum
S. M. Ali, V. A. Constantinides, P. A. Georgiou, G. Brown, R. Goldin, A. Antoniou, P. P. Tekkis, London, United Kingdom
- P198** Appropriate Postoperative Surveillance System Based on Clinical Outcomes
K. Yonaga, H. Hasegawa, Y. Ishii, T. Endo, K. Okabayashi, Y. Kitagawa, Tokyo, Japan
- P199** Association of Colorectal Cancer Development and Prognosis with DNA Repair Genes
E. Canbay, B. Agachan, M. Gulluoglu, T. Isbir, E. Balik, S. Yamaner, T. Bulut, U. Zeybek, S. Sozen, C. Cacina, A. Yilmaz, D. Bugra, Istanbul, Turkey
- P200** Modulation of the Proteasome Subunit Rpt4 Sensitizes Colonic Carcinoma to Apoptosis: The Potential of Proteasome Inhibition in the Treatment of Colon Carcinoma
N. McCawley, S. Conlon, C. Concannon, J. Prehn, E. W. Kay, D. McNamara, Dublin, Ireland
- P201** miR-181a: The Biomarker of Metachronous Liver Metastasis in Colorectal Cancer
Z. Chen, J. Gu, Beijing, China
- P202** Preliminary Results of Colonocyte Quantification in Colorectal Cancer Diagnosis
L. Mahadavan, I. Daniels, A. Loktionov, A. Llewelyn, A. Shore, W. Hamilton, Exeter, Devon, United Kingdom; Bristol, United Kingdom; Cambridge, United Kingdom

Quality of Life After Surgery

- P203** Long-term Functional Outcomes Following Rectal Cancer Surgery: Can We Improve?
A. S. Scheer, R. P. Boushey, S. Liang, S. Doucette, A. M. O'Connor, D. Moher, Ottawa, ON, Canada
- P204** Anorectal Function after Sphincter Preserving Surgery for Mid to Low Rectal Cancer
I. Park, J. Kim, Seoul, South Korea
- P205** Risk Factors for Persistent Anal Incontinence after Restorative Proctectomy in Rectal Cancer Patients with Anal Incontinence: Prospective Cohort Study
T. Lee, S. Kang, S. Hong, D. Kim, Seongnam-si, Gyeonggi-do, South Korea
- P206** Colonic Myotomy for Restoration of Rectal Capacity Following Low Anterior Resection
O. H. Llaguna, J. E. Martz, W. E. Enker, Chapel Hill, NC; New York, NY



Poster Presentations

- P207** **Quality of Life in Rectal Cancer Patients with a Temporary Stoma**
H. B. Newman, J. Park, S. Fuzesi, K. Duhamel, M. Weiser, G. Nash, P. Paty, J. Guillem, D. Wong, L. Temple, Madison, WI; Winnipeg, MB, Canada; New York, NY
- P208** **Prospective Comparison of Long-term Quality of Life in Patients with Low Rectal Cancer Undergoing Abdominoperineal Resection and Low Anterior Resection**
L. de Campos-Lobato, P. R. Kiran, I. C. Lavery, Cleveland, OH
- P209** **Effectiveness of Biofeedback Therapy in Treatment of Anterior Resection Syndrome after Rectal Cancer Surgery**
K. Kim, C. S. Yu, Seoul, South Korea
- P210** **Reconstruction after Low Anterior Resection: Comparative Study**
H. S. Tawfik, Benha, Egypt
- P211** **Sexual Dysfunction after Surgery for Rectal Cancer**
Y. Lee, D. Schrag, S. Patil, P. Paty, J. Guillem, M. Weiser, G. Nash, K. Goodman, D. Wong, K. Duhamel, L. Temple, New York, NY; Boston, MA
- P212** **Is it Possible to Prospectively Assess Sexual Dysfunction in Female Rectal Cancer Patients?**
M. Leon-Carlyle, S. J. Schmocker, J. C. Victor, N. Baxter, A. J. Smith, R. McLeod, E. Kennedy, Toronto, ON, Canada
- P213** **A Comparison of Instruments to Assess Male Sexual Function Following Treatment for Rectal Cancer**
M. Leon-Carlyle, S. J. Schmocker, J. C. Victor, N. Baxter, A. J. Smith, R. McLeod, E. Kennedy, Toronto, ON, Canada
- P214** **A Comparative Study of Voiding and Sexual Function after Total Mesorectal Excision for Rectal Cancer: Laparoscopic vs Robotic Surgery**
J. Kim, H. Hur, N. Kim, B. Min, K. Lee, Seoul, South Korea

