Date: October 06-07, 2012
Venue: China University Hospital Building

Contents

Date: October 06-07, 2012
Venue: China University Hospital Building

Welcome Message

It gives me great pleasure to invite you to participate in the 3rd Annual Colorectal Surgery Forum. This forum is scheduled to take place on October 6-7, 2012 at China Medical University Hospital, Taichung, Taiwan. This forum will focus on the standardization and trends of colorectal surgery, current concepts in anorectal surgery, and other topics regarding the future of colorectal surgery. Similar to last year, we hope to present cutting-edge, complex, and even controversial topics in the field of colorectal surgery, catering to the diverse interests of our attendees which include superb faculty from China, France, Hong Kong, Japan, Korea, Singapore, and Taiwan. Topics such as NOTES, robotics, TEM, TME, robotic colorectal surgery, and advanced laparoscopy will be highlighted throughout the meeting. Hopefully, this forum will not only bring all these developments to light, but also serve as a platform for us to discuss the current status of colorectal surgery in these challenging areas.

For those that have not visited our city, Taichung is a beautiful city located in the central part of Taiwan. It is blessed with temperate weather (yearly average temperature of 22.8 degrees- Celsius), making all the seasons reminiscent of spring. It is a city that boasts abundant natural resources and supports a population of more than 2 million people. The people of Taichung are full of culture and welcome international visitors, making it a great city for tourism. Along with the hospitality, Taichung is surrounded by vast mountains and rivers that offer once-in-a-lifetime experiences for sightseeing!

On behalf of the President of the China Medical University System, Chang-Hai Tsai, China Medical University Hospital, and the rest of the organizing committee, I extend my warmest welcome to everyone who will be participating in the Colorectal Surgery Forum 2012 in Taichung. I look forward seeing you in October!

William Tzu-Liang Chen, M.D.
Forum Director

Organizing Committee

Organizing Committee

Prof. William Tzu-Liang Chen	China Medical University Hospital, Taichung
Dr. Tao-Wei Ke	China Medical University Hospital, Taichung
Dr. Hua-Che Chiang	China Medical University Hospital, Taichung
Dr. Sheng-Chi Chang	China Medical University Hospital, Taichung

International Faculty

Prof. Abe Fingerhut	Centre Hospitalier Intercommunal de Poissy-Saint-Germain
Prof. Francis Seow-Choen	Seow-Choen Colorectal Centre, Mt Elizabeth Medical Centre, Singapore
Prof. Nam-Kyu Kim	Younsei Hospital, Korea
Prof. Seon-Hahn KIM	Korea University Anam Hospital, Korea University College of Medicine, Korea
Prof. Gyu-Seog Choi	Kyungpook National University Hospital, Korea
Prof.Joel Leroy	Associated Professor of Digestive Surgery, University of Lille, France
Prof. Fumio Konishi	Jichi Medical University, Japan
Prof. Michael Li	Pamela Youde Nethersole Eastern Hospital, Hong Kong
Prof. Tsang Bih Shiou	National University Cancer Institute, Singapore
Prof. Hester Cheung	Pamela Youde Nethersole Eastern Hospital, Hong Kong
Prof. Ken Ohata	JR Tokyo General Hospital of East Japan

Local Faculty

Prof. Jaw-Yuan Wang	Kaoshiung Medical University Chung-Ho Memorial Hospital
Prof. Hwei-Ming Wang	Taichung Veterans General Hospital
Dr. Sheng-Chi Chang	China Medical University Hospital, Taichung
Dr. Chung-Hung Yeh	Chiayi Chang-Gung Memorial Hospital, Chiay
Dr. Kuang-Hung Hsiao	Buddhist Tzu Chi General Hospital
Prof. Jin-Tung Liang	Taiwan Association for Endoscopic Surgery
Dr. Cheng-Shying Chang	Changhua Christian Hospital

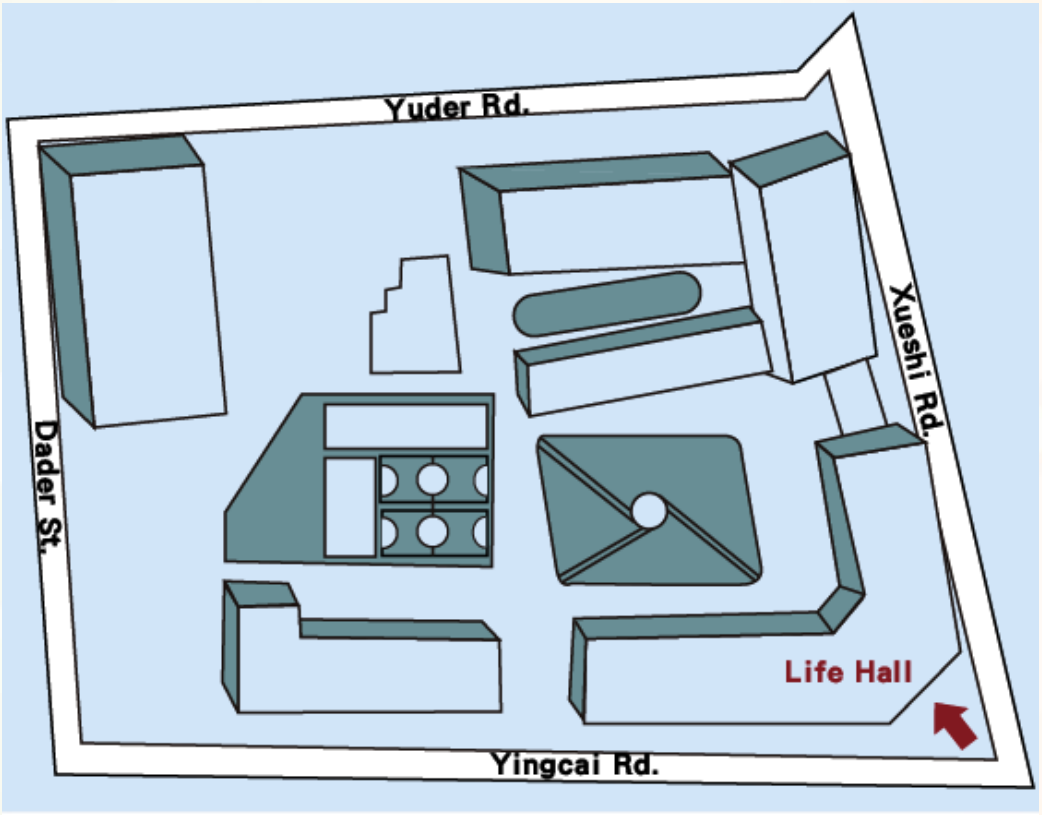
Conference Information

Date

October 6-7 (Saturday-Sunday), 2012

Venue

Location: Conference Hall, B1, Lifu Teaching Building, China Medical University
Address: 2 Yuh-Der Road, Taichung City, Taiwan 40447



Language

The official language of the conference is English.

Conference Policy

- Smoking is prohibited at all times in the conference rooms and the whole building, by law.
- Food and drinks are not allowed in the conference rooms.
- Please switch your mobile phones off or to vibration mode during all sessions.
- Please wear your badge to enter conference rooms.

Registration

The official desk will be open at the 1st floor lobby of Lifu Hall as follows:

Date	Time
October 6, 2012	08:30-17:00
October 7, 2012	08:00-15:00

On-site Registration

On-site registration is accepted at the on-site counter during the Forum period. Only cash (NTD) will be accepted.

Secretariat Office & Preview Room

- Secretariat Office & Preview Room are located in Room 101
- Open Time：October 6-7, 08:30-16:30
- Preview Room are located in Room 101, and all meeting rooms will be equipped with a Windows 7 based PCs with Microsoft PowerPoint 2010 installed. Verification of proper performance in the Preview Room is essential, particularly if video and animation is included in the presentation. Please note that Internet access will not be available during your presentation.
- When reviewing your presentation in the Preview Room, make sure all fonts, images, and animations appear as expected and that all audio or video clips are working properly. The computers in the meeting rooms are the same as the computers in the Speaker Ready Room, therefore: IF THE PRESENTATION DOES NOT PLAY PROPERLY IN THE SPEAKER READY ROOM, IT WILL NOT PLAY PROPERLY IN THE MEETING ROOM.

Coffee Break

Refreshments will be served on the B1 and 1F of Lifu Teaching Building, China Medical University

Lunch

Lunch will be served on t Room 202 of Lifu Teaching Building, China Medical University

Banquet

Date: Saturday, October 6, 2012

Time: 19:00-21:00

Venue: Splendor Room, 13 floor, The Splendor Hotel Taichung

Address: No. 1049, Jianxing Rd., Taichung 403 (next to Taichunggang Rd.)

Dress: Smart Casual

Shuttle Bus

Saturday, October 6, 2012

Route	Boarding Area	Boarding Time	Departure Time	Arrival Time
Bus A	Hotal Lobby	08:00-08:10	08:10	08:20
Bus B	Lobby,Lifu Hall	17:00-17:10	17:10	17:20

Sunday, October 7, 2012

Route	Boarding Area	Boarding Time	Departure Time	Arrival Time
Bus A	Hotal Lobby	08:00-08:10	08:10	08:20
Bus B	Lobby,Lifu Hall	16:00-16:10	16:10	16:20

Exhibition

The exhibition is located on the B1 and 1st floor of Lifu Teaching Building, China Medical University. All participants are welcomed to visit during the exhibition hours.

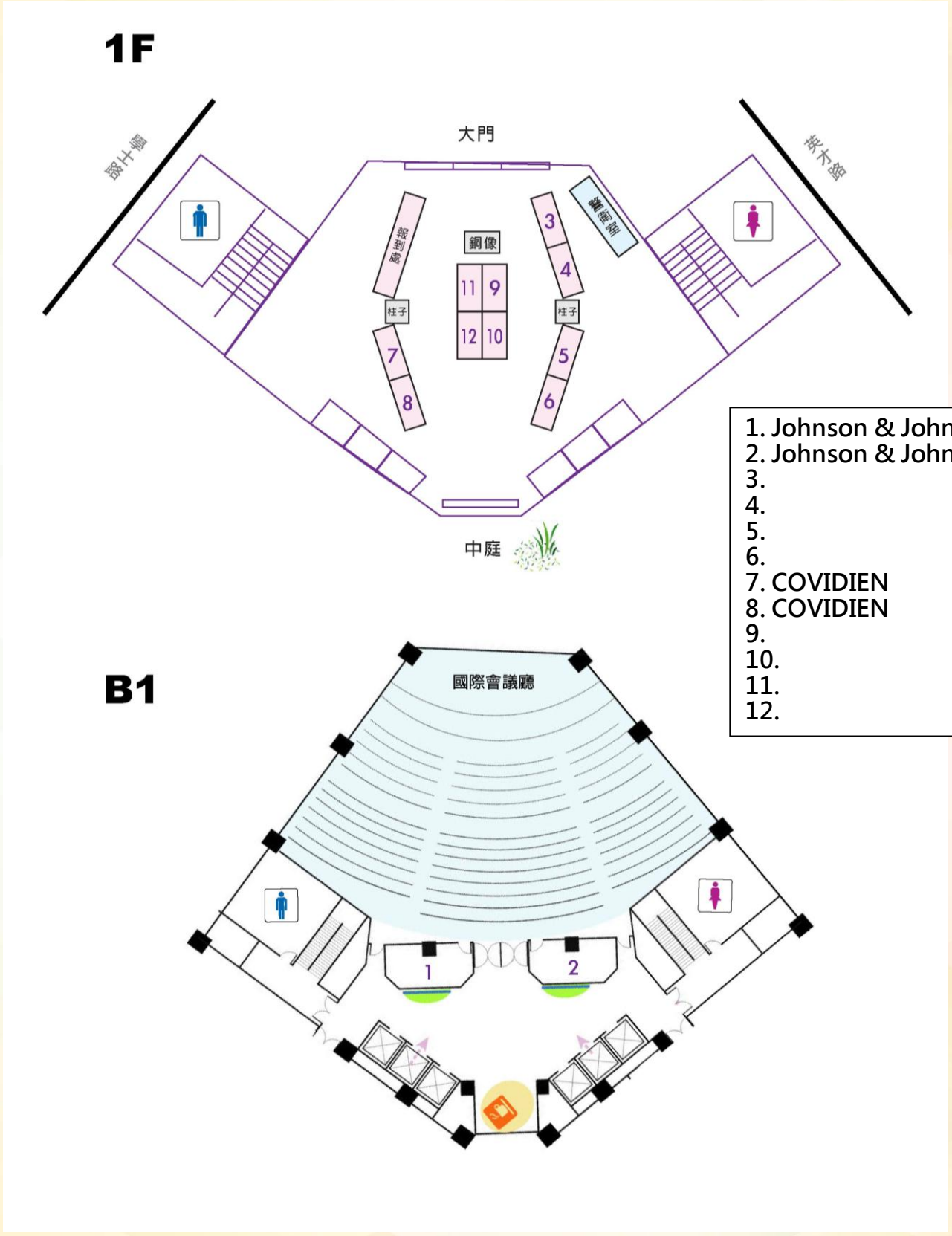
Exhibition Hours

Saturday, October 6, 2012 08:30 – 17:00

Sunday, October 7, 2012 08:30 – 15:00

Date: October 06-07, 2012
Venue: China University Hospital Building

Booth Layout



1. Johnson & Johnson
2. Johnson & Johnson
3.
4.
5.
6.
7. COVIDIEN
8. COVIDIEN
9.
10.
11.
12.

ColoRectal Surgery Forum 2012

The 2012 Autumn Annual Meeting of the Society of Colon and Rectal Surgeons, Taiwan

