



# 7<sup>TH</sup> INTERNATIONAL CONGRESS OF LAPAROSCOPIC COLORECTAL SURGERY

2 - 4 November 2012

The University of Hong Kong, Hong Kong

• Final Program •



Department of Surgery  
Li Ka Shing Faculty of Medicine  
The University of Hong Kong



香港肛腸科學會  
Hong Kong Society for Coloproctology



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## WELCOME MESSAGE FROM PROGRAM DIRECTOR

Dear Colleagues,

On behalf of the International Society of Laparoscopic Colorectal Surgery, we are very pleased and honored to invite you to the 7th Annual Congress to be held at the Faculty of Medicine, The University of Hong Kong on 2-4 November 2012. With the first congress outside the United States, the meeting last year at Colchester, United Kingdom was a great success. This year the Annual Congress will be held for the first time in an Asian city.

Hong Kong is known as the 'Pearl of the Orient'. Nestled in the Pearl River delta on the shores of the South China Sea, Hong Kong boasts an iconic skyline along the Victoria Harbor, relaxing outlying islands and ancient walled villages along with British colonial charm. This colorful, ever-changing city exhilarates visitors with the East-meets-West cultural fusion, famed shopping, dining and exciting nightlife.

The 3-day congress will consist of live demonstrations, lectures, videos, abstracts and poster presentations. A pre-congress workshop on single incision laparoscopic and transanal surgery is also organized. We are excited to have luncheon symposia sponsored by the key industry leaders to show their new technologies. We are honored to have an international faculty of experts in minimally invasive colorectal surgery. The Congress will offer a high quality program of interest to both surgeons and residents.

We look forward to your active participation and interaction during the meeting.

**Professor WL Law**  
Program Director



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## GENERAL INFORMATION

### The International Society of Laparoscopic Colorectal Surgery

provides a forum to support collaboration between surgeons and scientists interested in the advancement of laparoscopic colorectal surgical techniques, helps in the education of surgeons wishing to learn these techniques, and will work collaboratively with existing national and regional societies supporting laparoscopic colorectal surgery.

The philosophy of the ISLSCR is to provide an international group of surgeons and scientists interested in the advancement of laparoscopic colorectal surgical techniques, which will work collaboratively with currently existing national and regional societies supporting laparoscopic colorectal surgery.

#### The specific purposes for which the ISLSCR is organized are to:

1. Improve the quality of care of patients undergoing laparoscopic colorectal surgery.
2. Educate and train surgeons interested in using laparoscopic colorectal techniques.
3. Help provide international standardization of guidelines for training and accreditation for laparoscopic colorectal surgery.
4. Help internationally standardize and optimize the techniques used to perform and teach laparoscopic colorectal surgery.
5. Serve as a resource for institutions and surgeons commencing laparoscopic colorectal programs.
6. Provide a forum for the presentation of data, discussion of controversial areas and new techniques, and to facilitate collaborative studies.
7. Improve efficiency of care provided using laparoscopic colorectal techniques.

### TRANSPORTATION TO CONGRESS

Daily transfers to The University of Hong Kong meeting venue will be provided each morning (on 2-4 November) from both Le Meridien Hotel and the Courtyard by Marriott. Please meet in the main hotel lobby 30 minutes prior to the meeting start time.

### EXECUTIVE COUNCIL

John H. Marks (President)  
Conor P. Delaney (Secretary-Treasurer)  
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C.C. Foo  
J.H. Lai

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Queen Mary Hospital  
102 Pokfulam Road  
Hong Kong  
Phone: 852-2255-4231  
Fax: 852-2816-2094  
Email: islcrs12@hku.hk

### LUNCH SYMPOSIUM

You are invited to attend these sponsored Lunch Symposia

#### SATURDAY, 3 NOVEMBER 2012

G/F Seminar Room, William MW Mong Block  
21 Sassoon Road, Hong Kong  
Topic: Innovation in Colorectal Surgery  
*Sponsored by Covidien*

#### SUNDAY, 4 NOVEMBER 2012

G/F Seminar Room, William MW Mong Block  
21 Sassoon Road, Hong Kong  
Topic: Experiences on new surgical instrument - with fully integrated advanced bipolar and ultrasonic energy  
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To become a member of the ISLCRS, complete an electronic application ONLINE today and upload your required documents electronically, or download a Membership Application and mail it with copies of the required documents to the ISLCRS Secretariat Office.

For additional information, go to [www.islcrs.org](http://www.islcrs.org)

**MEMBERSHIP DUES**

Current ISLCRS dues are \$150(US).  
 Membership dues are invoiced after acceptance into membership.

**SCHEDULE OF EVENTS**

**THURSDAY, 1 NOVEMBER 2012**

Seminar Room, 9/F Laboratory Block, Li Ka Shing Faculty of Medicine, 21 Sassoon Road

9:00am – 17:00pm

**Optional Postgraduate Course: Single Incision Laparoscopic Colectomy and Transanal Surgery**

Course Directors

Conor P. Delaney, MD, MCh, PhD  
 University Hospital Case Medical Center

John H. Marks, MD  
 Lankenau Medical Center

W.L. Law, MD  
 The University of Hong Kong

Target Participants: Colorectal Fellows  
 Fee: \$1,000  
 30 person capacity

**FRIDAY, 2 NOVEMBER 2012**

Underground Lecture Theatre, New Clinical Building, Queen Mary Hospital, 102 Pokfulam Road

8:20am – 8:30am

**Opening**  
 John H. Marks, MD  
 Lankenau Medical Center

8:30am – 10:10am

**Laparoscopic Colorectal Surgery Around the World**

**Session 1**  
 Moderators: Roger W. Motson, MD, Janet F.Y. Lee, MD

8:30am – 8:50am

**Situation in the US After the COST Trial**  
 Conor P. Delaney, MD, MCh, PhD  
 University Hospital Case Medical Center

8:50am – 9:10am

**The National Training Program: Lapco in UK**  
 Robin H. Kennedy, MD  
 St. Mark's Hospital

9:10 am – 9:30am

**Laparoscopic Colorectal Surgery in Hong Kong**  
 W.L. Law, MD  
 The University of Hong Kong

9:30am – 9:50am

**Training and Accreditation in Japan**  
 Hirotooshi Hasegawa, MD  
 Keio University

9:50am – 10:10am

**Discussion**

10:10am – 10:30am

**TEA BREAK**

10:30am – 15:00pm

**Live Demonstration**

Moderators: Hermann Kessler, MD, Hirotooshi Hasegawa, MD, Simon Ng, MBChB, Robin H. Kennedy, MD

- Robotic Rectal Resection
- Single Incision Colectomy
- TEMS/TEO
- Laparoscopic TME Intersphincteric Dissection

Conor P. Delaney, MD, MCh, PhD  
 John H. Marks, MD  
 Yves Panis, MD, PhD  
 S.H. Kim, MD  
 W.L. Law, MD

14:40pm – 15:00pm

**TEA BREAK**

15:00pm – 15:30pm

**Using New Technology to Facilitate Laparoscopic and Open Rectal Transection**

Conor P. Delaney, MD, MCh, PhD  
 University Hospital Case Medical Center

15:30pm – 16:30pm

**Video Session**

Moderators: Jensen T.C. Poon, MD, John H Marks, MD

15:30pm – 15:40pm

**Laparoscopic Oncologic Left Hemicolectomy**  
 Sakamoto Y, Shin JW, You BE, Kim SH  
 Korea University Anam Hospital



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## SCHEDULE OF EVENTS CONTINUED

15:40pm – 15:50pm

**D3 Resection of An Advanced Hepatic Flexure Cancer – A Presentation of Its Technical Aspects in Laparoscopic Extended Right Hemicolectomy**  
Sng K, Yoo BE, Lim TW, Hara M, Kim SH  
Korea University Anam Hospital

15:50pm – 16:00pm

**Laparoscopic Extraperitoneal Sigmoid Colostomy in APR for Low Rectal Cancer**  
Jin H, He Y  
Nanjing University of Traditional Chinese Medicine