Treatment of Advanced Cancer

- P215** **Comparison of Laparoscopic Colorectal Resection vs an Open Approach in Patients Undergoing Simultaneous R0 Resection for Liver Metastases**
J. Huh, B. Oh, H. Kim, Y. Kim, Gwangju, South Korea
- P217** **Trends in Treatment for Colorectal Synchronous Liver Metastases: Differences in Outcome Before and After 2000**
N. Ayez, A. E. Van Der Pool, Z. S. Lalmahomed, J. H. De Wilt, A. M. Eggermont, J. N. IJzermans, C. Verhoef, Rotterdam, Netherlands
- P218** **Clinical Risk Score for Patients with Colorectal Liver Metastases in the Era of Neoadjuvant Chemotherapy**
N. Ayez, Z. S. Lalmahomed, A. E. Van Der Pool, A. M. Eggermont, J. N. IJzermans, C. Verhoef, Rotterdam, Netherlands
- P219** **Extended Lymphadenectomy for Recurrent and Locally Advanced Primary Rectal Cancer**
P. A. Georgiou, S. M. Ali, G. Brown, A. Antoniou, A. W. Darzi, R. J. Nicholls, P. O. Tekkis, London, United Kingdom
- P220** **Treatment Outcomes for Recurrent Rectal Cancer Following Local or Radical Primary Therapy: A Comparative Study**
D. Christoforidis, P. K. Horst, J. Pollack, A. Mellgren, D. A. Rothenberger, R. Madoff, Luasanne, Switzerland; Minneapolis, MN; Stockholm, Sweden

- P221** **Is There a Survival Advantage for Elective Primary Tumor Resection in Asymptomatic Patients with Incurable Stage IV Colorectal Cancer?**
L. A. Julien, C. A. Ternent, R. S. Nelson, J. S. Beaty, A. G. Thorson, J. S. Reyes, G. J. Blatchford, M. S. Shashidharan, Omaha, NE

Outcomes

Hand Assisted Laparoscopic Surgery

- P222** **In a Minimally Invasive Colorectal Practice that Offers Both Hand-assisted and Laparoscopic-assisted Colorectal Surgery: Which Patients Truly Undergo Minimally Invasive Surgery?**
B. Mizrahi, B. Loh, A. Ferrara, J. Gallagher, P. Williamson, S. DeJesus, R. Mueller, Orlando, FL
- P223** **Hand-assisted vs Straight Laparoscopic Training on a Hybrid Virtual-reality Simulator for Laparoscopic Colorectal Skills Acquisition**
F. Leblanc, B. J. Champagne, P. C. Neary, A. Senagore, N. Ellis, C. P. Delaney, Cleveland, OH; Dublin, Ireland; Grand Rapids, MI; Mobile, AL
- P224** **Hand-assisted Laparoscopic Colorectal Surgery: Defining the Learning Curve**
R. Pendlimari, S. D. Holubar, J. Pattana-arun, D. W. Larson, E. J. Dozois, J. H. Pemberton, R. R. Cima, Rochester, MN
- P225** **Early Multi-institution Experience with Single Incision Laparoscopic Colectomy**
H. Ross, M. Whiteford, S. Lee, S. Steele, M. R. Albert, M. Mutch, B. Davis, H. Vargas, L. Fischer, M. Weiser, D. Rivadeneira, P. W. Marcello, Red Bank, NJ; Portland, OR; Orlando, FL; Fort Lewis, WA; St. Louis, MO; New York, NY; Smithtown, NY; Cincinnati, OH; Lexington, KY; Burlington, MA

