

• 2015 Preliminary Program •

The American Society of Colon and Rectal Surgeons



BOSTON



Annual Scientific Meeting

May 30 - June 3, 2015

Hynes Convention Center & Sheraton Boston Hotel

fascrs.org

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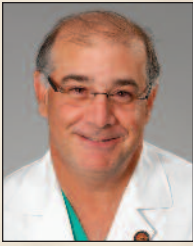
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Education Information



David Margolin, MD
Program Chair



H. David Vargas, MD
Program Vice-Chair

Annual Scientific Meeting Mission, Goal, Purpose and Learning Objectives

The goal of the American Society of Colon and Rectal Surgeons' Annual Scientific Meeting is to improve the quality of patient care by maintaining, developing and enhancing the knowledge, skills, professional performance and multidisciplinary relationships necessary for the prevention, diagnosis and treatment of patients with diseases and disorders affecting the colon, rectum and anus. The Annual Program Committee is dedicated to meeting these goals.

This scientific program is designed to provide surgeons with in-depth and up-to-date knowledge relative to surgery for diseases of the colon, rectum and anus with emphasis on patient care, teaching and research. Presentation formats include podium presentations followed by audience questions and critiques, panel discussions, e-poster presentations, video presentations and symposia focusing on specific state-of-the-art diagnostic and treatment modalities.

The purpose of all sessions is to improve the quality of care of patients with diseases of the colon and rectum.

At the conclusion of this meeting, participants should be able to:

- Recognize new information in colon and rectal benign and malignant treatments, including the latest in basic and clinical research.
- Describe current concepts in the diagnosis and treatment of diseases of the colon, rectum and anus.
- Apply knowledge gained in all areas of colon and rectal surgery.
- Recognize the need for multidisciplinary treatment in patients with diseases of the colon, rectum and anus.

This activity is supported by educational grants from commercial interests. Complete information will be provided to participants prior to the activity.

Target Audience

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

Accreditation



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

Continuing Medical Education Credit

The American Society of Colon and Rectal Surgeons (ASCRS) designates this live activity for a maximum of 50.25 *AMA PRA Category 1 Credits™*. **Physicians should claim only the credit commensurate with the extent of their participation in the activity.** Attendees can earn 1 CME Credit hour for every 60 minutes of educational time.

Successful Completion: Participants must be registered for the conference and attend the session(s). Each participant will receive a username and password for completion of the evaluations for the ASCRS 2015 Annual Scientific Meeting; participants must complete an online evaluation form for each session they attend to receive credit hours. There are no prerequisites unless otherwise indicated.

Self Assessment Credit

Many of the sessions offered will be designated as self assessment CME credit, applicable to Part 2 of the ABS MOC program. In order to claim self assessment credit, attendees must take a post-test. Information/instructions will be given to all meeting registrants.

Annual Scientific Meeting Information

ASCRS Mission

The American Society of Colon and Rectal Surgeons is an association of surgeons and other professionals dedicated to assuring high quality patient care by advancing the science through research and education for prevention and management of disorders of the colon, rectum and anus.

Disclaimer

The primary purpose of the ASCRS Annual Meeting is educational. Information, as well as technologies, products and/or services discussed, are intended to inform participants about the knowledge, techniques and experiences of specialists who are willing to share such information with colleagues. A diversity of professional opinions exist in the specialty and the views of the American Society of Colon and Rectal Surgeons disclaims any and all liability for damages to any individual attending this conference and for all claims which may result from the use of information, technologies, products and/or services discussed at the conference.

Disclosures and Conflict of Interest

In compliance with the standards of the Accreditation Council for Continuing Medical Education and the ASCRS, faculty has been requested to complete a *Disclosure of Financial Relationships*. Disclosures will be made at the time of presentation, as well as included in the Program Book and mobile app. All perceived conflicts of interest will be resolved prior to presentation; and, if not resolved, the presentation will be denied.

Social Events

The **Welcome Reception** will be held Sunday, May 31st from 7:00 – 8:30 pm (complimentary to all registered attendees) and will feature hors d'oeuvres, cocktails and entertainment. The Welcome Reception will be held at the Sheraton Boston Hotel. The Research Foundation will join forces with ASCRS to welcome all at this reception.

This year the Welcome Reception will be known as “Jersey Night.” Make sure to wear your team’s favorite jersey (collegiate or professional) to show your colleagues which team you root for!

The **Annual Dinner Dance** is scheduled for Wednesday, June 3rd with the reception beginning at 7:00 pm and the dinner at 8:00 pm. There is no additional cost for a ticket for full-paying Members and Fellows. Members/Fellows must indicate whether they want to attend the dinner dance

either online or on the registration form, and then obtain their seating ticket onsite prior to the dinner dance. The cost for others is \$75 per ticket.

Free WiFi Available

There will be complimentary WiFi in the Hynes Convention Center for all meeting attendees.

Accommodations

The meeting will be held at the Hynes Convention Center & Sheraton Boston Hotel in Boston, Massachusetts.

The Hynes Convention Center and nearby hotels are approximately 15 minutes from Boston Logan International Airport.

Hotels & Room Rates:

Sheraton Boston Hotel

\$258 Single / Double (+14.45% tax)

(Headquarters – connected to the Convention Center via mall)

Hilton Boston Back Bay Hotel

\$250 Single / Double (+14.45% tax)

\$309 “Premium” Single / Double (+14.45% tax)

(Adjacent to the Convention Center & Sheraton)

Boston Marriott Copley Place Hotel

\$290 Single / Double (+14.45% tax)

(Connected to the Convention Center and Sheraton via mall)

Internet:

For best availability, make your reservation online.

Sheraton Boston Hotel

<https://www.starwoodmeeting.com/Book/ASCRS15>

Hilton Boston Back Bay

<http://www.hilton.com/en/hi/groups/personalized/B/BOSBHHH-ASCRS-20150525/index.jhtml>

Boston Marriott Copley Place Hotel

https://resweb.passkey.com/Resweb.do?mode=welcome_ei_new&eventID=13841449

Phone:

If making a reservation by phone, call the following phone numbers and ask for the ASCRS room block.

Sheraton Boston Hotel (888) 627-7054

Hilton Boston Back Bay (617) 236-1100

Boston Marriott Copley Place Hotel (877) 901-2079
or (617) 236-5800

Hotel reservations/rate availability are not guaranteed after the room block is full or after **April 27, 2015**. Please register early – only a limited number of rooms are available.

**The deadline for hotel reservations is
Monday, April 27, 2015.**

Annual Scientific Meeting Information

Special Needs



In compliance with the Americans with Disabilities Act, ASCRS requests that participants in need of special accommodations submit a written request to ASCRS well in advance.

Official ASCRS Travel Agency

To book your reservation, call ASCRS's official travel agency, Uniglobe Preferred Travel, at (800) 626-0359 and after the prompt dial "0" (M-F 8:30 am – 5:30 pm CST). If you prefer you may:

- Book your travel online at www.uniglobepreferred.com. Click the down arrow next to "Business Travel" then click on Rapid-Rez link. When the booking page comes up, click on "Create New User." Enter personal information, click "done"; the next page is for more detailed personal information – here you **must** enter a credit card number and billing address to make a reservation. Scroll down and click "Save." Click on the "Travel Planner" tab to make a reservation and select ASCRS for the "Trip Reason." Please record your User ID and your Password for future use. Booking on this site will have a reduced agency service fee of \$15.

Exhibit Hours

Sunday, May 31, 3:00 – 5:00 pm

PM refreshment break

Monday, June 1, 9:00 am – 4:30 pm

AM and PM refreshment breaks

Complimentary box lunch

Tuesday, June 2, 9:00 am – 2:00 pm

AM refreshment break

Complimentary box lunch

Temperature

The average temperature in May / June ranges from a low of 60° to a high of 76°F.

Child Care Services

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

Dining and Places to see in Boston

Suggested things to do in and around Boston, [click here](#).

Spouse/Guest Program

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

Package #1 (\$100) Includes:

Welcome Reception, 7:00 – 8:30 pm, Sunday, May 31, Sheraton Boston Hotel

Annual Reception, 7:00 – 8:00 pm, Wednesday, June 3, Sheraton Boston Hotel

Annual Dinner Dance, 8:00 – 10:30 pm, Wednesday, June 3, Sheraton Boston Hotel

Admission to scientific sessions and the exhibit area

Package #2 (\$55) Includes:

Welcome Reception, 7:00 – 8:30 pm, Sunday, May 31, Sheraton Boston Hotel

Admission to scientific sessions and the exhibit area

Join ASCRS

Non-members, please consider joining the ASCRS to receive the "member" rate for the Annual Meeting.

Please [click here](#) for benefits of joining ASCRS.

[Click here](#) for application form.

Please Note: Times and speakers are subject to change.

Transanal Endoscopic Surgery Workshop

7:00 am – 4:30 pm

Fee: \$495 • Limit: 48 participants • Lunch Included

Registration Required • No refunds after May 11



Didactic Session: 7:00 – 8:25 am

Transanal excision of tumors of the rectum has been limited by the technical difficulties of operating in a confined space with inadequate instrumentation. Access to lesions higher than 6 cm from the anal verge is not feasible with standard transanal techniques. Transanal endoscopic microsurgery (TEM) was designed to overcome these limitations and has proven to be an invaluable endoscopic tool in treating rectal lesions which might otherwise require proctectomy. Over the last several years, the armamentarium of transanal approach has increased with the development of two new platforms, Transanal Endoscopic Operations (TEO) and Transanal Minimally Invasive Surgery (TAMIS). These platforms offer other options for advanced transanal surgery.

Radical resection of the rectum for benign and malignant neoplasms is associated with rates of perioperative complications and functional disorders that largely exceed the morbidity associated with other types of bowel resections. This has led surgeons to attempt less invasive surgical alternatives including transanal excision and traditional endoscopic approaches. Standard transanal excisional techniques are limited by instrumentation and anatomy to the distal 6-12 cm of the rectum and are associated with substantial recurrence rates for benign and malignant disease. In the early 1980's, transanal endoscopic microsurgery (TEM) was described. In the past decade, its acceptance has increased and several authors have demonstrated decreased recurrence rates for benign and early stage malignant neoplasms when compared to standard transanal excision. Morbidity for TEM has been low and similar to transanal excision. With the recent introduction of new devices (TEO, TAMIS/SILS) to perform transanal endoscopic resections, surgeons now have more flexibility in terms of equipment and operative setup. Surgeons experienced in transanal endoscopic surgery (TES) have learned valuable lessons in patient selection, operative setup, technical pearls and troubleshooting, and postoperative management that can accelerate learning for those interested in adopting this technique.

Existing Gaps

What Is: Despite increased acceptance of TES and reported decreased rates of recurrence compared to standard transanal excision, many colorectal surgeons have not adopted TES into their practices.

What Should Be: Comprehensive review of indications for transanal endoscopic microsurgery and of all devices currently available, and hands-on practice in an inanimate lab training session under the guidance of experts, will allow for more surgeons to adopt TES and offer it to patients as an alternative to radical resection when clinically indicated.

Objectives: At the conclusion of this session, participants should be able to: a) Recognize the surgical indications and preoperative preparation for TES; b) Recall the operative set up, transanal devices and equipment currently used to perform TES; c) Demonstrate how to troubleshoot technical difficulties during TES; d) Explain intraoperative complications and postoperative management of patients undergoing TES; e) Demonstrate the technical skills necessary to perform TES and become familiar with all the available transanal devices; f) Chart how to bill appropriately for the various TES techniques; g) Describe the requirements necessary to start a TES program at their institution.

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Transanal Endoscopic Surgery Workshop (Continued)

Co-Director: Peter Cataldo, MD, Burlington, VT

Co-Director: Joshua Bleier, MD, Philadelphia, PA

7:00 am	Introduction to TES: Past and Present Peter Cataldo, MD, Burlington, VT	7:50 am	Excision and Suturing Techniques (all platforms) Peter Cataldo, MD, Burlington, VT
7:05 am	Indications for TES, Patient Selection Dana Sands, MD, Weston, FL	8:05 am	Complications Scott Steele, MD, Fort Lewis, WA
7:20 am	Oncology Results Joshua Bleier, MD, Philadelphia, PA	8:25 am	Break into Groups
7:35 am	Setup and Positioning (all platforms) Theodore Saclarides, MD, Maywood, IL		

Group A – Hands-on Lab

8:30 am – noon

Peter Cataldo, MD, Lab Director

TEO

Skandan Shanmugan, MD, Philadelphia, PA;
Patricia Sylla, MD, Boston, MA; Brian Valerian,
MD, Albany, NY

TEM

Traci Hedrick, MD, Charlottesville, VA; Dana Sands,
MD, Weston, FL; Elizabeth Raskin, St. Paul, MN

SILS

Eric Haas, MD, Houston, TX; Jaime Sanchez,
Tampa, FL; Scott Steele, MD, Fort Lewis, WA

TAMIS

Matthew Isho, MD, San Diego, CA; Sergio
Larach, MD, Orlando, FL; Elisabeth McLemore,
Los Angeles, CA; Theodoros Voloyiannis, MD,
Houston, TX

Noon **Lunch (provided)**

Group A – TES Panel Discussion with Videos

1:00 – 4:30 pm

Joshua Bleier, MD, Workshop Director

Panel: Charles Finne, MD, Minneapolis, MN; Jorge Marcet,
MD, Tampa, FL; Bruce Orkin, MD, Chicago, IL;
Theodore Saclarides, MD, Maywood, IL; Mark
Whiteford, MD, Portland, OR

Participants are welcome to bring questions and difficult
cases to the panel.

4:30 pm **Adjourn**

Group B – TES Panel Discussion with Videos

8:30 am – noon

Joshua Bleier, MD, Workshop Director

Panel: Liliana Bordeianou, MD, Boston, MA; Rodrigo Perez,
MD, Sao Paulo, Brazil; Theodore Saclarides, MD,
Maywood, IL; Mark Whiteford, MD, Portland, OR

Participants are welcome to bring questions and difficult
cases to the panel.

Noon **Lunch (provided)**

Group B – Hands-on Lab

1:00 – 4:30 pm

Peter Cataldo, MD, Lab Director

TEO

Elisabeth McLemore, MD, Los Angeles, CA;
Patricia Sylla, MD, Boston, MA; Brian Valerian,
MD, Albany, NY

TEM

Traci Hedrick, MD, Charlottesville, VA;
Dana Sands, MD, Weston, FL; Elizabeth Raskin,
St. Paul, MN

SILS

Eric Haas, MD, Houston, TX; Jaime Sanchez,
Tampa, FL; Scott Steele, MD, Fort Lewis, WA

TAMIS

Matthew Isho, MD, San Diego, CA; Sergio
Larach, MD, Orlando, FL; Theodoros Voloyiannis,
MD, Houston, TX

4:30 pm **Adjourn**

AIN and HRA: What the Colorectal Surgeon Needs to Know Workshop

7:00 am – 12:30 pm

Fee: \$495 • Limit: 39 participants

Registration Required • No refunds after May 11



The incidence of anal cancer is increasing due to rising rates of human papilloma virus (HPV) infection. HPV infection can lead to anal intraepithelial neoplasia (AIN) that can be identified with high-resolution anoscopy (HRA). While colon and rectal surgeons are very familiar with the evaluation and treatment of anal cancer, many do not know how to identify the anal cancer precursor, AIN, with HRA.

Through a didactic and hands-on educational initiative, we will review HPV infections and the indications and use of HRA for AIN. The participants will be divided into three groups and will have rotations between didactic, hands-on and video sessions.

Existing Gaps

What Is: While colon and rectal surgeons understand the evaluation and treatment of anal cancer, many are not skilled at the evaluation and treatment of AIN and use of HRA.

What Should Be: Colon and rectal surgeons should have a thorough understanding of AIN. In addition, colon and rectal surgeons should have an understanding of how to use HRA to evaluate and treat AIN. Finally, surgeons should know all the treatment options available for patients with AIN.

Director: Stephen Goldstone, MD, New York, NY

Assistant Director: Naomi Jay, NP, PhD, San Francisco, CA

7:00 am	Welcome Stephen Goldstone, MD, New York, NY	9:30 am	Hands-on Workshop: HRA Including Use of the Colposcope and Biopsy Techniques J. Michael Berry-Lawhorn, MD, San Francisco, CA Stephen Goldstone, MD, New York, NY
7:05 am	Intro to HPV: Scope of the Problem Joel Palefsky, MD, San Francisco, CA	10:00 am	HRA the Movie Joel Palefsky, MD, San Francisco, CA
7:20 am	How to Diagnose AIN: Screening and Diagnostics J. Michael Berry-Lawhorn, MD, San Francisco, CA Naomi Jay, NP, PhD, San Francisco, CA	10:30 am	Refreshment Break in Foyer
7:40 am	HRA Findings of AIN Naomi Jay, NP, PhD, San Francisco, CA	10:45 am	IRC and Hyfrecator Movie Stephen Goldstone, MD, New York, NY
8:00 am	HRA Guided Treatment Options Stephen Goldstone, MD, New York, NY Joel Palefsky, MD, San Francisco, CA	11:15 am	Hands-on Workshop: HRA Treatment Naomi Jay, NP, PhD, San Francisco, CA Joel Palefsky, MD, San Francisco, CA
8:40 am	Panel Discussion/Questions J. Michael Berry-Lawhorn, MD, San Francisco, CA Stephen Goldstone, MD, New York, NY Naomi Jay, NP, PhD, San Francisco, CA Joel Palefsky, MD, San Francisco, CA	11:45 am	Cases: Identifying Lesions, Determining Sites for Biopsies J. Michael Berry-Lawhorn, MD, San Francisco, CA
9:00 am	Hands-on Workshop: Lesion Identification (understanding lesion patterns to differentiate LG from HG) Naomi Jay, NP, PhD, San Francisco, CA	12:15 pm	Panel Discussion/Questions J. Michael Berry-Lawhorn, MD, San Francisco, CA Stephen Goldstone, MD, New York, NY Naomi Jay, NP, PhD, San Francisco, CA Joel Palefsky, MD, San Francisco, CA
		12:30 pm	Adjourn

Objectives: At the conclusion of this session, participants should be able to: a) Describe the prevalence of anal HPV infection; b) Recognize how to best diagnose AIN; c) Demonstrate how to perform high resolution anoscopy; d) Identify treatment options available for AIN.

Laparoscopic Colectomy Symposium and Workshop

Didactic Session: 7:30 – 11:45 am • Didactic is open to all registrants (Complimentary)



Didactic Session: 7:30 – 11:45 am

The utilization of laparoscopic techniques to perform colon and rectal resections has been expanding for years, and will continue to do so in the face of new technological developments and advancement in instrumentation. Thought and opinion leaders continue to develop new techniques that simplify laparoscopic colorectal procedures and foster adoption of minimally invasive approaches. In the effort to ensure the best outcomes for our patients, it is essential that practicing colorectal surgeons have a solid grasp on key concepts for the performance of laparoscopic colorectal surgery.