16:00pm – 16:10pm

**Short Term Outcome in Anterior Resection Using Da Vinci's Surgical System for Colorectal Cancer**  
Hanai T, Maeda K, Sato H, Koide K, Matsuoka H, Katsuno H, Matsuoka S, Mizuno M  
Fujita-Health University

16:10pm – 16:20pm

**Single Incision Surgery for Ileo-Sigmoid Fistula**  
Conor P Delaney, MD, MCh, PhD  
University Hospital Case Medical

16:20pm – 16:30pm

**Complications in Minimally Invasive Rectal Resections for Cancer**  
Lai JH, Fan JKM, Poon JTC, Law WL  
The University of Hong Kong

## SATURDAY, 3 NOVEMBER 2012

**Cheung Kung Hai Lecture Theatre 1, William MW Mong Block, Li Ka Shing Faculty of Medicine, 21 Sassoon Road**

7:30am

**ISLCRS Council Meeting**

8:00am

**Poster Display Setup**

8:30am – 10:10am

**Minimizing the Surgical Access**

**Session 2**

Moderators: Patrick Y.Y. Lau, MD, Willem A. Bemelman, MD

8:30am – 8:50am

**SILS Colectomy: From Segmental Resection to TME**  
Yves Panis, MD, PhD  
Hopital Beaujon

8:50am – 9:10am

**Transanal Retrieval of Specimen: A Safe Option**  
Morris E. Franklin Jr., MD  
Southeast Surgical Associates

9:10am – 9:30am

**Transvaginal Retrieval After Robotic and Laparoscopic Resection**  
Gyu-Seog Choi, MD  
Kyungpook National University Hospital

9:30am – 9:50am

**SILS Colectomy: Results of a Randomized Trial**  
Jensen T.C. Poon, MD  
The University of Hong Kong

9:50am – 10:10am

**Discussion**

10:10am – 10:30am

**TEA BREAK**

## SCHEDULE OF EVENTS CONTINUED

10:30am – 12:10pm

**Transanal and Endoluminal Approach**

**Session 3**

Moderators: William C.S. Meng, MD, Neal C. Ellis, MD

10:30am – 10:50am

**TEMS: From Transanal Excision to NOTES**

John H. Marks, MD  
Lankenau Medical Center

10:50am – 11:10am

**Combined Laparo-Endoscopic Procedure with TEO**

Hester Cheung, MD  
Pamela Youde Nethersole Eastern Hospital

11:10am – 11:30am

**FLEX**

Robin H. Kennedy, MD  
St. Mark's Hospital, London

11:30am – 11:50am

**ESD for Colon Neoplasm: Comparison with Laparoscopic Resection**

Simon Ng, MD  
The Chinese University of Hong Kong

11:50am – 12:10pm

**Discussion**

12:10pm – 13:00pm

**LUNCH**

13:00pm – 14:40pm

**Improving Outcome After Laparoscopic Colectomy**

**Session 4**

Moderators: Cliff C.C. Chung, MD, Eric Weiss, MD

13:00pm – 13:20pm

**Fast Track in Laparoscopic Colectomy: Result from the LAFA Trial**

Willem A. Bemelman, MD  
Amsterdam Medical Centre

13:20pm – 13:40pm

**Advances in Management of Postoperative Ileus**

Conor P. Delaney, MD, MCh, PhD  
University Hospital Case Medical Center

13:40pm – 14:00pm

**Ways to Stretch the Limit in Fast Track Colectomy**

Timothy Rockall, MD  
The Royal Surrey County Hospital

14:00pm – 14:20pm

**Is There a Changing Role for the Colorectal Surgeon in the Management of Low-Lying Rectal Cancer?**

Yanek S. Chiu, MD  
California Pacific Medical Center

14:20pm – 14:40pm

**Discussion**

14:40pm – 15:00pm

**TEA BREAK**

15:00pm – 16:20pm

**Minimally Invasive Surgery for Inflammatory Bowel Disease**

**Session 5**  
Moderators: Jensen T.C. Poon, MD, Morris E. Franklin, Jr., MD

15:00pm – 15:20pm

**Primary and Recurrent Crohn's Disease**

Eric Weiss, MD  
Cleveland Clinic Florida

15:20pm – 15:40pm

**Laparoscopic and Hand Assisted Proctocolectomy for Ulcerative Colitis**

Hiroto Hasegawa, MD, FRCS  
Keio University

15:40pm – 16:00pm

**Emergency MIS for Inflammatory Bowel Diseases**

Willem A. Bemelman, MD  
Amsterdam Medical Centre

16:00pm – 16:20pm

**Discussion**

18:30pm

**Congress Dinner**

Jumbo Floating Restaurant



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## SCHEDULE OF EVENTS CONTINUED

### SUNDAY, 4 NOVEMBER 2012

**Cheung Kung Hai Lecture Theatre 1, William MW Mong Block, Li Ka Shing Faculty of Medicine, 21 Sassoon Road**

8:30am – 10:10am

#### MIS for Benign Diseases

##### Session 6

Moderators: Hester Cheung, MD, Yves Panis, MD, PhD

8:30am – 8:50am

#### Rectal Prolapse

Roger W. Motson, MD  
The Oaks Hospital

8:50am – 9:10am

#### Minimally Invasive Surgery for Diverticulitis

Eric Weiss, MD  
Cleveland Clinic Florida

9:10am – 9:30am

#### Laparoscopic Colectomy for Endometriosis

Timothy Rockall, MD  
The Royal Surrey County Hospital

9:30am – 9:50am

#### Incisional and Para-Stomal Hernia With Biological Mesh

Neal C. Ellis, MD, FACS, FASCRS, FACG  
VA Gulf Coast

9:50am – 10:10am

#### Discussion

10:10am – 10:30am

#### TEA BREAK

10:30am – 12:10pm

#### Techniques in Distal Rectal Cancer

##### Session 7

Moderators: Joe K.M. Fan, MD, Timothy Rockall, MD

10:30am – 10:50am

#### Prolapsing Technique

Min Hua Zheng, MD  
Ruijin Hospital

10:50am – 11:10am

#### TATA

John H. Marks, MD  
Lankenau Medical Center

11:10am – 11:30am

#### Laparoscopic Intersphincteric Resection

Yves Panis, MD, PhD  
Hopital Beaujon

11:30am – 11:50am

#### Advantages of Surgical Robot in Distal Rectal Cancer

S.H. Kim, MD  
Korea University Anam Hospital

11:50am – 12:10pm

#### Discussion

12:10pm – 13:00pm

#### LUNCH

13:00pm – 14:40pm

#### Radical Surgery for Cancer

##### Session 8

Moderators: John H. Boey, MD, John H. Marks, MD

13:00pm – 13:20pm

#### Total Mesocolon Resection

Hermann Kessler, MD  
University of Erlangen

13:20pm – 13:40pm

#### Laparoscopic D3 Dissection for Colon Cancer

Jin-Tung Liang, MD, PhD  
National Taiwan University Hospital

13:40pm – 14:00pm

#### Laparoscopic Colectomy for Advanced Diseases

Yves Panis, MD, PhD  
Hopital Beaujon

14:00pm – 14:20pm

#### Laparoscopic TME

Michael K.W. Li, MD  
Hong Kong Sanatorium & Hospital

14:20pm – 14:40pm

#### Discussion

14:40pm – 15:00pm

#### TEA BREAK

15:00pm – 17:00pm

#### Free Paper Session

##### Session 9

Moderators: Conor P. Delaney, MD, MCh, PhD,  
John H. Marks, MD,  
W.L. Law, MD

## ABSTRACTS

1500-1510

### 1. THE ROLE OF LAPAROSCOPY IN EMERGENCY SURGERY FOR OBSTRUCTIVE COLORECTAL CANCER: A CASE-MATCH STUDY

Odermatt M, Miskovic D, Siddiqi N, Khan J, Parvaiz A  
Minimally Invasive Colorectal Unit, Queen Alexandra Hospital, Portsmouth, UK

**Background:** The role of laparoscopy in emergency surgery for obstructive colorectal cancer is unclear. Aim was to investigate the short- and long-term outcomes of laparoscopic versus open resections for emergencies.