Date: October 06-07, 2012
Venue: China University Hospital Building

Scientific Program

Oct. 6 (Saturday)			
From-To	**Topic**	**Speaker**	**Moderator**
08:30-08:50	Registration		
08:50-08:55	Opening Speech	Prof. William Tzu-Liang Chen Forum Director	
08:55-09:00	Welcome Speech	Prof. Der-Yang Cho Superintendent of China Medical University Hospital	
09:00-09:05	Welcome Speech	Dr. Jinn-Shiun Chen President, Society of Colon and Rectal Surgeon, Taiwan	
09:05-09:10	Welcome Speech	Prof. Jin-Tung Liang President, Taiwan Association for Endoscopic Surgery	
Anorectal disease			
09:10-09:25	Anal Fistula Management: Imaging for Anal Fistulas, Sphincter Preserving Techniques, LIFT in Singapore: What Have We Learned So Far?	Prof. Tsang Bih Shiou	Dr. Shung-Haur Yang Dr. Brian Hung
09:25-09:40	Minimally Invasive Ana Fistula Surgery; The Role of VAAFT	Prof. Francis Seow-Choen	
09:40-09:55	Current Update in Treatment of Hemorrhoid	Prof. Francis Seow-Choen	
09:55-10:10	Energy Hemorrhoidectomy	Dr. Kuang-Hung Hsiao	
10:10-10:25	Stapled TransAnal Surgery-- The Tips, Complication, and Experiences of PPH and STARR Procedure in Taiwan --	Dr. Chung-Hung Yeh	
10:25-10:40	Management of Constipation-Are We Sure We Are Right?	Prof. Francis Seow-Choen	
10:40-10:55	Panel Discussion		
10:55-11:10	Coffee Break		
Live Demostration			
11:10-14:10	Live Surgery	Prof. William Tzu-Liang Chen	Prof. Hwei-Ming Wang Prof. Abe Fingerhut
14:10-14:25	Neoadjuvant Systemic Chemotherapy and Short Course Radiotherapy Followed by Surgery in Locally Advanced Rectal Cancer with Distant Metastasis	Prof. Nam-Kyu Kim	Prof. Hong-Hwa Chen Prof. Jin-Tung Liang
14:25-14:40	Surgical Treatment for Locally Advanced Rectal Cancers Following Pre-operative Chemoradiotherapy	Prof. Jaw-Yuan Wang	
14:40-14:55	What is the Value of Extended Lymphadenectomy?	Prof. Abe Fingerhut	
14:55-15:10	Is Screening for Colorectal Cancer at 50 Years of Age Correct?	Prof. Francis Seow-Choen	
15:10-15:25	Coffee Break		
15:25-15:40	Updates and Debates in Preoperative Chemoradiation for Rectal Cancer	Prof. Nam-Kyu Kim	
15:40-15:55	Rectal Cancer and Minially Invasive Surgery: What is the Future?	Prof. Joel Leroy	
15:55-16:10	The Continent Issue After Low Rectal Surgery and the ART Testing in Taiwan	Dr. Chung-Hung Yeh	
16:10-16:25	Panel Discussion		
Video Show			
16:25-16:45	Surgery for Complicated Colorectal Procedures	Prof. Gyu-Seog Choi	Dr. Jinn-Shiun Chen
16:45-17:05	Robotic Intersphincteric Resection for Very Low Rectal Cancer: Abdominal and Anal Phases of the Procedure	Prof. Seon-Hahn Kim	

Oct. 7 (Sunday)

From-To	Topic	Speaker	Moderator
08:00-08:30	Registration		
Laparoscopy			
08:30-08:45	Randomized Controlled Trial Comparing Laparoscopic vs Open for Colon Cancer.-Large Scale Japanese Trial and Its Short Term Outcome	Prof. Fumio Konishi	Prof. William Tzu-Liang Chen Dr. Shung-Haur Yang
08:45-09:00	Simulation for Teaching in Laparoscopic Surgery: Why Do We Need It	Prof. Abe Fingerhut	
09:00-09:15	Laparoscopic Complete Mesocolic Excision with D3 Lymphadenectomy: When, Why and How	Prof. Seon-Hahn Kim	
09:15-09:30	MIS in Colorectal Surgery: How Far We Have Gone?	Prof. Gyu-Seog Choi	
09:30-09:45	Endo-laparoscopic Approach to Obstructing Colonic Tumors: Long Term Outcomes	Prof. Hester Cheung	
09:45-10:00	Advances in MIS Colorectal Surgery	Prof. Michael KW Li	
10:00-10:15	Panel Discussion		
10:15-10:30	Coffee Break		
Robotic Surgery			
10:30-10:45	Robot Assisted Laparoscopic Rectal Cancer Excision: Operative and Functional Outcomes	Prof. Hester Cheung	Prof. Joel Leroy Prof. Michael KW Li
10:45-11:00	Robotic Surgery for Colorectal Diseases; Is It Worthy?	Prof. Gyu-Seog Choi	
11:00-11:15	Critical Assessment of Robic Versus Laparoscopic Surgery for the Treatment of Distal Rectal Cancer-National Taiwan University Hospital Experience	Prof. Jin-Tung Liang	
11:15-11:30	Panel Discussion		
Lunch Symposium			
12:00-13:00	Lunch Symposium	Dr. Cheng-Shying Chang	Prof. Hwei-Ming Wang
Scarless Surgery			
13:00-13:15	Single Incision Laparoscopic Colectomy	Prof. Hwei-Ming Wang	Prof. Hwei-Ming Wang Dr. Hong-Jhang Chen
13:15-13:30	How Can We Reduce the Abdominal Wall Trauma in Larparoscopic Left Colonic Resections	Prof. Joel Leroy	
13:30-13:45	Laparoscopic Colectomy with Natural Orifice Specimen Extraction(NOSE): A Bridge to NOTES	Dr. Sheng-Chi Chang	
13:45-14:00	Pure transanal TME without Abdominal Scar Incision Using the Peri-Rectal Oncologic Gateway for Retroperitoneal Endoscopic Single Site Surgery.	Prof. Joel Leroy	
14:00-14:15	Treatment Strategy of Early Stage Colorectal Cancer	Prof. Fumio Konishi	
14:15-14:30	Basic Technique and Pit Fall of EMR	Prof. Ken Ohata	
14:30-14:45	Colorecatl ESD Up to Date	Prof. Ken Ohata	
14:45-15:00	Panel Discussion		
15:00-15:15	Coffee Break		

Speakers Profile

International Faculty

Prof. Abe Fingerhut	Centre Hospitalier Intercommunal de Poissy-Saint-Germain
Prof. Francis Seow-Choen	Seow-Choen Colorectal Centre, Mt Elizabeth Medical Centre, Singapore
Prof. Nam-Kyu Kim	Younsei Hospital, Korea
Prof. Seon-Hahn KIM	Korea University Anam Hospital, Korea University College of Medicine, Korea
Prof. Gyu-Seog Choi	Kyungpook National University Hospital, Korea
Prof.Joel Leroy	Associated Professor of Digestive Surgery, University of Lille, France
Prof. Fumio Konishi	Jichi Medical University, Japan
Prof. Michael Li	Pamela Youde Nethersole Eastern Hospital, Hong Kong
Prof. Tsang Bih Shiou	National University Cancer Institute, Singapore
Prof. Hester Cheung	Pamela Youde Nethersole Eastern Hospital, Hong Kong
Prof. Ken Ohata	JR Tokyo General Hospital of East Japan

Local Faculty

Prof. Jaw-Yuan Wang	Kaoshiung Medical University Chung-Ho Memorial Hospital
Prof. Hwei-Ming Wang	Taichung Veterans General Hospital
Dr. Sheng-Chi Chang	China Medical University Hospital, Taichung
Dr. Chung-Hung Yeh	Chiayi Chang-Gung Memorial Hospital, Chiay
Dr. Kuang-Hung Hsiao	Buddhist Tzu Chi General Hospital
Prof. Jin-Tung Liang	Taiwan Association for Endoscopic Surgery
Dr. Cheng-Shying Chang	Changhua Christian Hospital

Abe Fingerhut

France

E-mail: cheuys@ha.org.hk

AFFILIATIONS

- Visiting professor, Digestive Surgery Unit Hippokrateon Hospital Athens, Greece
- Professor, Visceral and Digestive Surgical Unit, Centre Hospitalier Intercommunal, Poissy, France
- President ESTES 2010 – 2011 (European Society for Trauma and Emergency Surgery)
- Executive Board Member European Association for Endoscopic Surgery
- Advisory Board Member World Journal of Emergency Surgery

EDUCATION

- A.B., University of Pennsylvania, Philadelphia, Pennsylvania
- M.D., University of Paris, Paris, France

RESEARCH

I am affiliated and deeply involved with two multicenter surgical research associations (ARC: French Association for Research in Surgery) and ARCIF: Ile-de-France Association for Research in Surgery) who now have merged into one called FRENCH. This organization conducts multicenter randomized controlled trials, nationwide as well as in Europe and North Africa. The list of their publications and communications is included in my CV.

I was one of the founding members of SACRE (Surgical Association for Clinical Research in Europe). This multicenter, multinational organization provides an European format for clinical trials in Europe.

Francis Seow-Choen

Singapore

E-mail: seowchoen@colorectalcentre.com

AFFILIATIONS

- Medical Director and Senior Consultant Fortis Colorectal Hospital

AFFILIATIONS

- MBBS 1981
- FRCSED 1987
- FAMS 1991

RESEARCH

Prof Seow-Choen's distinguished achievements can be seen by his appointments to the Editorial Boards of many prestigious journals including, Diseases of the Colon and Rectum (USA), Colorectal Disease (European), British Journal of Surgery (UK), Techniques in Coloproctology (Italian-co-editor), Indian Journal of Coloproctology (Indian), Digestive Surgery (Germany), Chinese Journal of Coloproctology(Zhongguo gangchangbing zazhi) PRC-dy chairman, Journal of Surgical Oncology, BMC Surgical Journal, the World Journal of Gastroenterology, World Journal of Gastrointestinal Surgery, World Journal of Colorectal Surgery as well as the Chinese Integrative Journal of Colorectal Disease. He has published 39 chapters in surgical textbooks and more than 261 original articles in peer reviewed surgical journals. He also has written 32 papers in entomological journals and three books on stick insects. Dr Seow-Choen is also the chairman of two charitable organizations in Singapore ie. Guide Dogs Association of the Blind Singapore and City College in Singapore.