This symposium will address issues often encountered when performing minimally invasive colon and rectal surgery:

- **Review of Laparoscopic and Anatomic Principles**
- **Port Placement Philosophy**
- **Procedural Reviews**
 - Right colectomy
 - Left colectomy
 - Proctectomy
 - Rectopexy
 - Hartmann reversal
 - Peristomal hernia repair
- **Technical Descriptions**
 - Medial to lateral approach
 - Lateral to medial approach
 - Stapling
 - Safe Energy utilization
 - Hand assist colectomy
- **New Technologies**
 - Single site
 - Florescence imaging
- **New Techniques**

This symposium will address laparoscopic colectomy techniques, with an emphasis on creative and excellence in teaching followed by a workshop that will allow for hands-on experience.

Co-Director: Amir Bastawrous, MD, Seattle, WA

Co-Director: Eric K. Johnson, MD, Fort Lewis, WA

7:30 am	Right Colectomy, the Laparoscopic Gateway Drug Marc Singer, MD, Chicago, IL	9:30 am	HALS-Role and Advantages Darren Pollock, MD, Seattle, WA
7:45 am	Video Presentation Inferior to Superior Right Colectomy Imran Hassan, MD, Iowa City, IA	9:45 am	Panel Discussion
8:00 am	Video Presentation Medial to Lateral Right Colectomy Nell Maloney Patel, MD, New Brunswick, NJ	10:05 am	Refreshment Break in Foyer
8:15 am	Anastomotic Options Alan Harzman, MD, Columbus, OH	10:15 am	Laparoscopic Proctectomy and TME, the Differentiator Joseph Carmichael, MD, Orange, CA
8:30 am	Panel Discussion	10:30 am	Video Presentation TME Slawomir Marecik, MD, Park Ridge, IL
8:45 am	Laparoscopic Left Colectomy, the Next Challenge Konstantin Umanskiy, MD, Chicago, IL	10:45 am	Video Presentation Tips for the Difficult Pelvis Daniel Herzig, MD, Portland, OR
9:00 am	Video Presentation Medial to Lateral Left Colectomy Tal Raphaeli, MD, Humble, TX	11:00 am	Panel Discussion
9:15 am	Video Presentation Splenic Flexure Approaches John Griffin, MD, Salt Lake City, UT	11:15 am	Complications and Challenges Eric K. Johnson, MD, Fort Lewis, WA
		11:45 am	Adjourn
		11:45 am	Lunch Provided for Hands-on Lab Participants
		12:30 pm	Bus Departs for Tufts Medical Center

Continued next page

Laparoscopic Colectomy Symposium and Workshop (Continued)

Hands-on Lab Session: 1:00 – 4:30 pm • Limit 20 • Fee: \$595
Lunch Included for Hands-on Lab Registrants • **Registration Required** • No refunds after May 11
Location for Hands-on Lab: Tufts Medical Center
Transportation will be provided



Existing Gaps

What Is: Despite the evidence supporting improved outcomes with the use of minimally invasive techniques, adoption has been slow. At least 50% of colectomies continue to be performed utilizing traditional open techniques. Even among fellowship of trained colon and rectal surgeons, most do not use laparoscopy routinely in their practice. While some cases require an open approach, many more do not. These techniques cannot be learned from a textbook.

What Should Be: New and experienced colorectal surgeons should have access to quality educational material as well as the opportunity to take a hands-on approach to learning the most up-to-date minimally invasive techniques for colorectal resection. Because of the nature of many of the problems encountered, experts in several fields should be able to personally pass on knowledge built from experience with these issues. A better understanding of basic and complex principles will assist the surgeon in providing quality care, optimizing outcomes and ensuring future personal, practice, and institutional revenue in a competitive market.

1:00 – 4:30 pm (Off Site)

Hands-on Session

(Registration Required)

Demonstrate the knowledge you acquired during the morning symposium to strengthen your skills. We will begin with laparoscopic right colectomy, then left colectomy, then low anterior resection, hand assist, and SILS.

Faculty for hands-on session includes:

Amir Bastawrous, MD, Seattle, WA; Joseph Carmichael, MD, Orange, CA; John Griffin, MD, Salt Lake City, UT; Alan Harzman, MD, Columbus, OH; Imran Hassan, MD, Cedar Rapids, IA; Daniel Herzig, MD, Portland, OR; Eric K. Johnson, MD, Fort Lewis, WA; Nell Maloney Patel, MD, New Brunswick, NJ; Slawomir Marecik, MD, Park Ridge, IL; Darren Pollock, MD, Seattle, WA; Tal Raphaeli, MD, Humble, TX; Marc Singer, MD, Chicago, IL; Konstantin Umanskiy, MD, Chicago, IL

Objectives: At the conclusion of this session, participants should be able to: a) Discuss the potential advanced approaches to complex situations encountered during laparoscopic colorectal resection; b) Describe the appropriate utilization of available stapling and energy technology; c) Reproduce the basic approaches to right and left colectomy; d) Explain tips and tricks of laparoscopic rectal mobilization and e) Describe potential advantages to the robotic approach to pelvic dissection.

Optimal Management of Fecal Incontinence Symposium and Workshop

Didactic Session: 7:30 am – noon
Didactic is open to all registrants (*Complimentary*)



Didactic Session: 7:30 am – noon

The prevalence of fecal incontinence is difficult to estimate as it is frequently underreported due to embarrassment and reluctance of patients to discuss symptoms with their physicians. Patients with fecal incontinence can benefit from specialized assessment with ultrasound, manometry, motility testing and defecography.

The surgical treatment of fecal incontinence in the United States has been limited. Sphincter repair has good short-term results, but continence tends to deteriorate over time. The placement of an artificial bowel sphincter has a high morbidity and revision rate. Diverting colostomy is generally a last resort. Both sacral nerve stimulation (SNS) and the injection of bulking agents have been used for many years in the urologic field. These treatment modalities have recently become recognized in the field of colorectal surgery for the treatment of fecal incontinence. In addition to these new procedures, there are additional procedures being investigated such as the pelvic sling and magnetic anal sphincter.

Through a didactic course and hands-on laboratory session, we will address the workup and management of patients with fecal incontinence including the review of both traditional as well as emerging procedures that are used to treat this condition. The lecture portion will be followed by a workshop that will allow for hands-on experience as well as the discussion of cases.

Existing Gaps

What Is: Anorectal and physiology testing play an important role in the assessment of patients with anorectal and pelvic floor disorders. The accuracy of these examinations depends upon the operator's ability to perform the exam and properly interpret the results.

Despite the introduction of new treatment modalities into the field of colorectal surgery, many colorectal surgeons have not adopted either procedure into their practice.

What Should Be: It is important that colorectal surgeons develop hands-on expertise in the use of anorectal ultrasound in order to effectively manage patients with fecal incontinence.

Objectives: At the conclusion of this session, participants should be able to: a) Explain the initial assessment and management of patients with fecal incontinence; b) Demonstrate and interpret endorectal ultrasound; c) Identify with the interpretation of anal manometry; d) Describe and interpret defecography; e) Distinguish the operative setup, identification of landmarks and steps for optimal lead placement in the performance of SNS; f) Recall the postoperative management of patients with an Interstim implant including troubleshooting difficulties; g) Recognize when and how to inject bulking agents into the anal canal; h) Outline the clinical results of procedures for fecal incontinence; i) Distinguish alternatives to these procedures.

Continued next page

Optimal Management of Fecal Incontinence Symposium and Workshop *(Continued)*

Co-Director: Anders Mellgren, MD, PhD, Chicago, IL

Co-Director: Kelly Garrett, MD, New York, NY

7:30 am	Introductions Anders Mellgren, MD, PhD, Chicago, IL Kelly Garrett, MD, New York, NY	10:00 am	Injectable Bulking Agents: Clinical Results Wilhelm Graf, MD, PhD, Uppsala, Sweden
7:40 am	Initial Assessment of Patients with Fecal Incontinence Joshua Bleier, MD, Philadelphia, PA	10:10 am	Sacral Nerve Stimulation: Steps of the Procedure Margarita Murphy, MD, Pleasant, SC
7:50 am	Ultrasound Technique and Image Interpretation Johan Nordenstam, MD, PhD, Chicago, IL	10:20 am	Sacral Nerve Stimulation: Postoperative Complications and Troubleshooting Steven Siegel, MD, St. Paul, MN
8:10 am	Normal Anorectal Ultrasound Anatomy Andreas Kaiser, MD, Los Angeles, CA	10:30 am	Sacral Nerve Stimulation: Clinical Results Klaus Matzel, MD, Erlangen, Germany
8:20 am	Normal Pelvic Floor Ultrasound Anatomy Giulio Santoro, MD, PhD, Treviso, Italy	10:40 am	Refreshment Break in Foyer
8:30 am	Ultrasound in the Assessment of Patients with Fecal Incontinence Liliana Bordeianou, MD, Boston, MA	11:00 am	The Role of Secca in the Management of Fecal Incontinence Mariana Berho, MD, Hollywood, FL
8:40 am	Ultrasound in the Assessment of Pelvic Floor Disorders Sthela Murad-Regadas, MD, PhD, Fortaleza, Brazil	11:20 am	Treat the Prolapse! The Role of Ventral Rectopexy Andre D'Hoore, MD, Leuven, Belgium
8:50 am	Radiologic Evaluation of Pelvic Floor Amy Thorsen, MD, Minneapolis, MN	11:30 am	When to Consider an Artificial Bowel Sphincter Shane McNevin, MD, Spokane, WA
9:00 am	Anorectal Manometry Technique and Interpretation Sarah Vogler, MD, Minneapolis, MN	11:40 am	Emerging Therapies: Topas Sling Procedure and Initial Results Massarat Zutshi, MD, Cleveland, OH
9:30 am	Non-surgical Treatment of Fecal Incontinence Kelly Garrett, MD, New York, NY	11:50 am	Emerging Therapies: Magnetic Anal Sphincter and Initial Results Paul-Antoine Lehur, MD, PhD, Nantes, France
9:40 am	The Role of Overlapping Sphincteroplasty Ian Paquette, MD, Cincinnati, OH	Noon	Adjourn
9:50 am	Injectable Bulking Agents: How I do It Mitchell Bernstein, MD, New York, NY	Noon	Lunch Provided for Hands-on Lab Participants
		12:30 pm	Bus Departs for Tufts Medical Center

Continued next page

Optimal Management of Fecal Incontinence Symposium and Workshop (Continued)

Hands-on Lab Session: 1:00 – 4:30 pm • Limit 80 • Fee: \$495
Lunch Included for Hands-on Lab Registrants • **Registration Required** • No refunds after May 11
Location for Hands-on Lab: Tufts Medical Center
Transportation will be provided



Hands-on Training

1:00 – 2:30 pm

Groups 1-9	Hands-on Sessions					
	1:00 pm	1:15 pm	1:30 pm	1:45 pm	2:00 pm	2:15 pm
Group 1	SNS Cadaver Model Dr. Siegel		Ultrasound Dr. Santoro		SNS Inanimate Model Dr. Bordeianou	Manometry Dr. Graf
Group 2	SNS Inanimate Model Dr. Bordeianou	Manometry Dr. Graf	SNS Cadaver Model Dr. Siegel		Ultrasound Dr. Santoro	
Group 3	Ultrasound Dr. Santoro		SNS Inanimate Model Dr. Bordeianou	Manometry Dr. Graf	SNS Cadaver Model Dr. Siegel	
Group 4	SNS Cadaver Model Dr. Paquette		Ultrasound Dr. Murad-Regadas		SNS Inanimate Model Dr. Vogler	Manometry Dr. Bernstein
Group 5	SNS Inanimate Model Dr. Vogler	Manometry Dr. Bernstein	SNS Cadaver Model Dr. Paquette		Ultrasound Dr. Murad-Regadas	
Group 6	Ultrasound Dr. Murad-Regadas		SNS Inanimate Model Dr. Vogler	Manometry Dr. Bernstein	SNS Cadaver Model Dr. Paquette	
Group 7	SNS Cadaver Model Dr. Murphy		Ultrasound Dr. Thorsen		SNS Inanimate Model Dr. McNevin	Manometry Dr. Zutshi
Group 8	SNS Inanimate Model Dr. McNevin	Manometry Dr. Zutshi	SNS Cadaver Model Dr. Murphy		Ultrasound Dr. Thorsen	
Group 9	Ultrasound Dr. Thorsen		SNS Inanimate Model Dr. McNevin	Manometry Dr. Zutshi	SNS Cadaver Model Dr. Murphy	
Groups 10-18	Case Discussions Drs. Joshua Bleier, Kelly Garrett, Paul-Antoine Lehur, Klaus Matzel, Anders Mellgren, Steven Siegel, Amy Thorsen, Steven Wexner					

2:30 pm

Break

Continued next page

Optimal Management of Fecal Incontinence Symposium and Workshop (Continued)

Hands-on Training

3:00 – 4:30 pm

Groups 10-18	Hands-on Sessions					
	3:00 pm	3:15 pm	3:30 pm	3:45 pm	4:00 pm	4:15 pm
Group 10	SNS Cadaver Model Dr. Siegel		Ultrasound Dr. Santoro		SNS Inanimate Model Dr. Bordeianou	Manometry Dr. Graf
Group 11	SNS Inanimate Model Dr. Bordeianou	Manometry Dr. Graf	SNS Cadaver Model Dr. Siegel		Ultrasound Dr. Santoro	
Group 12	Ultrasound Dr. Santoro		SNS Inanimate Model Dr. Bordeianou	Manometry Dr. Graf	SNS Cadaver Model Dr. Siegel	
Group 13	SNS Cadaver Model Dr. Paquette		Ultrasound Dr. Murad-Regadas		SNS Inanimate Model Dr. Vogler	Manometry Dr. Bernstein
Group 14	SNS Inanimate Model Dr. Vogler	Manometry Dr. Bernstein	SNS Cadaver Model Dr. Paquette		Ultrasound Dr. Murad-Regadas	
Group 15	Ultrasound Dr. Murad-Regadas		SNS Inanimate Model Dr. Vogler	Manometry Dr. Bernstein	SNS Cadaver Model Dr. Paquette	
Group 16	SNS Cadaver Model Dr. Murphy		Ultrasound Dr. Thorsen		SNS Inanimate Model Dr. McNevin	Manometry Dr. Zutshi
Group 17	SNS Inanimate Model Dr. McNevin	Manometry Dr. Zutshi	SNS Cadaver Model Dr. Murphy		Ultrasound Dr. Thorsen	
Group 18	Ultrasound Dr. Thorsen		SNS Inanimate Model Dr. McNevin	Manometry Dr. Zutshi	SNS Cadaver Model Dr. Murphy	
Groups 1-9	Case Discussions Drs. Joshua Bleier, Kelly Garrett, Paul-Antoine Lehur, Klaus Matzel, Anders Mellgren, Steven Siegel, Amy Thorsen, Steven Wexner					

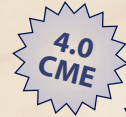
4:30 pm

Adjourn

Robotic Colon and Rectal Surgery: Tips, Tricks, and Simulation Symposium and Workshop

Didactic Session 8:00 am – noon or 12:30 – 4:30 pm
Didactic is open to all meeting registrants (complimentary).

Hands-on Lab Session: 8:00 am – noon or 12:30 – 4:30 pm • Limit 36 • Fee: \$495
Lunch Included for Hands-on Lab Registrants • **Registration Required** • No refunds after May 11



Robotic colon and rectal surgery has slowly gained interest and traction among the membership. New instruments, technology, and techniques are constantly being added to the field. A combination of video and lectures highlighting the new techniques and instruments will provide an opportunity for surgeons to learn about the advances in the field.

Existing Gaps

What Is: Robotic surgery has slowly gained acceptance for use in rectal cancer and in pelvic surgery, but many colon and rectal surgeons have not adopted robotics into their practices.

What Should Be: Studies have demonstrated the effectiveness of the use of simulation combined with videos and lectures to facilitate adoption of a new or advanced technique. The speakers will attempt to bridge the knowledge gap associated with the implementation, use, and outcomes of robotics to educate colon and rectal surgeons on how best to use and adopt robotics into their practice.

Co-Director: Vincent Obias, MD, Washington, DC

Co-Director: Elizabeth Raskin, MD, St. Paul, MN

Lab Assistants: Jamie Cannon, MD, Birmingham, AL; Joseph Martz, MD, New York, NY
and Nell Maloney Patel, MD, New Brunswick, NJ

Group A

8:00 am – noon	Didactic Lectures (complimentary)
12:30 – 4:30 pm	Hands-on with Robotic Simulators

Group B

8:00 am – noon	Hands-on with Robotic Simulators
12:30 – 4:30 pm	Didactic Lectures (complimentary)

Objectives: At the conclusion of this session, participants should be able to: a) Describe the basic techniques of robotic port placement and docking; b) Define the anatomy of the colon, its vasculature and retroperitoneum from a robotic perspective; c) Explain the sequence of steps necessary to perform robotic procedures safely; and d) Identify what new technology there is concerning robotics, and how it can help their patients.

Continued next page

Robotic Colon and Rectal Surgery: Tips, Tricks, and Simulation Symposium and Workshop (Continued)

Group A – Didactic

8:00 am – noon

- 8:00 am **Robotic Surgery – Starting Up: Academic and Private View**
Jeffrey S. Cohen, MD, Marietta, GA
- 8:25 am **Tips in Docking the Robot and How to do Safe Robotic Surgery**
Deborah Nagle, MD, Boston, MA
- 8:50 am **Robotic Low Anterior Resection**
John Marks, MD, Wynnewood, PA
- 9:15 am **Robotic Abdominoperineal Resection**
George Chang, MD, Houston, TX
- 9:40 am **Panel Discussion**
- 10:05 am **Refreshment Break in Foyer**
- 10:15 am **Robotic Surgery for Pelvic Floor Diseases**
I. Emre Gorgun, MD, Cleveland, OH
- 10:30 am **Robotic Multiport Right Hemicolectomy with Intracorporeal Anastomosis**
Robert Cleary, MD, Ann Arbor, MI
- 10:55 am **Novel New Techniques in Robotics – Single Incision, Parastomal Hernia Repair, J pouch, Transanal Surgery**
Jorge Lagares-Garcia, MD, Charleston, SC
- 11:20 am **Robotic New Instruments: Firefly, Stapler, Vessel Sealer, and Xi**
Eduardo Parra-Davila, MD, Celebration, FL
- 11:45 am **Panel Discussion**

Group A – Hands-on with Simulators

Noon – Complimentary Lunch

12:30 – 4:30 pm

Group B – Hands-on with Simulators

8:00 am – noon

Noon – Complimentary Lunch

Group B – Didactic

12:30 – 4:30 pm

- 12:30 pm **Robotic Surgery-Starting Up: Academic and Private View**
Jeffrey S. Cohen, MD, Marietta, GA
- 12:55 pm **Tips in Docking the Robot and How to do Safe Robotic Surgery**
Deborah Nagle, MD, Boston, MA
- 1:20 pm **Robotic Low Anterior Resection**
John Marks, MD, Wynnewood, PA
- 1:50 pm **Robotic Abdominoperineal Resection**
George Chang, MD, Houston, TX
- 2:10 pm **Panel Discussion**
- 2:20 pm **Refreshment Break in Foyer**
- 2:30 pm **Robotic Surgery for Pelvic Floor Diseases**
I. Emre Gorgun, MD, Cleveland, OH
- 2:55 pm **Robotic Multiport Right Hemicolectomy with Intracorporeal Anastomosis**
Robert Cleary, MD, Ann Arbor, MI
- 3:20 pm **Novel New Techniques in Robotics – Single Incision, Parastomal Hernia Repair, J pouch, Transanal Surgery**
Jorge Lagares-Garcia, MD, Charleston, SC
- 3:45 pm **Robotic New Instruments: Firefly, Stapler, Vessel Sealer, and Xi**
Eduardo Parra-Davila, MD, Celebration, FL
- 4:10 pm **Panel Discussion**
- 4:30 pm **Adjourn**

Symposium

Advanced Endoscopy and Endoluminal Surgery

12:30 – 4:00 pm



There has been significant expansion of new techniques and instrumentations for advancement of endoscopic procedures. These techniques broaden our ability to perform more complex procedures in much less invasive ways. As colorectal surgeons, we are uniquely positioned to adopt these techniques and to lead in this field.