Lap Colectomy Outcomes

- P226** **Laparoscopic Colorectal Resection for Octogenarians is a Safe and Optimal Approach**
W. Law, J. T. Poon, J. K. Fan, O. S. Lo, Hong Kong, China
- P227** **Should Elderly Patients Still Undergo Open Colorectal Surgery?**
J. C. Roos, C. Elton, D. Kazzazz, T. Agarwal, P. Mathur, London, United Kingdom
- P228** **Laparoscopic Colorectal Surgery for Cancer in the Very Elderly**
A. Privitera, C. Liao, M. Tutton, T. Arulampalam, R. Austin, N. Pawa, R. Motson, Colchester, Essex, United Kingdom
- P229** **Is Laparoscopic Rectal Resection for Cancer Indicated in Elderly Patients?**
M. Rottoli, S. Bona, R. Rosati, U. Fumagalli, M. Molteni, U. Elmore, M. Montorsi, Milan, Italy
- P230** **Outcomes of Laparoscopic Surgery for Colorectal Cancer: Does Gender Matter?**
A. Barnes, S. Liang, H. Moloo, R. Auer, J. Mamazza, E. Poulin, R. P. Boushey, Ottawa, ON, Canada



Poster Presentations

- P231** Effect of Warmed, Humidified CO₂ Gas on Cytokine Response to Minimally Invasive Colorectal Surgery: A Randomized Trial
S. T. Tohme, M. H. Shantha Kumara, C. X. Yan, A. Nasar, V. Cekic, R. L. Whelan, New York, NY
- P232** Comparative Study of Postoperative Inflammation and Tumor Stimulation Factors Between Open and Laparoscopically-assisted Anterior Resection for Sigmoid Colon Cancer
J. Kim, B. Min, K. Lee, N. Kim, Goyang-si, Gyeonggi-do, South Korea; Seoul, South Korea
- P233** Immune Response after Open, Laparoscopic, and Hand-assisted Colon and Rectal Resections
H. Bahna, B. Loh, M. Donigan, L. Norcross, J. Aversa, M. Ferrara, P. Williamson, S. DeJesus, R. Mueller, A. Ferrara, J. Gallagher, C. Baker, Orlando, FL
- P234** Minilaparotomy is Another Valuable Minimal Invasive Approach to Rectal Cancer: 8 Years Experience in Single Center
X. Wang, T. Zeng, T. Yang, C. Qin, L. Jia, L. Li, Chengdu, Sichuan, China
- P235** Laparoscopic Proctectomy Following Neoadjuvant Therapy: Safety and Long-term Follow-up
M. M. Cone, K. C. Lu, D. O. Herzig, J. D. Rea, B. S. Diggs, S. C. Oommen, Portland, OR; Concord, CA
- P236** Laparoscopic Total Mesorectal Excision and Delayed Coloanal Anastomosis without Stoma for Low Rectal Cancer: Report of 50 Consecutive Cases
J. Faucheron, D. Voirin, R. Palaghiu, P. Waroquet, G. Poncet, Grenoble, France
- P237** A Comparison of Oncologic Results after Laparoscopic Abdominoperineal Resection and Ultra-low Anterior Resection with Hand-sewn Coloanal Anastomosis in Distal Rectal Cancer
K. Lim, G. Choi, J. Park, Y. Jang, S. Jun, Daegu, South Korea
- P238** Clinical and Oncological Outcomes of Laparoscopic Surgery for Transverse Colon vs Right-sided Colon Cancer: A Case-controlled Study
J. Kawamura, K. Trencheva, T. Sonoda, J. Milsom, S. Lee, New York, NY
- P239** A 13-year Review of Laparoscopic and Open Colectomy for Transverse Colon Cancer
S. Agarwal, S. Dharmarajan, M. Gincheran, E. H. Birnbaum, M. Mutch, J. W. Fleshman, St Louis, MO