Prof Seow-Choen is also very actively involved in lecturing and demonstrating the finer act of surgery around the world. He had chaired many medical courses, published extensively and had been instrumental in the training of many world renown colorectal surgeons from around the world. He was the American Society of Colon and Rectum Surgeons' first International Travelling Fellow in 1993. He was also the ESR Hughes Lecturer for the Royal Australian College of Surgeons in 1999 and the Rupert B Turnbull Memorial Lecturer for the Cleveland Clinic, Ohio, USA in 2004 and the Philip Gordon lecturer for the Canadian Colorectal Society in 2005. Prof Seow-Choen's international achievements was recognised by Singapore in the conferment upon him of The Excellence for Singapore Award in 2000

Nam-Kyu Kim

Korea

E-mail: namkyuk@yuhs.ac

AFFILIATIONS

- 2010-present: Chairman of board of regent of Korean Society of Clinical Oncology
- 2009-2011: Chairman of board of regent of Korean Society of Coloprotology
- 2007-2009: Chair of Scientific Committee of Korean Society of Coloproctology
- 2004-2006: Editor in Chief, Journal of Korean Society of Coloproctology
- 2005-present: Director, Colorectal Cancer Special Clinic, Severance Hospital, Yonsei University College of Medicine, Seoul Korea
- 2003-present: Professor, Chief of Division of Colorectal Surgery Yonsei University College of Medicine, Seoul Korea

EDUCATION

- 1981 Graduated from Yonsei University College of Medicine (M.D.)
- 1982-1986 General Surgery Residency, Severance Hospital, Yonsei Univ. (Board of Surgery)
- 1992 Graduate school of Yonsei University College of Medicine (Ph.D.)
- 1994-1996 Colorectal Surgical research fellowship, Ferguson Clinic, Michigan State University, Michigan USA

HONORS AND AWARDS

- Best Professor of Year, Yonsei Univ. College of Medicine, 1999
- Yuhan Medical Award, 2001
- Best professor in Clinical activities at Severance Hospital, 2003
- Professor of Best Academic Achievement award, Yonsei University , 2005
- Professor of Best Academic Achievement Award, Yonsei Univ. College of Medicine, 2010
- Professor of Best Academic Achievement award, Yonsei University, 2011

Seon-Hahn Kim, MD, PhD

Korea
E-mail: drkimsh@korea.ac.kr

CURRENT AFFILIATIONS

- Head and Professor, Colorectal Division, Department of Surgery, Korea University Anam Hospital, Korea University College of Medicine, Seoul, Korea
- Yeoh Ghim Seng Visiting Professor and Senior Consultant, Division of Colorectal Surgery, National University Hospital, Singapore

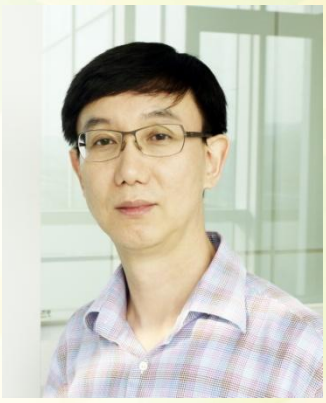
EDUCATION

- Surgical Resident, Dept of Surgery, Korea University Hospital (’83-’88)
- Research Fellow, Dept of Colorectal Surgery, Cleveland Clinic, OH (’95-’97)

MAIN RESEARCH

- Robotic rectal cancer surgery
- Laparoscopic rectal cancer surgery
- Laparoscopic CME and D3 dissection for colon cancer
- Selective use of preoperative radiotherapy for T3 or N+ rectal cancer

Gyu-Seog Choi
Korea
E-mail: kyuschoi@mail.knu.ac.kr



AFFILIATIONS

- 1996~ present: professor in department of surgery, Kyungpook National University Medical Center
- 2000-2002,; Visiting professor; Cancer Research UK, Oxford

EDUCATION

- 1981-1987; kyungpook national university, school of medicine
- 2000 : PhD, kyungpook national university, school of medicine

MAIN RESEARCH

- Main interests
- Minimally invasive surgery of colorectal cancer
- Cancer genetics
- Peritoneal carcinomatosis, radiation response

Joël Leroy
France
E-mail: joel.leroy@ircad.fr

CURRENT POSITIONS

Since 1998

- **Laparoscopic colorectal surgeon. Department of Digestive and Endocrine Surgery** (Head of the department: Professor Jacques Marescaux), University Hospital of Strasbourg, France
- **Scientific Co-Director of IRCAD / EITS** (ircad.fr / eits.fr)
  Institut de Recherche Contre les Cancers de l'Appareil Digestif / European Institute of TeleSurgery

Since 2000

- **Member of the Editorial Board of WeBSurg** (websurg.com) World Electronic Book of Surgery

TITLES

- 2005 F.R.C.S., Fellow of the Royal College of Surgeons of England (London)
- 2005 Visiting Professor, Osaka Medical College, Japan
- 2003 Honorary Professor University of Winnipeg, Manitoba, Canada
- 1997 Professor Laparoscopy and Digestive Surgery
- 1976 M.D., University of Lille, France

CURRENT MEMBERSHIPS

- APHS Asia Pacific Hernia Society (2005)
- BGES Honorary Belgium Group for Endoscopic Surgery (1994)
- EAES European Association of Endoscopic Surgery (1994)
- EATS Founding member of the European Association for Transluminal Surgery
- EHS International Advisory Board of the European Hernia Society (1997)
- RCS Royal College of Surgeons of England, London
- AFC French Association of Surgery (1990)

Fumio Konishi M.D., PhD

Japan
E-mail: DZD00740@nifty.ne.jp

AFFILIATIONS

- 1981-1986 Staff Surgeon, Department of Surgery, University of Tokyo
- 1998-2000 Associate Professor, Department of Surgery, Jichi Medical University
- 2000-2012…Professor and Chair, Department of Surgery, Saitama Medical Center, Jichi Medical University
- 2012- Professor Emeritus, Jichi Medical University
- 2012- Emeritus Consultant, Nerima Hikarigaoka Hospital Tokyo

EDUCATION

- 1972 Graduated form The Faculty of Medicine, University of Tokyo
- 1972 Licensed as a medical practitioner (M.D.)
- 1972-1973 Resident, First Department of Surgery, University of Tokyo
- 1973-1976 Resident, Department of Surgery Tokyo Koseinenkin Hospital
- 1984 Doctor in Medicine (PhD. University of Tokyo)

RESEARCH

- Endoscopic and laparoscopic treatment of colorectal cancer
- Sphincter saving operation for low rectal cancer
- Genetic analysis of colorectal cancer and its clinical application
- Surgical treatment of inflammatory bowel disease
- Training and surgical skill qualification of laparoscopic colectomy

Michael Ka Wah LI

Hong Kong
E-mail: mkwli@ha.org.hk

AFFILIATIONS

- Professor of Surgery, University College London, United Kingdom
- Honorary Consultant in General Surgery, Director of Minimally Invasive & Robotic Surgery Development, Hong Kong Sanatorium & Hospital
- Consultant Surgeon in Department of Surgery, Director of Minimal Access Surgery Training Centre, Pamela Youde Nethersole Eastern Hospital, Hong Kong
- Adjunct Associate Professor in Surgery, Department of Surgery, Prince of Wales Hospital, Faculty of Medicine, The Chinese University of Hong Kong
- Honorary Clinical Associate Professor in Surgery, Department of Surgery, Queen Mary Hospital, Li Ka Shing Faculty of Medicine, The University of Hong Kong

EDUCATION

- St. Bartholomew's Hospital Medical School

QUALIFICATIONS

- MRCS LRCP 1977
- MBBS (London) 1977
- FRCS (Edinburgh) 1982
- FRCS (England) 1982
- FCSHK 1993
- FHKAM (Surgery) 1993

Tsang Bih Shiou
Singapore
E-mail: charles_tsang@nuhs.edu.sg

AFFILIATIONS

-
-

EDUCATION

-

QUALIFICATIONS

-
-

Cheung Yui Shan, Hester

Hong Kong
E-mail: cheuys@ha.org.hk

AFFILIATIONS

- Consultant Surgeon, Chief of Colorectal Team, Department of Surgery, Pamela Youde Nethersole Eastern Hospital
- Honorary Treasurer, Hong Kong Society for Coloproctology
- Member - Hong Kong Society of Minimal Access Surgery
- Editorial Broad Member - Cutting Edge (Newsletter of the College of Surgeons of Hong Kong)

EDUCATION

- Bachelor of Medicine & bachelor of Surgery (M.B., Ch.B.), Chinese University of Hong Kong
- Fellowship of the Royal Australasian College of Surgeons (FRACS)
- Fellowship of the College of Surgeons of Hong Kong (FCSHK)
- Fellowship of the Hong Kong Academy of Medicine (FHKAM, Surgery)
- Member of the Royal College of Surgeons of Edinburgh (MRCS Edin)

RESEARCH

- Stapled Haemorrhoidectomy for Acute Thrombosed Hemorrhoids: A Randomized Trial with Long Term Results
- Towards painless colonoscopy: A double blinded randomized controlled trial on carbon dioxide insufflation colonoscopy
- Outcomes of Laparoscopic Rectal Cancer Surgery after Neoadjuvant Chemo-irradiation: A Comparative Study
- Endo-laparoscopic approach Vs Conventional Open Surgery in the Management of Obstructing Left-sided Colonic Carcinoma: A Randomized Trial
- Randomized Controlled Trial of Hybrid NOTES colectomy vs conventional laparoscopic colectomy for left-sided colonic tumours

Ken Ohata

Japan

E-mail: ken.ohata1974@gmail.com

AFFILIATIONS

- Japan Gastroenterological Endoscopy Society, Specialist Endoscopist
- The Japanese Society of Internal Medicine, Certified Physician

EDUCATION /TRAINING

- Doctor of Medicine, Universtiy of Japan, Conferred upon: March 1998
- Internship at Japan Railway General Hospital, 1998-2000

GASTROENTEROLOGY CAREER

- 2000-2005 Japan Railway General Hospital, Attending Gastroenterologist
- 2005-2007 Japan Railway General Hospital, Chief of Gastroenterology
- 2007-2009 NTT Medical Centert Tokyo, Attending Gastroenterologist
- 2009-Current NTT Medical Centert Tokyo, Chief of Endoscopy Center
- 2011-Current NTT Medical Centert Tokyo, Chief of Gastroenterology

SPECIFIC STRENGTHS

- Expertise in diagnosis and endoscopic treatment of early stage cancers of all the GI tract with special concentration in ESD. ESD treatment experience since 2000, ESD operator in 20 mid-lower pharyngeal, 200 esophageal, 2000 gastric, 600 colorectal cases.
- The Chief Endoscopist and highly motivated and encouraging mentor/educator of ESD at Endoscopy Center of NTT Medical Center Tokyo, nationally recognized as a prominent and outstanding ESD training center. The Endoscopic Center ranks in top 5 in Japan for number of ESDs performed (77 esophageal, 245 gastric, 194 colorectal cases.)

William, Tzu-Liang Chen

Taiwan
E-mail: wtchen@mail.cmuh.org.tw

AFFILIATIONS

- Chief of Colorectal Surgery Department, China Medical University Hospital, Taichung, Taiwan.
- Chai Chairman, Department of Surgery, China Medical University Hospital, Taichung, Taiwan.
- Director, Minimally Invasive Surgery Center, China Medical University Hospital, Taichung, Taiwan.
- Chief, Department of Colorectal Surgery, China Medical University Hospital, Taichung, Taiwan.

EDUCATION

- China Medical University, School of Medicine Taichung, Taiwan 1983-1990
- Doctor of Medicine, June, 1990

HONORS & AWARDS

- Best Surgeon of the Year, 2007, China Medical University Hospital
- Treasure, Endoscopic and Laparoscopic Surgeon of Asia
- Board member, Taiwan Society for Endoscopic Surgery

BIOGRAPHY

Dr. William T. Chen is currently the Chief of Department of Surgery at his alma mater, China Medical University in Taichung. After earning his medical degree in Taiwan, he completed a research fellowship in colorectal surgery at the Cleveland Clinic in Florida. Utilizing his training and clinical experiences, he has made notable contributions to literature regarding cutting edge techniques for treating colorectal cancer. Dr. Chen is also a charismatic speaker who has been invited to present at over 20 international conferences. Along with serving as a practitioner and researcher, Dr. Chen enjoys his position as an assistant professor in the Department of Surgery at China Medical University.