A number of new, advanced endoscopic techniques have been developed over the past few years. These techniques have not only broadened the ability of the endoscopist to successfully scope all patients but they also allow identification and treatment of colonic pathologies such as polyps, cancer, and inflammatory bowel disease. New endoscopic techniques have resulted in higher cecal intubation rates and lesion identification. Enhanced imaging technology increases polyp detection. Endoscopic clipping can control bleeding and treat colonic perforation. Colonic stenting is a non-operative means of treating colonic obstruction and can convert a two-stage operation into a one-stage procedure. Extended submucosal dissection and the use of both CO2 and laparoscopic assistance have allowed surgeons to resect more complex colonic lesions without major surgery.

Existing Gaps

What Is: Colorectal surgeons may be unfamiliar with several new techniques to improve the success rate of colonoscopy as well as imaging techniques for lesion identification. A significant number of surgeons are not performing endoscopic submucosal resection of colorectal neoplasia or combined laparo-endoscopic resection. With the continued advances of technology in endoluminal therapy, surgeons will need training to incorporate these methods into their practice.

What Should Be: Surgeons need to have a comprehensive understanding of the newer visualization techniques as well as the indications and uses for endoscopic submucosal resection, colonic stenting, and endoscopic clipping. This important learning session will provide the basis for the meaningful implementation of these newer endoluminal techniques and improve their patients' colorectal care.

Co-Director: Peter Marcello, MD, Burlington, MA

Co-Director: Sang Lee, MD, New York, NY

12:30 pm	Introductions Peter Marcello, MD, Burlington, MA Sang Lee, MD, New York, NY	1:10 pm	Endoscopic Submucosal Dissection: Another Perspective I. Emre Gorgun, MD, Cleveland, OH
12:35 pm	Difficult Colonoscopy: Tricks and New Techniques for Getting to the Cecum Daniel Feingold, MD, New York, NY	1:25 pm	The Future of ESD and Full Thickness Endoluminal Resection with Closure Sergey Kantsevov, MD, Baltimore, MD
12:45 pm	Advanced Endoscopic Imaging: Polyps and Dysplasia Detection David Rivadeneira, MD, Woodbury, NY	1:50 pm	Panel Discussion/Questions
12:55 pm	Beyond Polypectomy: EMR and ESD Richard Whelan, MD, New York, NY	2:10 pm	Combine Endoscopic Laparoscopic Surgery (CELS) Sang Lee, MD, New York, NY

Continued next page

Advanced Endoscopy and Endoluminal Surgery (Continued)

2:25 pm	Technical Tips for Endoluminal Stenting Maher Abbas, MD, Abu Dhabi, United Arab Emirates	3:25 pm	Future Endoscopic Tool Box: New Tools, Changing Paradigms? Jeffrey Milsom, MD, New York, NY
2:40 pm	Colonic Stenting Jeffrey Marks, MD, Cleveland, OH	3:40 pm	Panel Discussion/Questions
2:55 pm	Endoluminal Management of Anastomotic Complications Govind Nandakumar, MD, New York, NY	4:00 pm	Adjourn
3:10 pm	Other Advanced Endoluminal Procedures and Innovations: A Gastroenterologist Perspective Christopher Thompson, MD, Boston, MA		

Objectives: At the conclusion of this session, participants should be able to: a) Demonstrate methods to improve cecal intubation rates and lesion detection; b) State the available enhanced endoscopic visualization techniques; c) Recognize the indications and uses for endoscopic submucosal resection for colorectal neoplasia; d) Recognize the indications and technical aspects of combined laparoscopic and endoscopic resection of colorectal neoplasia; e) Outline the indication and utility of colonic stent placement and f) Recall all available techniques for endoscopic closure of bowel wall.



Hynes Convention Center

Photo Credit: Greater Boston Convention & Visitors Bureau

Question Writing Workshop: How to Write Exam Questions

12:30 – 3:30 pm
Limit 70 • **Registration Required**



There are multiple areas of examination in the realm of colon and rectal surgery that require written questions to assess knowledge. These include the certifying written exam, the recertification exam, CARSITE, and CARSEP among others. Despite looking straightforward, it is extremely difficult to write a good exam question. Many concepts are controversial and what is not controversial can become trivial. There are basic guidelines that help the writer and this is a skill that can be learned and improve with practice. In recent years emphasis has been placed on how to write an acceptable exam question and guidelines have been published by organizations such as the National Board of Medical Examiners.

Existing Gaps

What Is: Most professionals such as colon and rectal surgeons feel that it is easy to write high quality questions. However the majority of questions that are submitted for review each year are rejected or have fundamental flaws that require significant revisions before they can be accepted for use.

What Should Be: There should be many interested members that are able to write high quality questions that can be used with minimal to no revisions.

Director: Tracy Hull, MD, Cleveland, OH

12:30 pm	Introduction Tracy Hull, MD, Cleveland, OH	1:45 pm	Fundamental Problems with Questions Marcus Burnstein, MD, Toronto, ON, Canada
12:45 pm	What Is a Key Concept? Najjia Mahmoud, MD, Philadelphia, PA	2:05 pm	Refreshment Break in Foyer
1:05 pm	Formatting the Stem: Tips Shane McNevin, MD, Spokane, WA	2:15 pm	Let's Write Questions
1:25 pm	Formatting the Answers: Avoiding Common Errors Glenn Ault, MD, Los Angeles, CA	3:00 pm	Questions Review
		3:15 pm	Conclusion
		3:30 pm	Adjourn

Objectives: At the conclusion of this session, participants should be able to: a) Identify fundamental problems with construction of written questions; b) Explain the sequential thinking process used to write an acceptable question and understand key concepts; c) Demonstrate how to write a stem for a question; d) Prepare a two-step question that combines diagnosis and management and format the answers in an acceptable form; and e) Recall what happens to a question after it is submitted by a writer before it is used in a test.

Symposium

Improving Outcomes-Identifying and Managing the Complex Surgical Patients

4:00 – 5:30 pm



In this symposium, by making use of evidence-based recommendations, each lecture will include not only diagnostic and therapeutic guidelines, but will also provide a narrative by the presenter (where appropriate) on his/her operative technical details and perioperative “tips and tricks” that they utilize in the management of these complex surgical challenges. In other cases, they will lend their personal insight into situations where data may be more sparse, but individual and collective experience is paramount to making sound decisions and thereby optimizing patient outcomes.

Furthermore, we will focus on the initial assessment of risk and intervention methods utilized to minimize perioperative complications. The presenters will focus on expanding the audience’s understanding of the details that make these situations challenging, while offering evidence and experience-based solutions for surgeons of all levels to better care for these complex patients. The underlying focus will be on providing pragmatic and understandable solutions that can be readily implemented by surgeons of varying experience to successfully treat complex colorectal problems.

This multidisciplinary symposium will serve as a comprehensive discussion of the topics listed above with emphasis on the pathologic assessment, surgical technique, adjuvant therapy, and genetic testing to improve outcomes.

Existing Gaps

What Is: Surgeons are faced with complex decisions in determining the optimal care for patients with difficult colorectal surgery disease. Multiple options exist regarding the assessment, optimization, surgical treatment, and post-operative management of these patients, while less is understood about what the ideal method is.

What Should Be: This symposium will be useful to colorectal, general and oncologic surgeons who are increasingly called upon to care for patients with complex colorectal diseases. Furthermore, this symposium will be of particular interest to the surgeons-in-training, and the general and colorectal surgeon who is often called upon to manage a variety of complications and dilemmas that may be outside of his or her specialty or niche within colorectal surgery.

Director: Scott Steele, MD, Fort Lewis, WA

Assistant Director: Sean Langenfeld, MD, Omaha, NE

4:00 pm	Introduction Scott Steele, MD, Fort Lewis, WA	4:39 pm	Functional Problems After Colorectal Surgery: When the Surgery Goes “Great” but Problems Arise: Now What? Liliana Bordeianou, MD, Boston, MA
4:03 pm	Perioperative Risk Assessment: Who, What, When and Why? W. Donald Buie, MD, Calgary, AB, Canada	4:51 pm	Enhanced Recovery Pathways: Beyond the Basics Conor Delaney, MD, PhD, Cleveland, OH
4:15 pm	The Body’s Response to Surgical Stress: What Every Clinician Should Know Anjali Kumar, MD, Washington, DC	5:03 pm	Cases/Panel Discussion
4:27 pm	Intra-operative Nightmares: The Intra-operative Consult When Things Go Wrong Bradley Davis, MD, Cincinnati, OH	5:30 pm	Adjourn

Objectives: At the conclusion of this session, participants should be able to: a) Discuss the ideal preoperative risk assessment and how to identify high-risk patients, optimize patients and maximize outcomes; b) Describe the importance of the body’s response to surgical stress and how to minimize the negative aspects of this natural phenomenon; c) Describe the multimodal and surgical approach to technical failures and challenging situations that arise intra-operatively and methods to minimize secondary complications; d) Discuss options for patients with functional problems following colorectal surgery in the presence and absence of complications; and e) Identify the components and importance of enhanced recovery pathways and how the outcomes extend beyond the benefits of individual element to the collective care plan.

Core Subject Update

7:15 – 9:30 am



The Core Subject Update is a continuing medical education activity which was developed to assist in the education and recertification of colon and rectal surgeons. Twenty-four core subjects have been chosen and are presented in a four-year rotating cycle. Presenters are experts on their selected topics and present evidence-based reviews on the current diagnosis, treatment and controversies of these diseases. Following each 20-minute presentation, a brief question period is moderated by the course director. A written summary of each talk is available on the ASCRS website, and questions developed from each presentation are included in the American Board of Colon and Rectal Surgery's recertification question bank.

Director: Justin Maykel, MD, Worcester, MA

7:15 am	Anatomy/Physiology/Complications Todd Francone, MD, Burlington, MA	8:21 am	Crohn's Disease Karim Alavi, MD, Worcester, MA
7:32 am	Discussion	8:38 am	Discussion
7:37 am	STD's Cindy Kin, MD, Stanford, CA	8:43 am	Endoscopy/Polyps Donald Kim, MD, Grand Rapids, MI
7:54 am	Discussion	9:00 am	Discussion
7:59 am	Constipation Amy Thorsen, MD, Minneapolis, MN	9:05 am	Advanced Colon and Rectal Cancer Gregory Kennedy, MD, PhD, Madison, WI
8:16 am	Discussion	9:22 am	Discussion
		9:30 am	Adjourn

Objectives: At the conclusion of this session, participants should be able to a) Recognize the complications commonly associated with colorectal surgical procedures and understand the methods of prevention and treatment; b) Describe the common sexually transmitted diseases of the anorectum and be able to provide comprehensive treatment plans; c) Explain the different types of constipation as well as the evaluation process and medical and surgical treatment options; d) Demonstrate an understanding of Crohn's disease including the presentation, medical management and surgical options for small intestine, colon, rectal, and anal involvement; e) Recognize the indications for endoscopic evaluation of the colon as well as endoscopic options for lesion diagnosis and treatment; and f) Describe the presentation, evaluation, surgical treatment and oncologic management of advanced colon and rectal cancer.

Symposium

Healthcare Economics in the ACA Era

8:00 – 9:45 am



The Affordable Care and Accountability Act of 2012 (ACA) set in motion changes to the American Healthcare system, the likes of which have never been seen before in the United States.

These changes are significantly altering the way medicine is delivered by providers, including hospitals and individual physicians. While the primary thrust of the legislation was to increase access to healthcare for millions of Americans, implementation of the ACA has ushered in a variety of other measures that are dramatically changing how medicine is practiced.

Existing Gaps

What Is: The Affordable Care Act and critical elements that are related to it including value-based purchasing, ICD-10, value-based care and the Accountable Care organization, meaningful use, and the two midnight rule.

What Should Be: Surgeons need to have an understanding about key environmental changes impacting their practice. Understanding the ACA and critical initiatives that are creating significant change in the healthcare environment will help to make them much more successful.

Director: James Merlino, MD, Chicago, IL

Assistant Director: David O'Brien, MD, Portland, OR

8:00 am	Affordable Care Act Overview; What it Means for Individual Physicians Anthony Senagore, MD, Parma, OH	8:40 am	ICD-10; Delayed, but Not Forgotten David Maron, MD, Weston, FL
8:10 am	The ACA Impact on Individual Physicians; How Can We Cope Stephen Sentovich, MD, Duarte, CA	8:50 am	New Models of Care Delivery Jeffrey L. Cohen, MD, Hartford, CT
8:20 am	Moving from Volume to Value; How We will be Paid Differently Frank Opelka, MD, New Orleans, LA	9:00 am	Update on the Two Midnight Rule W. Brian Perry, MD, San Antonio, TX
8:30 am	Meaningful Use and its Impact on the Physician Practice Guy Orangio, MD, New Orleans, LA	9:20 am	Discussion
		9:45 am	Adjourn

Objectives: At the conclusion of this session, participants should be able to: a) Discuss the impact of the Affordable Care Act on providers; b) Describe and understand the importance of value-based-care delivery; c) Recall how critical elements of the affordable care act relate to physician practice; d) Describe and understand updates on value-based purchasing, meaningful use, ICD-10, and the two-midnight rule.

Symposium

Quality Initiatives in Clinical Practice

9:00 – 11:00 am



Quality improvement is integral to clinical practice. Ongoing efforts to improve the quality of surgical care have had a significant and positive impact on patient outcomes. While participation in national initiatives such as SCIP and NSQIP is important, it is crucial that we actively use data to change quality of care within our own institutions and practices.

Existing Gaps

What Is: Although surgeons are aware of national quality initiatives, few have the tools to implement quality initiatives within their own institution.

What Should Be: Surgeons should understand the quality improvement process, be able to implement quality initiatives and access data to evaluate effectiveness.

Co-Director: Arden Morris, MD, Ann Arbor, MI

Co-Director: Larissa Temple, MD, New York, NY

9:00 am	Building the Systems and Culture of Prevention Elizabeth Wick, MD, Baltimore, MD	10:00 am	Improving Outcomes: Decreasing Readmission Deborah Nagle, MD, Boston, MA
9:10 am	Six Sigma, Lean, Rapid Results: What Do They All Mean? Nancy Baxter, MD, PhD, Toronto, ON, Canada	10:08 am	Improving Outcomes: Decreasing Length of Stay Julie Thacker, MD, Durham, NC
9:20 am	Steps to a Successful Quality Improvement Project Robert Cima, MD, Rochester, NY	10:16 am	Improving Processes: Leveraging the Electronic Medical Record Stefan Holubar, MD, Lebanon, NH
9:40 am	Measuring Success of Quality Improvement Genevieve Melton-Meaux, MD, Minneapolis, MN	10:25 am	Panel Discussion
9:50 am	Leveraging IT to Improve Outcomes Allison McCoy, PhD, New Orleans, LA	11:00 am	Adjourn

Objectives: At the conclusion of this session, participants should be able to understand: a) Identify the principals of a culture of safety and quality improvement; b) Recognize methods used to develop quality improvement initiatives; c) Describe the practical steps to implementing and maintaining a quality improvement project; d) Define how to evaluate the success of a quality improvement initiative.

Symposium

Laparoscopic Nuts & Bolts and Robotic Rivets

9:30 – 11:45 am



Laparoscopic and robotic surgical techniques are an integral part of modern colorectal surgical practice.

The education of surgeons in these techniques occurs in a variety of settings including fellowship training, industry-sponsored training programs, and professional society continuing medical education programs. In this symposium, state of the art laparoscopic and robotic approaches to common colorectal conditions are presented by experts in the field. The educational format will be short videos followed by question and answer sessions. The aim of this symposium is to expand the knowledge base of society members and guests in the areas of laparoscopic and robotic colorectal surgery.

Existing Gaps

What Is: Laparoscopic and robotic colorectal surgical techniques are developing at a rapid pace. Continuing medical education for surgeons in practice to learn these techniques are limited.

What Should Be: Periodic educational programs that allow practicing surgeons to learn basic and advanced laparoscopic and robotic colorectal surgical techniques.

Director: Mark Whiteford, MD, Portland, OR

Assistant Director: Jon Vogel, MD, Aurora, CO

9:35 am	Lap Right Colectomy: Complete Mesocolic Excision Hermann Kessler, MD, PhD, Cleveland, OH	10:20 am	Splenic Flexure: The Inside Passage, IMV Gateway to the Lesser Sac Armando Melani, MD, Barretos, Brazil
9:40 am	Single Incision Colectomy: Steps to Success for the Right and Transverse Colon Jamie Murphy, MD, London, United Kingdom	10:25 am	Splenic Flexure: Give Me a Hand (HALS) Kelly Garrett, MD, New York, NY
9:45 am	Taking Control: Clip, Seal, or Staple the Large Vessels? Karin Hardiman, MD, PhD, Ann Arbor, MI	10:30 am	Splenic Flexure: A Robot in Your Corner Meagan Costedio, MD, Cleveland, OH
9:50 am	Laparoscopic Ileocolic Resection for Crohn's Disease: What to Do When It's Really Stuck Sanghyun Kim, MD, New York, NY	10:35 am	TME: A Hand for the Holy Planes (HALS) Matthew Mutch, MD, St. Louis, MO
9:55 am	Laparoscopic Hartmann's Reversal Armen Aboulian, MD, Cleveland, OH	10:40 am	TME: Mr. Roboto David Etzioni, MD, Phoenix, AZ
10:00 am	Laparoscopic Parastomal Hernia Repair Scott Steele, MD, Fort Lewis, WA	10:45 am	TME: Laparoscopic Cylindrical APR. Nothing to Waist Yi-Qian Nancy You, MD, Houston, TX
10:05 am	Panel Discussion	10:50 am	Panel Discussion

Continued next page

Laparoscopic Nuts & Bolts and Robotic Rivets (Continued)

11:00 am	Laparoscopic IPAA: Making the Pouch Reach Every Time David Larson, MD, Rochester, MN	11:15 am	Robotic Mishaps: Getting Into and Out of Trouble Alessio Pigazzi, MD, PhD, Orange, CA
11:05 am	Laparoscopic Stapling of the Low Rectum: Maximizing the Odds of Using a Minimum of Staple Loads David Maron, MD, Weston, FL	11:20 am	Laparoscopic Rectopexy: Anterior or Posterior Approach? Christopher Cunningham, MBChB, Oxford, United Kingdom
11:10 am	Laparoscopic Colorectal Anastomosis: There's an Air-Leak. Now What? Jason Hall, MD, Burlington, MA	11:25 am	Panel Discussion
		11:45 am	Adjourn

Objectives: At the conclusion of this session, participants should be able to: a) Perform basic and advanced laparoscopic and robotic colorectal surgical techniques while avoiding surgical complications; b) Identify complications that can occur while recognizing various approaches to common and extraordinary surgical problems; c) Describe to their patients the pros and cons of laparoscopic and robotic techniques.