- P240** The Long-term Outcomes for Patients with Right-sided Colon Cancer: Impact of Laparoscopic Surgery
B. Kye, J. G. Kim, H. M. Cho, S. Kim, W. K. Kang, J. Lee, H. J. Chung, H. H. Kim, J. C. Lee, H. J. Kim, S. T. Oh, Seoul, South Korea; Suwon, South Korea
- P241** The Negative Effects of Surgery Persist Beyond the Early Postoperative Period after Laparoscopic Colorectal Resection
M. Ince, P. R. Kiran, H. T. Kirat, D. Geisler, F. Remzi, Cleveland, OH
- P242** Long-term Outcome in Laparoscopic Colorectal Surgery: Results of a Randomized Single Institution Trial
N. Pecorelli, M. Braga, M. Frasson, W. Zuliani, V. Di Carlo, Milan, Italy
- P243** 48 Hours Hospitalization and Laparoscopic Colorectal Surgery. Feasibility and Predictive Factors
M. Laporte, A. Canelas, M. E. Bun, E. E. Sadava, B. Helman, C. Peczan, N. Rotholtz, Capital Federal, Argentina
- P244** Incisional Hernia after Laparoscopic Colorectal Surgery. Is There any Factor Associated?
N. Rotholtz, J. Kerman Cabo, A. G. Canelas, B. Helman, M. E. Bun, M. Laporte, C. Peczan, Buenos Aires, Argentina
- P245** Assessment of Suitability of Rectal Cancer for a Laparoscopic Approach – A Single Center Experience of 122 Patients
D. Good, J. M. O’Riordan, D. Moran, F. B. Keane, E. Eguare, D. O’Riordan, P. C. Neary, Dublin, Ireland
- P247** Risk Factors Associated to Anastomotic Leakage in Laparoscopic Colorectal Surgery
A. G. Canelas, M. E. Bun, M. Laporte, J. Kerman Cabo, C. Peczan, N. Rotholtz, Buenos Aires, Argentina
- P248** A Randomized Clinical Trial Comparing Cost and Effectiveness of Bipolar Vessel Sealers vs Clips and Vascular Staplers in Straight Laparoscopic Colectomy
M. Adamina, B. J. Champagne, B. N. Bae, L. Hoffman, M. Laughinghouse, C. P. Delaney, Cleveland, OH
- P249** Laparoscopic vs Open Appendectomy: Comparison in Terms of Clinical Outcomes and Quality of Life
T. Tezcaner, S. Leventoglu, R. Kozan, E. Karaahmetli, B. B. Montes, B. Aytac, Ankara, Turkey

Lap and Obesity

- P250** Impact of Obesity on Outcomes of Laparoscopic Left Colectomy: Is Obesity a Contraindication?
R. Essani, J. Marks, E. Larkin, G. Marks, Wynnewood, PA
- P251** Obesity and Laparoscopic Colectomy: Postoperative Outcomes Using the ACS-NSQIP Dataset
W. C. Mustain, D. Davenport, J. S. Hourigan, H. Vargas, Lexington, KY
- P252** Obese Patients have Higher Risk Factors of Wound Infection after Laparoscopic Colorectal Surgery
K. Narita, C. Reategui, D. R. Sands, E. Weiss, J. Nogueras, S. D. Wexner, Weston, FL

Lap Training

- P253** Laparoscopic Colorectal Competency Assessment Tool for the UK National Training Program
D. Miskovic, S. Wyles, N. K. Francis T. A. Rockall, R. H. Kennedy, G. B. Hanna, London, United Kingdom; Yeovil, United Kingdom; Guildford, Surrey, United Kingdom
- P255** Laparoscopic Training in the UK
D. C. Brown, D. Miskovic, G. B. Hanna, London, United Kingdom