Jaw-Yuan Wang

Taiwan
E-mail: cy614112@ms14.hinet.net

AFFILIATIONS

- Division of Gastrointestinal and General surgery, Department of Surgery, Kaohsiung Medical University Hospital
- Colorectal Cancer Team, Cancer Center of Kaohsiung Medical University Hospital
- Graduate Institute of Clinical Medicine, Kaohsiung Medical University, Kaohsiung, Taiwan

EDUCATION

- 1982-1989 MD, Kaohsiung Medical College, Kaohsiung, Taiwan
- 1993-1996 MS, Kaohsiung Medical College, Kaohsiung, Taiwan
- 1999-2003 PhD, Kaohsiung Medical University, Kaohsiung, Taiwan

RESEARCH

Professor Jaw-Yuan Wang is Professor of the Department of Surgery, Faculty of Medical; Graduate Institute of Clinical Medicine and Graduate Institute of Medical Genetics, Kaohsiung Medical University, Kaohsiung. Taiwan. At present, he is also an Director of Division of Gastrointestinal and General surgery at Kaohsiung Medical University Hospital. He went on to receive further training as a Research Fellow at the State University of New York, Stony Brook, USA. He now serves as Chairman of the Nutritional Support Council, Chief of Division of Pediatric Surgery, Leader of Nutritional Support Team, Kaohsiung Medical University Hospital; Director of Master Program of the Graduate Institute of Medicine ,and Chief of Experimental Surgery, College of Medicine, Kaohsiung Medical University, Taiwan. He is an active member in numerous professional organizations including the Taiwan Surgical Association, Society of Colon and Rectal Surgical Society of Gastroenterology, Taiwan; Taiwan Society of Parenteral and Enteral Nutrition, Clinical Oncology Socity of Taiwan, Parenteral and Enteral Nutrition of Asia, International Association of Surgeons and Gastroenterologists, International Gastric Cancer Association, The Academy of Surgical Research and The Chinese Oncology Society. He also holds appointments as Board director of Taiwan Society of Parenteral and Enteral Nutrition; Board Director of Society of Colon and Rectal Surgeons, Taiwan; Board Director of Taiwan Society of Coloproctology and Executive Board Director of Taiwan Genomic Medicine and Biomarker Society.

Besides being a recipient of numerous awards since 2003, he has published widely at least 178 peer-reviewed clinical papers (135 SCI and 43 Non-SCI) and 3 book chapters. Prof. Wang is a reviewer for more than 30 prestigious journals including Oncology, American College of Surgeons, BMC Cancer, Clinical Cancer Research, and British Journal of Cancer etc. He is also an editor in several prestigious international Journals.

Hwei-Ming Wang

Taiwan

E-mail: whm@vghtc.gov.tw

AFFILIATIONS

- Division of Colorectal Surgery, Taichung Veterans General Hospital

EDUCATION

- 1981 Graduated Taipei Medical University, Taipei, Taiwan
- 1989 Fellowship/ Second Surgical Department, Yokohama City University, Yokohama, Japan
- 1990 Post-graduate Visitor at St. Mark's Hospital, London, UK

RESEARCH

- Minimally Invasive Colorectal Surgery- SILS, NOTES
- Circulation tumor cell detection in colorectal cancer patient – Enhancing Detection of Circulating Tumor Cells for Predicting Early Relapse of Colorectal Cancer Patients by Weighted Enzymatic Chip Array Method
- Personalized therapy for metastatic colorectal cancer by pharmacogenotyping
- Post-Genome-wide association studies analysis of colorectal cancer in Taiwanese

Sheng-Chi Chang
Taiwan
E-mail: aaa54382000@yahoo.com.tw

AFFILIATIONS

- Attending Staff, Colorectal Surgeon, Since 2010, China Medical University Hospital
- Fellow of Colorectal Surgery, 2008/7 - 2010/6, China Medical University Hospital
- Surgical Chief Resident, 2007/7 - 2008/6, China Medical University Hospital
- Surgical Resident, 2004/2 - 2007-6, China Medical University Hospital

EDUCATION

- 1996 - 2001 Medical College, China Medical University, Taiwan
- 2001 - 2002 Intern training, National Taiwan University Hospital
- Doctor of Medicine, 2002

MEDICAL LICENSE & SPECIALIST

- Specialist of Surgery (2008)
- Specialist of Endoscopic Surgery (2009)
- Specialist of Colon and Rectal Surgery (2010)

Chung-Hung Yeh

Taiwan

E-mail: yin0321@gmail.com

AFFILIATIONS

- Senior Lecturer, Division of Colon and Rectal Surgery, Chang-Gang Memorial Hospital, Chia-Yi Chang-Gang Memorial Hospital, Chia-Yi
- 1991~1995 General Surgery Residency, Municipal Zhong-Xiao Hospital, Taipei
- 1996~1997 Fellow, Division of Colon and Rectal Surgery, Chang-Hwa Christian Hospital
- 1997 Dec.~1999 Aug. Fellow, Division of Colon and Rectal Surgery, Chang Gung Memorial Hospital, Lin-Kou
- 1999 Sep.~2001 Nov. Staff, Division of Colon and Rectal Surgery, Chang Gung Memorial Hospital, Kaohsiung
- 2001 Dec.~2009 Jun. Chief, Division of Colon and Rectal Surgery, Chang Gung Memorial Hospital, Chai-Yi
- 2006 Mar.~2007 Feb. Research Fellow, Department of General Surgery, Royal Melbourne Hospital

EDUCATION

- 1982 ~ 1989 Taipei Medical University

HONORS & AWARDS:

- Surgical Society, R.O.C.
- Society of Colon and Rectal Surgeons, R.O.C.
- Taiwan Surgical Society of Gastroenterology
- American Society of colon and Rectal Surgeons

Kuang-Hung Hsiao

Taiwan

E-mail: a68601@yahoo.com.tw

AFFILIATIONS

- Chief, Department of Colorectal Surgery, Buddhist Tzu Chi General Hospital
- Member, The Association of Coloprotology of Great Britain and Ireland
- Member, The Taiwanese Society of Surgeons
- Member, The Taiwanese Society of Colorectal Surgeon
- Member, The Taiwanese Society of Gastrointestinal Surgery
- Member, The Taiwanese Society of Endoscopic Surgery
- Member, The Taiwanese Society of Parental Enteral Nutrition
- Member, The Chinese Oncology Society
- Member, Formosa Medical Association

EDUCATION

- Taipei Medical college, Taipei, Taiwan 1987-1995

HONORS & AWARDS

- National Board of Medicine of Taiwan
- Diplomate, Taiwanese Board of Surgery
- Diplomate, Taiwanese Board of Colorectal Surgery
- Diplomate, Taiwanese Board of Endoscopic Surgery

Jin-Tung Liang

Taiwan
E-mail: jintung@ntu.edu.tw

STAFF APPOINTMENTS

- Staff surgeon, Division of Colorectal Surgery, Department of Surgery, National Taiwan University Hospital, Taipei, Taiwan
- Director, Cancer Center in Yun-Lin Branch of National Taiwan University Hospital, Taipei, Taiwan
- Chief, Division of Colorectal Surgery, Department of Surgery, National Taiwan University Hospital, Taipei, Taiwan
- Vice-chairman, Department of Surgery, National Taiwan University Hospital, Taipei, Taiwan

EDUCATION

- MD, Department of Medicine, Medical college, National Taiwan University, Taipei, Taiwan
- PhD, Graduate Institute of Clinical Medicine, Medical college, National Taiwan University, Taipei, Taiwan
- Researcher, National Cancer Center of Tokyo, Japan（1996）
- Researcher, Cleveland Clinics Florida, USA（1997）

Cheng-Shyong Chang

Taiwan
E-mail: 15120@cch.org.tw

AFFILIATIONS

- Attending Physician, Division of Hematology-Oncology, Department of Internal Medicine, Changhua Christian Hospital, Changhua, Taiwan
- Adjunct Assistant Professor, National Formosa University, Yunlin, Taiwan

EDUCATION

- M.D. Department of Chinese Medicine, Private China Medical College

BIOGRAPHY

As a qualified hematologist and oncologist, Dr. Chang has been extensively involved in more than 70 phase I-IV clinical trials (investigator initiated or sponsored) of anticancer therapy and published over 40 articles in peer review journals. He was Director of Tumor Center of CCH from 1998 to 2003, Director of Clinical Trial Center and Vice-Superintendent of CCH from 2003 to 2007. After that he actively joins the team in NHRI to conduct “Accreditation Program on Cancer Care Quality” in Taiwan.

Moderators Profile

Dr. William Tzu-Liang Chen	China Medical University Hospital, Taichung
Prof.Abe Fingerhut	Centre Hospitalier Intercommunal de Poissy-Saint-Germain
Prof.Joel Leroy	Associated Professor of Digestive Surgery, University of Lille, France
Prof. Michael Li	Pamela Youde Nethersole Eastern Hospital, Hong Kong
Dr. Hwei-Ming Wang	Taichung Veterans General Hospital
Prof. Brian Hung	Mennonite Christian Hospital
Prof. Jin-Tung Liang	Taiwan Association for Endoscopic Surgery
Dr.Jinn-Shiun Chen	Society Of Colon And Rectal Surgeons, Taiwan
Dr. Hong-Hwa Chen	Department of Surgery Chang Gung Memorial Hospital - Kaohsiung Medical Center
Dr. Hong-Jhang Chen	Changhua Christian Hospital
Prof. Chien-Yuh Yeh	Society Of Colon And Rectal Surgeons, Taiwan
Dr. Shung-Haur Yang	Taipei Veterans General Hospital

Date: October 06-07, 2012
Venue: China University Hospital Building

Abstract

October 06, 2012

ColoRectal Surgery Forum 2012

The 2012 Autumn Annual Meeting of the Society of Colon and Rectal Surgeons, Taiwan

Date: October 06-07, 2012
Venue: China University Hospital Building

ColoRectal Surgery Forum 2012
The 2012 Autumn Annual Meeting of the Society of Colon and Rectal Surgeons, Taiwan
Date: October 06-07, 2012
Venue: China University Hospital Building

MINIMALLY INVASIVE ANAL FISTULA SURGERY: THE ROLE OF VAAFT (VIDEO ASSISTED ANAL FISTULA TREATMENT)

Francis Seow-Choen

Anal fistula is mainly easy to treat but recurrences are common especially in difficult cases. Difficult cases include cases where the fistula tract is high and surgery may compromise anal sphincter integrity or because there are secondary tracts. Such cases also include cases where the internal opening cannot be found. VAAFT or Video Assisted Anal Fistula Treatment is a new method of totally non invasive videoscope directed treatment of available for all sorts of anal fistula and which is especially suitable for high and difficult anal fistulas. The use of the fistuloscope allows the surgeon to follow the tract and identify the primary tract, internal opening and all secondary tracts. The surgeon then uses an electrode to coagulate granulation tissue in the tracts. This is followed by the use of an endobrush to curette granulation tissue and dirt. Following identification, the internal opening is closed with staplers. We have peformed VAAFT in 18 patients; age: 34.5 years (20-55). Length of FU: 22 weeks (11-28). 17 have healed with 1 recurrence only. An accurate knowledge of anal sphincter anatomy in relation to the fistula is not absolutely essential. VAAFT is superior to any other current technique as there is no division of anal sphincter. Whatever wound is left is small in size and there is no tissue injury outside the fistula. VAAFT has the ability to trace accurately all primary and secondary tracts. It also has the capability to trace & deal with all internal openings and has an excellent cure rate.

ColoRectal Surgery Forum 2012
The 2012 Autumn Annual Meeting of the Society of Colon and Rectal Surgeons, Taiwan
Date: October 06-07, 2012
Venue: China University Hospital Building

CURRENT UPDATE IN THE TREATMENT OF HAEMORRHOIDS

Francis Seow-Choen

Hemorrhoids or piles are very common problems faced by a great many people during the most fruitful times of their lives.

Although it is often a very minor problem, the symptoms of pain, bleeding and swelling can result in serious worries and lead severe disruption to daily life and work. The common causes of piles include hereditary factors, constipation, reading whilst on the toilet, use of the squat toilet, pregnancy and delivery as well as too much fibre in the diet.