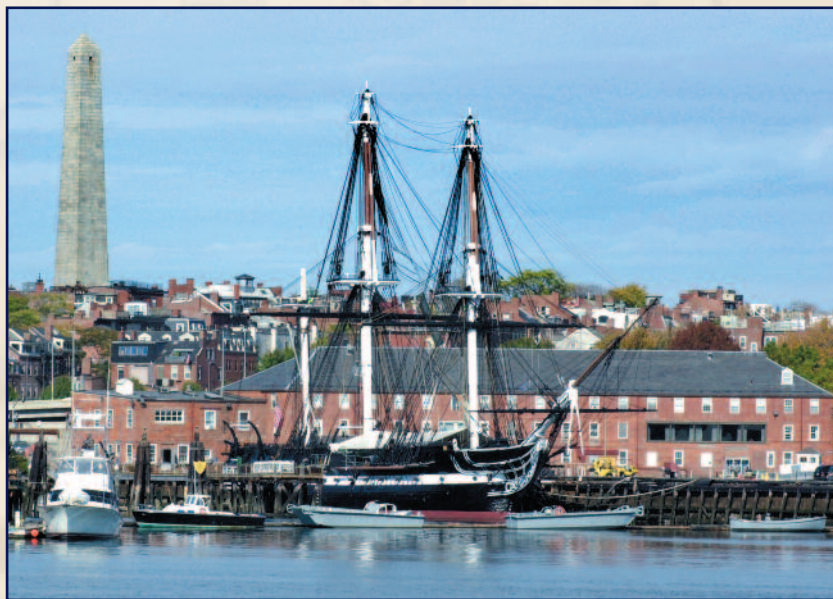


Photo Credit: Greater Boston Convention & Visitors Bureau

The USS Constitution was nicknamed "Old Ironsides," after the War of 1812, when shots from the British appeared to bounce off her thick oak hull as if it were made from iron.

Symposium

Complications: Prevention and Management

9:45 – 11:45 am



Complication prevention and management guides every aspect of our treatment paradigms. Although the preoperative assessment is a broad, more global patient evaluation, it is comprised of many data points, including the pathology, aspects of the particular planned procedure, the current and past health issues of the patient and postoperative care. The challenge to the surgeon is to take this detailed evaluation and use it to optimize operative outcomes while minimizing perioperative and postoperative morbidity. The increasing complexity of our patient's medical and surgical issues and the expectation for perfect outcomes makes management evermore daunting. Furthermore, the increasing oversight of surgical outcomes, individual and institutional costs, and patient satisfaction make the prevention and management of surgical complications crucial to the successful practice of surgery in the current era.

Existing Gaps

What Is: The increasingly complex nature of patient care and the lack of evidenced based treatment algorithms for complications in colon and rectal surgery make management of the varied complications challenging.

What Should Be: Treatment algorithms for colorectal surgical complications should be evidence and consensus based to allow for management that optimizes outcomes, limits costs and improves patient satisfaction.

Co-Director: John Eggenberger, MD, Ypsilanti, MI

Co-Director: Harry Reynolds, MD, Cleveland, OH

9:45 am	Locally Advanced and Recurrent Rectal Cancers: Avoiding and Treating Complications in the Difficult Pelvis Philip Paty, MD, New York, NY	10:45 am	Global Surgery Challenges in 2015 Rudolph Rustin, MD, Mt. Pleasant, SC
9:57 am	The Problematic Low Rectal Anastomosis: Dealing with Stacking, Stenosis, Bleeding and Disruption Kirk Ludwig, MD, Milwaukee, WI	10:57 am	How Do We Prevent Perioperative Anastomotic Complications: Surgical Technique and/or Manipulation of the Microbiome? John Alverdy, MD, Chicago, IL
10:09 am	Management of the Stenotic, Bleeding, Leaking or Fistulizing Colonic Anastomosis Michael McGee, MD, Chicago, IL	11:09 am	Optimization of Patient Satisfaction Despite Adversity: Complication Prevention and Management in the Era of Surgical Outcome Tracking James Merlino, MD, Chicago, IL
10:21 am	Understanding Perioperative Anticoagulation with Emphasis on Novel Anticoagulants, Antiplatelet Agents, Drug Eluting Stents, and DVT Teresa Carman, MD, Cleveland, OH	11:22 am	Panel Discussion
10:33 am	C. Difficile Colitis: Resect, Divert, Antibiotics, or Transplant? Mark Manwaring, MD, Greenville, NC	11:45 am	Adjourn

Objectives: At the conclusion of this session, participants should be able to: a) Define strategies to avoid and manage complications arising during resections of locally advanced or recurrent rectal cancers; b) Describe strategies to avoid and treat complications of coloanal anastomoses, including stenosis, bleeding, and disruption with presacral abscess and chronic fistula; c) Discuss management strategy in the patient with ileocolic, colocolic, or colorectal anastomotic bleeding, leak, obstruction and fistula; d) Manage and limit complications in the urgent operation of patients on novel anticoagulation agents, antiplatelet agents and drug eluting stents; e) Explain how gut bacteria and subsequent host pathogen interactions may influence anastomotic healing; f) Describe optimal prevention and management of parastomal and ventral hernias in the colorectal surgical patient; g) Establish medical and surgical treatment algorithms for the management of difficile infection; and h) Develop strategies of complication prevention and management that optimize patient outcomes, expectations and the "patient experience" in an era in which, increasingly, surgeons are being measured and compared with their peers by hospitals, third party payers and governmental agencies.

Current Advances in the Management of Fecal Incontinence

11:45 am – 1:15 pm



Control of fecal material is a complex process that involves coordinated interaction of the colon, rectum, and anus. Also, there are many aspects of fecal incontinence which include various degrees of control for gas, liquid, and solid material. This is further complicated when there is associated urgency. Campaigns designed to make patients and caregivers aware of the debility associated with fecal incontinence have led to more patients seeking help. Many times patients have searched the internet and come with many questions that caregivers may not be able to address.

Existing Gaps

What Is: There are many treatments available and unclear recommendations when a treatment should be considered for a patient.

What Should Be: Caregivers should be aware of all current treatment options and what is projected to be available in the future. They also should be able to individualize treatment to meet the needs and symptoms of the specific patient.

Director: Tracy L. Hull, MD, Cleveland, OH

Assistant Director: Liliana Bordeianou, MD, Boston, MA

11:45 am	How Do We Assess Fecal Incontinence to Individualize Treatment Plans? Ian Paquette, MD, Cincinnati, OH	12:25 pm	What are the Options when the Primary Surgical Options Fail (an Algorithm for Choices) Alex Ky, MD, New York, NY
11:55 am	What About Sphincter Repair, Radiofrequency, and the Artificial Bowel Sphincter? Anders Mellgren, MD, PhD, Chicago, IL	12:35 pm	Are Stem Cells Going to be Available Soon? Massarat Zutshi, MD, Cleveland, OH
12:10 pm	What are the Newest Treatments (Injectables and Sacral Nerve Stimulation)? Klaus Matzel, MD, Erlangen, Germany	12:45 pm	Panel and Case Presentations
		1:15 pm	Adjourn

Objectives: At the conclusion of this session, participants should be able to: a) Name acceptable treatments for fecal incontinence; b) Recall where injectable therapy and sacral nerve stimulation fit into the treatment options; c) Prepare an acceptable algorithm for treatment options for fecal incontinence when the primary option fails; d) Describe the limitations of multiple treatments and alternative therapies and; e) Define the development of stem cells for fecal incontinence treatment

The Genetics of Colorectal Cancer and Cancer Related Syndromes

11:45 am – 1:15 pm



Central to our understanding of colorectal cancer biology are the cellular genetic alterations that lead to the development of cancer, whether these are related to a hereditary or acquired gene mutation. Roughly one third of colorectal cancers have some hereditary component, and approximately 10% are related to a hereditary colorectal cancer syndrome such as non-polyposis (Lynch syndrome and hereditary nonpolyposis colorectal cancer (HNPCC)) or polyposis syndromes (adenomatous polyposis (like FAP and MYH-associated polyposis), hamartomatous polyposis, and serrated polyposis). Multiple strategies have emerged to help identify these hereditary syndromes through screening and other methods. Once the diagnosis is made, timing and extent of surgical treatment as well as the subsequent surveillance of the patient and their families is dependent on an understanding of the implications of the outcomes of genetic testing. It is essential that the ASCRS membership be up-to-date regarding the genetics of colorectal cancer, the means to diagnose the most common hereditary cancer syndromes, the application of genetic knowledge to patient care, and the latest surgical and surveillance strategies for the most common syndromes.

Existing Gaps

What Is: In their routine daily practice, clinicians do not often appreciate the relevance of understanding cancer genetics and its impact on cancer development, and thus patients and families with hereditary cancer syndromes frequently go unrecognized. As a result, these patients and their families are not diagnosed and therefore do not receive appropriate treatment, surveillance, and/or genetic counseling.

What Should Be: Patients with hereditary cancer syndromes are readily identified and offered appropriate counseling and medical and surgical therapy. Surgical strategies should also include understanding of the appropriate timing and extent of resection as well as appropriate post-operative surveillance.

Director: Paul Wise, MD, St. Louis, MO

Assistant Director: Matthew Kalady, MD, Cleveland, OH

11:45 am	Introduction Paul Wise, St. Louis, MO	12:20 pm	Lynch Syndrome/HNPCC: When to Operate, How Much to Take, and Why Molly Cone, MD, Nashville, TN
11:50 am	Colorectal Cancer Genetics: Making Sense of the Alphabet Soup James Church, MD, Cleveland, OH	12:30 pm	Hereditary Cancer Syndrome Surveillance: You've Done the Colectomy, So Now What? Craig Messick, MD, Houston, TX
Noon	Recognizing the Red Flags: Does My Patient Have Hereditary Colorectal Cancer? Heather Hampel, MS, LGC, Columbus, OH	12:40 pm	Panel and Case Discussion
12:10 pm	Polyposis Syndromes: When to Operate, How Much to Take, and Why Timothy Sadiq, MD, Chapel Hill, NC	1:15 pm	Adjourn

Objectives: At the conclusion of this session, participants should be able to: a) Identify the genetics of colorectal cancer and the genetics of the various hereditary colorectal cancer syndromes; b) Describe the methods by which patients with hereditary colorectal cancer syndromes might be identified in a surgical practice, including screening methods to diagnose the most common syndrome(s); c) Define the appropriate operations for the polyposis and non-polyposis syndromes, the best timing for those operations, why they should be performed, and the evidence to support these decisions; d) Describe the post-colectomy surveillance routines for the hereditary colorectal cancer syndromes as well as any practical extracolonic surveillance routines and the evidence to support them.

Welcome and Opening Announcements

1:15 – 2:00 pm

Terry Hicks, MD, New Orleans, LA
President, ASCRS

David Margolin, MD, New Orleans, LA
Program Chair

H. David Vargas, MD, New Orleans, LA
Program Vice-Chair

Jason Hall, MD, Burlington, MA
Awards Chair

Paul Shellito, MD, Boston, MA

Kelly Tyler, MD, Springfield, MA
Local Arrangements Co-Chairs

Steven Wexner, MD, Weston, FL
President, ASCRS Research Foundation

Roberta Muldoon, MD, Nashville, TN
Public Relations Chair



Faneuil Hall Marketplace

Photo Credit: Greater Boston Convention & Visitors Bureau

Technical Pearls – How it's Really Done

2:00 – 4:00 pm



It is clear that master surgeons exist, and that these surgeons perform operations with techniques they have learned from experience. These learned “tricks” often allow a surgeon to perform operations in a way that most cannot. When asked to describe what they do to complete these procedures, the master surgeon often cannot verbalize it as these techniques have become a part of their muscle memory. In this symposium, we will ask these surgical masters to demonstrate these techniques in this open forum. Different approaches to these maneuvers will then be reviewed and discussed.

Existing Gaps

What Is: Surgical skill varies widely resulting in disparate patient outcomes for the treatment of many common surgical diseases.

What Should Be: A patient undergoing surgical treatment of common disease should be able to get treatment in their community and expect the same high level treatment as the patient treated by the surgical master for the same common disease.

Co-Director: Michael Stamos, MD, Orange, CA
Co-Director: Gregory Kennedy, MD, PhD, Madison, WI

2:00 pm	Transabdominal Approaches to Rectal Prolapse – Cutting Edge vs Tried and True Mark Arnold, MD, Columbus, OH	2:50 pm	Laparoscopy in the Super Obese – Tips to Get it Done Conor Delaney, MD, PhD, Cleveland, OH
2:10 pm	Approaches to Complex Fistula Disease: Outcomes and My Preferred Options Susan Gearhart, MD, Baltimore, MD	3:00 pm	A Simple Operation that Needs More Work – the Perfect Ileostomy John Pemberton, MD, Rochester, MN
2:20 pm	Bowel Preservation in Crohn's Disease – Complex Decisions for Complex Procedures Robin McLeod, MD, Toronto, ON, Canada	3:15 pm	Transanal Excision and Tumor Scatter – How to Achieve a Negative Margin Theodore Saclarides, MD, Maywood, IL
2:30 pm	Parastomal Hernia Repair – Local Repair versus Stoma Resite Kirk Ludwig, MD, Milwaukee, WI	3:25 pm	Gracilis Interposition to Treat Complex Fistula Disease Steven Wexner, MD, Weston, FL
2:40 pm	Finding the Ureter and Taking Down the Splenic Flexure in the Reoperative Abdomen Charles Friel, MD, Charlottesville, VA	3:35 pm	Panel Discussion
		4:00 pm	Adjourn

Objectives: At the conclusion of this session, participants should be able to: a) Identify the approach of a surgical master to rectal prolapse; b) Describe principles of prevention of injury to the spleen when mobilizing the splenic flexure; c) State the proper technique to performing a gracilis interposition procedure d) Name the options available to perform a loop ileostomy; e) Describe the role of novel approaches to rectopexy; and f) Recognize the factors that need to be considered in the management of colonic polyps.

Neoplasia I

2:00 – 3:30 pm



2:00 pm	Impact of Hospital Volume on Quality Indices for Rectal Cancer Surgery in British Columbia, Canada R. McColl*, M.J. Raval, T.P. Phang, A.A. Karimuddin, C.J. Brown, C. McGahan, E. Cai, Vancouver, BC, Canada	S1	2:47 pm	Discussion	
2:07 pm	Discussion		2:50 pm	Surgical Resection of the Primary Tumor in Stage IV Colorectal Cancer without Metastasectomy is Associated with Improved Overall Survival Compared to Chemotherapy/Radiation Therapy Alone B.C. Gulack*, D. Nussbaum, J.E. Keenan, A.M. Ganapathi, Z. Sun, M. Worni, J. Migaly, C. Mantyh, Durham, NC	S6
2:10 pm	Transanal Endoscopic Microsurgery (TEM) Following Neoadjuvant Chemoradiation for Rectal Cancer – Is Salvaging Local Recurrences Too Little Too Late? R. Perez, A. Habr-Gama*, G.P. São Julião, I. Proscurshim, L.M. Fernandez, J. Gama-Rodrigues, Sao Paulo, Brazil	S2	2:57 pm	Discussion	
2:17 pm	Discussion		3:00 pm	Correlation Between Extramural Vascular Invasion (EMVI) and DNA Hypermethylation in Rectal Cancer H.G. Jones*, R. Radwan, G. Jenkins, N. Williams, P. Griffiths, J. Beynon, D. Harris, Cardiff, United Kingdom	S7
2:20 pm	S3 Transanal Total Mesorectal Excision: The Oxford Experience N.C. Buchs*, G. Nicholson, T. Yeung, N. Mortensen, C. Cunningham, O. Jones, S. Ashraf, R. Guy, R. Hompes, Oxford, United Kingdom	S3	3:07 pm	Discussion	
2:27 pm	Discussion		3:10 pm	Waist Hip Ratio Better Predicts Oncological Quality of Resection and Outcome after Colon Cancer Surgery than Body Mass Index N. Hetsch, D. Leonard*, A. Kartheuser, A. van Maanen, Brussels, Belgium; H. Paterson, Edinburgh, United Kingdom; F. Penninckx, Leuven, Belgium	S8
2:30 pm	Determining the Optimal Timing for Initiation of Adjuvant Chemotherapy After Resection for Stage II/III Colon Cancer Z. Sun*, M. Abdelgadir Adam, J. Kim, D. Nussbaum, E. Benrashid, C.R. Mantyh, J. Migaly, Durham, NC	S4	3:17 pm	Discussion	
2:37 pm	Discussion		3:20 pm	Q&A	
2:40 pm	Observation Versus Surgical Resection in Patients with Rectal Cancer Who Achieved Complete Clinical Response after Neoadjuvant Chemoradiotherapy: Preliminary Results of a Randomized Trial (NCT02052921) S.C. Nahas, C.S. Nahas*, U. Ribeiro, Jr., C. Sparapan Marques, G. C. Cotti, C. Ortega, R. Azambuja, A. Chen, P. Hoff, I. Cecconello, Sao Paulo, Brazil	S5	3:30 pm	Adjourn	

*Presenting Author

Refreshment Break in Exhibit Hall and ePoster Presentations

4:00 – 4:45 pm

Norman D. Nigro, MD, Research Lectureship



4:45 – 5:15 pm

**The Evolution of Minimally Invasive
Surgery for Colorectal Cancer:
Past, Present, and Future**

Professor Antonio Lacy, MD, PhD
Barcelona, Spain

Introduction: Steven Wexner, MD



The Boston Skyline, as seen from the HarborWalk.

Photo Credit: Greater Boston Convention & Visitors Bureau

After Hours Debate

5:15 – 6:30 pm



All surgical specialties have certain topics/diseases that contain controversy. Understanding the optimal treatment plan for patients often depends on a physician's ability to see clarity in these lines of gray. Debates are excellent tools to show differences in perspective and opinion regarding these topics. They effectively challenge and break down surgical dogma and open people to new points of view. They often help audience members crystalize their own values and beliefs. Speakers with passionate views about opposing treatment, with clear guidelines for the debate, can effectively create an effective and novel learning environment. Furthermore, an assertive and experienced moderator can challenge the speakers and engage the audience to both optimize critical thinking and illustrate what treatment plan may be best for different scenarios.