**Methods:** Retrospective analysis of a prospective database. Emergency colorectal cancer resections were included. Laparoscopic and open cases were matched 1 to 2. For age ( $\pm 1$  year) exact match was used; gender, ASA, tumour site and stage were propensity matched. Overall and disease-free survival were analysed using Kaplan-Meier curves and adjusted for postoperative mortality. Oncologic quality surrogates (lymph node harvest, R stage), need of stoma, length of hospital stay and postoperative complications (mortality, reoperations) were compared.

**Results:** From 10/2006 to 12/2011, a total of 230 emergency resections were identified. Thirty-six cases were performed laparoscopically and matched to 72 open cases. Median follow up was 2.3 (CI 95% 1.3-3.5) years. Mean overall survival was 3.0 (95% CI 2.4-3.5) in the laparoscopic versus 2.5 (CI 95% 1.9-3.1) years in the open group ( $p=0.024$ ). Disease-free survival was 2.6 (CI 95% 2.0-3.2) versus 2.2 (CI 95% 1.7-2.8) years, respectively ( $p=0.061$ ). Mean lymph node harvest (17.7 versus 13.6,  $p=0.014$ ) and mean length of hospital stay (10.8 versus 15.8,  $p=0.027$ ) were in favour of laparoscopy. R1/2 rate (14% versus 28%,  $p=0.08$ ), stoma rate (22% versus 29%,  $p=0.46$ ), mortality (8% versus 17%,  $p=0.38$ ) and reoperations (11% versus 7%,  $p=0.48$ ) showed no significant difference.

**Conclusion:** Our data suggest that emergency laparoscopy for obstructive colorectal cancer is feasible and safe in experienced hands. There is evidence of both short- and longterm benefits for laparoscopic emergency surgery.

1510-1520

### 2. TRANSANAL VS. TRANSABDOMINAL SPECIMEN EXTRACTION WITH LAPAROSCOPIC LOW ANTERIOR RESECTION: A COMPARATIVE ANALYSIS ON 432 PATIENTS WITH RECTAL CANCER

Liang S, Franklin, M  
Texas Endosurgery Institute  
San Antonio, Texas, USA

**Background:** This prospective comparison study focused on the patients with rectal cancer who underwent either transanal or transabdominal specimen extraction after laparoscopic low anterior resection with total mesorectal excision and was specifically aimed at investigating if the transanal approach can be accepted as a safe and effective method for extracting the malignant specimen from peritoneal cavity.

**Methods:** A prospectively designed database of a consecutive series of patients undergoing laparoscopic low anterior resection for rectal malignancy with various TMN classifications between April 1991 to May 2011 at the Texas Endosurgery Institute was analyzed, and all the statistical calculations were performed with SPSS.

**Results:** A total of 432 patients underwent laparoscopic low anterior resection (LLAR) with total mesorectal excision (TME) during this study period. Transabdominal specimen extraction was applied to 256 patients for delivering specimens out of the peritoneal cavity after the laparoscopic procedure while 179 patients experienced transanal specimen extraction. In comparison on perioperative data, transanal group did not show significant difference from transabdominal arm on age (67yo vs 69yo;  $p=0.12$ ), operative time (180.9 $\pm$ 43.5 minutes vs 198.3 $\pm$ 43.5 minutes;  $p=0.07$ ), estimated blood loss (126.6 $\pm$ 73.6 ml vs 172.2 $\pm$ 144 ml,  $p=0.82$ ), intraoperative complications (1.1% vs 0.8%;  $p=0.69$ ), postoperative complications (2.8% vs 4.2%,  $p=0.59$ ), and hospital stay (6.9 $\pm$ 2.8 days vs 9.1 $\pm$ 3.7 days;  $p=0.83$ ). During long-term follow-up, 9 out of 179 patients who underwent LLAR/TME with transanal specimen extraction were confirmed to have malignant recurrence with 2-year local recurrence rate of 5.0%, which did not statistically differ from that of transabdominal group (2.3%,  $p=0.15$ ).

**Conclusion:** Transanal specimen extraction in laparoscopic rectal cancer resection is a safe and effective approach with comparable recurrence rate of cancer and postoperative complication rates, thus it can be integrated into laparoscopic low anterior resection as an alternative approach to extract the malignant specimen(s) from the abdominal cavity.



## ABSTRACTS CONTINUED

1520-1530

### 3. SINGLE-FIRE RECTAL TRANSECTION DECREASES ANASTOMOTIC LEAKAGE IN LAPAROSCOPIC LOW ANTERIOR RESECTION

Hara M, Shin JW, Yoo BE, Sng K, Lee DW, Kwak JM, Kim J, Kim SH  
Colorectal Division, Department of Surgery, Korea University Anam Hospital  
Seoul, South Korea

**Background:** Although technical and instrumental advance has made laparoscopic surgery safer, leakage after laparoscopic low anterior resection (LaLAR) is still a great issue. Recently, many investigators have reported the relationship between the number of firing (NOF) on the distal rectal stump and the risk of leakage. This study focuses on the use of the single firing technique on the distal rectal stump, and aims to describe the transition of NOF in our hospital, to analyze the factors associated with the multi-fire, and to demonstrate our single firing technique in video.

**Methods:** Between September 2006 and August 2011, 185 patients underwent LaLAR in our hospital. From the prospectively collected database, we calculated the mean NOF of each year and whole span. Risk factors associated with multi-fire (more than two) were evaluated with uni- and multivariate analysis of patient characteristics (age, gender and body mass index), tumor characteristics (tumor size, distance from the anal verge and depth of tumor) and chronological phase (before and after 2009 when the single-fire technique was developed in our unit). Anastomotic leakage included a minor leak which did not require any intervention.

**Results:** Single-fire was performed in 44 patients (23.8%). The mean NOF was 2.0 (range, 1~8). Annual ratio of the mean NOF decreased year on year (2.6 to 1.5). Among the 44 patients undergoing single firing transection, leakage was seen in only 1 case (2.3%). Leaks were significantly frequent after multi-fire (17.0%,  $p=0.01$ ). The uni- and multivariate analysis showed no significant factors which influenced NOF in both patient and tumor characteristics except chronological phase.

**Conclusion:** Multivariate analysis showed that only the chronological phase was related to the NOF. Technical advance in our surgical team has succeeded in increasing the single firing rate in LaLAR, and this will decrease the risk of anastomotic leaks.

1530-1540

### 4. INCISIONAL HERNIA RATE AFTER LAPAROSCOPIC COLORECTAL RESECTION REDUCED WITH STANDARDISATION OF EXTRACTION SITE

Navaratnam AV, Ariyaratnam R, Smart N, Motson RW, Arulampalam T  
ICENI Centre  
Colchester, UK

**Background:** Incisional hernia is a common complication of laparoscopic colorectal surgery. The majority of incisional hernias occur within the first two postoperative years. Extraction site may influence the rate of incisional hernias. Major risk factors for the development of incisional hernias include age, diabetes, obesity and smoking status. In this study we investigated the effect of specimen extraction site on incisional hernia rate.

**Methods:** In this retrospective single-center study, two cohorts of patients that underwent laparoscopic colorectal resections were identified in year groups 2005 ( $n=110$ ) and 2009 ( $n=151$ ). In 2005 all specimens were extracted through transverse muscle cutting incisions. In 2009 all specimens were extracted through midline incisions. Demographic variables, rate of incisional hernias and risk factors for hernia development were compared between the year groups. All patients had been followed up clinically for two years.

**Results:** The total incisional hernia rate for the series was 8.4% at two year follow up. For the 2005 group, the incisional hernia rate was 13.6% ( $n=15$ ) and for the 2009 group, it was 4.6% ( $n=7$ ) (RR= 2.94, CI 1.24, 6.97,  $p=0.01$ ). There was no statistically significant difference between the two year groups in regards to age, sex, diabetes, BMI, smoking status or ASA. There was no statistically significant difference between incisional hernia and non-incisional hernia patients in regards to age, sex, diabetes, BMI, smoking status or ASA within each year group or in total.