Treatment should be tailored according to the symptoms. Most piles in fact do not need treatment other than resuurance and advice regarding toilet and dietary habits. Initial treatment consists of correcting bowel habits. A decrease in dietary fibre rather than an increase in dietary fibre helps to ease bowel habit. Simple measures like injection sclerotherapy and rubber band ligation are sufficient for first and second degree piles but surgery may be needed for third and fourth degree piles. Excision of piles by various methods may be needed for filiform shaped prolapsed piles or for singular prolapsed. A well performed closed haemorrhoidectomy heals well by and large although excessive excision may be very painful. Circumferential prolapsed piles may be normally treated by stapling hemorrhoidectomy due to its ease of use and good results thereby. Large second degree and third degree piles with recalcitrant bleeding however should be treated by transanal haemorrdoidal dearterialization.

ColoRectal Surgery Forum 2012
The 2012 Autumn Annual Meeting of the Society of Colon and Rectal Surgeons, Taiwan
Date: October 06-07, 2012
Venue: China University Hospital Building

STAPLED TRANSANAL SURGERY -- THE TIPS, COMPLICATION, AND EXPERIENCES OF PPH AND STARR PROCEDURE IN TAIWAN –

Chung-Hung Yeh

Stapled transanal mucosectomy, firstly aiming to treat rectal internal mucosal prolapse and obstructed defecation, is proposed by Dr. Antonio Longo for the treatment of hemorrhoids. Subsequently called stapled hemorrhoidopexy or procedure for prolapse and hemorrhoids (PPH), the technique gained a wide popularity due to the low postoperative pain. Almost all studies, with a few exceptions, also found an early return to work.

In 2005, the practice parameters of the American Society of Colon and Rectal commended: Stapled hemorrhoidopexy is a new alternative available for individuals with significant hemorrhoidal prolapse. Meanwhile, exceptionally rare but potentially devastating complications including anovaginal fistula, substantial hemorrhage, fistula, retroperitoneal sepsis, rectal perforation have been reported. Even though the documented adverse events happen scattered and presented as case-report, severe complications have been reported world-wide. It did raise the concern about the safety of this new procedure. Performing the procedure with care and sharing the experience with each other could help surgeons keep away from trouble.

Rectal wall resection with two circular staplers was the basis for the development of the stapled transanal rectal resection (STARR) procedure. This procedure consists of a double transanal rectal resection and stapling and is aimed at correcting the anatomical anomaly of the rectum in patients with rectocele and rectal intussusception causing obstructed defecation. This procedure has quickly gained popularity among surgeons, too; when encouraging short-term results have been reported after STARR with good to excellent outcome in 91% of patients. Other studies have shown persistence of symptoms in 44% of patients and lack of improvement at mean follow-up of 20 months in 35% of patients and failures and complications have recently been reported. Avoiding complication and improving the successful rate are still the important issues.

In Taiwan, Cha-yi Chang-Gung Memorial Hospital, we use stapled hemorrhoidopexy to treat patients with prolapsed hemorrhoids since 2001. More than one hundred cases per year in my hospital accepted this treatment and the patient number raised gradually. With more experiences about stapled anal surgery, STARR procedure was utilized to treat patients of obstructed defecation syndrome (ODS) since 2007. No severe complication has ever been encountered. We shall share our experiences of these new-adapted procedures, and discuss the tricks to improve the results and to avoid the complications.

ColoRectal Surgery Forum 2012
The 2012 Autumn Annual Meeting of the Society of Colon and Rectal Surgeons, Taiwan
Date: October 06-07, 2012
Venue: China University Hospital Building

MANAGEMENT OF CONSTIPATION: ARE WE SURE WE ARE RIGHT?

Francis Seow-Choen

Fibre is widely used for the prevention and treatment of constipation[1]. It is even thought to prevent colorectal cancer such that once some patients are diagnosed with colorectal cancer, their carnivorous habits are blamed and thenceforth a strict vegetarian diet is instituted in the belief that fibre will prevent cancer recurrence.

Giving fibre to a constipated patient is akin to adding cars to a congested road to ease traffic flow[2]. Fibre is not called bulky agent or roughage for no reason. In a loaded colon, the addition of bulk makes the constipation much worse. Even in normal individuals, my experience of a fibre free diet is that most if not all patients develop easier motions. Giving bulky agents ie fibre and laxatives together is common practice and is totally illogical as these agents act in opposite ways!

There is no convincing evidence that fibre works in the prevention of colorectal cancer. A much better and sure proof method is the routine use of surveillance colonoscopy in the right age group and at regular intervals. A recent study looking at 61566 people found that that was no apparent protective effect of fibre against colorectal cancer[3]. Fibre did not positively prolong longevity compared with non-vegetarians in another recent study[4].

References

1. Chuwa EWL, F Seow-Choen. Dietary Fibre. Br J Surgery 2006: 93:3-4.
2. Tan KY, F Seow-Choen. Fiber and colorectal diseases: separating facr from fiction. World J Gastroenterol 2007: 13; 4161-7.
3. Key TJ, Appleby PN, Spencer EA, Travis RC et al. Cancer incidence in British vegetarians. Br J Cancer 2009: 101; 192-7
4. Key TJ, Appleny PN, Spencer EA, Travis RC et al. Mortality in British vegetarians: results from the European prospective investigation into cancer and nutrition (EPIC-Oxforn). Am J Clin Nutr 2009: 89; 161S-9S.

ColoRectal Surgery Forum 2012
The 2012 Autumn Annual Meeting of the Society of Colon and Rectal Surgeons, Taiwan
Date: October 06-07, 2012
Venue: China University Hospital Building

UPFRONT SYSTEMIC CHEMOTHERAPY AND SHORT COURSE RADIATION FOR UNRESESECTABLE RECTAL CANCER WITH RESECTABLE LIVE METASTASIS

Nam Kyu Kim, M.D. Ph.D, FACS

Optimal treatment strategy for patients with unresectable rectal cancer and synchronous systemic metastases seems to be challenging issues. Pelvic radiation therapy for rectal cancer and systemic chemotherapy for distant metastasis must be conducted simultanesouly. For these endpoints, Upfront chemothetpay and short radiotherapy with delayed surgery will be attractive in this clinical situation.

Short course radiation therapy followed by immediate surgery has been widely accepted in Europe and it has been effective for decreasing rate of local recurrence,

In this setting , low dose 5 Fu based chemotherapy has been given to the patients for both radiosensitizing and preventing micrometastasis during the chemoradiation treatment. Therefore, rectal cancer patients who need long course CRT sometime have a resectable liver metastasis, 5 FU based chemotherapy seems not to be effective for treatment for liver metastasis. Therefore there have been many debates for treatment strategy in localized advanced rectal cancer with resectable liver metastasis. It has been very challenging issues to determine the most effective treatment strategy for patients with mesorectal fascia involvement (positive CRM) and potentially resectable synchronous live metastasis. In theses group of patients, there will be s risk of distant metastasis arising during conventional long-course chemoradiation treatment, but also a risk of local progression in preoperative chemotherapy regimen to treat metastasis without pelvic radiation therapy.

According to our protocol. FOLFOX 4 cycles and short course radiation therapy and additional FOLOFX 4 cycles and assess whether primary and metastasis can be resected or not.

We developed a protocol and started since 2009, the aim of this study is to assess treatment response, patient compliance and toxicities, surgery related complication as well as oncologic outcomes.

BACKGROUND

The most effective approach for locally advanced rectal cancer with synchronous distant metastases is a current clinical challenge. The aim of this retrospective study was to determine the clinical outcome and the oncologic outcomes after upfront systemic chemotherapy and short-course radiotherapy (RT) with delayed surgery.

METHODS

Between march 2009 and august 2012, among total 30 number of enrolled patients were locally advanced primary rectal cancer with synchronous resectable distant metastases. 28 patients was performed delayed surgery, 2 patients was not performed surgery due to

progression of disease Local staging for rectal cancer was done with transrectal ultrasonography and rectal MRI, cT3 (n=19, 63.3%), cT4 (n=11, 36.4%) , and N positive (n=28, 100%), Threatened circumferential resection margin was noted in 23 patients (76.7%). Pelvic side wall positive lymph node was noted in 15 patient (50%). The site of distant metastasis was liver (N=18, 60%), Liver +ovary (n=2, 6.8%), lung (n=4, 13.3%), paraaortic node (n=4, 13.3%), bone +lung (n=1, 3.3%) and neck node (n=1, 3.3%). 30 patients were selected for upfront chemotherapy and short-course RT (5 x 5 Gy). Standard protocol was following sequences: 4 cycles of FOLFOX followed by short course radiotherapy and additional 4 cycles of FOLFOX. Only 13 patients (43.3%) has given standard protocol, cycles of chemotherapy before and after short course radiotherapy showed some range depend on patients condition and tumor response. The median duration between short course RT and surgery was 12.7 weeks (range, 3-21).

RESULTS

The median patient age was 60.0 years (range, 33-73). The mean tumor distance from the anal verge was 7.2 ± 2.9 cm. Total toxicity of neoadjuvant chemotherapy was 10 patients (33.3%). Toxicity was G 3 neutropenia (n = 3, 10%), thyrombocytopenia (n = 1, 3.3%), general weakness (n = 2, 6.8%), nausea and vomiting (n = 3, 10.3%), diarrhea (n = 2, 6.8%), Cr elevation (n = 1, 3.3%). R0 resection was achieved 23 patients (76.7%). R1 resection of lesion was performed 5 patients (16.5%). Postoperative morbidity was 10 patients (35.7%).Type of surgery was LAR (n=14, 51.7%), uLAR and CAA (n=9, 41.2%), Hartman (n=3, 10.3%), APR (n=2, 6.8%). Complication was occurred in 10 patients (n=10, 35.7%). It can summarized as follows: wound infection (n = 3, 10.7%), anastomotic leakage (n = 5, 17.9%), intestinal obstruction (n = 1, 3.6%), intraabdominal abscess (n = 1, 3.6%). The median follow up duration was 14.4 months. %). Pathologic results show that ypT0 (n=4, 14.3%), ypT2 (n=4, 14.3%), ypT3 (n=20, 71.4%), ypN0 (n=8,28.6%), ypN1 (n=13, 46.4%), ypN2 (n= 7, 25%), ypM0 (n=6,21.4%), ypM1(n=22, 78.6%). Mean harvested number of LN is 16.1 ± 7.6

Mean proximal resection margin was 16.8± 5.9 cm, mean distal resection margin is 2.4 ± 1.6 cm. CRM showed all negative. The 2 year overall survival for all patients was 80.2% and 2 year disease free survival rates was 41.8%. Medan follow up is 14 months The overall recurrence was noted in 10 patients (43.3%) after R0 resection. Recurrence was noted at 44.8%, which showed liver (n = 2, 8.7%), lung (n = 5, 21.7%), paraaortic node and multiple node (n = 1, 4.3%), neck node + multiple node (n = 1, 4.3%), appendix (n = 1, 4.3). Interestingly, there was no local recurrence.

CONCLUSIONS

Upfront chemotherapy and short course RT with delayed surgery seems to be feasible and can be performed safely. Based on preliminary observation, although treatment duration was long, but treatment compliance and postoperative morbidity seems to be acceptable. High Ro resection can be obtained , but unfortunately, 2 year disease free survival rate showed low, Therefore we must follow up patients for more long time

ColoRectal Surgery Forum 2012
The 2012 Autumn Annual Meeting of the Society of Colon and Rectal Surgeons, Taiwan
Date: October 06-07, 2012
Venue: China University Hospital Building

RECTUM-CONSERVING SURGERY FOR LOCALLY ADVANCED RECTAL CANCERS FOLLOWING PRE-OPERATIVE CHEMORADIOTHERAPY

Jaw-Yuan Wang

INTRODUCTION

This paradigm shifted with the use of pre-operative chemoradiotherapy (CRT), which not only provides the best local control but also improves sphincter preservation and surgical outcomes. The recent developments of multimodality treatment, especially on sphincter-saving operation in patients with locally advanced rectal cancer (LARC) will be presented in this talk.