Existing Gaps

What Is: The role of surgical skills testing is an area of evolving discussion. There are different and often opposing views on it's appropriateness, indication and it's utility in surgical education and certification. Surgeons are unsure what effect this will have in the future. While laparoscopic surgery has become more and more mainstream, there is still some question about the efficacy and outcomes of laparoscopic node positive rectal cancer surgery.

What Should Be: Surgeons should have a clearer vision of the role of skill testing in relation to certification and recertification. They also need a better understanding of the role of laparoscopic rectal cancer surgery as opposed to colon cancer surgery.

Moderator: James Fleshman, MD, Dallas, TX

5:15 pm	Surgical Skills Testing Helen MacRae, MD, Toronto, ON, Canada vs Charles Whitlow, MD, New Orleans, LA	6:30 pm	Adjourn
5:45 pm	Laparoscopic Surgery for Stage 3 Rectal Cancer Richard Whelan, MD, New York, NY vs Scott Steele, MD, Fort Lewis, WA		

Objectives: At the conclusion of this session, participants should be able to: a) Recognize the role of skill testing in relation to certification and recertification; b) Describe the evidence and practical implications for performing or avoiding mechanical bowel preparation; and c) Explain the outcomes in minimally invasive surgery for the treatment of node positive rectal cancer.

Welcome Reception

7:00 – 8:30 pm
Sheraton Boston Hotel

• **Jersey Night!** •

Wear your favorite team's jersey to show your colleagues which team you support.

The **Welcome Reception** will be held at the Sheraton Boston Hotel and is complimentary to all registered attendees. The event will feature hors d'oeuvres, cocktails and entertainment. The Research Foundation will join forces with ASCRS to welcome all at this reception.

Meet the Professor Breakfasts

6:00 – 7:00 am

Limit: 30 per breakfast • Fee \$40 • **Tickets Required** • Continental Breakfast

*Registrants are encouraged to bring problems and questions to this informal discussion.
Please register early and indicate your 1st and 2nd choice on the Registration Form.*



M-1 HNPCC and Polyposis: Knowing When to Operate

Charles Ternent, MD, Omaha, NE
Matthew Kalady, MD, Cleveland, OH

M-2 Quality Metrics and Colorectal Surgery

Juan Nogueras, MD, Weston, FL
Rocco Ricciardi, MD, Burlington, MA

M-3 Coding Pearls

Guy Orangio, MD, New Orleans, LA
Stephen Sentovich, MD, Duarte, CA

M-4 The Management of T1 Rectal Cancer

Robert Madoff, MD, Minneapolis, MN
Maher Abbas, MD, Abu Dhabi,
United Arab Emirates

M-5 How to Produce a High Quality Manuscript for Scientific Journals

Thomas Read, MD, Burlington, MA
W. Donald Buie, MD, Calgary, AB, Canada

M-6 Rectal Prolapse

Stanley Goldberg, MD, Minneapolis, MN
Brooke Gurland, MD, Cleveland, OH

Objectives: At the conclusion of this session, participants should be able to: a) Describe the procedures and approaches discussed in this session.

Residents' Breakfast



6:00 – 7:00 am

The Road Less Traveled or the High Road? Charting a Path to Success

Michael Stamos, MD
Chair Department of Surgery
University of California, Irvine Health
Orange, CA



Open to Residents Only
Registration Required

Robotic Colorectal Surgery

7:00 – 9:15 am



While the practice of surgery continues to evolve with respect to new techniques and technology, it remains critical that the attention of surgeons and society as a whole focus on improving the quality of patient care. Innovations therefore must be assessed through science and experience in order that these goals are achieved. Controversy over the cost, potential complications, training, highlighted in both the lay press and publications, demonstrate the need for this discussion. These unanswered questions regarding the use of robotic surgery represent fertile ground from which a robust discussion can ensue. Therefore, a critical need exists to review the current state of the robotics in order that surgeons are informed of ongoing and future studies pertaining to the use of robotic surgery.

Existing Gaps

What Is: The approach and use of robotic surgery remains varied and diverse. To date, few institutions exist with large experiences in colorectal disease. Moreover, the appropriate application of robotics is often based on local prevailing customs and expertise due to limited data and training.

What Should Be: Surgeons should understand the appropriate application of robotic technics and a basis for literature reported outcomes in colorectal surgery. In addition, surgeons should have a basic understanding of the potential pitfalls and costs associated with this approach.

Director: David Larson, MD, Rochester, MN
Assistant Director: Scott Kelley, MD, Cincinnati, OH

7:00 am	What's New with the Robot (Tools, Capabilities) and How Might it Improve My Practice Howard Ross, MD, Philadelphia, PA	8:00 am	Complex Pelvic Surgery, Techniques and Tricks Amir Bastawrous, MD, Seattle, WA
7:15 am	The Evidence: Where are We? David Jayne, MD, Leeds, United Kingdom	8:15 am	Robotic Rectal Cancer Surgery and Robotic-Intersphincteric Resection Jin Kim, MD, Seoul, South Korea
7:30 am	Role of Robotics in Colon Surgery? Julio Garcia-Aguilar, MD, PhD, New York, NY	8:30 am	Economics of Robotics Craig Rezac, MD, New Brunswick, NJ
7:45 am	The Costs of Robotics, Pitfalls and Economics Robert Cleary, MD, Ann Arbor, MI	8:45 am	Questions and Panel Discussion
		9:15 am	Adjourn

Objectives: At the conclusion of this session, participants should be able to: a) Identify the capabilities and tools associated with different robotic technologies; b) Describe the principles derived from the literature on the benefit or lack of benefit from a robotic approach; c) Recall the proper technical issues of both abdominal and pelvic robotic surgery; d) Describe the current and ongoing trials of robotic surgery; and e) Distinguish the financial burden associated with robotic surgery and the opportunities for cost savings.

Rectal Cancer: Optimizing Outcomes through Techniques

7:00 – 9:15 am



With continued technological advancements and their implementation into surgical practice, the number of surgical approaches for the management of rectal cancer continues to expand. Depending on the stage and location of the rectal cancer and patient co-morbidities and wishes, one surgical approach may be preferred over another. Nevertheless, regardless of surgical approach, short-term and long-term oncological and functional results are greatly dependent on surgical technique.

The purpose of this symposium is to present expert commentaries by high-volume surgeons on the essential technical components of a broad range of specific open and minimally invasive surgical approaches commonly used for the management of rectal cancer.

Existing Gaps

What Is: Although colorectal surgeons are trained in all the different surgical options for rectal cancer management, the science and art in a specific surgical technique are mastered after years of practice and experience.

What Should Be: This Symposium aims to highlight and disseminate optimal surgical techniques used by expert high volume surgeons in the surgical management of rectal cancer.

Director: José Guillem, MD, New York, NY
Assistant Director: Patricia Sylla, MD, Boston, MA

7:00 am	Introduction José Guillem, MD, New York, NY	7:45 am	Discussion and Cases
7:05 am	Open Low Anterior Resection Robert Madoff, MD, Minneapolis, MN	8:00 am	Robotic Rectal Cancer Resections Slawomir Marecik, MD, Park Ridge, IL
7:15 am	Open Ultra-Low Resection with Coloanal Anastomosis: Mucosectomy vs Intersphincteric Resection Thomas Read, MD, Burlington, MA	8:10 am	TEM/TAMIS Sergio Larach, MD, Orlando, FL
7:25 am	Abdominal Perineal Resection: Prone Position/Cylindrical Approach: When and How? Torbjörn Holm, MD, Stockholm, Sweden	8:20 am	Transanal Total Mesorectal Excision Antonio Lacy, MD, PhD, Barcelona, Spain
7:35 am	ALaCaRT: Australian Laparoscopic Cancer of the Rectum Trial Andrew Stevenson, MD, Chermside, Australia	8:30 am	Results of Robotic vs Laparoscopic Resection for Rectal Cancer: ROLARR Study Alessio Pigazzi, MD, PhD, Orange, CA
		8:40 am	Discussion
		9:15 am	Adjourn

Objectives: At the conclusion of this session, participants should be able to: a) Describe the most commonly performed and evolving open and minimally invasive surgical approaches for rectal cancer with an emphasis on proper patient selection and optimal surgical technique; and b) Identify specific preferred techniques, potential technical difficulties and pitfalls in order to assure optimal oncological and functional outcome.

Memorial Lectureship Honoring John M. MacKeigan, MD



9:15 – 9:45 am

**A Short Walk Through the History of
the Quality Movement**



Martin Luchtefeld, MD

*Chief, Div. of Colon and Rectal Surgery
Clinical Asst. Professor, MSU College of Medicine
Ferguson Clinic-Spectrum Health Medical Group
Spectrum Health
Grand Rapids, MI*

Introduction: Anthony Senagore, MD

Presidential Address



9:45 – 10:15 am

**A Surgeon's Puzzle:
"The Missing Pieces"**



Terry Hicks, MD

*Vice Chair, Dept. of Colon and Rectal Surgery
Ochsner Clinic
New Orleans, LA*

Introduction: Michael Stamos, MD

Refreshment Break in Exhibit Hall and ePoster Presentations

10:15 – 11:00 am

Navigating a Career Path in Colon and Rectal Surgery – Orchestrating and Optimizing Career Transitions at All Levels

11:00 am – 12:30 pm



Surgeons at all phases of their career face difficult decisions about potential transitions in their professional and personal lives. The optimal strategic approach to these life changing events can be elusive and may lead to a “trial by error” experience with dramatic consequences. We must try to understand that these changes come from the impossibility to live otherwise than according to the demands of our conscience and not from our mental resolution to try a new form of life. Furthermore, not every opportunity is growth, as all movement is not forward.

Existing Gaps

What Is: Graduating colorectal residents and attending surgeons looking for a career change receive very little counseling and pragmatic advice to assist them in their potential transition to a new position.

What Should Be: Career transitions should be approached and handled by an individual with a team of mentors and advisors. The absence of this “team” can be balanced by national courses and symposia with speakers well educated in this arena.

Director: Bradley Champagne, MD, Cleveland, OH

Assistant Director: Andrew Russ, MD, Knoxville, TN

11:00 am	Life after Training – You are Now the Attending of Record! Mark Manwaring, MD, Greenville, NC	11:36 am	A View from Above – How to Effectively Lead a Team! Michael Stamos, MD, Orange, CA
11:12 am	Mid-Life Crisis, Build your Own or Lead from the Center! Gregory Kennedy, MD, PhD, Madison, WI	11:48 am	Emotional Intelligence – The Real Key to Success James Fleshman, MD, Dallas, TX
11:24 am	From Private Practice to Hospital Acquisition – Lifestyle, Dollars and Sense! Wayne Ambroze, MD, Atlanta, GA	Noon	Question and Answer
		12:30 pm	Adjourn

Objectives: At the conclusion of this session, participants should be able to: a) Recognize the importance of a thoughtful and strategic approach to the first years in practice after training; b) Describe the key components to the decision making process when a surgeon is deciding between moving to another position with potential leadership opportunities vs. staying in their current role; c) Identify the current challenges with Private Practice and why hospital based practice may be advantageous; d) Recognize how to turn a Vision into reality by effective implementation of the strategic plan; and e) Identify that mental toughness and emotional intelligence are difficult to measure but are the cornerstone of personal and professional success.

Benign Colonic Disease

11:00 am – 12:30 pm



- | | | | | | |
|----------|---|------------|----------|---|------------|
| 11:00 am | Surgical Site Infection Following Colorectal Surgery: In the Eye of the Beholder?
T.L. Hedrick*, A. Harrigan, B. Umapathi, R. Sawyer, C.M. Friel, Charlottesville, VA | S9 | 11:46 am | Discussion | |
| 11:07 am | Discussion | | 11:49 am | Parastomal Hernia Prevention Through Laparoscopic Modified Sugarbaker Technique with Composite Mesh (Physiomesh™). A Multicenter Randomized Controlled Trial.
X. Serra-Aracil*, L. Mora, A. Serracant, M. Lopez-Cano, S. Biondo, D. Fracalvieri, E. Espin, J. Sanchez, Barcelona, Spain | S14 |
| 11:09 am | Diverticulitis In The United States: A Decade Analysis Of Changing Trends
M.H. Hanna*, Z. Moghadamyeghaneh, G. Hwang, L. Malellari, S.D. Mills, J.C. Carmichael, M.J. Stamos, A. Pigazzi, Orange, CA | S10 | 11:56 am | Discussion | |
| 11:16 am | Discussion | | 11:59 am | Killingback Award
High vs low Urine Output Targets in Elective Surgical Patients: A Randomized Clinical Trial
J. Puckett*, J. De Zoysa, M. Kluger, Auckland, New Zealand; S. Palmer, J. Pickering, Z. Endre, Christchurch, New Zealand; M. Soop, Auckland, New Zealand | S15 |
| 11:19 am | Sigmoid Colectomy for Acute Diverticulitis in Immunosuppressed vs. Immunocompetent Patients: Outcomes from the ACS-NSQIP Database
A. Al-Khamis*, J. Abou Khalil, C. Vasilevsky, N. Morin, G. Ghitulescu, P. Gordon, M. Demian, J. Faria, M. Boutros, Montreal, QC, Canada | S11 | 12:06 pm | Discussion | |
| 11:26 am | Discussion | | 12:09 pm | The Current State of Colorectal Surgery Training: A Survey of Program Directors, Current Colorectal Residents, and Recent Colorectal Graduates.
M.B. Bailey*, P.E. Miller, S. Pawlak, M. Thomas, H. Vargas, T. Hicks, C. Whitlow, D. Beck, D. Margolin, New Orleans, LA | S16 |
| 11:29 am | The Readmission After Acute Diverticulitis (RAD) Score – A Nomogram for Determining 60-day Readmission Risk for Diverticulitis Patients Using 145,325 Admissions from the State Inpatient Database (SID) (2006-2011).
V. Chakravorty*, K. Mahendraraj, R.S. Chamberlain, Livingston, NJ | S12 | 12:16 pm | Discussion | |
| 11:36 am | Discussion | | 12:19 pm | Q&A | |
| 11:39 am | Conservatively Treated Diverticular Abscess Associated with High Risk of Recurrence and Disease Complications
B. Devaraj*, K. Cologne, A.M. Kaiser, Los Angeles, CA | S13 | 12:30 pm | Adjourn | |

**Complimentary Box Lunch in Exhibit Hall
and ePoster Presentations**

12:30 – 1:30 pm

Past Presidents' Panel: Controversies and Cases

1:30 – 3:00 pm



The management of complicated colorectal disorders is what differentiates this specialty from general surgery. Colorectal surgeons are often called upon to manage complex medical and surgical conditions, especially reoperative surgery. This session will highlight the strategies of senior colorectal surgeons' management of the most complicated reoperative conditions addressed by our specialty.

- Recurrent Anal Fissures
- Recurrent Rectal Cancer
- Hemorrhoid Disease
- Inflammatory Bowel Disease
- Complex Fistula

Existing Gaps

What Is: Many surgeons are comfortable with the straightforward management of common colorectal conditions. Complex cases, reoperative surgery and those with complications are often referred to a tertiary care center.

What Should Be: Surgeons should be familiar with the management options for complicated colorectal diseases and the potential interventions necessary to provide satisfactory outcomes.

Director: Steven Wexner, MD, Weston, FL

1:30 pm	Recurrent Anal Fissures Richard Billingham, MD, Seattle, WA	2:15 pm	Inflammatory Bowel Disease Michael Stamos, MD, Orange, CA
1:45 pm	Recurrent Rectal Cancer H. Randolph Bailey, MD, Houston, TX	2:30 pm	Complex Fistula Ann Lowry, MD, St. Paul, MN
2:00 pm	Hemorrhoid Disease Lester Rosen, MD, West Palm Beach, FL	2:45 pm	Roundtable Discussion
		3:00 pm	Adjourn

Objectives: At the conclusion of this session, participants should be able to: a) Recognize the management options of recurrent anal fissures, complex anal fistula, hemorrhoid disease, rectal cancer and IBD; and b) Identify the technique of colonoscopy and how to manage potential complicated lesions endoscopically.

Pelvic Floor/Anorectal

1:30 – 3:00 pm



1:30 pm	Treatment of Fecal Incontinence with Gatekeeper (™) Implantation A. Heydari*, E. Merolla, S. Giuratrabocchetta, M. Piccoli, G. Melotti, Modena, Italy; R. Fazlalizadeh, Orange, CA	S18	2:19 pm	Percutaneous Tibial Nerve Stimulation has Sustained Benefit in the Treatment of Fecal Incontinence at 12 Months J.B. Cowley*, P.W. Waudby, H. O'Grady, G.S. Duthie, Beverley, United Kingdom	S23
1:37 pm	<i>Discussion</i>		2:26 pm	<i>Discussion</i>	
1:39 pm	The Impact of a Novel Vaginal Bowel Control System on Bowel Function M.G. Varma*, San Francisco, CA; C.A. Matthews, Chapel Hill, NC; H. Richter, Birmingham, AL	S19	2:29 pm	Outcomes of Re-Implantation of Sacral Neurostimulation for Fecal Incontinence are Similar to Those of First Time Implants A. Cracco*, A. Chadi, S. Wexner, F. Rodrigues, G. DaSilva, Weston, FL; M. Zutshi, B. Gurlanb, Cleveland, OH	S24
1:46 pm	<i>Discussion</i>				
1:49 pm	The Effect of Coexisting Pelvic Floor Disorders on Fecal Incontinence Quality of Life Scores: A Prospective Survey-Based Study L. Bordeianou, C.W. Hicks*, A. Olariu, L.R. Savitt, S.J. Pulliam, M. Weinstein, P. Sylla, M.M. Wakamatsu, Boston, MA; T. Rockwood, Minneapolis, MN; J. Kuo, Waltham, MA	S20	2:36 pm	<i>Discussion</i>	
1:56 pm	<i>Discussion</i>		2:39 pm	Use of Biofeedback Combined with Diet for Treatment of Obstructed Defecation Associated with Paradoxical Contraction of Puborectalis Muscles (Anismus). Predictive Factors and Short-term Outcome S.M. Murad-Regadas*, F.S. Regadas, C. Bezerra, M.C. Oliveira, F. Regadas Filho, R. Vasconcelos, S. Almeida, G. Fernandes, Ceara, Brazil	S25
1:59 pm	The TOPAS™ Treatment for Fecal Incontinence: A Close Look at Complications M. Zutshi*, Cleveland, OH; A. Mellgren, Chicago, IL; D.E. Fenner, Ann Arbor, MI; V. Lucente, Allentown, PA; P. Culligan, Summit, NJ; M. Nihira, Oklahoma City, OK	S21	2:46 pm	<i>Discussion</i>	
2:06 pm	<i>Discussion</i>		2:49 pm	Ligation of Intersphincteric Fistula Tract (LIFT) Versus LIFT-Plug Procedure in Patients with Transsphincteric Anal Fistula: A Multicenter Prospective Randomized Trial. Z. Wang*, J. Han, Y. Zheng, J. Cui, C. Chen, Beijing, China; X. Wang, X. Che, Shan'xi, China; W. Song, Tianjin, China	S26
2:09 pm	Long Term Efficacy of Sacral Nerve Stimulation for Fecal Incontinence – A Single Center Experience J.B. Cowley*, P.W. Waudby, H. O'Grady, G.S. Duthie, Beverley, United Kingdom	S22	2:56 pm	<i>Discussion</i>	
2:16 pm	<i>Discussion</i>		3:00 pm	Adjourn	

*Presenting Author

Monday, June 1

Harry E. Bacon, MD, Lectureship



3:00 – 3:30 pm

Changes in Student and Residency Education in Surgery: Unanticipated Consequences and Challenges



Hiram C. Polk, Jr., MD

*Ben A. Reid, Sr. Professor of Surgery, Emeritus
Former Chair, Department of Surgery,
School of Medicine
University of Louisville
Louisville, KY*

Introduction: Terry Hicks, MD

Ice Cream & Refreshment Break in Exhibit Hall and ePoster Presentations

3:30 – 4:15 pm

Parviz Kamangar Humanities in Surgery Lectureship



4:15 – 4:45 pm

Spirituality and Faith in Serious Illness



Robert Fine, MD, FACP, FAAHPM

*Clinical Director
Office of Clinical Ethics and Palliative Care
Baylor Scott and White Health
Dallas, TX*

Introduction: Ira Kodner, MD

Special Lecture



4:45 – 5:15 pm

The Trials and Tribulations of Clinical Research: Why Johnny Can't Add

Thomas Read, MD
Lahey Clinic Medical Center
Dept. of Colon and Rectal Surgery
Burlington, MA



No CME Credit Awarded

New Technologies Symposium

5:15 – 6:45 pm

The New Technologies Session is dedicated to the principle that through imagination and innovation many of the most challenging problems in the field of colon and rectal surgery can be solved. Impactful new innovations in the area of colorectal surgery; pharma, devices, prototypes, techniques and approaches will be the focus of this session. This session will feature presentations on the latest advances in colorectal surgery.