**Conclusion:** The 2005 group had a statistically significantly higher incisional hernia rate than the 2009 group. This is due to the differences in the incision technique and extraction site in the two year groups.

## ABSTRACTS CONTINUED

1540-1550

### 5. LAPCO A YEAR ON: IMPACT AND TRAINING ANALYSIS OF THE NATIONAL TRAINING PROGRAMME IN LAPAROSCOPIC COLORECTAL SURGERY.

Coleman MG, Cuming T, MacKenzie H, Nii M, Langsford L, McMeeking A, Francis N, Hanna G  
Derriford Hospital  
Plymouth, UK

**Background:** Instituted in 2008, the National Training Programme in Laparoscopic colorectal surgery in England (Lapco) has 144 enrolled consultant trainees and 65 consultant trainers. Training is provided through 11 training centres in England. There is a Lapco 'Train the Trainers' (TT) course. The aim of the analysis is to assess the impact of the Lapco training programme.

**Methods:** Educational assessment and clinical outcome data from the programme, collected online at the Lapco web site ([www.lapco.nhs.uk](http://www.lapco.nhs.uk)). National hospital episode statistics (HES) give a trend for the increased adoption of laparoscopic colorectal versus open resection. Pre and post TT course testing is used to determine the attitudes and practices in training of our experts. Theoretical calculation of health economic benefits has been carried out.

**Results:** A total of over 1,700 individual Lapco training sessions have taken place since the on line recording commenced through the web site in April 2009. There are 149 acute hospitals in England that have colorectal cancer teams, and Lapco has had wide exposure within these units. The spread of laparoscopic colorectal surgery has been evidenced through the increase in HES data for Laparoscopic Colorectal resections which has risen from 11% in 2007/2008 to 36% for elective (non emergency) resections (April to September 2011). Pre and post TT course testing demonstrates highly significant improvements in experts.

**Conclusion:** A total of over 1,700 individual Lapco training sessions have taken place since the on line recording commenced through the web site in April 2009. There are 149 acute hospitals in England that have colorectal cancer teams, and Lapco has had wide exposure within these units. The spread of laparoscopic colorectal surgery has been evidenced through the increase in HES data for Laparoscopic Colorectal resections which has risen from 11% in 2007/2008 to 36% for elective (non emergency) resections (April to September 2011). Pre and post TT course testing demonstrates highly significant improvements in experts' abilities as trainers. Accounting for the costs of the programme there has been net theoretical saving to the tax payer of over £11m.

1550-1600

### 6. DOES DEVIATION FROM THE POSTOPERATIVE ELEMENTS OF ERAS INFLUENCE THE LENGTH OF STAY OF PATIENTS UNDERGOING LAPAROSCOPIC COLORECTAL RESECTIONS?

Liyanage A S D, Marwan K, Smart NJ, Parker M, Motson RW, Arulampalam T  
Colchester General Hospital  
Colchester, UK

**Background:** Enhanced recovery after surgery (ERAS) programmes result in shorter lengths of stay (LOS) and better outcomes for patients undergoing colorectal surgery. Which elements of the ERAS programme are most important is unclear. The aim of this study was to determine whether deviation from the postoperative ERAS elements influenced LOS after laparoscopic colorectal surgery.

**Methods:** One thousand and one consecutive patients due to undergo surgery had data prospectively entered onto a colorectal database between April 2005 and September 2011. Patients who died before surgery and those with missing notes were excluded from the analysis. Data was extracted for length of stay, demographic variables, epidural failure and five key postoperative elements, namely: urinary catheter removal, discontinuation of intravenous fluids, tolerating diet, mobilization and epidural removal. As all variables had markedly skewed distributions, logarithmic transformations were used. Ordinary linear regression models and classification trees were used to seek an explanation for the variation in LogLOS. Analyses were performed using the computer program.

**Results:** A total of 868 (425 male) patients were included in the analysis. Mean age was 65.4 years and median LOS was 7 days (range 1 to 168 days). Epidural failure rate was 6.8%. Median day for the key postoperative elements to occur were: urinary catheter removal day 3, discontinuation of intravenous fluids day 2, tolerating diet day 1, mobilization day 2 and epidural removal day 3. Prediction models seeking to explain variation in LogLOS produced intermediate fits, with the best models accounting for 40% of the variation. The number of days to urinary catheter removal was the most important variable. Then either the day of mobilization or discontinuation of intravenous fluids explain the additional variation.

**Conclusion:** Deviation from the postoperative elements of ERAS is an intermediate predictor of postoperative length of stay in patients undergoing laparoscopic colorectal surgery.





## ABSTRACTS CONTINUED

1600-1610

### 7. IS LAPAROSCOPIC SURGERY FEASIBLE FOR LOCALLY ADVANCED LOW RECTAL TUMOURS?

Bracey EE, Odermatt M, Miskovic D, Conti J, Flashman K, Khan JS, Parvaiz AC.  
Colorectal Unit, Queen Alexandra Hospital, Portsmouth, UK

**Background:** Both low rectal tumours and locally advanced rectal tumours present challenges for colorectal surgeons using a laparoscopic approach. The aim of this study was to determine whether patients undergoing laparoscopic resections for locally advanced low rectal cancers experience similar short-term outcomes compared to open resections.

**Methods:** Data on patients undergoing laparoscopic or open resections for rectal cancer in a single Colorectal Unit were prospectively collected from January 2007 to December 2011. Patients with a locally advanced (T $\geq$ 3 or N+) and low rectal cancer (within 6cms of the anal verge) were included in this study. Short-term clinical and oncological outcomes between the laparoscopic and open groups were compared. Clinical outcomes assessed were; length of hospital stay, reoperation, readmission and post-operative mortality. Oncological outcomes assessed were lymph node harvest and R0 resection. The data was analysed using t-test and Fisher's exact test.

**Results:** 66 patients (37 laparoscopic, 29 open) had a rectal resection for a locally advanced low rectal cancer. There were no differences between the open and laparoscopic groups with respect to age, sex, ASA, tumour height from anal verge, pre-operative radiotherapy, operation type or T stage. The laparoscopic group had a statistically significant shorter length of hospital stay compared to the open group (Median 8 days vs 15 days, p=0.0047) but the other short-term clinical outcomes were similar between the two groups. There were a higher percentage of R0 resections in the laparoscopic group compared to the open (92% vs 79%) however this did not reach statistical significance (p=0.166) and there was no difference in the lymph node harvest.

**Conclusion:** Laparoscopic rectal resection for locally advanced low rectal tumours is technically feasible and in our experience has better short-term outcomes when compared to open resections.

1610-1620

### 8. LAPAROSCOPIC COLECTOMY WITH AND WITHOUT ROUTINE MECHANICAL BOWEL PREPARATION BEFORE OPERATION: A COMPARATIVE STUDY

Chan MY, Poon JTC, Law WL  
The University of Hong Kong  
Hong Kong, China

**Background:** Although it is a common belief that preoperative mechanical bowel preparation (MBP) reduces the risk of complications after elective colorectal operations, many studies have shown that MBP does not improve operative outcomes. However, most of the evidence was from open surgery. The study evaluates the outcomes of elective laparoscopic colectomy with and without bowel preparation.

**Methods:** This is a retrospective comparative study of patients who had elective laparoscopic colectomy for colon cancer without preoperative MBP in our centre during the period of October 2009 to July 2011 (No-MBP group) and patients with MBP during Jan 2007 – May 2009 (MBP group). Patient demographics, operative outcomes, morbidity and mortality were retrieved from a prospective database and comparison between the two groups was compared.