Outcomes / Miscellaneous

- P256** Lengthening of the Colon for Low Rectal Anastomosis: Soft Cadaveric Study
J. Pattana-arun, S. Thum-umnaysuk, Bangkok, Thailand; Pitsanulok, Thailand



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P257 A Prospective Audit of the Natural History of Stomas
G. Kaur, T. Wilson, E. Ewart, Scunthorpe, North Lincs, United Kingdom

P258 Restrictive Covenants in Physician Contracts:
A Survey of Young ASCRS Members
W. C. Cirocco, Kansas City, KS

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P259 The Motion of Wind To and Fro in the Guts: Predicting Gastrointestinal Impairment in the Postoperative Patient Using Spectral Analysis of Intestinal Sounds
D. E. Wandrey, K. Emmett, A. Mathew, J. W. Cromwell, Memphis, TN

P260 The Prokinetic Agent TZP-101 (a Ghrelin Agonist) Accelerates GI Recovery in Partial Colectomy Patients Independently of Total Opioid Use and Type of Surgery
G. Bochicchio, P. Charlton, J. C. Pezzullo, G. Kosutic, A. Senagore, Durham, NC; Baltimore, MD; Washington, DC; Grand Rapids, MI

P261 Introduction of Alvimopan Into an Enhanced Recovery Protocol for Colectomy Offers Benefit in Open Colectomy
J. Barletta, T. Asgeirsson, S. K. Suryadevara, K. I. El-Badawi, A. Senagore, Grand Rapids, MI

P262 Case Matched Assessment of Alvimopan for Laparoscopic Segmental Colectomy with a Standardized Enhanced Recovery Pathway
I. D. Obokhare, C. P. Delaney, B. J. Champagne, D. M. Krpata, Cleveland, OH

P263 Alvimopan Decreases Length of Hospital Stay in a Busy Private Practice Setting
M. Morris, H. R. Bailey, M. Snyder, Houston, TX

P264 A Prokinetic Effect of Hydroxy-Alpha-Sanshool, an Active Principle of a Traditional Japanese Medicine Daikenchuto
N. Ohtake, T. Hibino, R. Ikemura, M. Yamamoto, Y. Kase, Ami-machi, Inashiki-gun, Ibaraki, Japan

P265 C-reactive Protein as a Predictor of Recovery Following Colorectal Surgery
D. M. Krpata, E. Marderstein, I. D. Obokhare, C. P. Delaney, Cleveland, OH

Process Outcomes

P266 Practice Variations in the Performance of Segmental Colectomy: A State-wide Audit
M. Luchtefeld, J. Kubus, A. Senagore, M. Englesbe, D. Campbell, Grand Rapids, MI; Ann Arbor, MI

P267 Multidisciplinary Clinic Management of Colorectal Cancer Enhances Preoperative Evaluation and Compliance with NCCN Guidelines
R. A. Levine, B. Chawla, H. Wasvary, Royal Oak, MI

P268 Evaluation of Myocardial Ischemia after Colorectal Surgery: So many Troponin Tests, so Little Value
H. T. Kirat, E. Ozturk, P. R. Kiran, L. de Campos-Lobato, E. Wick, J. D. Vogel, Cleveland, OH

P269 MS-DRG Grouping Poorly Defines Risk and Reason for Unplanned Visits after Colectomy: Implications for Bundled Payment Policy
T. Asgeirsson, S. K. Suryadevara, K. I. El-Badawi, A. Senagore, Grand Rapids, MI

P270 Differences in Colonoscopy Technique: How do they Impact Patient Care?
J. M. Church, S. Kravochuck, R. Gao, Cleveland, OH

P271 Rigid Sigmoidoscopy in the Colorectal Fast-track Clinic. An Outdated Modality?
K. Futaba, K. Busby, J. Francombe, M. Osborne, P. Murphy, M. Stellakis, Warwick, United Kingdom

P272 Successful Implementation of a Communities of Practice Model to Facilitate Quality Improvement Initiatives in Colorectal Cancer Surgery
L. J. Williams, R. Morash, S. Shin, J. Smylie, H. Moloo, R. Auer, E. Poulin, J. Mamazza, J. Watters, M. Fung-Kee-Fung, R. P. Boushey, Ottawa, On, Canada