METHODS

New-generation chemotherapeutic and targeted agents have been incorporated into clinical trials; however, at this time, the use of oxaliplatin or targeted agents as component of multimodality treatment outside of clinical trials is not recommended. Surgery remains an essential therapy for patients with LARC. The move from digital blunt dissection of the rectum to the more precise TME has substantially reduced rates of local recurrences and improved overall survival. A complete pathological response occurs in 10–30% of patients with LARC undergoing neoadjuvant CRT. When accurately selected, these complete responders might be considered for less invasive treatments instead of standard surgery. Addition of DWI to standard rectal MRI improves the selection of complete responders after chemoradiation. The standard of care has been radical surgery with high morbidity risks and the challenges of stomata despite the favorable prognosis. Three major issues encountered in the surgical resection of these patients are (1) adequate tumor-free surgical resection margin (2) significant anastomotic leakage following surgery causing significant morbidity and mortality (3) to increase sphincter-preserving rate by local excision or total mesorectal surgery. Minimally invasive techniques such as laparoscopy have garnered great interest. Results of randomized phase III trials demonstrate equivalent outcomes between laparoscopic versus open colectomy for colon cancer. Novel clinical trials address the role of induction chemotherapy, of delayed, minimal or omitted surgery following CRT, or the omission of radiotherapy for selected patients.

CONCLUSIONS

The inclusion of different treatment options, according to tumor stage, location, imaging features, and response, will render the multimodal treatment approach of rectal cancer more risk-adapted

[1]. Department of Surgery, Kaohsiung Medical University Hospital, Kaohsiung Medical University. No. 100 Tzyou 1st Rd, Kaohsiung 807, Taiwan

ColoRectal Surgery Forum 2012

The 2012 Autumn Annual Meeting of the Society of Colon and Rectal Surgeons, Taiwan

Date: October 06-07, 2012
Venue: China University Hospital Building

IS SCREENING FOR COLORECTAL CANCER AT 50 YEARS OF AGE CORRECT?

Francis Seow-Choen

Colorectal cancer is one of the commonest cancers in the developed world. In Singapore it is the leading cause of cancer when males and females are combined. The incidence of colorectal cancer rises dramatically at about the age of 45 to 50 years of age. As a result most cancer agencies and colorectal and gastroenterological societies recommend colorectal screening from the age of 50 in order to effectively detect the most cases of colorectal cancer.

However, the detection of colorectal cancer should not be the motive of colorectal cancer screening as it not a positive result for the patient. Colorectal surgeons and others who are interested in decreasing the huge mortality and morbidity associated with colorectal cancer should perform colonoscopy to detect and remove polyps and not diagnose cancer. It may be less dramatic but the detection and removal of precancerous colorectal polyps is a positive result for the patient as it then allows very effective cancer prevention. Colorectal polyps are usually present at least 10 to 15 years before they undergo malignant change. There is therefore a wide window of opportunity to screen and remove these polyps and therefore prevent cancer and decrease deaths and lower healthcare costs! I recommend that routine screening should begin at the age of 35 in high risk populations in the developed world.

ColoRectal Surgery Forum 2012
The 2012 Autumn Annual Meeting of the Society of Colon and Rectal Surgeons, Taiwan
Date: October 06-07, 2012
Venue: China University Hospital Building

UPDATES AND DEBATES IN PREOPERATIVE CHEMORADIATION TREATMENT IN RECTAL CANCER

Nam Kyu Kim, M.D., Ph.D, FACS

Large randomized controlled clinical trials have demonstrated that preoperative chemoradiation therapy (preopCRT) significantly decreased the risk of local recurrence in patients with locally advanced rectal cancer. The histological tumor response to preoperative chemoradiotherapy has been reported to be closely related to oncologic outcomes, Disease free survival and overall survival are significantly better in patients with histologic complete regression or with tumor downstaging than in patients without such findings.

Short course or standard long course CRT preoperatively has shown improved local control, but not survival, Recently report from German CAO/ARO/AIO-94 randomized phase III trial after median follow up of 11 years showed that long course preop CRT can affect decreasing local recurrence, but no survival benefits, Finally authors emphasized that more effective systemic chemotherapy must put into the multimodality approach to reduce systemic metastasis and improve survival.

NCCN guideline recommended standard FOLFOX based long course chemoradiation treatment based on preoperative staging such as transrectal ultrasonogrphy and abdominopelvic CT and select patients who need preop.CRT.

Based on European countries including UK, they used to perform MRI staging and categorized patients into the low risk (T2N-), low to moderate risk (T2, N- /N+, no CRM) , those patients need direct surgery and Moderate risk (T3N- or T3N+, no CRM recommended short course radiotherapy followed by surgery . Finally high risk patients (T3N+, CRM+, extramural vessel lymphatic invasion etc) strongly recommended long course FOLFOX or XELOX based CRT. In Korea, usually we adopted NCCN guideline based on MRI and transrectal ultrasonographic finding, 5 FU based long course chemoradiation has been widely accepted in advanced resectable mid or lower rectal cancer.

With percentage of neoadjuvant CRT increased, it result in downstaging of tumor with 8-16% of patients achieving a pathologic complete response. The Lyon R96-02 trial reported 10 years results. Neoadj EBRT 39 Gy in 13fraction (n=43) vs same EBRT with endocavitary contact radiotherapy of 85 Gy in three fraction (n=45) 88 patients with distal rectal cancer T2 or T3 after 10 year follow up contact radiation with preop. Endocavitary contact radiotherapy increase complete clinical response ad sphincter preservation but there was no difference in local recurrence or overall survival.

There has been many trial to increase tumor response rate and downstaging. Neoadjuvant concurrent chemotherapy regimen has been under investigation. Phase III randomized clinical trials of capecitabine versus 5 FU was conducted (NSABP R-04 trial). Recent We finished to enrolled the patients which compare S-1 plus irinotecan versus 5 FU plus leucovorin with

long course radiation therapy. Based on phase II study, pCR rate shows better in S-1 and irinotecan chemoregimen.

Oxaliplatin has also attracted interest in neoadjuvant chemoregimen, STAR-01 randomized study (5 FU vs 5 FU plus oxaliplatin) which showed no difference of pCR, but higher toxicities in Oxaliplatin treated group of patients. ACCORD 12/0404-Profdige 2 randomized study (capecitabine vs capecitabine plus weekly oxalipatin) which showed higher toxicities in oxaliplatin group, but pCR was 39% vs 28.9%. The impact of oxaliplatin cannot be clearly defined for contributing enhancing treatment tumor respsonse. while adding target drug such as cetuximab, or Bevacizumab, even pCR was high rate , but toxicities also high. Therefore risk and benefits should be carefully analyzed furthermore.

Postoperative adjuvant chmoradiotherapy has been tried in pT1 with high risk or pT2, however, longterm outcomes showed radical surgery much better oncologic outcomes.

You et al compared local excision and standard resection in patients with stage 1 rectal cancer retrieved from national cancer database. Local excision (n=601) compared with standard resection (n=493). Local excision was associated with threefold higher risk of local recurrence compared to standard resection for T1 rectal cancer. For more limited surgery, preoperative chemoradiation trial begun. Preoperative CRT has been tried for cT2N0 distal rectal cancer. Lezoche et al compared TEM with laparoscopic TME for rectal cancer, TEM group treated with preoperative long course chemoradiation therapy followed by TEM (transanal local excision). TEM was known to best way to avoid fragmentation of the tumor and get adequate resection margin. A median follow up of 84 months, there was no difference of cancer specific survival between two groups. In addition to that, ACOSOG Z6041trial was finished, long course chemoradiation therapy followed by local excision for cT2N0 rectal cancer , chemoregimen was capacitabine with oxaliplatin. Among enrolled 84 patients, 44% got pCR , but over 50% of complications were recorded. These treatment modality seems to be very attractive because it can avoid radical surgery which result in poor bowel function and sexual and voiding dysfunction. However, long term results of anorectal function and quality of life assessment will be necessary to determined this modality truly superior to the radical surgery alone.

Furthermore, Habr Gama et al recommended wait and see if the patients shows a clinical CR after long course CRT for selected patients with rectal cancer. Problems is to how to know complete abscence of tumor cells in mucosa after preop-CRT. Recently Maas et al reported that 21 patient who showed cCR based on MRI, endoscopy and biopsies. They were followed for median 25 ± 19 months, only one patient showed local recurrence who treated with salvage surgery. The other patients alive without cancer, who compared with control group who treated with radical surgery (pCR), there were no difference. they conclude wait an see policy for cCR after CRT foe rectal cancer with strict selection criteria and follow up with up-to- date imaging techniques is feasible and safe.

Future treatment paradigm for rectal cancer will be more tailored according to individual patients,

These direction should be both curative and palliative. We still need some evidence for debated issue for chemoradiation for rectal cancer.

ColoRectal Surgery Forum 2012
The 2012 Autumn Annual Meeting of the Society of Colon and Rectal Surgeons, Taiwan
Date: October 06-07, 2012
Venue: China University Hospital Building

THE CONTINENT ISSUE AFTER LOW RECTAL SURGERY AND THE ANORECTAL PHYSIOLOGY TESTS IN TAIWAN

Chung-Hung Yeh

INTRODUCTION

Anorectal physiology tests are used to evaluate the function and coordination of the anal sphincters and pelvic floor muscles of anorectum. Used in conjunction with other complimentary examinations, it is diagnostic for patients with faecal incontinence and constipation. The anorectal physiology tests include anorectal manometry, pudendal nerve terminal motor latency and electromyography (EMG) of the pelvic floor. For anorectal manometry, several tests including resting pressure measurement, squeeze pressure measurement, balloon expulsion test, rectal (volume) sensation threshold test, and recto-anal inhibitory reflex could be done.

Colorectal cancer has been the second common malignancy in Taiwan. Contributing to the progress of surgical technique and device, there are more and more sphincter-saving surgery adopted in our daily practice for patient suffer from lower rectal malignancy . Although the total mesorectal excision (TME) and splanchnic nerve preservation have become standard procedure, the dissection over pelvis becomes lower and lower and sometimes all the way to anal canal; e.g. inter-sphincteric resection, which may compromise the anogenital function. At the same time, for patient with advanced rectal cancer, preoperative radiation /chemoradiation have been regarded as standard neoadjuvant therapy which also causes the continent problem. Anorectal physiology tests are indicated for some particular patients. Faecal incontinence occurs in approximately 2.2% of the general population, and surgical or non-surgical injury is one of the main risk factors in patient with lower rectal cancer. Injury to the pelvic floor muscle during operation is well recognized and anal sphincter muscles damage by inter-sphincteric resection is the most important risk factor for post-operative faecal incontinence. The anorectal physiology tests could be used to predict or assess the outcome of anorectal function after treatment for lower rectal cancer.

SHORT-TERM CLINICAL OUTCOMES FROM A RANDOMIZED CONTROLLED TRIAL TO EVALUATE LAPAROSCOPIC AND OPEN SURGERY FOR STAGE II- III COLORECTAL CANCER: JAPAN CLINICAL ONCOLOGY GROUP STUDY JCOG 0404

Konishi F, *Yamamoto S, Inomata M, Watanabe M, and Kitano S.*

The benefits of laparoscopic surgery (LAP) in comparison with open surgery (OPEN) have been suggested. However, the long-term survival after LAP for advanced colorectal cancer (CRC) requiring complete mesocolic excision is still unclear. We conducted a large scale randomized controlled trial to confirm the non-inferiority of LAP to OPEN in terms of overall survival with less frequent post-operative morbidity. The primary analysis is planned in 2014, and short-term outcomes including post-operative complications are presented here.

Inclusion criteria were as follows: Tumor located in cecum, ascending colon, sigmoid colon or rectosigmoid, T3 or T4 (without involvement of other organs), N0-2 and M0, and tumor size < 8 cm. Primary endpoint was overall survival. Secondary endpoints were relapse-free survival, short term clinical outcomes, incidence of adverse events and conversion rate. Sample size was 1050. Actual accrual was carried out from October 2004 to Match 2009.

1,057 patients were recruited for the JCOG 0404 study, and short-term clinical benefits of LAP were demonstrated.

Conversion rate was low (5.4%). Postoperative grade 3/4 complication rate was similar in both groups, the amount of intraoperative bleeding and rate of wound related complication were significantly lower in LAP than in OPEN, and postoperative hospital stay was significantly shorter in LAP than in OPEN. Long-term oncological results will be available in 2014.

ColoRectal Surgery Forum 2012

The 2012 Autumn Annual Meeting of the Society of Colon and Rectal Surgeons, Taiwan

Date: October 06-07, 2012
Venue: China University Hospital Building

ColoRectal Surgery Forum 2012
The 2012 Autumn Annual Meeting of the Society of Colon and Rectal Surgeons, Taiwan
Date: October 06-07, 2012
Venue: China University Hospital Building

LAPAROSCOPIC COMPLETE MESOCOLIC EXCISION WITH D3 LYMPHADENECTOMY: WHEN, WHY AND HOW

Seon-Hahn Kim, M.D.