**Results:** The No-MBP group had 97 patients and the MBP group had 159 patients. The mean age of No-MBP and MBP groups were both 70.7 (p = 0.988). Conversion rates in No-MBP and MBP groups were 5.2% and 6.9% respectively (p = 0.572). The ASA score of the patients, size of tumour and stage of disease were all similar in both groups. There were no significant difference between two groups in operative time, blood loss and hospital stay. The anastomotic leakage rates were the same (1%) in both groups. Two patients in No-MBP group (2.2%) and 1 patient (0.7%) in MBP group had intraabdominal collection (p = 0.560). Wound infection rate were 4.1% and 3.8% in No-MBP group and MBP group respectively (p = 1.000). Other surgical complication included postoperative bleeding [3 patients (3.1%) in No-MBP group & 1 patient (0.6%) in MBP group; p=0.560], intestinal obstruction [4 patients (4.1%) in No-MBP group & 1 patient (0.6%); p=0.07]. Total surgical morbidity rate was 11.3% in No-MBP group and 8.2% in MBP group (p = 0.399). Six patients (6.2%) in No-MBP group and 4 patients (2.5%) in MBP group required reoperations (p=0.186). There was no mortality in No-MBP group and one mortality (0.6) in MBP group (p= 1.000).

**Conclusion:** Preoperative MBP offers no additional benefits to laparoscopic colectomy for colon cancer and routine administration of preoperative MBP is not indicated.

## ABSTRACTS CONTINUED

1620-1630

### 9. INTRODUCTION OF ROBOTIC ABDOMINO-PERINEAL EXCISION DIRECTLY FROM OPEN SURGERY

Hallb  
Department of Surgery  
Link, Sweden

**Background:** We started our programme with robotic rectal surgery as the first institution in Sweden. During the same timeperiod we did not have an on-going program for conventional laparoscopic colorectal surgery. Our initial experience and short-term results with robotic abdomino-perineal excision is reported.

**Methods:** From the introduction in April 2010 to March 2012 we did 21 APEs, women n=7. Rectal adenocarcinoma n=20 and palliative operation for anal cancer n=1. Median (range) age was 74 (45-92), BMI 26 (16-38) and American Society of Anesthesiologists (ASA) score I n=6, II n=10, III n=5. The abdominal part of the operation was done with the daVinci robotic system and the perineal part as an open operation after the patient had been turned over into prone jack-knife position.

**Results:** Two operations were converted to open surgery, in patient #2 in the series due to long operating time and in patient #14 due to uncertainty of the dissection planes. No reoperations or deaths occurred. Median total operating time including the perineal phase was 5.6 hrs (maximum 8 hrs in patient #2 and minimum 4.1 hrs in patient #19). The corresponding consol-time was 3.3 hrs (max 4.6 in #2 and min 1.8 in #21). The last 7 patients had a total operating time less than 5 hrs. Median (range) blood loss 100 (25-219) ml and postop length of stay 6 (4-14) days. pT1 n=3, pT2 n=8, pT3 n=7, pT4 n=3. Median number of nodes in the specimen 16 (8-40). All specimens were R0 (microscopically free margins) except one (palliative for anal cancer).

**Conclusion:** In the absence of an on-going programme for conventional laparoscopic colorectal surgery, we have shown that the initial learning-curve from the start using this technique has been short. The short-term oncological results are on par with those of open surgery.

1630-1640

### 10. MAJOR POSTOPERATIVE COMPLICATIONS IN COLORECTAL SURGERY HAVE AN IMPACT ON LONGTERM SURVIVAL

Miskovic D, Odermatt M, Khan J, Senapati A  
Colorectal Department, Queen Alexandra Hospital, Portsmouth, UK

**Background:** Major postoperative complications (Clavien-Dindo stage 3b-4) have known short-term effects on patients in colorectal surgery. The aim of this study was to determine if postoperative complications also influence long-term survival.

**Methods:** Methods: A prospective database for colorectal cancer from a single high-volume institution with minimum follow-up of 3 years was used for this analysis. Patient demographics, case and cancer specifics, type of surgery, postoperative mortality and data on recurrence and survival were collected. Univariate variables with a p <0.250 were included into a multivariate binary regression model with 3-year survival as a dependent variable and adjusted for postoperative mortality.

**Results:** In the years 2003-2009, 868 cases were performed (586 open, 282 laparoscopic, 36.3% rectal resections). Median follow-up time was 4.8 years. Sixty-three major complications (Clavien-Dindo  $\geq$  3b) were identified (25 leaks, 22 medical conditions, 6 stoma dysfunctions, 10 others). In the regression model, UICC stage (p <0.001), local and distant recurrence (p <0.001), male gender (p=0.014), increasing age (p <0.001) and postoperative major complications (HR 3.133; CI95% 1.3-7.7, p=0.013) were significant predictors for decreased 3-year survival (area under the curve 0.9, CI95% 0.88-0.93, p <0.001). Other factors, such as open versus laparoscopic surgery, conversion to open surgery and length of stay were not significant predictors. Mean survival was 6.0 (4.8-7.1) for patients with major complications versus 7.5 years (7.3-7.7) for those without (p=0.003). In the Cox-regression model the adverse effect of major complications on survival (HR 2.6, p <0.001) continued to be present after 3 and 5 years.

**Conclusion:** Postoperative complications have a negative long-term impact on patients' survival. This data underlines the need to avoid any surgical complication in colorectal cancer patients.



## ABSTRACTS CONTINUED

1640-1650

### 11. ASSOCIATION BETWEEN THE INCIDENCE OF SURGICAL INFECTION AND OBESITY-RELATED FACTORS IN LAPAROSCOPIC COLORECTAL SURGERY

Hasegawa H, Shigeta K, Okabayashi K, Ishii Y, Endo T, Kitagawa Y  
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Tokyo, Japan

**Background:** Surgical site infection (SSI) is one of the most common postoperative complications. Several studies reported strong relationship between the incidence of SSI and obesity. Despite gaining the acceptance of laparoscopic surgery, there has been remained unclear in terms of the risk of SSI after resection of the colon or rectum by laparoscopic surgery. The aim of this study is to clarify the relationship between the incidence of SSI and obesity in colorectal laparoscopic surgery.

**Methods:** Between 2004 and 2011, 483 patients who underwent resection of the colon or rectum cancer by laparoscopic surgery were retrospectively enrolled to this study. Preoperative body mass index (BMI), weight, circumference of waist and hip were measured as obesity-related factor. The relationship between the incidence of SSI and these obesity-related factors were analyzed using a receiver operating characteristic (ROC) curve and logistic regression model.

**Results:** A total of 483 patients, 287 male and 196 female patients, were included in this study and SSI occurred in 61 patients. Quartiles of each obesity-related factor were associated with the incidence of SSI. Area under the curves estimated by ROC curves of each obesity-related factor were BMI 0.617, weight 0.586, waist 0.596, hip 0.582, respectively. In logistic regression analysis the significant associations were identified between the incidence of SSI and BMI (Odds ratio (OR) 2.21, 95%CI 1.26-3.85, p=0.005), waist (OR 1.98, 95%CI 1.13-3.47, p=0.017), and hip (OR 1.86, 95%CI 1.07-3.24, p=0.029).

**Conclusion:** In laparoscopic colorectal surgery, obesity-related factors were correlated with the incidence of SSI. Especially, BMI, waist and hip were considered to be a significant predictive factor for the incidence of SSI.

1650-1700

### 12. ROBOTIC-ASSIST INTERSPHINCTERIC RESECTION FOR LOW RECTAL CANCER

Kuo LJ, Wei PL  
Division of General Surgery, Department of Surgery, Taipei Medical University Hospital  
Taipei, Taiwan

**Background:** Intersphincteric resection (ISR) for low rectal cancer has been described as the ultimate sphinctersaving procedure. Robotic rectal cancer surgery is regarded overcoming many limitations of laparoscopic rectal surgery in the narrow pelvis. This study therefore aimed to investigate the feasibility of robotic-assist intersphincteric resection for low rectal cancer and to assess its short-term oncological outcomes.

**Methods:** A total of 42 patients with low rectal cancer who received laparoscopic or robotic-assist ISR between November 2009 and October 2012 were retrospectively chart reviewed. There were 28 patients who received a laparoscopic procedure and 14 that underwent robotic-assist surgery. The surgical and oncological outcomes were evaluated. Comparisons of operating time, estimated blood loss, surgical outcomes, and histopathologic status were analyzed.