P273 Surgeons Can Accurately Predict Complications after Major Abdominal Colorectal Surgery
E. Marderstein, P. Knoll, H. Reynolds, B. J. Champagne, C. P. Delaney, Cleveland, OH

P274 Using Technology to Facilitate Data Capture and Integration of Patient Reported Outcomes Into Colorectal Surgical Practice
B. Gurland, P. Ferreira, T. Sobol, P. R. Kiran, Cleveland, OH

P275 Specialized Practice Reduces Inpatient Cost and Mortality in the Care of Colorectal Patients
J. D. Rea, M. M. Cone, B. S. Diggs, K. C. Lu, D. O. Herzig, Portland, OR

P276 Quality of Colorectal Cancer Care in the Safety Net: Lessons from Los Angeles County
R. R. Cannom, J. L. Bennett, M. A. Maggard, B. A. Petrie, G. T. Ault, D. A. Etzioni, Los Angeles, CA; Torrance, CA

P277 Multidisciplinary Care in Rectal Cancer: Are We Failing?
K. Kazanjian, S. Roy-Chowdhury, S. Lum, J. Morgan, J. Wong, Loma Linda, CA

P278 Are There National Disparities in the Management of Left-sided Large Bowel Obstruction?
K. Alavi, J. Simons, J. A. Maykel, P. Sturrock, J. A. Cervera-Servin, W. B. Sweeney, Worcester, MA

P279 Has the Use of Anti-adhesion Barriers Changed the Admission Rate for Bowel Obstruction?
T. M. Geiger, R. Ricciardi, P. L. Roberts, P. W. Marcello, T. E. Read, D. J. Schoetz, J. Hall, Burlington, MA

Robot

P280 Institutional Cost Analysis of Robotic Colorectal Surgery
A. Abodeely, M. Vrees, D. Cloutier, J. A. Lagares-Garcia, Pawtucket, RI; Providence, RI

P281 Integration of Robotics into Clinical Practice: 100 Cases Suggest an Evolving New Standard for Minimally Invasive Colon and Rectal Surgery
S. M. Rauh, S. J. Ognibene, B. Domajnko, A. Farid, B. A. Macey, Rochester, NY



Poster Presentations

P282 Safety and Feasibility of Robotic-assisted Laparoscopic Colorectal Surgery: Experience in 70 Cases
D. I. Ramos-Valadez, C. B. Patel, M. Ragupathi, D. Gandhi, E. M. Haas, Houston, TX

P283 Safety and Learning Curve in Robotic Colorectal Surgery
A. Abodeely, J. A. Lagares-Garcia, M. Vrees, P. R. Sturrock, D. Cloutier, Pawtucket, RI; Providence, RI

P284 Safety and Feasibility of DaVinci Robot-assisted Total Mesorectal Excision in Rectal Cancer; Analysis of 294 Consecutive Patients in a Single Center
J. Kang, H. Hur, Y. Park, B. Min, S. Baik, K. Lee, N. Kim, S. Sohn, Seoul, South Korea

P285 Factors Affecting the Difficulty of DaVinci Robotic-assisted Total Mesorectal Excision for Mid and Low Rectal Cancer
J. Kim, H. Hur, N. Kim, B. Min, K. Lee, Seoul, South Korea

P286 Robotic-assisted vs Laparoscopic Surgery for Low Rectal Cancer: Short-term Outcomes Analysis of a Case-matched Study
G. Choi, J. Park, K. Lim, Y. Jang, S. H. Jun, Daegu, South Korea

P287 Total Robotically-assisted Laparoscopic Colorectal Resection: Single Stage Technique Using the Standard DaVinci Surgical System with 4 Arms
D. C. Koh, S. Kim, C. B. Tsang, Singapore; Seoul, South Korea