BACKGROUND

There is emerging evidence that complete mesocolic excision (CME) for colon cancer produces a good quality surgical specimen, with a maximal lymph node harvest. In the era of minimally invasive surgery, laparoscopic colectomy is becoming a "standard" practice. We aimed to evaluate the feasibility of the CME technique with D3 lymphadenectomy in laparoscopic colectomy and its short- and long-term outcomes.

METHODS

Between September 2006 and December 2009, 168 laparoscopic colectomies identified stages II and III colon cancer. Prospectively collected data on demographics, tumor characteristics, complications and outcomes were analyzed retrospectively.

RESULTS

Eighty-seven patients (51.8%) had stage II colon cancer and 81 patients had stage III cancer. The mean operative time was 196.0 ± 61.2 min. Overall morbidity rate was 14.8%, which included anastomotic leak in 10 patients (5.7%). There was no operative mortality. The number of lymph nodes harvested was 27.8 ± 13.6. With a median follow-up of 44.3 months; locoregional recurrence and systemic metastasis developed in 6 (3.6%) and 13 patients (7.7%), respectively. Three patients died of causes related to cancer and all had been diagnosed with stage III cancer. The overall survival rates at 5-year for stage II and stage III were 98.9% and 92.6%, respectively. The disease-free survival at 5-year was 96.5% for patients with stage II and 80.8% for patients with stage III.

CONCLUSION

Standardization of laparoscopic CME and D3 lymphadenectomy is expedient with acceptable morbidity and provides excellent oncologic outcomes for stage II and stage III colon cancer. A longer follow-up is needed to validate the enhancement of oncological outcome related to this surgical concept.

Fig 1. A laparoscopic view of D3 lymph node dissection at the origin of the middle colic vessels. A: middle colic artery, V: middle colic vein, P: pancreas head, superior mesenteric artery (arrow head), superior mesenteric vein (arrow)

[1]. Division of Colorectal Surgery, Korea University Anam Hospital, Seoul, Korea

ColoRectal Surgery Forum 2012

The 2012 Autumn Annual Meeting of the Society of Colon and Rectal Surgeons, Taiwan

Date: October 06-07, 2012
Venue: China University Hospital Building

ColoRectal Surgery Forum 2012
The 2012 Autumn Annual Meeting of the Society of Colon and Rectal Surgeons, Taiwan
Date: October 06-07, 2012
Venue: China University Hospital Building

ENDO-LAPAROSCOPIC APPROACH VS CONVENTIONAL OPEN SURGERY IN THE TREATMENT OF OBSTRUCTING LEFT-SIDED COLON CANCER: LONG TERM FOLLOW UP OF A RANDOMIZED TRIAL

Hester Yui Shan Cheung, *Karen Lok Man Tung, Cliff Chi Chiu Chung, Michael Ka Wah Li*

ABSTRACT

BACKGROUND:

We have previously conducted a randomized trial comparing endo-laparoscopic approach (i.e. placement of self-expandable metallic stents (SEMS) followed by laparoscopic resection) versus conventional open surgery in the treatment of obstructing left-sided colon cancer. This study is a follow-up of the previous randomized trial and aims to report the long term outcomes in the 2 groups.

METHODS

Forty-eight patients included in the randomized trial were followed up in outpatient clinic with regular surveillance. Patients were compared for clinicopathological variables, disease recurrence and survival rates.

RESULTS

Clinicopathological details were comparable between the two groups. Within median follow up of 32 – 65 months in the 2 groups, no statistically significant difference was observed in disease recurrence rate, 5-year overall survival and 5-year disease free survival rates.

CONCLUSION

Preoperative SEMS insertion, besides being a safe bridge to subsequent elective laparoscopic surgery, does not adversely affect oncological outcomes and patient survival. Based on our data, the endo-laparoscopic approach is the treatment of choice for patients presenting with malignant left-sided colonic obstruction.

ColoRectal Surgery Forum 2012
The 2012 Autumn Annual Meeting of the Society of Colon and Rectal Surgeons, Taiwan
Date: October 06-07, 2012
Venue: China University Hospital Building

ADVANCES IN MIS COLORECTAL SURGERY

Michael Li

The development of minimally invasive surgery (MIS) in colorectal disease began with the first report of laparoscopic assisted colectomy in 1991. There is now a wealth of evidence indicating the laparoscopic approach confers definite short term benefits to patients. Even for colorectal cancer, a common malignant condition worldwide, evidence in the literature demonstrates comparable oncological outcomes as to open approach. Moreover, with the progress in technology and skills, in the last decade MIS techniques have been gradually incorporated into the clinical pathway of rectal cancer management. Not only laparoscopic distal rectal cancer with sphincter preservation could be safely performed, but investigators have also shown that MIS in patients with prior neoadjuvant chemo-irradiation is safe and carries similar short term benefits as in patient without chemo-irradiation. Even for tumours within 5cm from the anal verge, successful sphincter-preserving excision has been described using a combined laparoscopic and transanal technique.

Like other advanced laparoscopic procedures, laparoscopic colectomy was initially practised in the elective cases. The presence of intestinal obstruction, a common acute surgical emergency, was generally considered as a contraindication for MIS owing to limited access as a result of distended bowel. With the advent of self-expanding metallic stent (SEMS), laparoscopic colectomy could be performed after endoluminal stenting. This 'endo-laparoscopic' approach allows patients to enjoy the full benefits of MIS, obviating the need of emergency laparotomy and thus stoma creation.

Further inspired by transanal endoscopic microsurgery championed by Buess, we have tried to develop other kinds of natural orifice transluminal endoscopic surgery (NOTES). Our unit has recently reported a 'hybrid' technique, combing laparoscopic and transluminal techniques in performing 'incisionless' laparoscopic colecotmy with intra-corporeal anastomosis in patients with left-sided colorectal tumours. The mini-laparotomy wound for specimen retrieval was completely abolished with transanal extraction of specimens, thus avoiding wound-related as well as pain-related complications.

Other recent advances in MIS for colorectal cancer are single port access and robotic assisted colorectal resections. The introduction of single port access surgery has likewise revolutionized MIS and NOTES. Specimens can be extracted through the umbilicus, a natural orifice, producing "scarless surgery". It was initially used for simple laparoscopic procedures such as appendectomy and cholecystectomy. Later on, the technique has been employed in laparoscopic colectomy. In our unit, the technique was recently combined with the 'hybrid' NOTES procedure, in which the colon specimen was extracted through the rectum, obviating the need to extend the incision used for single port access surgery.

With the acquisition of the surgical robotic system in late 1990s, we have successfully integrated the robot in our robotic endo-laparoscopic theatre since 2009. The surgical robotic system is potentially superior to traditional laparoscopy for difficult anastomosis and better nerve preservation especially in confined space like the pelvic cavity, due to better 3-dimensional imaging, improved dexterity and better instrumentation.

MIS colorectal surgery will continue to flourish in the coming decades. This is reflected by the establishment of various endo-laparoscopic OR, robotic surgery centres and training centres on laparoscopic surgery and NOTES. The next generation of colorectal surgeons will be entering a new era – the era of endo-laparoscopic and robotic-assisted laparoscopic surgery. And this will be soon approaching.

RECTAL CANCER AND MINIMALLY INVASIVE SURGERY: WHAT IS THE FUTURE?

Joel Leroy

The abdomino and perineal resection (APR) of the rectum was proposed by Miles in 1907. Until the end of the last century it was considered the gold standard to cure rectal cancer everywhere in the world.

In the beginning of the 80th of the previous century Heald (1982) described the Total Meso Rectal Excision of the rectal with sphincter preservation. Rapidly during the last 30 years this procedure was considered as the gold standard procedure for a selected rectal cancer.

With the development of the radiotherapy and chemotherapy during the last 20 years, more and more sphincters preservation were proposed. More and more paper proposed too local and/or transanal excision of the tumour reducing the morbidity risk without oncologic risk.

The purposes of this lecture are to discuss which surgical approach we will propose to our patients in rectal cancer.

ColoRectal Surgery Forum 2012

The 2012 Autumn Annual Meeting of the Society of Colon and Rectal Surgeons, Taiwan

Date: October 06-07, 2012
Venue: China University Hospital Building

ColoRectal Surgery Forum 2012
The 2012 Autumn Annual Meeting of the Society of Colon and Rectal Surgeons, Taiwan

Date: October 06-07, 2012
Venue: China University Hospital Building

Abstract

October 07, 2012

ColoRectal Surgery Forum 2012
The 2012 Autumn Annual Meeting of the Society of Colon and Rectal Surgeons, Taiwan
Date: October 06-07, 2012
Venue: China University Hospital Building

HOW CAN WE REDUCE THE ABDOMINAL WALL TRAUMA IN LAPAROSCOPIC LEFT COLONIC RESECTIONS?

Joel Leroy

The purposes of this lecture are to explain the evolution from multiport to single port left colectomies in benign disease and discuss the tips and tricks to perform a well standardized and reproducible technique in a lot of hands. Indications and risks of this new approach are also discussed

ColoRectal Surgery Forum 2012

The 2012 Autumn Annual Meeting of the Society of Colon and Rectal Surgeons, Taiwan

Date: October 06-07, 2012
Venue: China University Hospital Building

PURE TRANS ANAL TME WITHOUT ABDOMINAL SCAR INCISION USING THE PERI-RECTAL ONCOLOGIC GATEWAY FOR RETROPERITONEAL ENDOSCOPIC SINGLE SITE SURGERY (PROGRESSS).

Joel Leroy

Performing a pure oncologic transanal TME is not new and is daily performed everywhere in the world. Mobilizing the sigmoid and left colon by this way and ligating the inferior mesenteric vessels are more challenging.

The lecturer proposes an original oncologic surgical technique using the transanal approach for dissecting and mobilizing the sigmoid and descending colon and ligating the inferior mesenteric vessels.

The idea is to use a retroperitoneal dissection of the attachments of the distal colon and to perform a division of the vessels by transanal and perirectal approach.

The author shows the different steps to rich this goal (animal lab model, cadaver and finally human case).

ColoRectal Surgery Forum 2012
The 2012 Autumn Annual Meeting of the Society of Colon and Rectal Surgeons, Taiwan
Date: October 06-07, 2012
Venue: China University Hospital Building

TREATMENT STRATEGY OF EARLY COLORECTAL CANCER: WHAT CAN BE DONE?

Konishi F

THE MANAGEMENT OF T1 STAGE CANCER OF THE COLON AND RECTUM

The management of T1 colorectal cancer has been a controversial issue in the treatment of colorectal cancer in early stages. Firstly the colonoscopic appearances under meticulous observation are important findings that will determine whether colonoscopic resectionor bowel resection should be done as an initial treatment.. Magnifying colonoscopy is also an important tool to estimate the grade of invasion in the submucosal. When pit pattern V is seen it is considered to be the sign of deep invasion in the submucosal. However, there is a limitation in making the colonoscopic diagnosis, therefore, when the assessment as for the depth of invasion is unclear on colonoscopy, colonoscpic resection is usually performed when it is technically feasible. The indication for bowel resection will then be determined according to the histological findings of the resected specimens. Our histological analysis of T1 stage cancer, substantial invasion depth in the submucosal, lymphatic channel invasion, moderate to poor differentiation, invasive front on histology (budding) were significant risk factors for the estimating lymphnode metastasis. Therefore, when one of more of such features is seen, bowel resection should be considered. The treatment of T1 stage cancer should be discussed in a team of endoscopists, surgeons and histopathologists to choose an optimal method of treatment.

ENDOSCOPIC TREATMENT OF EARLY STAGE COLORECTAL CANCER

Endoscopic mucosal resection (EMR) is a useful and safe method to remove relatively large sessile lesions. In this method, saline or hyaluronic acid solution is infused in the submucosal to lift up the lesion. After the infusion and the lift up, a snare wire will be place around the tumor and the lesion will be removed by the usage of electrocoagulation. Endoscopic submucosal dissection (ESD) is used to remove even larger sessile lesions. In this method, after the injection of hyaluronic acid, the mucosa surrounding the lesion will be circumferentially divided by the usage of “needle knife” or “hook knife”. Subsequently the submucosal will be dissected by using similar devices from the distal side to the proximal side. Although this is a time consuming and tedious procedure, it can well be tolerated by the patients. The important advantage of ESD is the en block resection which will lead to a better treatment than piece meal resection. Although the time for this method is usually long, the procedure is less invasive than bowel resection.