**Results:** The mean estimated blood loss in the laparoscopic group was 104 ml (range, 30 to 250 ml), and 110 ml (range, 30 to 200 ml) in the robotic group. There was no statistical difference in estimated blood loss between these two groups. Operating time was 374.3 minutes (range, 210 to 570 minutes) in the laparoscopic group, and 561.7 minutes (range, 460 to 720 minutes) in the robotic group. There was a statistical difference in operating time between these two stages (P < 0.001). On pathologic examination, the mean number of lymph nodes harvested in the laparoscopic group was 13.9 (range, 5 to 31) and 11.2 (range, 2 to 18) for robotic group. There was no statistical difference between the groups. (P = 0.793).

**Conclusion:** Our data shows robotic-assist ISR for low rectal cancer is feasible and safe with no compromising oncological outcome. However, robotic surgery had a longer operating time.

## POSTERS

### Poster 1. LAPAROSCOPIC COLORECTAL RESECTION COUPLED WITH LAPAROSCOPIC PLACEMENT OF HEPATIC ARTERY CATHETER FOR COLORECTAL CANCER WITH LIVER METASTASES: A PROSPECTIVE ANALYSIS OF 31 PATIENTS

Franklin ME, Liang S  
Texas Endosurgery Institute  
San Antonio, Texas, USA

### Poster 2. THE IMPACT OF SPECIALIST COLORECTAL SURGEONS ON EMERGENCY RIGHT HEMICOLECTOMY: A RETROSPECTIVE COMPARATIVE ANALYSIS

Odermatt M, Dabare D, Khan O, Glashyer M, Miskovic D, Khan J, Parvaiz A  
Minimally Invasive Colorectal Unit, Queen Alexandra Hospital  
Portsmouth, UK

### Poster 3. DO INTRAOPERATIVE FACTORS INFLUENCE THE LENGTH OF STAY OF PATIENTS UNDERGOING LAPAROSCOPIC COLORECTAL RESECTIONS WITHIN A WELL ESTABLISHED ERAS PROGRAMME?

Marwan K, Liyanage A, Smart NJ, Parker M, Motson RW, Arulampalam T  
ICENI  
Colchester, UK

### Poster 4. LAPAROSCOPIC MONITORED COLONOSCOPIC POLYPECTOMY VS LAPAROSCOPIC RIGHT HEMICOLECTOMY: A COMPARATIVE ANALYSIS ON 187 PATIENTS WITH POLYS IN THE RIGHT COLON

Liang S, Franklin ME  
Texas Endosurgery Institute  
San Antonio, Texas, USA

### Poster 5. NATURAL ORIFICE SPECIMEN EXTRACTION IN LAPAROSCOPIC COLORECTAL PROCEDURE: TRANSANAL AND TRANSVAGINAL APPROACHES

Franklin ME, Liang S, Russek K  
Texas Endosurgery Institute  
San Antonio, Texas, USA

### Poster 6. DAMAGE CONTROL STRATEGY FOR THE MANAGEMENT OF PERFORATED DIVERTICULITIS WITH GENERALIZED PERITONITIS: LAPAROSCOPIC LAVAGE AND DRAINAGE VS. LAPAROSCOPIC HARTMANN'S PROCEDURE.

Liang S, Russek K, Franklin ME  
Texas Endosurgery Institute  
San Antonio, Texas, USA

### Poster 7. ROBOTIC EN-BIOPC INTERSPHINCTERIC RESECTION WITH PROSTATECTOMY FOLLOWING CHEMORADIATION; A CASE REPORT OF RECTAL CANCER INVADING TO THE PROSTATE

Shin JW, Kim SH, Choi JY, Cheon J, Kang SG, Hara M  
Korea University Anam Hospital, Korea University College of Medicine  
Seoul, South Korea

### Poster 8. OUTCOME COMPARISON OF LAPAROSCOPIC WITH OPEN ILEO-CECAL RESECTION FOR CROHN'S DISEASE PATIENTS; AN UPDATED HIERARCHICAL BAYESIAN META-ANALYSIS

Okabayashi K, Hasegawa H, Ashrafian H, Rao C, Darzi A, Kitagawa Y and Athanasiou T  
Keio University  
Tokyo, Japan

### Poster 9. SHORT-TERM OUTCOMES OF MINIMALLY INVASIVE SURGERY FOR COLORECTAL CANCER IN A DEVELOPING COUNTRY

Lesmana D, Basir I  
Division of Digestive Surgery, Medical Faculty of Universitas Indonesia  
Jakarta, Indonesia

### Poster 10. A REVIEW OF EXISTING POST-OPERATIVE PAIN MANAGEMENT FOLLOWING LAPAROSCOPIC COLORECTAL SURGERY

Oomman A, Gurung S, Gunasekaran, Anter A, Withyush JM  
General Hospital  
Haverfordwest, UK

### Poster 11. LAPAROSCOPIC ULTRALOW ANTERIOR RESECTION WITH TOTAL MESORECTAL EXCISION AND TRANSANAL SPECIMEN EXTRACTION FOR RECTAL CANCER: A CONSECUTIVE SERIES OF 51 PATIENTS

Franklin ME, Liang S  
Texas Endosurgery Institute  
San Antonio, Texas, USA

### Poster 12. LAPAROSCOPIC DIRECT SUTURE OF COLORECTAL PERFORATION CAUSED BY DIAGNOSTIC COLONOSCOPY

Yao L, Lu W, Zhang Y, Qin X, Xu M, Zhong Y, Chen W, Li Q, Ma L, Qin W, Hu J, Cai M, Wu H, Zhou P  
Shanghai Zhongshan Hospital  
Shanghai, China



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## POSTERS CONTINUED

**Poster 13.** EARLY OUTCOME OF ROBOTIC RECTAL RESECTION

Foo CC, Poon J, Fan J, Law WL  
The University of Hong Kong,  
Hong Kong, China

**Poster 14.** LONGER TERM FOLLOW-UP OF LAPAROSCOPIC ADHESIOLYSIS FOR CHRONIC ABDOMINAL PAIN

Butterworth JW, Sivaprakasam R  
Hinchingbrooke Hospital  
Cambridge, UK

**Poster 15.** IMPLEMENTATION OF A SURGICAL SAFETY CHECKLIST: IMPACT ON OPERATIVE EFFICIENCY AND QUALITY METRICS IN LAPAROSCOPIC COLECTOMY

Papaconstantinou HT, Thomas JS, Smythe WR, Wehbe-Janek H  
Scott & White Memorial Hospital  
Temple, Texas, USA

**Poster 16.** IMPROVING OUTCOMES IN LAPAROSCOPIC APPENDICECTOMY

Dinneen EP, Tillmann T, Preston J, Navaratnam R, Nair MS  
North Middlesex University Hospital  
London, UK

**Poster 17.** IMPACT OF METABOLIC SYNDROME ON SHORT-TERM SURGICAL OUTCOMES OF LAPAROSCOPIC COLORECTAL RESECTION FOR COLORECTAL CANCER OR POLYPS

Joh YG, Yu H, Son GM  
Pusan National University, Yangsan Hospital  
Yansan-si, Gyeongnam, South Korea

**Poster 18.** A MULTIDISCIPLINARY SURGICAL TEAM IMPROVES OUTCOME IN LAPAROSCOPIC COLORECTAL RESECTION FOR ENDOMETRIOSIS.