P288 Comparison of Short-term Outcomes after Hybrid vs Totally Robotic Total Mesorectal Excision
Y. Hong, S. Baik, H. Hur, B. Min, K. Lee, N. Kim, Seoul, South Korea

Single Incision Laparoscopic Colectomy

P289 Single-incision vs Laparoscopic-assisted Segmental Colectomy: A Case Matched Series
B. J. Champagne, E. C. Lee, F. Leblanc, C. P. Delaney, Cleveland, OH; Albany, NY

P290 Single-incision Laparoscopic Colectomy and Proctectomy: Feasibility and Safety in a Series of 10 Cases
A. Bouchard, P. Bouchard, P. Scott, T. Young-Fadok, Scottsdale, AZ

P291 Single-incision Laparoscopic Right Colectomy: Early Comparison with Multi-port Laparoscopic Right Colectomy
J. D. Adair, R. Lim, D. Nagle, Boston, MA; Honolulu, HI

P292 Single-port Laparoscopic D3 Colon Resection for Advanced Colon Cancer
K. Lee, S. Choi, B. Kang, S. Lee, Seoul, South Korea

With OP Complications

P293 Does Stopping Clopidogrel for Colonoscopy Cause Thromboembolic Events?
N. Allen, D. Beck, T. Hick, A. Timmcke, C. Whitlow, D. Margolin, New Orleans, LA

P294 Side-to-side Stapled vs End-to-end Handsewn Anastomoses for Laparoscopic Right Colectomy; Preliminary Results of a Randomized Controlled Trial
M. E. Bun, A. Canelas, B. Helman, M. Laporte, C. Peczan, N. Rotholz, Buenos Aires, Argentina

P295 Anastomotic Leak after Restorative Proctosigmoidectomy for Cancer: What are the Chances of a Permanent Ostomy?
J. W. Ogilvie, D. Dietz, J. M. Church, L. Stocchi, Cleveland, OH

P296 Comparison of Morbidity of Right vs Left Colectomy for Benign Colorectal Disease
B. Buchberg, H. Masoomi, D. E. Beck, B. G. Wolff, M. J. Stamos, S. Mills, Orange, CA; New Orleans, LA; Rochester, MN

P297 Pay-for-performance Policies Neglect Obese Patients: A Disparity in Surgical Site Infection Rates and Costs
E. Wick, K. Hirose, A. Shore, J. D. Vogel, S. L. Gearhart, J. Efron, J. Clark, M. A. Makary, Baltimore, MD; Cleveland, OH

P298 Evaluation of Ertapenem use as a Perioperative Antibiotic in Colorectal Surgery
H. Chern, E. Finlayson, L. Gibbs, E. Kim, J. Garcia-Aguilar, M. Varma, San Francisco, CA

P299 Risk Factors for Surgical Site Infections in Abdominal Colorectal Surgery
V. P. Ho, S. L. Stein, K. Trencheva, J. Milsom, S. Lee, T. Sonoda, New York, NY; Cleveland, OH

P300 SSI after Colorectal Surgery: Time to Skip Thinking about SCIP?
M. Larochelle, N. H. Nyman, T. Osler, Burlington, VT

P301 Effects of Preoperative Mechanic Bowel Preparation with Oral Antibiotics Over the Incidence of Postoperative Wound Infection
S. Ozdemir, E. Ozis, K. Gulpinar, Z. Sahli, A. Korkmaz, E. Gecim, Ankara, Turkey

P302 Inpatient Management of Clostridium Difficile Colitis: Determinants of Cost and Mortality
D. B. Stewart, C. Hollenbeak, Hershey, PA

Miscellaneous

P303 A Comparison of Minimally Invasive Treatments for Rectal Tumors: TEM vs Laparoscopic TME
R. Pierce, T. Goers, P. Leão, M. Cassera, L. Swanstrom, D. O'Brien, M. Whiteford, Braga Portugal; Portland, OR

P304 Long-term Survival in Young Adults with Colorectal Cancer: A Population-based Study
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