Existing Gaps

What Is: No platform for emerging technologies exists for colorectal surgery today.

What Should Be: The ASCRS annual meeting will serve as major conduit through which new and emerging technologies for colorectal surgery will be showcased. This session will also serve as an educational platform to learn about drug and device development and process for FDA approval.

Co-Director: Sonia Ramamoorthy, MD, La Jolla, CA

Co-Director: Eric Haas, MD, Houston, TX

Objectives: At the conclusion of this session, participants should be able to: a) Identify and employ emerging technologies relating to colorectal surgical issues; b) Recognize personal gaps in knowledge which will lead to further independent study; and c) Recognize safe and effective strategies to correct common colorectal disease processes.

Meet the Professor Breakfasts

6:30 – 7:30 am

Limit: 30 per breakfast • Fee \$40 • **Tickets Required** • Continental Breakfast

*Registrants are encouraged to bring problems and questions to this informal discussion.
Please register early and indicate your 1st and 2nd choice on the Registration Form.*

T-1 Enterocutaneous Fistulas, Anastomotic Leaks and other Catastrophes

David Beck, MD, New Orleans, LA
Joseph Carmichael, MD, Orange, CA

T-2 Modern Management of Fecal Incontinence

Kelly Garrett, MD, New York, NY
Amy Halverson, MD, Chicago, IL

T-3 Nonhealing Perineal Wounds

Martin Luchtefeld, MD, Grand Rapids, MI
Jon Hourigan, MD, Lexington, KY

T-4 Controversies the Management of Intestinal Crohn's Disease

Sandra Beck, MD, Pittsburgh, PA
Phillip Fleshner, MD, Los Angeles, CA

T-5 Pouch Problems and Solutions

Feza Remzi, MD, Cleveland, OH
David Larson, MD, Rochester, MN
Bonnie Alvey, APRN, WOCN, ACNS-BC,
New Orleans, LA

T-6 Rectal Cancer: Difficult Cases and Controversies

James Fleshman, MD, Dallas, TX
Kirk Ludwig, MD, Milwaukee, WI

T-7 Colitis and Dysplasia Surveillance and Management

David Etzioni, MD, Phoenix, AZ
Randolph Steinhagen, MD, New York, NY

Objectives: At the conclusion of this session, participants should be able to: a) Describe the procedures and approaches discussed in this session.



Photo Credit: Greater Boston Convention & Visitors Bureau

Situated on the waterfront, the JFK Library & Museum offers glorious unobstructed views of the city and the ocean.

Anorectal Disorders: Balancing Innovation with Conventional Wisdom

7:30 – 9:00 am



Billions of dollars are spent annually in the U.S. by patients on their own and as prescribed by a physician to manage the symptoms of a wide range of ano-rectal conditions. Surgical treatments include state of the art technologies and methods that have remained unchanged since the time of Shakespeare and even the Pharaohs. Do the newer approaches to these conditions provide better outcomes at reasonable cost, or just novelty and an opportunity to advance one's practice by being the "first kid on the block to have the newest toy?"

This symposium seeks to juxtapose the newest advances against the tried and true. We plan to review the emerging technologies with regard to outcomes and efficacy and also "bang for the buck" look at the improvements and innovation vs cost. There will be an in-depth discussion of how to integrate new technology into your ano-rectal practice and when to stick with what you were taught in fellowship.

Existing Gaps

What Is: A variety of emerging techniques and technologies that span the practice of ano-rectal surgery. The adoption and support for these changes in practice is often industry driven. The distinct benefit at possibly increased cost is not always known by the patient or the practitioner. Many different approaches, new and old, are currently applied across practices.

What Should Be: Surgeons adopting the newest innovative treatments and technologies should know the benefits and costs of these newer approaches in comparison to proven methods. The practitioners should be aware of potential risks or benefits of adopting new methods. Evolving changes in surgical techniques need to be compared to established standards using an evidence based approach, free from commercial bias.

Director: Thomas Cataldo, MD, Boston, MA
Assistant Director: Vitaliy Poylin, MD, Boston, MA

7:30 am	Latest Advances in Guided Hemorrhoid Ligation Vincent Obias, MD, Washington, DC	8:10 am	Management of Fistula-in-Ano: From Shakespeare to the Space Shuttle Brian Kann, MD, Philadelphia, PA
7:40 am	Hemorrhoidectomy – Do We Need to Reinvent the Wheel? Syed Husain, MD, Columbus, OH	8:20 am	Ventral Rectopexy for Obstructed Defecation P. Ronan O'Connell, MD, Dublin, Ireland
7:50 am	Management of Chronic Anal Fissures, to Rub on, Inject in, or Cut Through Elizabeth Raskin, MD, St. Paul, MN	8:30 am	Discussion
8:00 am	Injectable and Implantable Treatments for Fecal Incontinence Nishit Shah, MD, Providence, RI	9:00 am	Adjourn

Objectives: At the conclusion of this session, participants should be able to: a) Identify the newest techniques for management of symptomatic hemorrhoids, fistula-in-ano, anal fissure, rectal prolapse and incontinence; b) Review the newest innovations with respect to cost, risk, complications and success compared to well established techniques and technologies; and c) Plan for incorporation of innovative methods for management of anorectal conditions in the existing practice of colorectal surgery.

Update on Inflammatory Bowel Disease

7:30 – 9:00 am



The management of Crohn's disease and ulcerative colitis continues to evolve as we learn more about the genetics of these diseases. Additionally, our management of patients with IBD has changed greatly with new drug development, which then has downstream impact on their surgical therapy. Therefore, it is crucial to have a comprehensive understanding of these aspects of Crohn's disease and ulcerative colitis in order to provide the most comprehensive care for these patients.

Our understanding of the genetics of Crohn's disease and to a lesser extent, ulcerative colitis, has grown greatly in the past decade. The advances have to do with the discovery of the NOD2 gene and advances in technology such as the high throughput genetics. This understanding has led to improvement in identifying high-risk patients, and defining disease phenotypes. The introduction and expansion of biologic agents in the treatment of inflammatory bowel disease (IBD) has provided an effective alternative to long-term steroid therapy. Immunomodulator therapy is so widespread that it is uncommon for any patient with Crohn's or ulcerative colitis to not be treated with one of these agents. Data clearly supports its use in the acute and maintenance settings, but the long-term impact of the drugs on these patients regarding the need for surgery and quality of life remains controversial. Pouchitis is the most common complication associated with restorative proctocolectomies. The majority of cases are easily treated with antibiotics but a subset of these patients develops chronic pouchitis that is antibiotic dependent or requires immunomodulators to treat. We are gaining an increasing understanding of the pathophysiology of pouchitis and its treatments. Perianal Crohn's disease presents some of the greatest challenges to the patient and surgeon. The main goal for treating patients with perianal disease is focused control of symptoms and rarely on cure or eradication. It remains unclear how the widespread use of biologic therapy has impacted the surgical management of these patients. Restorative proctocolectomy with an ileal anal pouch has become the surgical standard of care for patients with ulcerative colitis. This procedure can be done in one, two or three stages, and the best approach remains controversial.

Existing Gaps

What Is: Our understanding of the genetics, pathophysiology, medical therapy and surgical therapy of IBD is constantly changing.

What Should Be: Surgeons should understand the genetic basis, the indications and outcomes associated with medical management, and the surgical principles for the treatment of IBD in today's world of medicine.

Director: Matthew Mutch, MD, St. Louis, MO

Assistant Director: Marc Singer, MD, Chicago, IL

7:30 am	Introduction Matthew Mutch, MD, St. Louis, MO	8:19 am	Perianal Crohn's Disease – Has Biologic Therapy Changed our Surgical Principles? Justin Maykel, MD, Worcester, MA
7:36 am	Genetics of IBD – What Have We Learned? David Stewart, Sr., MD, Hershey, PA	8:28 am	Restorative Proctocolectomy – 3 Stage vs 2 Stage vs 1 Stage Timothy Geiger, MD, Nashville, TN
7:49 am	Immunomodulators and Biologic Agents for Intestinal Disease – Surgery vs Drugs Sekhar Dharmarajan, MD, St. Louis, MO	8:41 am	Panel Discussion/Questions
8:02 am	Chronic Pouchitis – What Is it and How Do I Treat it? David Dietz, MD, Cleveland, OH	9:00 am	Adjourn

Objectives: At the conclusion of this session, participants should be able to: a) Recognize the genetics of IBD; b) Identify the impact of medical therapy on the treatment of Crohn's disease; c) Recognize the pathophysiology and treatment of chronic pouchitis; d) Describe the principle of managing perianal Crohn's disease; and e) Evaluate the indications for 3 stage, 2 stage, and 1 stage restorative proctocolectomy

Ernestine Hambrick, MD, Lectureship



9:00 – 9:30 am

Diverticulitis: What's New

Lisa Strate, MD, MPH
Associate Professor of Medicine
Department of Medicine
Division of Gastroenterology
University of Washington
Harborview Medical Center
Seattle, WA

Introduction: Ann Lowry, MD



Refreshment Break in Exhibit Hall and ePoster Presentations

9:30 – 10:15 am



Photo Credit: Greater Boston Convention & Visitors Bureau

Controversies in Rectal Cancer Management

10:15 – 11:45 am



Rectal cancer management is changing as new evidence emerges regarding the benefits of multidisciplinary treatment and techniques for optimizing surgical outcomes. Specifically, the need of routine preoperative radiotherapy, the role for long-course chemoradiotherapy versus short course radiotherapy alone, the management of patients with complete clinical response following chemoradiation, and the role of adjuvant therapy following neoadjuvant chemoradiation, are all unsolved clinical dilemmas. Some of this debate has been informed by improvements in surgical outcomes and our improved understanding of the impact of circumferential margins at resection, for both proximal and distal rectal cancers.

Existing Gaps

What Is: Current treatment guidelines for patients with rectal cancer do not account for the underlying heterogeneity of rectal cancers with respect to treatment response or risk for recurrence.

What Should Be: Surgeons should have an understanding about the determinants of outcomes following multidisciplinary treatment for rectal cancer and how treatment may be tailored to maximize oncologic outcome while minimizing the risk for unnecessary toxicity.

Director: George Chang, MD, Houston, TX
Assistant Director: Fergal Fleming, MD, Rochester, NY

10:15 am	The CRM is Widely Clear: Is Routine Preoperative Radiotherapy Still Necessary? Peter Sagar, MD, Leeds, United Kingdom	11:15 am	Adjuvant Chemotherapy Following Neoadjuvant CXRT for Rectal Cancer: Does Anybody Benefit? Yi-Qian Nancy You, MD, Houston, TX
10:30 am	Preoperative Radiotherapy for Rectal Cancer: When to Go Short and When to Go Long. Alexander Heriot, MD, Melbourne, VIC, Australia	11:30 am	Discussion
10:45 am	I Don't See Residual Tumor, What Should I Do? Julio Garcia-Aguilar, MD, PhD, New York, NY	11:45 am	Adjourn
11:00 am	Managing Minimally Invasive TME: Top Down or Bottom Up? John R.T. Monson, MD, Rochester, NY		

Objectives: At the conclusion of this session, participants should be able to: a) Discuss treatment heterogeneity among patients with rectal cancer; b) Describe issues in the management of rectal cancer patients with a clinical complete response to neoadjuvant chemoradiation therapy; c) Discuss the evidence regarding adjuvant chemotherapy for rectal cancer patients following neoadjuvant chemoradiation therapy; d) Discuss critical issues related to circumferential resection margins during rectal cancer surgery; and e) Discuss the critical issues within the evolving area of transanal TME.

Ostomies: Location, Creation and Complications

10:15 – 11:45 am



Despite improvements in surgical technique and enterostomal therapy care, complications following stoma creation are very common. The rate of stoma-specific complications in the literature varies between 10% and 70%, and is dependent on the length of follow-up and the definition of "complication." Complications include peristomal skin irritation, leakage, high output, dehydration, ischemia, retraction, stenosis, and recurrence of the disease for which a stoma was created, such as Crohn's disease.

Surgeons will be updated on how to construct intestinal stomas as well as how to prevent and treat stoma-related complications. This symposium will discuss the techniques of stoma siting and marking, stoma construction, prevention and management of complications including parastomal hernia, and management of patients with high-volume outputs. Technical tips to avoid complications and facilitate construction will be emphasized. Quality of life for patients with stomas will also be discussed.

Existing Gaps

What Is: Construction and management of stomas remains challenging and stoma-related complications remain high. Often the surgeon is the primary provider in the management of these complications, and many surgeons lack the experience necessary to adequately treat them.

What Should Be: Surgeons should know multiple options for stoma creation. Additionally, physicians should have an understanding of how to prevent and treat stoma-related complications.

Co-Director: Deborah Nagle, MD, Boston, MA
Co-Director: Joseph Carmichael, MD, Orange, CA

10:15 am	Patient Education and Stoma Site Selection A. Murray Corliss, RN, CWOCN, Boston MA	11:00 am	Other Stoma Complications Other Than Hernia Walter Peters, Jr., MD, Columbia, MO
10:30 am	Ostomy Selection, Construction and Technical Challenges Neil Hyman, MD, Chicago, IL	11:15 am	Complicated Cases/Panel Discussion
10:45 am	Parastomal Hernias: The Controversy Continues Michael Rosen, MD, Cleveland, OH	11:45 am	Adjourn

Objectives: At the conclusion of this session, participants should be able to: a) Discuss the preoperative optimization of patient to prevent stoma-related complications; b) Describe methods to medically manage common peristomal problems; c) Describe techniques to prevent and repair parastomal hernias; d) Discuss methods of managing patients with stoma retraction, stenosis, prolapse, and peristomal skin problems; and e) Describe methods of managing patients with high-volume output stomas.

General Surgery Forum

10:15 – 11:45 am



10:15 am	Bariatric Surgery Modulates IBD-Associated Microbiome Patterns in a Murine Model A. Vinci*, S. Li, M.J. Stamos, A. Pigazzi, Orange, CA; S. Jellbauer, M. Raffatellu, Irvine, CA	GS1	11:05 am	<i>Discussant</i>	
10:21 am	<i>Discussant</i>		11:08 am	<i>Discussion</i>	
10:24 am	<i>Discussion</i>		11:10 am	Colonoscopy After Left-Sided Diverticulitis: Utility or Futility? A.S. Walker*, J. Bingham, K. Janssen, E.K. Johnson, S.R. Steele, Tacoma, WA; J.A. Maykel, Worcester, MA; O. Ocampo, West Fairview, Quezon City, Philippines; J.P. Gonzalez, Cebu, Philippines	GS6
10:26 am	Combining Old with New: Bowel Rest and Biologic Therapy Aid in the Surgical and Medical Management of Penetrating Ileocolic Crohn's Disease M.D. Wagner*, M. McNally, J. Duncan, Bethesda, MD; N. Jaqua, M. Ally, J. Betteridge, Bethesda, MD	GS2	11:16 am	<i>Discussant</i>	
10:32 am	<i>Discussant</i>		11:19 am	<i>Discussion</i>	
10:35 am	<i>Discussion</i>		11:21 am	Robotic versus Open Total Mesorectal Excision: A Comparison of Clinical and Pathologic Outcomes J.L. Agnew* F.M. Chory, P.D. Strombom, G. Bonomo, New York, NY; K.A. Melstrom, W.E. Enker, J.E. Martz, New York, NY	GS7
10:37 am	Laparoscopic Radical Resection after Transanal Endoscopic Microsurgery: Is it Feasible and Safe? M. Masse*, A. Bouchard, A. Laliberté, A. Lebrun, S. Drolet, Quebec, QC, Canada	GS3	11:27 am	<i>Discussant</i>	
10:43 am	<i>Discussant</i>		11:30 am	<i>Discussion</i>	
10:46 am	<i>Discussion</i>		11:32 am	Relative Benefits and Risks of Alternative Modes of Bowel Preparation to Prevent SSI Following Elective Colorectal Resection N. Esnaola, Fox Chase Cancer Center, Philadelphia, PA; S. Koller*, R. Smith, S. Jayarajan, M. Philp, H.M. Ross, H. Pitt, Philadelphia, PA	GS8
10:45 am	Adjuvant Chemoradiation in the Management of T2N0 Rectal Cancer: A Population Based Clinical Outcomes Study Involving 4,054 Patients from the Surveillance Epidemiology and End Result (SEER) Database (1973–2010) K. Mahendraraj*, V. Chakravorty, N. Ghalyaie, R.S. Chamberlain, West Orange, NJ	GS4	11:38 am	<i>Discussant</i>	
10:54 am	<i>Discussant</i>		11:41 am	<i>Discussion</i>	
10:57 am	<i>Discussion</i>		11:45 am	Adjourn	
10:59 am	Does Cyanoacrylate Glue Reinforcement Reduce Anastomotic Failure? Results of an Experimental Comparative Study W. Gaertner, Minneapolis, MN; E. Nunez-Garcia, I. Baley-Spindel, J. Medina-Leon, R. Sordo-Mejia*, Mexico City, DF, Mexico	GS5			

Masters in Colorectal Surgery Lectureship Honoring David Schoetz, Jr., MD



11:45 am – 12:15 pm

The Value of Mentorship

Patricia L. Roberts, MD
*Chair, Division of Surgery
Lahey Hospital and Medical Center
Burlington, MA
Professor of Surgery
Tufts University School of Medicine
Boston, MA*

Introduction: Thomas Read, MD



Complimentary Box Lunch in the Exhibit Hall and ePoster Presentations

12:15 – 1:30 pm

Women in Colorectal Surgery Luncheon

12:15 – 1:30 pm • Complimentary • **Registration Required**

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

Anal Cancer: Prevention, Diagnosis and Treatment

1:30 – 3:00 pm



Anal cancer, unlike colorectal cancer, has been increasing in prevalence over the last 20 years. While the treatment of anal cancer has largely remained unchanged, the definitions of what constitutes an anal cancer have changed. Further, the terminology for the anal cancer precursor lesion, high-grade squamous intraepithelial lesion (HSIL) has been standardized. Finally, studies have shown that untreated precursor lesions may progress to anal cancer substantiating the proposal that treatment of precursor lesions may decrease anal cancer rates. This session will review the current understanding of prevention, diagnosis and treatment of premalignant and malignant lesions of the anus and perianus.