Loriau J, Petit E, Oberlin O, Champault A, Sauvanet E  
Groupe Hospitalier Paris St Joseph  
Paris, France

**Poster 19.** LYMPH NODE YIELD FOLLOWING TOTAL MESORECTAL EXCISION (TME) IN RECTAL CANCER SURGERY: COMPARATIVE ANALYSIS BETWEEN LAPAROSCOPIC AND OPEN APPROACH

Leung E, Taylor W  
University Hospitals Coventry  
Warwick, UK

**Poster 20.** DOES A DEDICATED OR1 EMERGENCY THEATRE AFFECT THE PROPORTION OF OPERATIONS PERFORMED LAPAROSCOPICALLY?

Eddama M, Haylock-Vize P, Smart NJ, Arulampalam T, Motson RW  
Colchester Hospital University NHS Foundation Trust  
Colchester, UK

**Poster 21.** ULTRA LOW CANCER OF THE RECTUM 20 CASES

Rua S, Pinto A  
Sousa Carlos Hospital Litoral Alentejano  
Santiago Do Cacem, Portugal

**Poster 22.** STUDY ON CLINICAL VALUE OF THREE LOCATING METHODS IN LAPAROSCOPIC COLORECTAL TUMOR SURGERY

Shi DB, Li XX, Cai SJ, Xu Y, Peng JJ, Gu WL, Guang ZQ, Cai GX, Wang MH, Lian P, Liu FQ, Li DW  
Fudan University Shanghai Cancer Center  
Shanghai, China

**Poster 23.** INTERSPHINCTERIC RESECTION: MALE/ FEMALE; ARE THERE SOME DIFFERENCES?

Rua S, Pinto A,  
Sousa Chospital Litoral Alentejano  
Santiago Do Cacem, Portugal

## VIDEOS

LAPAROSCOPIC ONCOLOGIC LEFT HEMICOLECTOMY  
Sakamoto Y, Shin JW, You BE, Kim SH  
Department of Surgery, Korea University Anam Hospital  
Seoul, South Korea

D3 RESECTION OF AN ADVANCED HEPATIC FLEXURE CANCER--A PRESENTATION OF ITS TECHNICAL ASPECTS IN LAPAROSCOPIC EXTENDED RIGHT HEMICOLECTOMY

Sng K, Yoo BE, Lim TW, Hara M, Kim SH  
Korea University Anam Hospital, Korea University  
College of Medicine  
Seoul, South Korea

LAPOROSCOPIC EXTRAPERITONEAL SIGMOID COLOSTOMY IN APR FOR LOW RECTAL CANCER

Jin H, He Y  
National Center of Colorectal Surgery, The 3rd Affiliated  
Hospital of Nanjing University of Traditional Chinese Medicine  
Nanjing, China

SHORT TERM OUTCOME IN ANTERIOR RESECTION USING DA VINCI S SURGICAL SYSTEM FOR COLORECTAL CANCER

Hanai T, Maeda K, Sato H, Koide K, Matsuoka H, Katsuno H, Matsuoka S, Mizuno M  
Fujita-Health University  
Toyoake City, Japan

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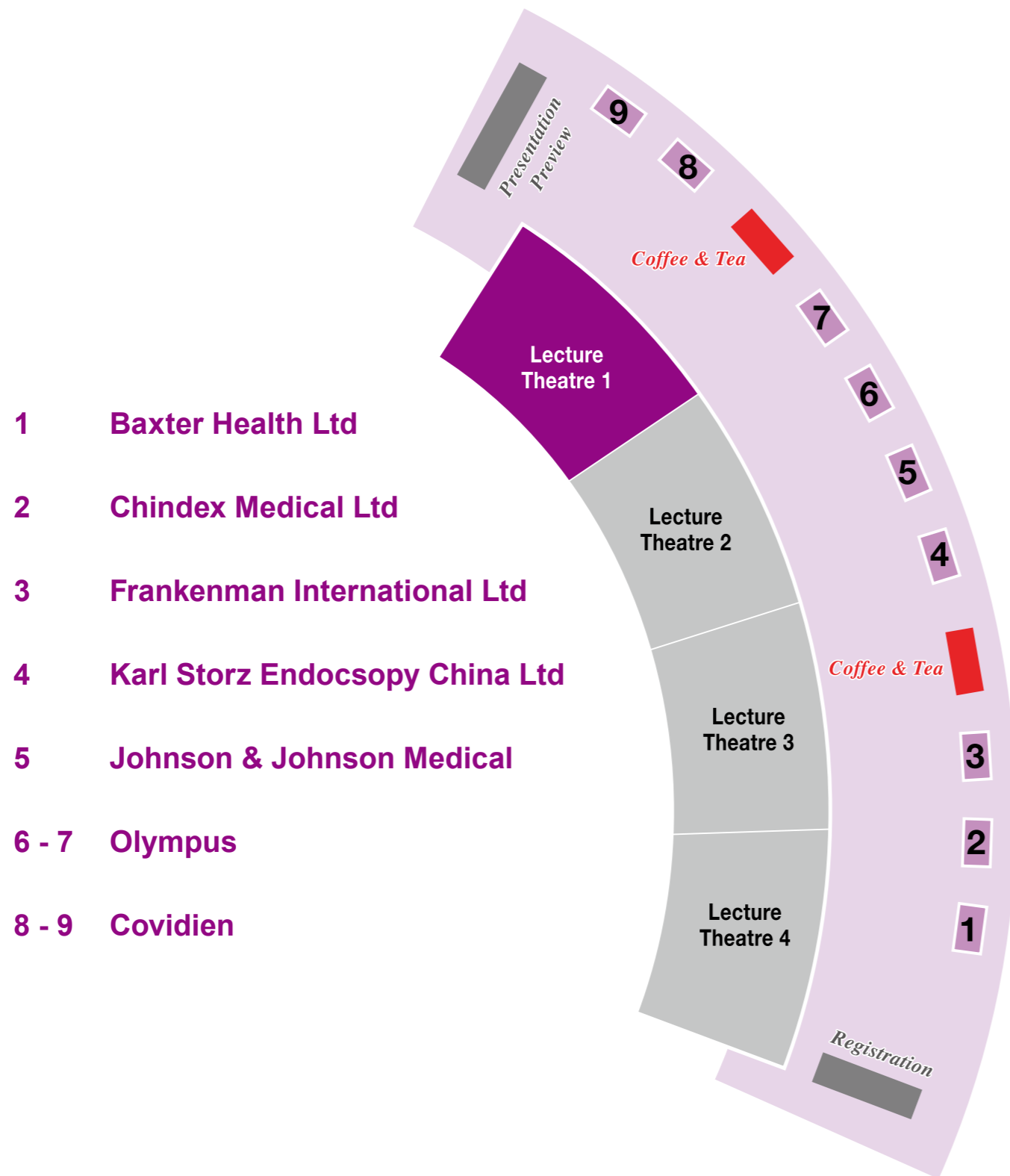
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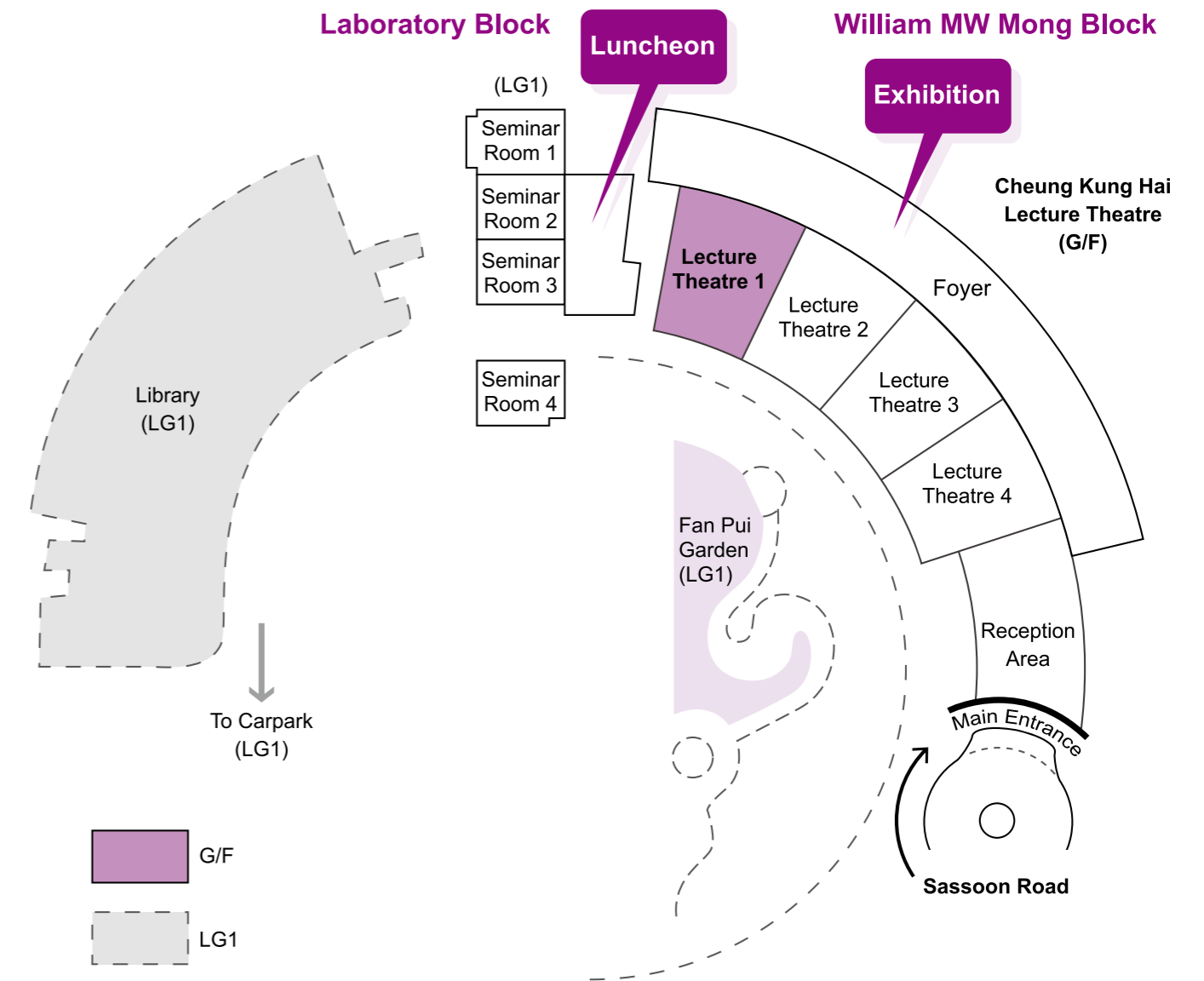
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- 8 - 9 Covidien