ColoRectal Surgery Forum 2012
The 2012 Autumn Annual Meeting of the Society of Colon and Rectal Surgeons, Taiwan
Date: October 06-07, 2012
Venue: China University Hospital Building

ROBOTIC ASSISTED LAPAROSCOPOIC RECTAL CANCER EXCISION: OPERATIVE AND FUNCINTAL OUTCOMES

Hester Yui Shan Cheung

ABSTRACT

INTRODUCTION

Despite improvement in surgical approach and technology, total mesorectal excision for low rectal cancer has been associated with significant post-operative sexual and urinary dysfunction. We hypothesize that robot-assisted laparoscopic total mesorectal excision can achieve maintenance of such functions by its more assured pelvic splanchnic nerve preservation.

METHOD

We prospectively assessed the pre- and post-operative sexual and urinary function of male patients who received robot-assisted laparoscopic total mesorectal excision for rectal cancer since May 2009. The International Prostatic Symptom Score (IPSS) and International Index of Erectile Function (IIEF-5) were employed for such assessment. The baseline and the 3-month postoperative assessments of sexual and urinary function were analyzed and compared.

RESULTS

In a 34-month period, thirty-three male patients received robotic-assisted rectal surgery. Their median age was 64 years (range 33-84). Twenty-six patients underwent sphincter-saving total mesorectal excision with four patients with neoadjuvant chemoirradiation. The median operating time was 205 mins (range 165-408) with the median blood loss of 70ml (range 30-300). At post-op 3 months, 1 patient (3%) still failed to produce spontaneous voiding. He was treated by long term Foley catheterization. The mean baseline and post-op 3 months IPSS scores were 4 and 4.1 respectively. There was no significant difference in IPSS score after operation. Fifteen patients (45.5%) were sexually active before operation. The mean baseline and post-op 3 months IIEF-5 scores were 20 and 9.4 respectively. There was no significant difference in IIEF-5 score before and after operation.

CONCLUSIONS

To better define the benefit and role of robot-assisted rectal surgery in the era of laparoscopic TME, results from larger prospective series, or preferably, prospective randomized control trials are necessary.

ColoRectal Surgery Forum 2012
The 2012 Autumn Annual Meeting of the Society of Colon and Rectal Surgeons, Taiwan
Date: October 06-07, 2012
Venue: China University Hospital Building

CRITICAL ASSESSMENT OF ROBOTIC VERSUS LAPAROSCOPIC SURGERY FOR THE TREATMENT OF DISTAL RECTAL CANCER-NATIONAL TAIWAN UNIVERSITY HOSPITAL EXPERIENCE

Jin-Tung Liang, M.D., Ph.D

Keyword：Rectal cancer, robotic surgery, da Vinci surgical system, laparoscopic surgery, total mesorectal excision

This is a preliminary report of our three-year research project to test the feasibility for the application of da Vinci surgical system in performing total mesorectal excision for the treatment of advanced rectal cancer, in comparison with standard laparoscopic approach using appropriate parameters of functional recovery and oncologic results. Our previous study （NSC 97-2314-B-002-025-MY3） has proved that standard laparoscopic approach can achieve the goal of personalized therapy for patients with rectal cancer, in which the surgical practice juggles the radical excision of rectal cancer, and minimal intra-operative and post-operative invasiveness for patients. Remarkably, however, robotic surgery devices have currently been beyond investigational devices and are becoming increasingly disseminated in all fields of surgery. The advantage of robotic surgery include embodying a steady surgical field (motion scaling), providing a magnified and three-dimensional view, and allowing surgeon's wrist action to be reflected in the tips of the instrument, and thus the less surgeon fatigue and potentially better oncologic outcome due to more stable and precise dissection. Several disadvantages with da Vinci system including the lack of haptic feedback, increased operative time, inability to access all four abdominal quadrants, and the need for an assistant, and most important of all, the high cost of acquisition and of maintenance of the platform are still prohibiting factors in widespread use.

In this project, we plan to recruit 60 patients (12, 24, 24 patients in the 1st, 2nd and 3rd year respectively) with low rectal cancer requiring a robotic-assisted total mesorectal excision. The surgical outcomes of such patients will be compared with patients receiving standard laparoscopic TME, by which approximately 100 cases were operate on annully in our institution. The surgical intraoperative or postoperative complications, and clinico-pathological features including the number of harvested lymph nodes, circumferential resection margin, postoperative recovery (flatus passage, oral feeding, and hospitalization) will be prospectively recorded. The minimal invasiveness of patients will be assessed by objective surgical stress-related factors including serum CD4+/CD8+, ESR, CRP, and IL-6. The postoperative genitourinary functional changes will be evaluated by IPSS, IIEF, FSFI scores. The patients will be followed up for at least 3 years after treatment to evaluate the overall survival.

Currently, the benefits of robotic-assisted TME for rectal cancer have not been shown to translate into long-term improved oncologic outcome and survival. In addition, studies are needed to assess for potential advantages in quality of life such as reduced risk of sexual and voiding dysfunction. If proven, these advantages could possibly offset the significantly increased cost of healthcare resources in Taiwan. All the above- mentioned issues inspire us to further conduct this 3-year project, with a view to enhancing the academic reputation of Taiwan Colorectal Surgery and the quality care of patients with rectal cancer in Taiwan.

Between March and July, 2012, twelve patients were recruited. Herein, we will present the technical details and short-term surgical outcomes.

ColoRectal Surgery Forum 2012
The 2012 Autumn Annual Meeting of the Society of Colon and Rectal Surgeons, Taiwan
Date: October 06-07, 2012
Venue: China University Hospital Building

BEVACIZUMAB: A REVIEW OF ITS USE IN METASTATIC COLORECTAL CANCER

Cheng-Shyong Chang

The anti-vascular endothelial growth factor (VEGF) monoclonal antibody bevacizumab, which binds to and neutralizes VEGF-A, has become a central part of the treatment of metastatic colorectal cancer since the FDA approved in 2004.

The addition of bevacizumab to fluoropyrimidine-based chemotherapy, with or without irinotecan or oxaliplatin, in both the first- and second-line treatment of metastatic colorectal cancer, significantly increased median progression-free survival or time to disease progression in most randomized controlled trials. Bevacizumab was generally, but not always, associated with overall survival advantage; in phase III trials, the increases in median overall survival attributable to bevacizumab were 4.7 months with first-line therapy and 2.1 months with second-line therapy. In addition, a significant increase in overall survival is seen when bevacizumab is added to oxaliplatin plus infusional 5-FU/leucovorin (FOLFOX) in patients with metastatic colorectal cancer who progressed on a non-bevacizumab-containing regimen. In patients who have progressed on a bevacizumab-containing regimen, continuation of bevacizumab is significantly associated with an improved survival based on observational cohort studies. Because of these data are from an observational study and will need to be validated in an ongoing, prospective, randomized study. Meanwhile the investigation of the role of bevacizumab as maintenance therapy is ongoing.

From previous clinical trial data, the addition to chemotherapy with bevacizumab significantly improves the survival of patients with metastatic colorectal cancer independently of its biomarker status. Given above challenges it is imperative to identify a set of biomarkers to select populations of likely responders and/or to monitor disease progression and response over the course of treatment in the general practice. Some promising data are emerging from recent studies.

This presentation aims to provide a concise update from recent findings of its use in metastatic colorectal cancer.

ColoRectal Surgery Forum 2012

The 2012 Autumn Annual Meeting of the Society of Colon and Rectal Surgeons, Taiwan

Date: October 06-07, 2012
Venue: China University Hospital Building

Appendix

Formosa, Taiwan

Taiwan is a solitary island on the western edge of the Pacific Ocean, lying off the southeastern coast of mainland Asia, across the Taiwan Strait from China. Taiwan known, especially in the past, as Formosa (Ilha Formosa) meaning "Beautiful Island" from Portuguese, is also reputable for its towering mountains and beautiful coastal scenes. Taiwan now has established 8 national parks and 13 national scenic areas to preserve its best natural ecological environment and cultural sites. The blending of Hakka, Taiwanese, indigenous people and Chinese cultures has produced a rich plethora of cultural and social color. Most importantly, National Palace Museum, located in outskirt of Taipei City, is home to essence of the five-thousand-year Chinese history. It has the finest collections of Chinese Arts, providing an eye-opening experience of Chinese culture.

Language

The official language of Taiwan is Mandarin Chinese, but other dialects are also spoken. The most commonly used foreign language is English. Taxi drivers, however, generally only speak Mandarin or Taiwanese.

Climate

Taiwan's climate is subtropical with average annual temperatures of 19℃ (66℉) in the north and 21℃ (69℉) in the south. Autumn from September through November, is usually cool with an average temperature from 20℃ to 24℃ (68℉ to 75℉). The weather report of Taiwan can be found at the website of Central Weather Bureau: http://www.cwb.gov.tw

Time Zone

Taiwan is eight hours ahead of Greenwich Mean Time (GMT) and does not practice daylight saving time during summer. Local time in Taiwan and the time difference from your home country can be found via this link: http://www.worldtimeserver.com

Electricity Power Supply

The utility power supply used in Taiwan is 110 volts/60Hz. Appliances from Europe, Australia or South-East Asia will require an adaptor.

Currency

Taiwan's currency is the New Taiwan Dollar (NT$).Bill denominations are NT$2,000, NT$1,000, NT$500, NT$200, and NT$100. Coin denominations are NT$1, NT$5, NT$10, NT$20, and NT$50.

The exchange rate is around NT$30 to US$1. Foreign currencies can be exchanged at the airport upon arrival, or at government-authorized banks, tourist hotels, and department stores. Please retain the currency exchange receipt to exchange unused NT Dollars back to original currency. Traveler's checks in major currencies may be cashed at some tourist-oriented businesses and most international tourist hotels.

Credit Card

Major credit cards are accepted by hotels, department stores, airlines, most stores and restaurants. Cash can be withdrawn from the ATM which has the same logo on your cards. Cash is generally preferred in most places in Taiwan.

Telecommunication Service

A single local call from a public phone costs NT$1 for 3 minutes with additional coins insertion for continuing service. If needed, the overseas operator may be reached by dialing "100". Direct international call is available from some phones, after dialing the prefix "002". Rate for direct international calls is charged every six seconds

Customs

Personal items are free of duty. Visitors over 20 years old may bring in, duty free, 200 cigarettes or 25 cigars or 0.5 kg of tobacco, one bottle of liquor and one used camera. Gold cannot be exported without a permit issued by the Ministry of Finance. Passengers arriving with gold and silver and planning to take it out at departure must declare it and leave the items with Customs until they leave Taiwan.

Helpful Phone Numbers

English-Speaking Police: +886-2-2555-4275 or +886-2-2556-6007
Emergencies/Fire Department: 119
Police: 110
English Speaking Directory Assistance: 106
International Operator Assistance: 100

Sponsors

Ethicon Endo-Surgery
PART OF THE Johnson & Johnson FAMILY OF COMPANIES

Johnson & Johnson Medical Taiwan
英商壯生和壯生(香港)股份有限公司台灣分公司

台灣達孚股份有限公司
YUANYU INDUSTRY CO., LTD
元佑實業有限公司
TSH biopharm
東生華製藥股份有限公司
TTY Biopharm
台灣東洋藥品工業股份有限公司

信文達股份有限公司
MSD Taiwan
美商默沙東藥廠(股)公司台灣分公司
COVIDIEN
台灣柯惠醫藥股份有限公司
惠興股份有限公司
Roche Products Ltd.
羅氏大藥廠股份有限公司
Merck Taiwan
台灣默克股份有限公司
Baxter International Inc.
百特醫療產品股份有限公司
Double Success Co. Ltd.
達勝有限公司
Pfizer Limited
輝瑞大藥廠股份有限公司
Microbio Co., Ltd.
中天生物科技股份有限公司
FRESENIUS KABI TAIWAN LTD
台灣費森尤斯卡比股份有限公司

達文西廠商

Memo

Memo