Existing Gaps

What Is: There is confusion about how to define lesions in the perianus as anal or perianal; along with confusion about efficacy and the need for treatment of premalignant lesions of the perianus. There is mixed usage of old terminology for anal and perianal lesions.

What Should Be: There will be a common understanding of what constitutes anal and perianal. There will be a common of standard terminology that applies to the lower anogenital tract and has been promulgated by the American College of Pathology.

Director: Mark Welton, MD, Stanford, CA

Assistant Director: Janice Rafferty, MD, Cincinnati, OH

1:30 pm	Introductions Mark Welton, MD, Stanford, CA Janice Rafferty, MD, Cincinnati, OH	2:20 pm	How Do We Manage Pre-Cancerous Lesions? Natalie Kirilcuk, MD, Stanford, CA
1:35 pm	Anatomic and Histologic Definitions Genevieve Melton-Meaux, MD, Minneapolis, MN	2:35 pm	What Is the Treatment and Expected Outcomes of Patients with Anal Cancer Both Immunocompetent and Immunocompromised? Larissa Temple, MD, New York, NY
1:50 pm	Who Should be Screened for Anal Cancer? Rocco Ricciardi, MD, Burlington, MA	2:50 pm	Panel Discussion
2:05 pm	How to Do the Screening and Who Should Do It? Bruce Robb, MD, Indianapolis, IN	3:00 pm	Adjourn

Objectives: At the conclusion of this session, participants should be able to: a) Explain the current terminology surrounding histologic findings of squamous lesions of the anus and perianus; b) Explain the current terminology used to define lesions of the anus and perianus as either anal or perianal; and c) Describe the current treatment recommendations for anal and perianal cancer.

Inflammatory Bowel Disease

1:30 – 3:00 pm



1:30 pm	IBD: A Growing and Vulnerable Cohort of Hospitalized Patients with Clostridium Difficile Infection A. Mabardy*, J. Coury, L. Ozcan, J. McCarty, A. Merchant, C. Armstrong, A. Hackford, H. Dao, Boston, MA	S27			The Healing Effect of Mesenchymal Adipose-Tissue-Derived Stem Cells on Colonic Anastomosis Under Ischaemic Condition Tony W.C. Mak*, Don W.C. Chin, Janet F.Y. Lee, Paul B.S. Lai, Anthony W.I. Lo, Ping Kuen Lam, Simon S.M. Ng, Shatin, Hong Kong	S32
1:37 pm	<i>Discussion</i>					
1:40 pm	Clostridium Difficile Infection in Ulcerative Colitis: Can Alteration of the Gut-Associated Microbiome Contribute to Pouch Failure? K. Skowron*, M. Rubin, R.D. Hurst, N. Hyman, K. Umanskiy, Chicago, IL; B. Lapin, Evanston, IL	S28	2:27 pm	<i>Discussion</i>		
			2:30 pm	Kono-S Anastomosis Devised for Aurgical Prophylaxis of Anastomotic Recurrence in Crohn's Disease: A Multicenter Study in Japan and the United States T. Kono*, Sapporo, Japan; A. Fichera, M. Krane, Seattle, WA; K. Maeda, Nagoya, Japan; Y. Sakai, Kyoto, Japan; H. Ohge, Hiroshima, Japan; M. Shimada, Tokushima, Japan; D. Rubin, Chicago, IL; A. Maemoto, Sapporo, Japan; F. Michelassi, New York, NY	S33	
1:47 pm	<i>Discussion</i>					
1:50 pm	Does Stool Leakage Increase in Aging Ileal Pouches? H. Kim*, L. Sun, B. Gurlanb, T.L. Hull, M. Zutshi, Cleveland, OH	S29				
1:57 pm	<i>Discussion</i>		2:37 pm	<i>Discussion</i>		
2:00 pm	Proctocolectomy: Impact on Relationship Quality in Ulcerative Colitis Patients and their Partners J.N. Cohan*, J. Rhee, E. Finlayson, M.G. Varma, San Francisco, CA	S30	2:40 pm	Ileostomy Closure Site Fascial Reinforcement with Cross Linked Acellular Porcine Dermis Biologic Mesh Yields No Incisional Hernias at 1 Year of Follow-Up M. Brozovich*, Wexford, PA	S34	
2:07 pm	<i>Discussion</i>		2:47 pm	<i>Discussion</i>		
2:10 pm	Rates of Colectomy for Ulcerative Colitis in the Era of Biologic Therapy C. Kin*, M.L. Welton, C. Woo, Stanford, CA; A.L. Lightner, Los Angeles, CA	S31	2:50 pm	Q&A		
2:17 pm	<i>Discussion</i>		3:00 pm	Adjourn		
2:20 pm	ESCP Best Paper					

*Presenting Author

Research Forum

1:30 – 3:00 pm



1:30 pm	Lymph Node Stromal Cell Microvesicles Mediate Colon Cancer Metastasis D. Margolin*, P.E. Miller, H. Green- Matrana, E. Flemington, X. Zhang, L. Li, New Orleans, LA	RF1	2:25 pm	Antitumor Activity of Dietary Phytochemicals in Colorectal Cancer B. Megna*, P. Carney, M. Nukaya, G.D. Kennedy, C. Diaz-Diaz, Madison, WI	RF6
1:36 pm	<i>Discussant</i>		2:31 pm	<i>Discussant</i>	
1:39 pm	<i>Discussion</i>		2:34 pm	<i>Discussion</i>	
1:41 pm	Diverticulitis and Crohn's Disease Have Distinct But Overlapping Tumor Necrosis Superfamily 15 (TNFSF15) Haplotypes T.M. Connelly*, Dublin, Ireland; C.S. Choi, W. Koltun, A. Berg, J. Coble, Hershey, PA	RF2	2:36 pm	Mesna and Hydroxypropyl Methylcellulose Assists in Delayed Submucosal dDssection in a Rabbit Cecal Model G. Subhas*, M. Patel, J.S. Bhullar, V. Mittal, Southfield, MI	RF7
1:47 pm	<i>Discussant</i>		2:42 pm	<i>Discussant</i>	
1:50 pm	<i>Discussion</i>		2:45 pm	<i>Discussion</i>	
1:52 pm	Combination Therapy for Colorectal Cancer Metastasis using an Orthotopic Xenograft Model D. Margolin, B.A. Reuter*, L. Li, X. Zhang, New Orleans, LA	RF3	2:47 pm	Genetic Heterogeneity in Rectal Cancer - Identification of Subpopulations of Tumor Cells Resistant to Neoadjuvant CRT R. Perez, F. Bettoni*, A. Camargo, E. Donnard, B. Correia, F. Koyama, P. Galante, A. Habr-Gama, J. Gama-Rodrigues, Sao Paulo, Brazil	RF8
1:58 pm	<i>Discussant</i>		2:53 pm	<i>Discussant</i>	
2:01 pm	<i>Discussion</i>		2:56 pm	<i>Discussion</i>	
2:03 pm	Depletion of let-7 microRNAs in the Intestinal Epithelium Promotes Upregulation of Oncofetal mRNAs and Intestinal Carcinogenesis A.N. Jeganathan*, R. Mizuno, A.K. Rustgi, Philadelphia, PA; B.B. Madison, St. Louis, MO	RF4	3:00 pm	Adjourn	
2:09 pm	<i>Discussant</i>				
2:12 pm	<i>Discussion</i>				
2:14 pm	Mesenchymal Stem Cells following Local Electrical Stimulation Improves Function in a Rat Anal Sphincter Injury Model at a Time Remote from Injury L. Sun*, Z. Xie, M. Zutshi, M. Damaser, Cleveland, OH	RF5			
2:20 pm	<i>Discussant</i>				
2:33 pm	<i>Discussion</i>				

Medical Legal Symposium: How to Protect Yourself

3:00 – 4:30 pm



Although traditionally physicians have focused on professional liability related to medical care delivery, the world has become more complex and now legal exposure extends to many other interactions. Physicians must understand the importance to maintain a professional and constructive relationship with their patients, while accurately and contemporaneously documenting the facts of the encounter. An accurate and complete medical record is essential to confirm both the thought process at the time but also the immediately available facts. However, all surgeons will face complications and managing both the discussion around the occurrence and the management of the complication are important components for reducing the risk of litigation. There is a current trend at the institutional level to “apologize”; however, this process must be managed well to avoid confusing adverse outcome from actual error in the minds of the patient and his/her family.

The complexity of the medical billing process is another area of increasing risk to the colorectal surgeon. Once again accurate documentation is essential to support a claim submission. The surgeon should also understand the process for correct code selection, use of tracking codes, and modifier use to support accurate reimbursement.

Existing Gaps

What Is: Communication is an important component which reduces the risk of having a medical malpractice claim filed against you. However, given the current climate even recognized treatment complications are a potential risk of such action. Currently, many colorectal surgeons are unfamiliar with the value of appropriate, timely, and accurate documentation of clinical encounters to reduce exposure should a malpractice claim be filed. The entire process from discovery through trial is something generally unfamiliar to many colorectal surgeons and these topics are rarely taught during training. In addition, most colorectal surgeons are unfamiliar with the various rules and regulations related to both documentation of clinical encounters and claims submissions. These gaps include knowledge of criteria for E/M code selection, modifier use, and implementation of correct coding initiative rules to allow accurate and complete claims submission. Similarly, the majority of colorectal surgeons have little knowledge or understanding of employment contract law and the interactions of these requirements with Stark provisions and other complex issues related to moving from private practice to corporate employment. Finally, direct contracting with large payors is a major challenge for colorectal surgeons. It is important to fully understand the complex language surrounding patient volumes, quality indicators and reporting, preauthorization rules, claims denials and claims adjudication.

What Should Be: The colorectal surgeon should understand his/her role and the specific components of clinical documentation and claim submission for patient encounters. Equally so, the colorectal surgeon considering selling his/her practice or directly entering corporate employment after training should be able to discuss the key components of a contract for such employment. Colorectal surgeons should fully understand their rights and privileges under contractual relationships with insurers to assure full and complete reimbursement while limiting unnecessary administrative overhead.

Objectives: At the conclusion of this session, participants should be able to: a) Formulate the role of timely and accurate clinical documentation in reducing exposure in a medical liability action against a colorectal surgeon; b) Explain the process of a medical liability action against a colorectal surgeon; c) Implement appropriate clinical documentation, code selection, and modifier use for accurate claim submission to insurance payors; d) Review the components of employment contracts and the rights and privileges expected by a colorectal surgeon transitioning from either private practice or residency training into full time corporate employment; and e) Define the components of contractual relationships with payors to assure full and prompt reimbursement while avoiding legal exposures (ie Stark regulations etc).

Continued next page

Medical Legal Symposium: How to Protect Yourself (Continued)

Director: Anthony Senagore, MD, Parma, OH
Assistant Director: Kyle Cologne, MD, Los Angeles, CA

3:00 pm **Professional Liability**
Michael Stamos, MD, Orange, CA

3:20 pm **Medical Documentation Billing**
Guy Orangio, MD, New Orleans, LA

3:40 pm **Employment Contracting**
Martin Luchtefeld, MD, Grand Rapids, MI

4:00 pm **Insurance Contracting**
Frank Opelka, MD, New Orleans, LA

4:20 pm **Panel Discussion**

4:30 pm **Adjourn**



Photo Credit: Greater Boston Convention & Visitors Bureau

Anal Fistulas: Diagnosis, Imaging and Therapy – Rational Approaches

3:00 – 4:30 pm



Anal fistula represents one of the most common and challenging anorectal diseases encountered by surgeons. The principles of successful treatment include appropriate diagnosis, destruction of the internal opening with preservation of sphincter function. Primary lay-open fistulotomy has a high success rate in treating fistulas; however, most surgeons are reluctant to perform this procedure in instances where substantial impairment of continence may result. As a result, several alternative treatments have been pursued which do not involve anal sphincter division. Rectal mucosal advancement flap, lateral intersphincteric fistula transaction (LIFT), and collagen plug have all been described as sphincter sparing fistula treatments with varying degrees of success. Understanding the indications, limitations, and success rates of the various treatment modalities would allow for more effective and efficient treatment of fistula in ano.

Existing Gaps

What Is: There are many treatment options for the treatment of anal fistulas. The goals of fistula resolution and sphincter preservation appear to be at odds given current treatments. Multiple options are available in the management of chronic anal fissures.

What Should Be: Surgeons will understand the appropriate diagnosis indications, success rates, and complications of the treatments available for anal fistulas.

Director: Charles Whitlow, MD, New Orleans, LA
Assistant Director: Jennifer Beaty, MD, Omaha, NE

3:00 pm	Fistulotomy – Does it Still Have a Place? M. Benjamin Hopkins, MD, Raleigh, NC	3:52 pm	LIFT Sean Langenfeld, MD, Omaha, NE
3:13 pm	Setons – How and When Jason Hall, MD, Burlington, MA	4:05 pm	New Innnovations for Fistulas James McCormick, DO, Pittsburgh, PA
3:26 pm	Advancement Flaps – 90% Success! Really?? Rebecca Hoedema, MD, Grand Rapids, MI	4:18 pm	Discussion
3:39 pm	Fistula Plugs and Glue Michael Snyder, MD, Houston, TX	4:30 pm	Adjourn

Objectives: At the conclusion of this session, participants should be able to: a) Define the different treatment modalities available for anal fistula; and b) Develop an algorithm for the management of different types of anal fistula.

Refreshment Break in Foyer

4:30 – 5:00 pm

After Hours Debate

5:00 – 6:15 pm



All surgical specialties have certain topics/diseases that contain controversy. Understanding the optimal treatment plan for patients often depends on a physician's ability to see clarity in these lines of gray. Debates are excellent tools to show differences in perspective and opinion regarding these topics. They effectively challenge and break down surgical dogma and open people to new points of view. They often help audience members crystalize their own values and beliefs. Speakers with passionate views about opposing treatment, with clear guidelines for the debate, can effectively create an effective and novel learning environment. Furthermore, an assertive and experienced moderator can challenge the speakers and engage the audience to both optimize critical thinking and illustrate what treatment plan may be best for different scenarios.

Existing Gaps

What Is: Treatment of chronic anal fissure has evolved to the point that surgery is studiously avoided in favor of different medical regimens. Rectal prolapse surgery in the form of transabdominal rectopexy has become a minimally invasive procedure – including increasing use of the robot.

What Should Be: Treatment of anal fissures should be appropriately balanced between operative and non-operative approaches. Operations with the robot should be justifiable with respect to outcomes and cost.

Moderator: David Schoetz, Jr., MD, Burlington, MA

5:00 pm	Anal Fissure – Is It a Surgical Disease? <i>Debating:</i> Phillip Fleshner, MD, Los Angeles, CA vs Neil Hyman, MD, Chicago, IL	6:15 pm	Adjourn
5:30 pm	Rectal Prolapse in the Robotic Age <i>Debating:</i> Bradley Champagne, MD, Cleveland, OH vs Todd Francone, MD, Burlington, MA		

Objectives: At the conclusion of this session, participants should be able to: a) Develop a sensible approach to the cure of chronic anal fissure; and b) Evaluate the appropriate operative techniques for performance of transabdominal rectopexy.

Residents' Reception

6:30 – 8:00 pm

General Surgery residents will have an opportunity to network and interact with colorectal program directors.

Open to general surgery residents and colorectal program directors only.

Meet the Professor Breakfasts

6:30 – 7:30 am

Limit: 30 per breakfast • Fee \$40 • **Tickets Required** • Continental Breakfast

*Registrants are encouraged to bring problems and questions to this informal discussion.
Please register early and indicate your 1st and 2nd choice on the Registration Form.*



- | | |
|---|---|
| <p>W-1 Complex Fistula
Ann Lowry, MD, St. Paul, MN
Scott Strong, MD, Cleveland, OH</p> <p>W-2 Stage 4 Cancer (What to Do)
Eric Szilagyi, MD, Detroit, MI
Julio Garcia-Aguilar, MD, PhD, New York, NY</p> <p>W-3 Pilonidal Disease: Options and Outcomes
Richard Billingham, MD, Seattle, WA
Eric Johnson, MD, Fort Lewis, WA</p> <p>W-4 Enhanced Recovery Pathways
Craig Reickert MD, Detroit, MI
Conor Delaney, MD, PhD, Cleveland, OH</p> | <p>W-5 Non-Operative Management of Rectal Cancer-
the Right Patient
Rodrigo Perez, MD, PhD, Sao Paulo, Brazil
Philip Paty, MD, New York, NY</p> <p>W-6 Parastomal Hernia and Stoma Complications
W. Brian Perry, MD, San Antonio, TX
Walter Peters, Jr., MD, Columbia, MO</p> |
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Objectives: At the conclusion of this session, participants should be able to: a) Describe the procedures and approaches discussed in this session.

Colon Cancer: Staging, Techniques and the Role of Adjuvant Therapy

7:30 – 9:00 am



The past 50 years has seen substantial progress in our understanding and in the management of colon and rectal cancer (CRC). Surveillance colonoscopy with resection of premalignant polyps has led to a decreased incidence of CRC even though compliance with the recommendations is suboptimal. Epidemiologic and genetic information allow us to identify individuals at risk for cancer and should allow us to prevent the disease in many individuals. Patients diagnosed with advanced CRC live much longer than in the past, and many are cured. This is attributed to many factors, including cross-sectional imaging that properly stages patient and identifies metastases earlier, new surgical approaches and numerous new chemotherapies. Higher resolution imaging modalities have improved the ability to properly stage patients; surgical advances include minimally invasive procedures and laparoscopic-assisted procedures and safer and more extensive lymphatic clearance. Biologic therapies have not yet been maximized, but we are learning when and where some should be used. Soon we expect to be staging patients by biologic and genetic characteristics rather than by gross pathology-treating patients based on biologic features but preferably identifying people at risk and preventing CRC altogether.

Existing Gaps

What Is: Colon cancer surgery is performed by a large number of general and colorectal surgeons in the country. Even in the elective setting a large number of cases are performed through a laparotomy, with incomplete preoperative staging and limited lymphatic clearance. Furthermore the use of adjuvant chemotherapy varies extensively across specialties, practice types and patient populations.