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## LI KA SHING FACULTY OF MEDICINE, THE UNIVERSITY OF HONG KONG

Established in 1911, The University of Hong Kong (HKU) is the territory's oldest institute of higher learning. Over the past century, the University has committed itself to creating knowledge, providing education, and serving society. It has grown with Hong Kong and generations of our graduates have helped shape the city from which the university takes its name. Today, HKU is internationally recognized as a research-led comprehensive university, with frontier research endeavours and scholarly achievements that have won it worldwide acclaim.

The Medical Faculty of The University of Hong Kong (HKU) is the longest established faculty in the tertiary education in Hong Kong. It was founded as the Hong Kong College of Medicine for Chinese by the London Missionary Society in 1887, and later renamed the Hong Kong College of Medicine in 1907.

The Faculty was accorded the position of premier Faculty when the University was opened in 1911. Serving Hong Kong for over a century, the Faculty is a medical school of learning, of innovation, and of enterprising; a medical school of morals, of vision, and of care. The Faculty and its predecessor have been playing a pioneering role in medical education, training and research. From its modest beginning, the Faculty has now become the largest faculty of the University, with around 300 full-time teaching staff and 600 research support staff. The undergraduate student population is about 2,000 and the postgraduate student population is about 1,300. The Faculty comprises 18 departments, School of Chinese Medicine, School of Nursing, School of Public Health and a number of research centres focusing on various strengths of research of the Faculty.



## LOCATION MAP

### Li Ka Shing Faculty of Medicine

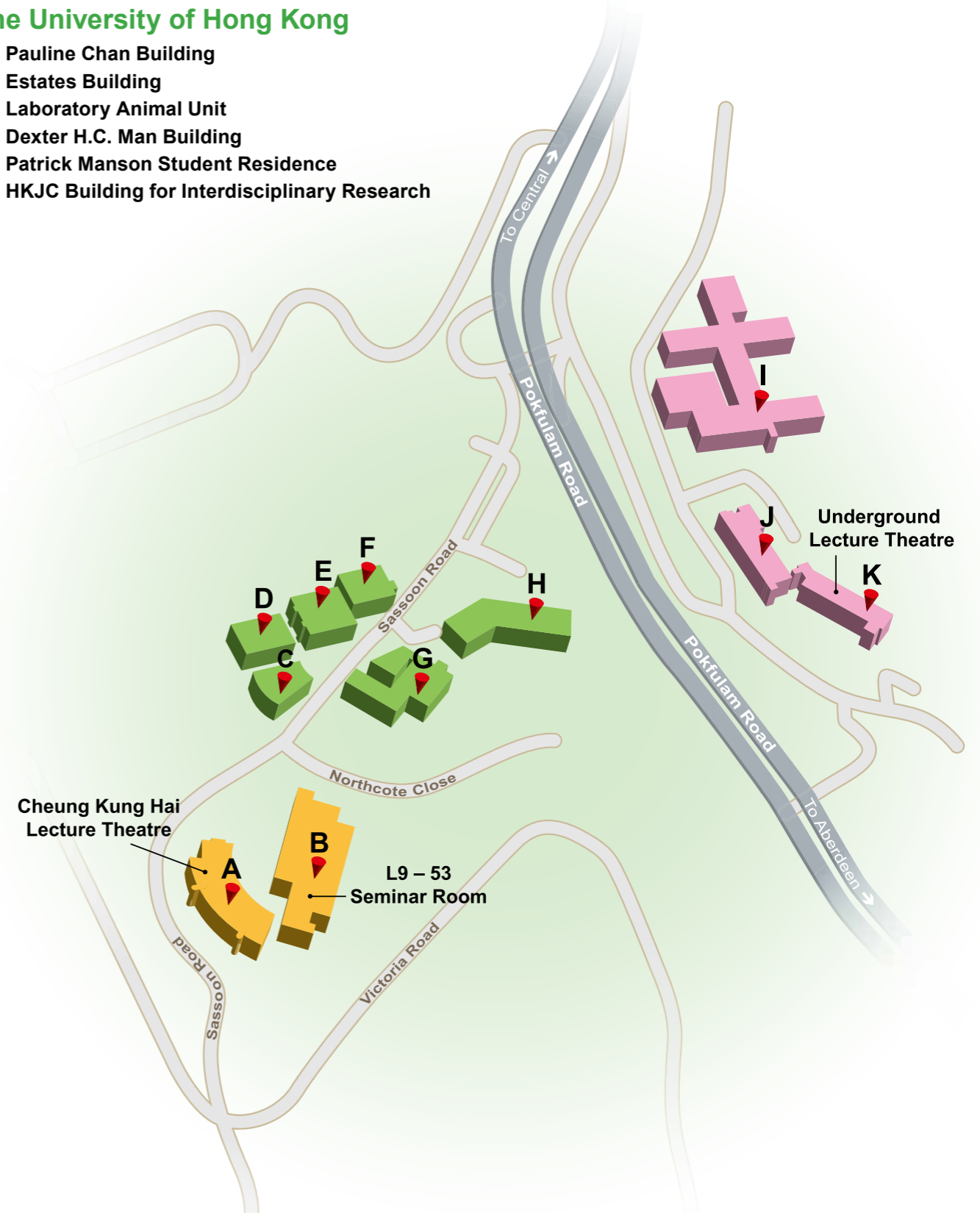
- A William MW Mong Block
- B Laboratory Block

### Queen Mary Hospital

- I Main Block
- J Professorial Block
- K New Clinical Building

### The University of Hong Kong

- C Pauline Chan Building
- D Estates Building
- E Laboratory Animal Unit
- F Dexter H.C. Man Building
- G Patrick Manson Student Residence
- H HKJC Building for Interdisciplinary Research





## NOTES

## NOTES



# 7<sup>TH</sup> INTERNATIONAL CONGRESS OF LAPAROSCOPIC COLORECTAL SURGERY

2 - 4 November 2012 • The University of Hong Kong, Hong Kong

## NOTES

SAVE THE DATE



# 8<sup>th</sup> International Congress of LAPAROSCOPIC COLORECTAL SURGERY

April 17 - 20, 2013 | Baltimore, MD



*Held in conjunction with*  
SAGES 2013 Scientific Session and Postgraduate Courses



## International Society of Laparoscopic Colorectal Surgery

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