What Should Be: Surgeons should understand proper staging and surgical techniques, indications for adjuvant therapy and the need for a multidisciplinary evaluation and management of colon cancer patients.

Director: Alessandro Fichera, MD, Seattle, WA
Assistant Director: Martin Weiser, MD, New York, NY

7:30 am	Introduction Martin Weiser, MD, New York, NY	8:20 am	Stage II Colon Cancer. Who Needs Adjuvant Chemo and Why? Blase Polite, MD, Chicago, IL
7:35 am	Preoperative Staging. What Does the Surgeon Needs to Know? Lawrence Schwartz, MD, New York, NY	8:35 am	Molecular Classification of Colorectal Cancer: Current Status. David Shibata, MD, Tampa, FL
7:50 am	Going Beyond MIS in Colon Cancer Surgery. Less is More. Peter Marcello, MD, Burlington, MA	8:50 am	Panel Discussion
8:05 am	Total Mesocolic Resection for Colon Cancer. Magic Bullet? Hermann Kessler, MD, PhD, Cleveland, OH	9:00 am	Adjourn

Objectives: At the conclusion of this session, participants should be able to: a) Describe the use of imaging for preoperative staging; b) Identify when to recommend MIS in the management of colon cancer; c) Define basic theories of lymphatic clearance; and d) Recognize new criteria and prognostic factors as indication for adjuvant therapy.

Outcomes

7:30 – 9:00 am



7:30 am	Frailty Predicts Dath, Disability and Institutionalization in Patients Undergoing Elective Colectomy Z. Torgersen, R.A. Forse, D. Mukkai Krishnamurthy*, A. Kallam, S.J. Langenfeld, J. Johanning, Omaha, NE	S35	8:16 am	Discussion	
7:37 am	Discussion		8:19 am	A Model of Cost Reduction and Standardization: Improved Cost Savings While Maintaining the Quality of Care M. Guzman*, K. Umanskiy, Chicago, IL; M. Gitelis, J.G. Linn, M.B. Ujiki, J.P. Muldoon, Evanston, IL	S40
7:39 am	Decreased Narcotic Consumption with the Addition of IV-Acetaminophen in Colorectal Patients: A Prospective, Randomized, Double-Blinded, Placebo-Controlled Study C. Juergens, C. Ogg, W. Sergeant, J. Ying, A.H. Aryaie*, S. Lalezari, T. Husted, C. Ratermann, Cincinnati, OH	S36	8:26 am	Discussion	
7:46 am	Discussion		8:29 am	Failing to Prepare is Preparing to Fail: A Single Blinded Randomized Controlled Trial to Determine the Impact of a Preoperative Instructional Video on Resident's Ability to Perform Laparoscopic Colectomy B. Crawshaw*, C.P. Delaney, W.C. Mustain, A.J. Russ, S. Shanmugan, B.J. Champagne, Cleveland, OH; S.R. Steele, Tacoma, WA; D. Lee, Albany, NY	S41
7:49 am	Patients Prefer Propofol for Conscious Sedation at Colonoscopy When Compared to Midazolam and Fentanyl C. Schroeder*, R. Tocco-Bradley, J. Obeir, C. Kaoutzanis, R.K. Cleary, K. Welch, Ann Arbor, MI	S37	8:36 am	Discussion	
7:56 am	Discussion		8:39 am	Surgical Specialization Increases Lymph Node Yield: Evidence From a National Database A.N. Jeganathan*, S. Shanmugan, J. Bleier, G.M. Hall, E.C. Paulson, Philadelphia, PA	S42
7:59 am	The Temporary Cessation of Clopidogrel and the Risk of Thrombotic or Bleeding Events in Patients Undergoing Colonoscopy P.E. Miller*, M. Bailey, M. Thomas, S. Pawlak, D. Beck, T. Hicks, H. Vargas, C. Whitlow, D. Margolin, New Orleans, LA	S38	8:46 am	Discussion	
8:06 am	Discussion		8:56 am	Q&A	
8:09 am	Extending the Mandate for Extended-Duration Thromboprophylaxis: Risk Factors for Post-Discharge Venothromboembolism in Colorectal Resections J.C. Iannuzzi*, C.T. Aquina, A.S. Rickles, B.J. Hensley, K. Noyes, J. Monson, F. Fleming, Rochester, NY	S39	9:00 am	Adjourn	

*Presenting Author

Challenges and Controversies: Surgical Management of Advanced Disease and Recurrent Cancer

9:00 – 10:30 am



The surgical and medical treatment of early stage colon and rectal cancer is fairly straightforward and a number of guidelines exist (NCCN, American Cancer Society, ASCRS) to help clinicians manage their patients with cancer. However, there are many complex situations that are difficult to manage and strategies for dealing with locally advanced disease, various patterns of distant metastatic disease and recurrent disease are not covered in guidelines. In addition, advances in chemotherapy mean that patients with advanced disease are surviving for longer periods of time and during these extended survival periods, surgeons are not infrequently asked to intervene in ways that in the past may have not been considered even remotely reasonable. In this setting, clinicians face issues that require discussion and direction. The aim of this session will be to offer evidence based guidance to clinicians faced with difficult issues centered on treating advanced and recurrent colon and rectal cancer.

Existing Gaps

What Is: There are many complex situations that are difficult to manage, and strategies for dealing with locally advanced disease, various patterns of distant metastatic disease and recurrent disease are not covered in guidelines. That, with advances in chemotherapy allowing patients to live longer, means surgeons are asked to intervene in ways that in the past may have not been reasonable.

What Should Be: Surgeons should be able to use evidence-based guidance when faced with difficult issues centered on treating advanced and recurrent colon and rectal cancer.

Director: Kirk Ludwig, MD, Milwaukee, WI

Assistant Director: Julio Garcia-Aguilar, MD, PhD, New York, NY

9:00 am	New Chemotherapy Paradigms for Stage 4 Disease: Can the Surgeon Help by Reducing Tumor Burden and Does this Make Sense? Cathy Eng, MD, Houston, TX	9:36 am	Contemporary Management of Carcinomatosis from Colon or Rectal Cancer: What Is Reasonable and Possible? Kiran Turaga, MD, Milwaukee, WI
9:12 am	Epithelial-Mesenchymal Transition and Somatic Alteration in Colorectal Cancer with and without Peritoneal Carcinomatosis Yury Shelygin, MD, Moscow, Russia	9:48 am	Chasing Advanced Lymph Node Disease: When and Why? Alessandro Fichera, MD, Seattle, WA
9:24 am	Managing Liver Metastases: Staged Resection, Combined Resection, or Liver First? Michael D'Angelica, MD, New York, NY	10:00 am	Case Discussion and Questions
		10:30 am	Adjourn

Objectives: At the conclusion of this session, participants should be able to: a) Explain new chemotherapeutic regimens for treating Stage 4 colorectal cancer and the role of the surgeon in treating Stage 4 disease; b) Describe contemporary management of carcinomatosis from colorectal cancer; and c) Explain when and why it might be reasonable to do extended dissections and lymph node dissections for colorectal cancer.

Best Videos

9:00 – 10:30 am



9:00 am	Martius Flap For Rectovaginal Fistulas K. Kniery*, S. Steele, Tacoma, WA	WV1	9:57 am	<i>Discussion</i>	
9:07 am	<i>Discussion</i>		10:00 am	Transanal Minimally Invasive Surgery with Inadvertent Rectal Injury and Repair M. Harfouche*, M. Philp, H.M. Ross, Philadelphia, PA	WV7
9:10 am	Robotic-Assisted Repair of Rectal Prolapse J. Mino*, M. Zutshi, B. Gurland, Cleveland, OH	WV2	10:07 am	<i>Discussion</i>	
9:17 am	<i>Discussion</i>		10:10 am	Laparoscopic Low Anterior Resection, Transanal Total Mesorectal Endoscopic Resection for Low Rectal Cancer M.H. Hanna*, G. Hwang, L. Malellari, A. Pigazzi, Orange, CA	WV8
9:20 am	Transperineal Minimally Invasive Approach in Miles Operation S. Hasegawa*, R. Takahashi, K. Hida, K. Kawada, Y. Sakai, Kyoto, Japan; S. Kato, Y. Kadokawa, Y. Asao, Tenri, Japan	WV3	10:17 am	<i>Discussion</i>	
9:27 am	<i>Discussion</i>		10:20 am	Wide Local Excision of Perianal Paget's Disease with Gluteal Flap Reconstruction G. Melich*, K. Kochar, J. Calata, A. Pai, J. Park, L. Prasad, S. Marecik, Park Ridge, IL	WV9
9:30 am	Laparoscopic Repair of Perineal Hernia S. Brathwaite*, S. Husain, A. Harzman, Columbus, OH	WV4	10:27 am	<i>Discussion</i>	
9:37 am	<i>Discussion</i>		10:30 am	<i>Adjourn</i>	
9:40 am	Full Thickness Excision for Benign Colon Polyps Using Combined Endoscopic Laparoscopic Surgery P.R. O'Mahoney*, J.W. Milsom, J.D. Smith, S.W. Lee, New York, NY	WV5			
9:47 am	<i>Discussion</i>				
9:50 am	Robotic-Assisted Low Anterior Resection with Transanal Extraction: Single Stapling Technique and Fluorescence Evaluation of Bowel Perfusion M.D. Jafari*, J.C. Carmichael, A. Pigazzi, Orange, CA	WV6			

Refreshment Break in Foyer

10:30 – 11:00 am

*Presenting Author

Optimizing Treatment for Rectal Prolapse, Constipation and Obstructed Defecation Syndrome

11:00 am – 12:30 pm



The management of rectal prolapse has been the debate for 100 years since Moschowitz first described its pathogenesis. Since that time, over 100 operations have been described for the correction of prolapse of the rectum. The operative approaches can be roughly divided into abdominal and perineal categories. The evaluation process and decision making with respect to the choice of surgical procedure and specific techniques will be reviewed. The surgical management of constipation requires a thorough understanding of both colonic function and the evacuatory mechanism. The evaluation of patients with these disorders and their surgical treatment options will be presented.

Existing Gaps

What Is: Many surgeons are unfamiliar with all of the new approaches to repair rectal prolapse. They do not have experience with different fixation and minimally invasive techniques available. Surgeons frequently are not familiar with the physiologic testing available for the evaluation of constipation and their significance and impact on surgical decision making.

What Should Be: Surgeons should be comfortable with several fixation techniques to repair prolapse. They should have an understanding of the different repairs available and their utility in treating different patient populations. Surgeons should be familiar with the physiologic evaluation tools available for constipated patients and have a strategy for surgical management.

Director: Dana Sands, MD, Weston, FL

Assistant Director: Virginia Shaffer, MD, Atlanta, GA

11:00 am	Functional Disorders: What Tests are Necessary? Heidi Bahna, MD, Miami, FL	11:45 am	Constipation: Surgical Indications and Outcomes Massarat Zutshi, MD, Cleveland, OH
11:15 am	Rectal Prolapse Abdominal Repairs: Fixation and Resection Techniques Brooke Gurland, MD, Cleveland, OH	Noon	Obstructed Defecation: Is it Surgically Correctable? Liliana Bordeianou, MD, Boston, MA
11:30 am	Rectal Prolapse Perineal Repairs: Still Relevant in the Era of Laparoscopy? Joseph Carmichael, MD, Orange, CA	12:15 pm	Discussion
		12:30 pm	Adjourn

Objectives: At the conclusion of this session, participants should be able to: a) Describe the abdominal approaches and different fixation techniques available for treatment of rectal prolapse; b) Explain the perineal approaches and different resection techniques for the treatment of rectal prolapse; c) Describe the value of laparoscopy in the management of prolapse; d) Identify the tools available to evaluate constipation and evacuatory dysfunction; and e) Plan a treatment algorithm for the management of constipation in different clinical settings.

Neoplasia II

11:00 am – 12:30 pm



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| <p>11:00 am Colorectal Specialization Improves Survival in Colorectal Cancer S44
G.M. Hall, E.C. Paulson*, J. Bleier, A.N. Jeganathan, S. Shanmugan, Philadelphia, PA</p> <p>11:07 am <i>Discussion</i></p> <p>11:11 am Enhanced Recovery Protocols in Colorectal Scheduled Surgery: Could We Do Better By Doing Less? S45
J. Ramirez*, E. Redondo, P. Royo, J. Gracia, B. Calvo, P. Carrera, Zaragoza, Spain</p> <p>11:18 am <i>Discussion</i></p> <p>11:21 am Does CD10 Expression Predict Lymph Node Metastasis in Colorectal Cancer? S46
I. Bernescu*, A. Reichstein, M. Luchtefeld, J. Ogilvie, A. Davis, W. Chopp, Grand Rapids, MI</p> <p>11:28 am <i>Discussion</i></p> <p>11:31 am Robotic Colorectal Surgery: How Honest are the Authors' Conclusions? An Assessment of Reporting and Interpretation of the Primary Outcomes S47
B. Howe, J. Van Koughnett, London, ON, Canada; S.V. Patel, New York, NY; S. Wexner, Weston, FL</p> <p>11:38 am <i>Discussion</i></p> <p>11:41 am Features Associated with Metastases Among Well-Differentiated Neuroendocrine (Carcinoid) Tumors of the Appendix: The Significance of Small Vessel Invasion In Addition to Size S48
D.A. Kleiman*, B.M. Finnerty, T. Beninato, R. Zarnegar, G. Nandakumar, T.J. Fahey, III, S.W. Lee, New York, NY</p> <p>11:48 am <i>Discussion</i></p> | <p>11:51 am Relative Value of Restaging MRI, CT and PET after Preoperative Chemoradiation for Rectal Cancer S49
D. Schneider*, A.C. Lynch, S. Warriar, A.G. Heriot, T. Akhurst, M. Michael, S. Ngan, East Melbourne, VIC, Australia</p> <p>11:58 am <i>Discussion</i></p> <p>12:01 pm Predictors of Outcome for Endoscopic Colorectal Stenting S50
M.A. Abbas*, G. Kharabadze, Abu Dhabi, United Arab Emirates</p> <p>12:08 pm <i>Discussion</i></p> <p>12:11 pm British Traveling Fellow TBD S51</p> <p>12:17 pm <i>Discussion</i></p> <p>12:20 pm Surgical Site Infection Rates Following Implementation of A Colorectal Closure Bundle In Elective Colorectal Surgeries S52
A. Ghuman*, C.J. Brown, A.A. Karimuddin, M.J. Raval, T.P. Phang, Vancouver, British Columbia, Canada</p> <p>12:27 pm <i>Discussion</i></p> <p>12:30 pm Adjourn</p> |
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Lunch on your own

12:30 – 1:30 pm

*Presenting Author

Symposium

Enhanced Perioperative Care Pathways and Postoperative Pain Management

1:30 – 3:00 pm



Enhanced recovery perioperative care principles are widely reported to decrease complications and to improve outcomes such as length of stay and cost. Many protocol examples are reported, and significant protocol differences exist. Unless involved in creating a protocol before now, one will find the current literature and recommendations intimidating, and in some aspects, conflicting. The impact reputedly reported and the importance of implementation of evidence based practices, however, require that we critically consider these principles in our practices.

In this symposium, the basic and controversial elements defined in the enhanced recovery literature, including postoperative pain management, will be discussed. Systematic implementation strategies will be shared, and case examples will be used to critically discuss care elements.

Existing Gaps

What Is: The literature of enhanced recovery abounds with varied examples rather than practice parameters or practical guides.

What Should Be: A systematic guide to implementing enhanced recovery would allow broad adoption of essential evidence based best care elements and would improve outcomes, decrease variability, and lower costs of colorectal surgery.

Director: Julie Thacker, MD, Durham, NC

Assistant Director: David Beck, MD, New Orleans, LA

1:30 pm	Essential Elements TBD	2:15 pm	Critical Review of Published Protocols TBD
1:45 pm	Head of the Table – The Role of the Anesthesiologist in Achieving Success Robert Thiele, MD, Charlottesville, VA	2:30 pm	Details and Outcomes Conor Delaney, MD, PhD, Cleveland, OH
2:00 pm	Multimodality Postoperative Pain Management Eric Haas, MD, Houston, TX	2:45 pm	Debate and Discussion
		3:00 pm	Adjourn

Objectives: At the conclusion of this session, participants should be able to: a) Explain the current evidence of enhanced recovery principles; b) Define for their practices, the elements most essential to implement; c) Define for their health care systems the best implementation strategy; d) Describe available methods to manage postoperative pain; and e) Recognize the outcomes they are most likely to impact with enhanced recovery implementation and how to monitor these outcomes.

Symposium

Is there a Paradigm Shift in the Management of Diverticular Disease?

3:00 – 4:30 pm



The management of diverticular disease has significantly changed in the past 10 years. More patients are managed with antibiotics and drainage for acute complicated diverticulitis, and avoiding emergent trips to the operating room. Even among those who are taken to the operating room, the traditional resection with Hartmann's closure of the rectum is being replaced by washout and drain placement, or even resection with primary anastomosis. Even the use of antibiotics in uncomplicated disease is changing, with data showing no benefit of the treatment to the disease process.

Those who are conservatively managed, undergo washout, or have recurrences will then present for consideration of elective resection. This has created a shift in the outpatient management as more patients present after hospitalization for complex disease. Deciding who will benefit from surgery has become more complex over time.

Existing Gaps

What Is: Who needs an operation, who can be medically managed, and what are the risks of each approach?

What Should Be: A cleared approach to both emergent and elective disease management.

Director: Timothy Geiger, MD, Nashville, TN
Assistant Director: Mukta Krane, MD, Seattle, WA

3:00 pm	Learning from History – The Evolution of the Management of Diverticulitis Patricia Roberts, MD, Burlington, MA	4:00 pm	Right-Sided Disease, Postoperative Recurrences, Diverticular Disease in Younger Patients and Other Unusual Presentations James Yoo, MD, Boston, MA
3:15 pm	Epidemiology and Etiology of Diverticular Disease – More than Nuts and Seeds Cary Aarons, MD, Philadelphia, PA	4:15 pm	Discussion
3:30 pm	Emergent Management of Acute Diverticulitis Scott Strong, MD, Cleveland, OH	4:30 pm	Adjourn
3:45 pm	Elective Management of Diverticular Disease – Who Needs Surgery? David Flum, MD, Seattle, WA		

Objectives: At the conclusion of this session, participants should be able to: a) Recognize the current literature on the etiology of diverticulosis and risks of recurrent disease; b) Distinguish the management of acute diverticulitis both in the hospitalized patient and in the outpatient settings; c) Recognize the current surgical approaches for acute diverticulitis, and the literature supporting each procedure; and d) Assemble a logical approach for management of recurrent disease.

Wednesday, June 3

ASCRS Annual Business Meeting and State of the Society Address

4:30 – 5:30 pm

ASCRS Annual Reception and Dinner Dance

Reception 7:00 – 8:00 pm

Dinner Dance 8:00 – 10:30 pm

Tickets Required